Open Agenda

Health and Social Care Scrutiny Commission

Tuesday 10 November 2020
6.30 pm
Zoom
(Link is available on request)

Membership

Councillor Victoria Olisa (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Sunny Lambe
Councillor Maria Linforth-Hall
Councillor Sandra Rhule
Councillor Charlie Smith
Councillor Bill Williams

Reserves

Councillor Nick Dolezal
Councillor Sunil Chopra
Councillor Renata Hamvas
Councillor Jane Salmon
Councillor Martin Seaton
Councillor Kath Whittam

INFORMATION FOR MEMBERS OF THE PUBLIC

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 2 November 2020

PRINTED ON RECYCLED PAPER

Health and Social Care Scrutiny Commission

Tuesday 10 November 2020
6.30 pm
Zoom

Order of Business

Item No.	Title	Page No.

PART A - OPEN BUSINESS

1. APOLOGIES

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.

Item No.	Title	Page No.
4.	**UPDATE ON CARE HOMES AND IMPACT OF COVID 19**	1 - 35

The item on Care homes will be focusing on two issues:

- How Southwark can work together to protect and treat people in Care Homes with COVID 19,
- Enabling Care Home residents to stay in touch with friends, family and the outside world.

A briefing has been provided by council social care officers and NHS Southwark on how residents will be protected and treated from Covid 19, and work with homes to enable residents to stay in touch with friends and family.

The item on Care homes will be focusing on two issues:

- how Southwark can work together to protect and treat people in Care Homes with COVID 19,

- enabling Care Home residents to stay in touch with friends, family and the outside world.

A briefing and presentation at the meeting has been requested from council socail care officers and NHS Southwark on how residents will be protected and treated from Covid 19 work with homes to enable residents to stay in touch with friends and family.

The following partners have been invited to contribute to this item, subject to confirmation:

- Care Home providers : Anchor Hanover and HC One
- Lewisham and Southwark Age UK and the Lay Inspectors
- Southwark Carers
- Link Age Southwark
- Entelechy Arts

A scrutiny review on Care Home quality assurance, completed July 2020, is enclosed as background information.

Item No.	Title	Page No.

5. COVID 19 INFECTION RATES AND NHS CAPACITY

Jin Lin, Acting Director of Public Health, will attend to outline what the Council is doing on in relation to outbreak prevention control.

6. UPDATE ON THE PROPOSED MERGER BETWEEN ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST AND GUY'S AND ST THOMAS' NHS FOUNDATION TRUST. 36 - 44

Jackie Parrott (Chief Strategy Officer for GSTT and KCH) and Robert Craig (Director of Development and Partnerships, RBHT) will attend the meeting to present the enclosed paper.

7. HEALTH INEQUALITIES 45 - 78

The previous Health & Social Care scrutiny commission undertook a review on the Mental Health of Children and Young People (CYP), which particularly looked at the cross cutting issue of the disproportionate mental ill health amongst Black And Minority Ethnic (BAME) CYP. A letter sent to the cabinet lead summarising that work is enclosed.

A follow up review is proposed focused on addressing the causes of health inequalities amongst BAME CYP.

A report by Baroness Doreen Lawrence on: AN AVOIDABLE CRISIS The disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities is enclosed.

8. WORK PROGRAMME

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

DISTRIBUTION LIST 20/21

Date: 2 November 2020

EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the sub-committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to Information Procedure rules of the Constitution."

Update on Care homes

Protecting and treating people in Care Homes with Covid 19

Enabling Care Home residents to stay in touch with friends and family

Action taken to protect and treat people in Care Homes with Covid-19

Partnership Southwark Recovery Plan
Care Well

- The recovery plan has four cells:
    1. Start Well
    2. Live Well
    3. Age Well
    4. Care Well

- Care Well is responsible for care settings, which includes **Residential and Nursing Care Homes**.
- The Recovery Plan acknowledges work undertaken in response to the first lockdown
- Preparation took place during the summer to enable homes to work in a different way within the context of an on-going pandemic and impending winter.

Partnership Southwark Recovery Plan

Care Well

The care home sector, in particular, has been impacted by COVID-19 due to the early and rapid spread of virus amongst high risk and vulnerable residents and a fragile and pressurised workforce.

To respond to this challenge Southwark's health, care and VCS worked together in a whole system approach through the emergency period.

The recovery plan covers the on-going work with the care homes to plan for and respond to any escalation of covid-19 either nationally, across London, locally or within the care home.

Working Together

Care Well has identified a number of actions and partners to support the care home sector in responding to any individual home with an 'outbreak' or in the event of a second national lockdown.

The proposals here are a combination of local initiatives but within the context of continually evolving and changing guidance from DHSC /NHS(E) and Public Health England. Therefore, any plans or local agreements may be superseded by national policy directives.

The local Public Health team are in direct contact with Care Homes in the event of any Covid-19 positive residents or staff and are advising them as to the actions they should/can take. This may involve a decision to lock the home down – no new admissions, limitations on visitors and a regime of retesting for all residents and staff.

Data Information – Sharing Intelligence and responding to emerging issues:

- There is a requirement that all care homes across the country complete the National Capacity Tracker on a daily basis. In relation to some basic information around business continuity and Covid-19 status.

- This includes data on PPE, positive Covid test results (outbreaks), staff numbers and absence within the homes and the number of empty rooms.

Data Information – Sharing Intelligence and responding to emerging issues:

- There are new questions being added on a regular basis for example
  - a set of questions around visitors to the home
  - and flu vaccinations
- The submitted data is monitored for any trends or concerns. That are then alerted to the relevant leads within the Council (commissioning, adult social care and/or public health) and/or the CCG as appropriate.
- Care Homes are contacted for a direct conversation to confirm the accuracy of the information, to offer support and to ensure due processes are being followed.

The Journey Covid-19 - What Changed and What Next

- We did – **Collaboration and Communications**:
  - Commissioning teams undertook daily (now weekly) touch-points and check-ins, newsletters to provide information and key guidance, and fortnightly provider forums.
  - An integrated approach to supporting older people's homes was put in place through joint working between primary care, GSTT and the Care Homes Intervention Team.
  - Health professionals endeavoured to make sure that individuals were well supplied with medication.
- **We are continuing with:**
  - **Weekly calls and fortnightly forum meetings**
  - **Dedicated GP service for the Older People Care Homes.**
  - **At Home team – community nursing (GSTT) continued to visit and support the care homes**
  - **WhatsApp group between health professional such as geriatricians and scheme managers. This practice was cited by Care Quality Commission as innovative**

The Journey Covid-19 - What Changed and What Next

- We did – **Personal Protective Equipment (PPE)**:
  - The Council acted quickly acquiring PPE, providing the care homes with an email address for any emergencies related to Covid-19 and delivering PPE swiftly.

- **We are continuing with:**
  - **The national portal is in place and care homes have reported using it with positive results.**
  - **Some Southwark Homes have acquired sufficient PPE supply to take them through the winter.**
  - **Daily reports and monitoring through the national capacity tracker shows any home whose supply of PPE is dropping this activates an immediate conversation with the care home to ensure they have arrangements in place for timely delivery of new supplies.**

The Journey Covid-19 - What Changed and What Next

- We did **Infection Prevention and Control (IPC)**:
  - CCG working with the Council offered IPC training to care home staff with all of the Southwark CQC registered homes taking up this offer.
  - Reporting on take up formed part of daily returns.

- **We are continuing with:**
  - **Offering more training led by the lead nurse for IPC in Southwark CCG**
  - **Establishing an 'Infection Control Link Group' to share good practice, identifying emerging problems and offer bespoke training to tackle these.**
  - **CCG reporting on numbers of staff taking up this training in place**

The Journey Covid-19 - What Changed and What Next

- We did **Testing:**
  - Shortly before the national decision to undertake a set of 'one off testing' of residents in care homes the above health professionals with the support of KCH lab took swabs of residents in some of our Older Peoples care homes.
  - The national programme for **'retesting'** has been established in all the Older People Care Homes after some initial problems the regime is now well established.
  - However, it does stretch resources when a positive result comes through and the whole home needs to be 'retested'.
  - Offer of local antibody testing in the early summer some care homes took this offer up and a small percentage of staff were shown to be positive.

- **We are continuing with:**
  - **Public Health Southwark/CCG have a local backup systems in place if the national system falters.**
  - **Care homes have a number of routes to raise concerns locally in the event of the system breaking down.**
  - **Care homes have provided mutual aid to enable residents to move from one home to another.**

New Admissions and Testing for Covid-19

At the beginning:

- At the outset of the pandemic most of Southwark Older People Care Homes took new residents from hospital not knowing if the persons did or didn't have Covid-19 in line with many other care homes across the country.

During the Summer:

- All of the Care Homes for all client groups in Southwark are clear that they will not take an existing resident or a new resident from hospital without them being tested first and receiving the results.

- They all understand the need for a period of isolation. All of the Older People Care Homes have at some point this year received new/returning residents and have experience of isolation, retesting and managing staff and residents tested positive.

- They understand their limitations and will/have declined an admission into the home if they feel unable to accommodate the person safely.

New Admissions and Testing for Covid-19

Current Guidelines:

- **Guidelines issued on 12th October introduced ‘**
  - **designated discharge destinations’ for those being tested positive for Covid-19 in hospital.**
  - **Applies equally to potential ‘new’ residents for care home or those who live in a care home and need to return to their ‘home’.**
  - **Positive Covid-19 patients can only be transferred to a care home that the CQC has inspected and approved as a designated site that meets the IPC standards, supply of PPE and other relevant policies/practices are in place and meet the relevant standards.**

The Journey Covid-19 - What Changed and What Next

- **Other initiative we are doing/continuing with:**

  - **Prevention/Early Warning** – Observational Tools
    - Two nursing care homes are piloting a new approach using a national tool known as RESTORE2 it supports them to be able to talk to the GP and/or emergency services clearly stating what has changed and why they are concerned.
    - Residential care homes who have not previously used Pulse Oximeters which is a medical device that indirectly monitors the oxygen saturation of a patient's blood. QHS have offered to support this with supplying the Pulse Oximeters, training and advice on recording findings.
  - **Flu vaccination**
    - NHS has stated that staff working in care homes are a priority group and can have the flu vaccination for free
    - Care Homes are completing the national capacity tracker providing information on residents and staff who have or have not been vaccinated.
    - Some Care Homes have reported that some care staff have reported difficulties in receiving the free vaccination. The CCG are looking at how to resolve this situation. However, one care home reported that a local pharmacist near them recently made contact to offer their services when they received their next supply.

Enabling Care Home residents to stay in touch with friends and family

Enabling Care Home residents to stay in touch with friends and family

At the beginning:

During the national lockdown care homes stopped family and friends from entering the home and visiting.

- At that time care homes did allow some visitors if the residents were nearing the end of their life and on one occasion when an individual with dementia had fallen.
- In doing this the family members were required to wear PPE, follow infection control protocols and were always escorted to ensure the safety of other residents.
- Homes offered different forms of communications via zoom so they could see each other or simply taking mobile phones to residents to talk to families.
- Some had set up schedules for calls – zoom/traditional telephone calls as staff needed to take iPad/mobiles around to different residents.

Enabling Care Home residents to stay in touch with friends and family

During the Summer:

- The care homes continued with compassionate visits
- They all established garden visits, with protocols in place that involved infection control measures, visits by appointment and clear requirements around social distancing.
- They required visitors to complete a check list to assess level of risk. One home talked about a discussion with a family member who should on return from a high risk country be in isolation so they agreed that the visit could not happen for 14 days.
- For those families/friends who had their own difficult situations or the resident was/is bedbound the offer of virtual visits remained in place
- Homes are planning for winter visits in different ways – some homes had alternative entry points to set up a visiting area, others were putting in log cabins in their gardens or gazebos
- Initial conversations had started around exploring if Southwark care homes could enable families or friends to be recognised as key workers. Responses were mixed highlighting that this could be complicated.

Enabling Care Home residents to stay in touch with friends and family

Current Position:

- Data is being collected on visitation from family and friends on the national capacity tracker
- New guidelines have been issued by Public Health
- Being in Tier Two requires the homes to return to lockdown conditions allowing
  - A default of visits enabled by digital technology
  - Compassionate visits but with limited numbers
- Care Homes are in contact with families and friends via a variety of methods. To varying degrees of success but they continue to adapt and try different approaches. Recently one home had up to twenty family/friends attend a virtual meeting. They asked for more frequent sessions.

Care Home quality assurance scrutiny review

Older people

Health & Adult Social Care Scrutiny Commission

July 2020

Contents

1 Summary of recommendations

Recommendation one

All homes, the Council and CCG ought to have a clear and well publicised Complaints, Quality Alert and Safeguarding processes that detail how to raise concerns with the homes, Council, CCG, CQC, who to go to, and at which point.

This ought to include a mechanism to appeal to the council and NHS CCG if a resident or advocate is unhappy with the outcome of an internal resolution process.

This ought to be managed through the contract monitoring and commissioning process.

Recommendation two

A record and summary of the number of Complaints and Quality Alerts made to the council, CCG and CQC ought to be provided in an annual report to Cabinet, with benchmarking against comparator boroughs.

Recommendation three

Ensure systems are is put in place to ensure that people in homes (in and out of Southwark) who are unbefriended have support by the Independent Lay Advocacy service, or similar.

Recommendation four

Ensure that care homes hold regular meeting for families and carers. These ought to happen at least quarterly, and there ought to be is a schedule of attendance by monitoring officers, commiserate with the number of Southwark residents and contract management resources.

Recommendation five

Commission the Older People's Hub to provide information and advice to prospective older people, friends and family on how to choose a care home.

Recommendation six

The commission endorse the organisational commitment shown by the council and Age UK Lewisham and Southwark to restart the Lay inspectors programme and establish complimentary and strong working relationships. A summary of the Lay Inspectors work ought to be included in an Annual Report on Care Homes.

Recommendation seven

An annual Cabinet report on Care Homes would be useful addition. This ought to summarise contract monitoring, CQC, Lay Inspector, Healthwatch, and CCG

reports, and include a summary of complaints and Quality Alerts, with benchmarking with comparative Local Authorities.

Recommendation eight

Complete the Residential and Nursing Care Charter by September.

Recommendation nine

Expedite the current plans for expansion of provision of Nursing Homes and review future plans to ensure that there will be enough local capacity, particularly for local people with more challenging dementia.

Recommendation ten

Lobby government to bring forward the expected White Paper on social care funding to ensure the service is sufficiently well funded and councils can agree fees with care homes that allows for payment of the London Living Wage, full sick pay and other terms of conditions that reflect the value that we place on this important service.

Recommendation eleven

Ensure the Ethical Home Care Charter includes a requirement for sick pay.

Recommendation twelve

Plans must be put place to manage a second wave of COVID 19 and the risk of further fatalities by ensuring adequate PPE, testing, and that care homes are not treated as a step down facility.

Recommendation thirteen

Roll out keyworker status to family and friends of older people in care homes, starting with people with dementia and moving to other isolated older people, to allow visitation during the pandemic. Everybody has a human right to family life, which includes regular contact[1].

[1] See Article 8 Respect for your private and family life.

2 Introduction

This report sets out to review the quality of care of Southwark providers and out of borough placements used by Southwark adults, to ensure people in both local and out of borough placements are safe, well and in suitable accommodation. The review has a particular focus on examining the assurance and inspection processes in place, to see if they are performing well.

As the review was nearing completion the COVID 19 pandemic struck, which placed care homes residents at particular risk. In order to address this the Commission heard further evidence, and this is included as an addendum.

The report concentrates on provision used by older people, in and out of Southwark. The Commission will take further evidence on provision for working age adults, commonly with a disability or requiring rehabilitation, and provide an additional report, if warranted.

3 Evidence considered

The review considered the following:

- Lay Inspectors work, hearing from volunteer lay inspectors, who deliver the service, Age UK Lewisham and Southwark, who coordinate the service, and Southwark officers, who commission the service
- Council and CCG commissioners quality assurance process
- CQC reports
- Unions
- Healthwatch
- Carers

4 Commissioning of homes for older people needing residential and nursing care

Southwark is well placed to deliver Extra Care to local people but has a shortage of local residential and nursing care provision.

Currently 70% of Southwark people requiring nursing beds are placed out borough. However, officers told the Commission that 80% of people that we place out of borough would prefer to be in Southwark.

	Adult/OP residential		Adult/OP nursing		Extra Care	
	No. schemes	No. SUs	No. schemes	No. SUs	No. schemes	No. SUs
Southwark	5	143	2	89	3	84
Other London	14	32	31	112	0	0
Outside London	39	50	47	56	0	0

4.1 Nursing homes

In 2015, Southwark decided to provide extra nursing homes in the borough. This was because of a combination of insufficient provision and poor performance by local care homes Camberwell Green, Burgess Park and Tower Bridge, who had all received poor CQC reports for a number of years.

Since then Camberwell Green and Burgess Park care homes closed, in 2016 and 2017 respectively.Tower Bridge Care Home has improved, however. The homes current CQC rating is 'Good' and has been rated as either 'Good' or 'Requires Improvement' since November 2015.

Nationally the CQC states that nursing care faces the most significant challenges in relation to financial sustainability and the maintenance of good quality care across the entire health and social care system. These national issues are compounded in Southwark which has seen a 46% reduction in nursing care beds since 2011 (five homes with a loss of 252 beds).This is comparable to several inner north London boroughs– e.g. Tower Hamlets and Islington, although none of our immediate south London neighbours have experienced such a sharp decline.

The reasons cited by providers for this decline are the higher land prices that deter the development in inner London, workforce challenges, a younger population and relatively few self-funders compared to outer London areas. This means that Southwark homes are far more reliant upon state funded placements; where the costs have been tightly managed by the council because of ongoing austerity measures.[2]

In 2017, a cabinet report set out plans to increase nursing provision, stating that by 2020 that there will be a total of 361 nursing home beds available, compared to the 115 beds in the borough currently in use.

In April 2019, cabinet set out plans to deliver this through a negotiated procurement process, with providers either currently operating or planning to operate nursing care homes within the borough.

[2] Cabinet report April 2019

The report outlined separate property deals to provide the physical buildings. Planning permission had been granted for development of a care home that will include 48 nursing beds, on the former site of Burgess Park (Picton Street), and a second nursing home that has outline planning permission for 80 nursing care beds.

The cabinet report stated that the total projected increase of beds was now set to be 260 by 2020, and if the second home comes online this would increase provision to 340 by 2022.

Officers update the Commission on progress since then. The intention is to tender with three bidders to award contracts for high quality care through the negotiated approach. An Engagement Group is coordinating the programme. This consists of council and CCG staff, Healthwatch and Age UK.

Wider engagement has taken place with the community sector, residents, older people in care homes and families. A Co-design group has been established of volunteers and this has conducted interviews with providers. These are now being evaluated. Presently the specification and price is being decided, with a decision pending May 2020.

Two providers are definitely offering to build new homes. Other provision might come from utilising existing buildings. There is a now a commitment to open two new nursing homes by 2022.

Officers advised the Commission that the council would achieve the planed 260 nursing home placements this year by:

- Utilizing Tower Bridge home, of which 122 out of 128 beds are for nursing care

- Queens Oak has 89 rooms of which 44 are for nursing care. Southwark now have access to up to 33 rooms and this will increase next year

- Burgess Park is being redeveloped to have 96 rooms, of which 48 will be for nursing

- Giles Court development on D'Eynsford Road propose 84 rooms of which the council will access at least 60% (50)

Home	**Number of (proposed) rooms**	**Cumulative total**
Tower Bridge	122	122
Queens Oak	44	166
Burgess Park	48	214
Giles Court	(50)	264

The above will help enable more residents to be placed closer locally, which is needed. Officers provided a breakdown of placements of older people placed out of borough, detailing home name, location and CQC rating. This showed that currently there are 169 residents placed outside of Southwark, of these just over a quarter are outside of London. This is long way for families and friends to visit. Residents placed further away from home will also not benefit from the closer monitoring which is undertaken in more local provision by monitoring visits and the Lay Inspector programme, as detailed below.

4.2 Residential care for older adults

The council has termed contracts with four residential care homes, all run by Anchor Hanover. The contract is due to expire in 2025. Anchor Hanover Care residential homes in Southwark are consistently rated Good by the CQC.

5 Monitoring and quality assurance of older peoples residential and nursery care homes in Southwark

The Commission heard that monitoring and quality assurance of care homes is delivered by:

- Contract Management oversight, visits and reports by council officers and CCG NHS and GPs.
- Quality Alerts and complaints
- Family, friends and advocacy
- CQC inspections
- Lay Inspections
- Healthwatch
- Providers Forum
- Strategic and member oversight

5.1 Providers Forum

There is an Adult Social Care Provider Forum in Southwark. The agenda has included topics that support care homes such as:

- Safeguarding representatives for the Southwark's Safeguarding Adults Board
- Council's skills strategy
- CQC regulations
- Recruitment and retention
- Good work standard
- Liberty Protection Safeguards
- Herbert Protocol

5.2 Council and NHS Southwark Clinical Commissioning (CCG) contract management

Council officers told us that visits are done to local homes at least 6 monthly and a risk-based approach is taken. If more visits are needed, because of concerns or other intelligence, then officers visit more frequently. Officers said that they are on a journey with contract management to improve performance.The Commission received 6 months worth of detailed contract management reports.

Social workers visit service users placed out of borough at least once a year and the monitoring team liaise with host authorities who have the majority of placements in these homes.

NHS CCG officers told us that all Southwark care homes are supported by the CCG funded enhanced primary care service, which is provided by Quay Health Solutions, a membership of GP Practices in north Southwark.

The service enables care homes residents to benefit from a wider Multi-Disciplinary Team (MDT) to enable high quality of care for patients within the homes and avoid unnecessary hospital admissions. This includes, but is not limited to: secondary care; the Care Homes Support Team; Community Pharmacists; Social Care; District Nursing; Palliative Care; Dieticians and other services contributing to resident's care.

There are four main elements to the service: i. Multi-disciplinary Team (MDT) ii.General Practice services iii. Scheduled visits by provider iv. Medication Reviews.

The MDT has had closer working during the pandemic and the services are working towards a 'one team approach' that will further integrate the MDT offer to care homes.

The service is monitored at least quarterly and during the COVID pandemic the CCG have been in frequent contact with the services.

Carers and Lay Inspectors told us council contract and CCG management is crucial to managing performance, particularly as the CQC only visit occasionally. Visits to homes are vital and monitoring cannot just be a desktop exercise.

5.3 Quality alerts and Complaints

Officers told us council Quality Alerts system is in place, which monitors any quality concerns in provider services and can act as an early warning system indicating the need for further monitoring of providers.

Officers also told the Commission that a council complaints system is in place that enables accurate capturing and tracking of complaints received by the team, and includes fortnightly meetings with the Complaints Team. Officers said the council investigates all complaints at all stages when received.

The council also have a separate complaints procedure for Adults Social Care.[3] NHS CCG officers told us that the CCG's website provides details on how to complain about NHS services[4].

Council officers reported Southwark receives less complaints than other boroughs in more affluent areas. This could be because these Local Authorities have more self-funders and so there could be more confidence and a greater sense of entitlement.

The Commission considered a scrutiny report that was produced in response to Francis Report on the Mid Staffordshire NHS Foundation Trust Public Inquiry. This examined the Frances Report's recommendations on the importance of information sharing across organisations, with a formal and informal role in monitoring standards in hospitals and care homes, and the use of complaints information to monitor standards.

The Commission requested a benchmarking exercise with a comparative borough to compare levels of complaints and Quality Alerts, and a summary of complaints, however this was not forthcoming.

Officers explained that the Council is not responsible for complaints from residents who pay privately (fully funded). In that case the CQC is responsible for complaints. The council used to be funded to monitor homes, now this is the CQC. Officers said the CQC are well placed to provide a summary of complaints and benchmarking. The Commission will ask for this when reviewing adult social care.

A carer of a service user told us she raised concerns about a care home a relative was in, and these were at least in part treated as a Quality Alert by the council. One concern she raised was about the GP service, which is monitored by the NHS CCG, not the council. The Commission do not know if the CCG NHS were involved in any part of the investigation.

Her complaints were investigated by the care home internally. When she was dissatisfied with the initial investigation, and she persisted, the complaints were then escalated to the regional care home, where there was a better outcome. She reported she found it difficult to get adequate resolution, even as a very involved family member.

She made a number of recommendations to the commission:

- Care homes need a clearer complaints systems,
- Relatives ought to be given independent access to council officers to raise concerns (rather than this being funnelled via the care home manager),
- A dedicated line to raise safeguarding concerns / abuse ought to be provided.

[3] https://www.southwark.gov.uk/social-care-and-support/adult-social-care/adult-social-care-complaints-and-compliments/complaints-about-adult-social-care
[4] http://www.selondonccg.nhs.uk/contact-us/how-to-make-complaints/

Improving the complaints process and uptake could be addressed through the CCG NHS nursing contract, the commissioning of the GP service by NHS CCG and via the council commissioning and monitoring process.

Recommendation one

All homes, the Council and CCG ought to have a clear and well publicised Complaints, Quality Alert and Safeguarding processes that details how to raise concerns with the homes, Council, CCG, CQC, and who to go to, and at which point. This ought to include a mechanism to appeal to the council and NHS CCG if a resident or advocate is unhappy with the outcome of an internal resolution process. This ought to be managed through the contract monitoring and commissioning process.

Recommendation two

A record and summary of the number of Complaints and Quality Alerts made to the council, CCG and CQC ought to be provided in an annual report to Cabinet, with benchmarking against comparator boroughs.

5.4 Family, friends and advocacy

A carer told us that developing and maintaining good relationships with carers, family and friends is crucial to the good care of residents.

Her perception was that the care home her relative was placed in did not particularly welcome her close monitoring of her husbands care. She also found it difficult to get adequate resolution of concerns and even as a very involved family member.

She told the Commission that homes ought to be asked if residents without family advocacy are having regular visits from the Independent Lay Advocacy Service. Relatives meetings are very important and ought to happen regularly, and at least quarterly with notice in advance .

Lay Inspectors told us when they visit they ask if there are times set aside for relatives and carers to visit and speak meet and speak with care home staff.

Healthwatch told us monitoring officers ought to attend some relative meetings.

Officers told us the Older People's Hub could give more information to prospective older people, friends and family on how to choose a care home. For example, encouraging people to visit prospective care homes, and looking out for how welcoming a home is.

Recommendation three

Ensure systems are is put in place to ensure that people in homes (in and out of Southwark) who are unbefriended have support by the Independent Lay Advocacy service, or similar.

Recommendation four

Ensure that care homes hold regular meeting for families and carers. These ought to happen at least quarterly, and there ought to be is a schedule of attendance by monitoring officers, commiserate with the number of Southwark residents and contract management resources.

Recommendation five

Commission the Older People's Hub to provide information and advice to prospective older people and friends and family on how to choose a care home.

5.5 CQC

Officers told us the CQC visit homes regularly depending on risk. A home rated Good will usually be visited no more than once every three years. The council will send intelligence to the CQC, although that may not necessarily trigger a visit.

Lay Inspectors can also contact the CQC; however it is unclear if this happens.

Previous nursing homes that were rated as inadequate /in special measures for a number of years by the CQC have closed down.

Carers and Healthwatch told that even homes rated as Good may not always have comprehensive activity programme in place that enable all residents to go out for walks , for example.

5.6 Healthwatch

Healthwatch have 'enter and view' powers and do occasional visits to care homes. A report detailing a visit to Tower Bridge care home was shared with scrutiny.

5.7 Lay inspectors

The Lay Inspectors is a scheme using volunteer older people to visit local care homes in Southwark. The scheme was initiated by older people from Southwark Pensioners Forum and council officers in partnership with Age Concern (who later merged with another organisation to become Age UK) around 2006. It was an initiative of the then Older People Partnership Board.

Age UK Lewisham and Southwark are now commissioned to coordinate the scheme. When fully functional the Lay Inspectors undertake at least one visit per year (3 in one) but would repeat if there were concerns. Six homes are regularly visited are by

a team of two to three older people. The homes visited are those most used by older people in the borough and include the commissioned Anchor Hanover care homes and the nursing homes with most Southwark residents**.**

The volunteer Lay Inspectors told the Commission that the scheme has evolved over the 14 years it has been in place. When visiting it is important the right questions are asked and that the Lay Inspectors know what good quality looks like, for example the ability to de-escalate conflict and calm things down. Good quality questions are vital and the ones used on the form supplied to the Commission have developed over time. Dementia and Safeguarding training is required for peer Lay Inspectors.

The former Lay Inspector coordinator told us she retired in the summer of 2019, however she had not been replaced by Age UK Lewisham and Southwark. In December 2019 the Lay Inspectors told the Commission that the absence of a coordinator meant the volunteers in place were not able to sustain the number of visits, which previously would sometimes be as many as 10 over a period of 4 or 5 months. At that point there was one inspection in the pipeline and they were finishing off one more. The Lay Inspectors clearly valued the scheme and were concerned about the continuity of the Lay Inspector scheme and organisational commitment to its continuation.

The Commission heard that there had been a hiatus in the funding, as well as staff changes at an operational and senior level at both Age UK Lewisham and Southwark and the Council, which risked a loss of organisational memory, knowledge and relationships. The Lay Inspectors said the quality of the relationship with the council's commissioning team is crucial to the schemes success.

Senior officers and the Age UK Southwark and Lewisham CEO told us that the Council reviewed the Lay Inspector project in 2009, while it was still a pilot, and found mixed performance against the key objectives. The Council and Age UK Lewisham and Southwark conducted a mini review in February 2020, in the midst of the review, in order to strengthen the Lay Inspectors programme with a view to restarting the scheme and resuming the funding.

This review established that the scheme would benefit from complementary and stronger working relationships between contract management and the Age UK Lewisham and Southwark, which need to be re-established following changes at various levels. New senior staff are now in place in the council and Age UK Lewisham and Southwark.

There is a joint commitment to restart the work using the existing Lay Inspectors and train more in due course. The new Lay Inspectors scheme will focus on seeking the views of service users, family and staff to obtain feedback, rather than formal inspections. The Council and Age UK Lewisham and Southwark also plan to start another initiative 'Care at Home' where older volunteers would ring people receiving care at home.

The Commission heard that the volunteer Lay Inspector welcomed the restarting of the scheme and the complimentary approach to the formal monitoring by commissioners.

Recommendation six

The commission endorse the organisational commitment shown by the council and Age UK Lewisham and Southwark to restart the Lay inspectors programme and establish complimentary and strong working relationships. A summary of the Lay Inspectors work ought to be included in an Annual Report on Care Homes.

5.8 Strategic and member oversight

Officers told us there is a commitment to establish a Residential and Nursing Care Charter, which officers originally said they intended to take to Cabinet in the spring of 2020. This charter will focus on supporting homes to focus on the drivers related to delivering high quality care.

Improving the quality of care homes is a priority of Partnership Southwark

Presently cabinet receive an Annual report on Home Care; an additional one on Care Homes could be a useful addition.

Recommendation seven

An annual Cabinet report on Care Homes would be useful addition. This ought to summarise contract monitoring, CQC, Lay Inspector, Healthwatch, and CCG reports, and include a summary of complaints and Quality Alerts, with benchmarking with comparative Local Authorities.

Recommendation eight

Complete the Residential and Nursing Care Charter.

6 Conclusions

There are comprehensive and committed local monitoring plans in place for residential and nursing home provision for older people based in Southwark, and the welcome restarting of the Lay Inspectors scheme.

Even with good monitoring in place quality remains a challenge given the resource challenges, and Southwark ought to investigate avenues to increase this and tackle the staffing challenges. Activities are not always comprehensive enough even in homes rated Good; staffing can be spread too thinly and disrepair can be an issue, even in Good homes.

There is not enough local capacity if older people get more unwell, and need more specialized dementia and nursing care. Most people want to be placed in local homes. The Nursing home strategy for frail older people will make a significant

difference, however the plans in the cabinet report in April 2019 ought to be reviewed to ensure that Southwark will have still have enough capacity and can deliver the target number of additional homes placements locally.

Nursing homes provision plans are thoughtful and engaging, however more haste is needed to expedite the provision. The council first identified the need for more nursing homes in 2015, however the full quota are now not due to be ready for residents until 2022.

A more detailed programmed ought to be put in place to monitor and support people placed out in out of borough placements, as these older people are far more isolated from the local connections and monitoring that benefit people in local placements.

Recommendation nine

Expedite the current plans for expansion of provision of Nursing Homes and review future plans to ensure that there will be enough local capacity, particularly for local people with more challenging dementia.

Recommendation ten

Lobby government to bring forward the expected White Paper on social care funding to ensure the service is sufficiently well funded and councils can agree fees with care homes that allows for payment of the London Living Wage, full sick pay and other terms of conditions that reflect the value that we place on this important service.

Addendum: COVID 19

Following the outbreak of the pandemic the Overview and Scrutiny Committee (OSC) received a report on the council response to COVID 19. OSC made a number of recommendations on Care Homes that cabinet accepted, these were:

- take proactive steps to co-ordinate weekly testing of all care staff and residents in Southwark care homes as a matter of urgency, in order to ascertain the level of Covid-19 infection.
- liaise with each Southwark care home provider to ensure that the relevant PPE and levels of PPE are being used in each local care home, to protect care staff as much as possible.
- monitor the pay of care staff at this time, to ensure that none of these low paid workers are being disadvantaged at this time, especially if they have to self-isolate themselves or shield themselves due to their medical conditions, as there is some evidence in the care industry, that some care workers are receiving less than their usual OSP during this crisis.
- remind all care providers to adhere to the key principles of the Ethical Care Charter that exists across the borough, especially at this difficult time.

The Commission also heard directly from council officers and the CCG who told us that visitation by families and friends to residents in care homes is being facilitated through video calls, social distancing and on occasions PPE.

PPE provision for staff has been challenging, but requirements are being met through local collaboration. Testing for homes is being rolled out, prioritised by need. Central government assumed homes could house patients leaving hospital, however residential and nursing homes are not there for this purpose.

As of 15 July 2020, 60 residents of Southwark care homes had sadly lost their lives to COVID 19. The number of residents are as follows:

Care Homes	Type of care home	Number
Greenhive House	OP residential	6
Queens Oak Care Home	OP nursing	12
Rose Court	OP residential	7
Tower Bridge Care Centre	OP nursing	34
Waterside	OP residential	1
		Total: 60

The Older Peoples Hub is assisting with advice for people shielding and hospital discharge, and will be fully open by the beginning of July.

Unison told us that at the start of the pandemic there was not always sufficient PPE for staff to work safely, however the situation has improved. The national PPE guidelines kept changing and manager's guidance to frontline workers not always clear. Unison voiced concerns that changes to PPE guidance had been driven by availability, rather than clinical need.

Sick pay is important to look after staff and prevent infection. Testing and contact tracing is key to managing the pandemic. Local staff and homes are now accessing testing.

The Commission considered research and the campaigns being undertaken by national organisations [5]* for older people, who have said that here has been a 52% increase in deaths amongst people with dementia during lockdown outside of the coronavirus figures – showing starkly that the restrictions put in place have taken a grave toll, alongside that of the virus. The government ought to grant designated family carer access to care homes, in line with that afforded to 'Key Workers' – the care home staff. That means access to testing and PPE.

[5] Dementia UK, John's Campaign, Innovations in Dementia, TIDE (Together in Dementia Everyday), Young Dementia UK, Alzheimer's Society and Alzheimer's Research UK letter dated 9 July 2020 to the Secretary of State

Recommendation eleven

Ensure the Ethical Home Care Charter includes a requirement for sick pay.

Recommendation twelve

Plans must be put place to manage a second wave and the risk of further fatalities by ensuring adequate PPE, testing, and that care homes are not treated as a step down facility.

Recommendation thirteen

Roll out keyworker status to family and friends of older people in care homes, starting with people with dementia and moving to other isolated older people. Everybody has a human right to family life, which includes regular contact[6].

[6] See Article 8 Respect for your private and family life.

Agenda Item 6

Royal Brompton & Harefield NHS Foundation Trust

Guy's and St Thomas' NHS Foundation Trust

Update on the proposed merger between Royal Brompton & Harefield NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust

Autumn 2020

1. Purpose

1.1 The purpose of this report is to provide a progress update on merger proposals being developed by Royal Brompton & Harefield NHS Foundation Trust (RBHT) and Guy's and St Thomas' NHS Foundation Trust (GSTT).

2. Introduction and context

2.1 RBHT is the largest specialist heart and lung centre in the UK providing services to adults and children from across the country, Europe and the world.

2.2 GSTT is one of the largest providers of specialised services in the UK. It provides a full range of hospital and community services for people in Lambeth, Southwark and Lewisham; and is a tertiary centre for cancer, renal, orthopaedic, paediatrics and cardiovascular, and many other specialist services.

2.3 GSTT is a partner in King's Health Partners (KHP), an academic health sciences centre for London that includes King's College London, King's College Hospital, and South London and Maudsley NHS Foundation Trusts.

2.4 KHP partnered with RBHT to develop proposals for a world-leading centre of clinical-academic excellence in cardiovascular and respiratory care, which they submitted in a joint response to NHS England's 2017 public consultation on proposals for future commissioning of congenital heart disease services. NHS England agreed to allow the Partnership sufficient time to develop detailed proposals for the future of these services. That work continues.[1]

2.5 In January 2020 after substantial work by the partners, the Board of NHS England (NHSE) indicated its support for the proposed direction of travel on proposed approaches on cardiovascular and respiratory services in London[2], which included:

- Support for North West London (NWL) finalising its clinical strategy and business cases to provide fit for purpose facilities at St Mary's, Hammersmith and Charing Cross;
- Developing proposals to move congenital heart disease (CHD) services from Sydney Street to Westminster Bridge, and achieve compliance with paediatric CHD service standards after estate developments at Evelina London; and
- Proposals to secure a sustainable future for RBHT and continued delivery of world-class care by merging RBHT and GSTT.

2.6 In March 2020 the Boards of RBHT and GSTT set out a non-binding, mutual agreement to pursue a merger of the two organisations. After presenting options to the boards of RBHT and GSTT in July 2020, a merger through acquisition was agreed to be the best organisational route to provide a strong, sustainable and resilient platform from clinical and governance perspectives.

[1] An update on this work is provided at Annex 2

[2] NHS England and NHS Improvement Board Meetings in Common – Minutes from the meeting 30 January 2020

2.7 Subject to receiving the necessary approvals from our Boards, councils of governors and regulators, and input from local stakeholders, we plan to be ready to merge our Trusts on 1 February 2021.

2.8 The merger would not directly affect the range of services available or the manner in which those services are provided to patients. The Trusts' public involvement and consultation duty[3] is therefore not triggered, however the Trusts fully intend to engage with stakeholders and governors throughout the process.

2.9 In December 2020, the boards and governors of both Trusts are expected to consider a motion to execute the merger transaction. In advance of that decision, the Trusts are required under the Transfer of Undertakings (Protection of Employment) Regulations (2006) (TUPE) to inform and consult affected staff in good time before the transfer happens. Formal staff consultation started on 01 October 2020 and will run for eight weeks.

2.10 The primary reason for pursuing this merger is our strong commitment to enhancing the healthcare we provide to our patients. The ambition of the merged organisation is to maintain and strengthen links with academic partners, to create the facilities, organisation and culture in which academic clinical services can flourish, and maximise our existing research strengths across basic science, clinical research and translation of new innovations and treatments. Our view of near, medium and longer term benefits is set out at Annex 1.

3. Impacts of the merger on management and operational capacity of GSTT

3.1 Organisational mergers of any size require effort and have the potential to cause disruption. Our planning and considerations at every step of the project have taken account of the risks. We have focussed on the need for stability and continuity, selecting courses of action that minimise or remove the risk of disruption to patients and staff, and minimise impact on management and operational capacity.

3.2 The organisations are confident the proposed form of the merger limits the potential for disruption of any kind. Management structures, terms and conditions, clinical teams, clinical services and service locations would remain the same. It keeps together the long-established, highly-valued, RBHT multi-disciplinary teams that provide paediatric cardiac and respiratory care. This mitigates the potential for losing highly-trained members of our teams, which in turn provides continuity of care assurance to patients with conditions at the most complex end of the care spectrum.

3.3 Planning for a corporate merger is administratively complex. Corporate actions required include the agreement of contracts with commissioners, preparation of mid-year accounts followed by full year accounts for the merged Trust, and staff consultation. The

[3] S242 NHS Act 2006 (as amended)

merger has a dedicated programme management office (PMO) to provide the required capacity and co-ordination.

3.5 Management capacity in winter can be an issue for trusts considering mergers and transaction dates are sometimes brought forward or delayed to account for this. This year we have added challenges of Covid-19. We consider the merger has relatively low exposure to these capacity risks. We will keep timing under review.

3.6 Both boards recognise that our past and future successes depend upon our staff, and our ability to attract and retain talented people. We will engage extensively with staff as we develop plans. Staff will be deeply involved in co-creating approaches to integrate working practices and clinical services that are identified post-merger.

3.3 We have designed a phased approach to discovery and integration. Day 1 would include:

- Very limited management and reporting, financial and employment change, to ensure continuity and stability for RBHT employees and services;
- RBHT transferring into GSTT in its entirety as a Strategic Business Unit (RB&H SBU) reporting to the GSTT board;
- A revised GSTT Board and GSTT membership, along with other slightly modified governance structures and procedures; and
- Plans initiated to revise GSTT Council of Governors (CoG) with elections to be completed.

3.7 The first 12 months would focus on the further development of working relationships, sharing best practice, and supporting staff across all sites through this change. After 6-12 months, strategic reviews would focus on further alignment and the development and co-creation of plans to deliver the very best environment for staff and patients.

3.9 To support staff through this period of change, an organisational development plan has been produced jointly by HR colleagues from both existing Trusts. The plan includes:

- Regular communications, briefings and sessions to keep staff informed of progress and to enable relationship building and sharing practices;
- Supporting a high level of delegation to the RB&H SBU; recognising the successful and mature organisation and now business unit with a workforce that identifies strongly with the RB&H brand**;**
- Coaching and mentoring support to enable RB&H SBU staff to understand and navigate GSTT and its systems; and
- A framework to enable teams to align in an organisationally healthy way.

3.10 The extent and pace of health service transformation has accelerated due to the impact of the Covid-19 pandemic. It makes sense for staff to undergo the transition and the new merged organisation to be ready to play its part in the restoration of services impacted by Covid-19 pandemic.

3.11 RBHT and GSTT have made significant contributions to the treatment of patients infected with Covid-19, and have collaborated well together. The depth of collaboration

has been supported by the understanding that we are a partnership and that we are progressing towards formal merger.

4. The merger transaction

4.1 The Boards of RBHT and GSTT considered a number of organisational forms for closer joint working including making no changes, joining management and executive teams, a joint venture, and a formal merger. On balance they found a merger to be the most beneficial course of action. Further consideration led to the clear conclusion that a corporate acquisition (under section 56A of the NHS Act 2006) presents the best opportunity to deliver the merger of the two organisations quickly with no disruption to service, and much-needed, immediate certainty for RBHT staff.

4.2 NHSEI has a statutory role to approve mergers and acquisitions, ensuring transactions follow its processes and meet legal requirements. NHSEI has reviewed the strategic case and, understanding that work to develop proposals for changes to services provided by the Trusts is separate and will all be subject to appropriate statutory patient involvement and public consultation, has classified the merger as a 'material' transaction. As such the transaction will be self-certified at Trust Board level against a range of considerations stipulated by the regulator.[4]

4.3 Formal due diligence was commissioned and is being considered by the Transaction Group and both Trust Boards. We aim to be ready to safely execute the corporate transaction on 1 February 2021. A more protracted timescale risks a longer period of uncertainty for our staff, patients and system partners.

[4] Transactions may be classed as 'material' or 'significant'. 'Significant' transactions require detailed review by the regulator.

Annex 1

1. Benefits of change

1.1 The near-term (0-2 years) benefits include:

Patient benefits:

- Combining the strengths in Extra Corporeal Membrane Oxygenation (ECMO) therapy of both Royal Brompton Hospital and St Thomas' Hospital to create a unique network of expertise for both severe acute respiratory failure and cardiogenic shock with world class outcomes.
- Delivering capacity and providing equity of access and outcomes to our patients by making more flexible use of the merged trust's estate and resource.
- Improving equity of access for patients by making an active contribution to two adult cardiac Operational Delivery Networks (ODN), and London Region NHS restoration plans.
- Standardising treatment for patients by accelerating the move to a single-service, two-site model for congenital heart disease, subject to NHS England consultation, including across our current CHD networks.

Greater sustainability and resilience:

- Working together on separation of Covid-19 positive and negative sites to maximise elective activity at Harefield and Guy's hospitals, and the Evelina London for children.
- Jointly planning and implementing a number of innovations, e.g. electronic healthcare record across the 4 hospital sites, transformation of ambulatory and out-patient models.

1.2 Medium term (2-6 years) benefits include:

Patient benefits:

- All children's services being provided within the expanded Evelina London Children's Hospital, subject to appropriate consultation and business case approvals. This means care will be provided in a purpose-built, age-appropriate setting, with comprehensive on-site access to paediatric specialists for patients with complex care needs and comorbidities.
- Minimising unwarranted variation in care delivery by achieving single-service, multi-site care models for adults and children in a faster and with greater flexibility in resource and estate than would be possible without the merger.

Greater sustainability and resilience:

- Providing greater resilience, stability and flexibility across our workforce, bringing benefits in areas where there are skills shortages and hard-to-recruit roles, as well as improving staff development opportunities.

- Improved academic-research opportunities, streamlined governance and data sharing, and a substantially improved combined ability to deliver breadth and excellence in clinical research (measured by NIHR metrics).
- Quality and efficiency benefits derived from the implementation of an integrated leading-edge electronic healthcare record system.

1.3 Longer-term (6-10 years) benefits (subject to necessary business case approvals and consultations) would include:

Patient benefits:

- Consolidation of sub-specialties, improving patient outcomes.
- Critical mass and a centre of expertise for rare and complex conditions.
- Co-location of age-appropriate environments for young people adjacent to adult services on the same campus. This will promote continuity of care and ease transition into adult services.

Greater sustainability and resilience:

- New world-class, high-specification facilities at Westminster Bridge, providing an excellent environment in which to be treated, recover, work and learn. This is part of a longer term estates programme, supported by an improved financial position across the merged Trust.

2. Academic relationships / R&D

2.4 The merger between GSTT and RBHT is an important step towards achieving our Partnership ambition of creating a new world-class academic health system for people of all ages with heart, vascular and lung diseases, working from prevention through to specialist treatment.

2.5 The two Trusts have strong track records of supporting academics and clinicians to work together to solve clinical problems.

2.6 Both GSTT and RBHT have multiple successful working relationships with numerous local and national partners across the health and life science ecosystem. When RBHT and GSTT merge, there is an opportunity to strengthen these relationships although initially, the day-to-day relationship management arrangements will not alter.

2.7 King's College London (KCL) is the main university partner of GSTT, and Imperial College London (ICL) is the main academic partner of RBHT. We believe the new specialist centre can continue to develop academic links with both (and other) leading universities.

Annex 2

The RBH-KHP partnership's vision for the future of children and adult cardiovascular and respiratory care

1. Since late 2016 RBHT has been working with GSTT and the other organisations in the King's Health Partners (KHP) Academic Health Sciences Network to explore how they can bring together their clinical services, education and research in the areas of cardiovascular and respiratory healthcare.

2. The partners identified a rare opportunity to transform heart and lung disease prevention, treatment and research in London, the UK, and internationally. In July 2017 RBHT and KHP set out their ambition for joint working in this area, in response to NHS England's consultation on future commissioning arrangements for congenital heart disease (CHD) services. The submission explained how the partners would work together to meet the new paediatric CHD service standards, and how CHD services could be an integral part of a wider cardiovascular and respiratory partnership (RBH-KHP Partnership).

3. The partners set out a vision to transform the care of patients with cardiovascular and respiratory health conditions by creating a new academic health system that would touch the lives of up to 15 million people in London and the south of England.

4. Since then, the RBH-KHP Partnership has been working on plans to deliver this vision. This has included the publication of a feasibility study in 2018 and submissions to NHS England and Improvement to support their commissioning decision-making processes. Detailed work on proposals followed during 2019 when the cost, including capital developments, of pursuing the vision were reviewed. Clinicians and patients were involved in developing proposals. On an operational level, the partners have been taking practical steps to establish closer working practices since late 2018.

5. The Partnership's goal is to deliver the best cardiovascular and respiratory outcomes for patients, wherever they receive care, improving the health and wellbeing of the population throughout their lifetime.

6. Demographic change and technological developments mean that healthcare is evolving rapidly. The growing burden of respiratory and cardiovascular disease represents one of the most significant health challenges in the UK today. Respiratory and cardiovascular health outcomes in the UK lag behind those in Europe:

- UK deaths from childhood asthma are the third highest in OECD[5] nations[6]
- Compared to other European nations, almost double[7] the proportion of deaths are attributed to respiratory diseases in the UK.

[5] Organisation for Economic Co-operation and Development
[6] Nuffield Trust. June 2017
[7] 13.4% in the UK, as compared to an average of 7.7% in the EU-28

- The UK has one of the lowest implant rates for cardioverter-defibrillators (ICDs) and pacemakers in Western Europe because many people are not diagnosed or treated.[8]

7. As more people live longer, a greater proportion have complex needs, often living with several chronic health conditions. This is changing the relationship they have with the health system. More patients are exercising greater choice over how and where their care is delivered, wanting to access services locally and to have their care managed at home. This is expected to grow over time, driven both by personalised medicine and widespread use of digital services and technology.

8. The RBH-KHP Partnership provides the opportunity to meet the challenges of the next decade. There are four parts to this opportunity:

- Clinical opportunity - The Partnership can address the high burden of cardiovascular and respiratory disease, and achieve the best outcomes for patients by using new treatments, leveraging scale, and collaborating between the Partnership organisations.
- Academic opportunity - To pursue world-leading translational research that supports lifelong care, and to recruit, retain and educate the best clinicians and scientists.
- Operational opportunity - To more effectively tackle capacity challenges, increase sustainability, and enhance education and training.
- Financial opportunity - To deliver scale benefits and enhanced efficiency, unlock the value of our estate, and develop new models for sustainable funding.

9. The key features of our vision are:

- Consolidating and integrating specialist clinical care - greater scale will mean we will be able to dedicate more resources to sub-specialities and rarer conditions, giving more people access to newer treatments and clinical trials.
- Delivering cutting-edge research, from basic science to implementation - we want to be a UK and world leader in cardiovascular and respiratory research using our scale and expertise to drive innovation to the benefit of people across the UK.
- Attracting and training a world-leading clinical academic workforce - the vision presents significant opportunities to attract the best talent across all disciplines and train and develop the world-class clinicians and scientists of the future.
- Collaborating across networks and partnerships - strong relationships at speciality, pathway, regional and national levels.
- Cutting-edge technology, digital and innovation - access to advances in digital, data, and technology will play a crucial role in delivering our aims.
- New organisational approaches - by combining expertise and collaborating we will be more successful in solving the challenges facing healthcare.
- Delivering for all - improving care services for the 15 million people who live in the area we serve.

[8] NICOR: Cardiac Rhythm Management Devices 2015-16

Councillor Victoria Olisa
Chair, Health and Social Care Scrutiny Commission

Councillor Jasmine Ali Cabinet Member for Children, Schools and Adult Care

15 September 2020

Dear Councillor Jasmine Ali,

The 2019/20 Heath & Social Care Scrutiny Commission undertook a review into the delivery of mental health services for children & young people, however the impact of the pandemic on Commission time led to a more limited review. The Commission, therefore, resolved to write to you with our initial findings, rather than issue a formal report.

The Commission set out to look at how the council and partners were setting about meeting the ambitious 100% access target, as well as addressing two cross cutting issues: BAME access to mental health services and boys' & men's mental health. These were chosen as the Commission were aware of evidence of unequal access and poorer outcomes for BAME communities and concerns about higher suicide rates amongst men.

Commission heard evidence from officers, NHS colleagues, Healthwatch and Black Thrive, which was set up through community organising in Lambeth to particularly address the systemic causes of mental health, and shift away from a focus solely on treatment of symptoms.

The Commission's initial findings confirmed concerns that young black people are more at risk of poorer mental health but frequently receive worst services.

Black young people and mental health: findings

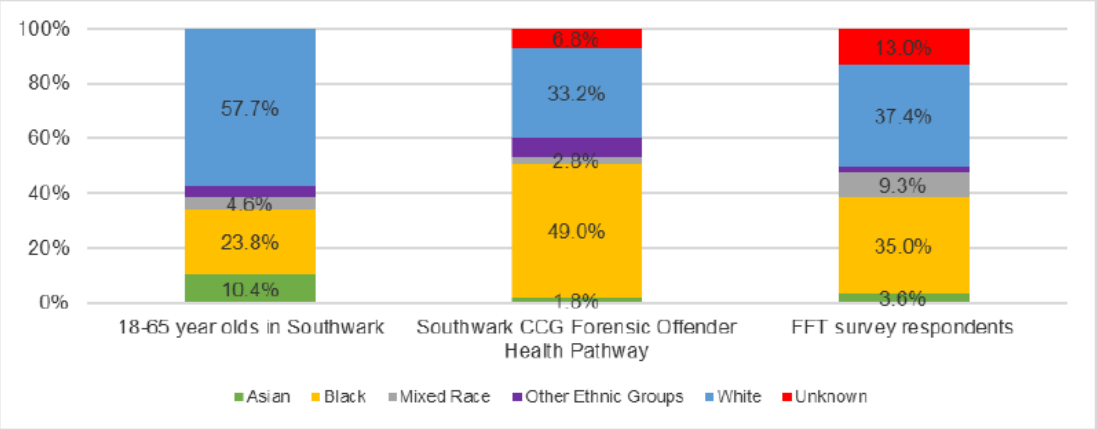
- **Black and minority ethnic communities are at comparatively higher risk of mental ill health because of the wider socio- economic detriments associated with mental ill health, including deprivation and racism.**

  Nationally 1 in 10 children and young people are estimated to have a clinically diagnosed mental health disorder. Almost one in five adults in Southwark are experiencing a common mental disorder, equating to approximately 47,000 individuals. The prevalence of severe mental illness in Southwark is 1.4% (approximately 3,800 patients) and severe mental illness disproportionately affects male, older and black ethnic population groups.

- **Black and minority ethnic communities are more likely to end up in crisis and forensic care.** Nationally black and minority ethnic people are 40 percent more likely to access mental health services via the criminal justice system than white people[1]: The same is true locally. The chart below shows the ethnicity profile of Southwark NHS Clinical Commissioning Group (CCG) service users in forensic offender mental health services (between April 2018 and March 2019) compared to the

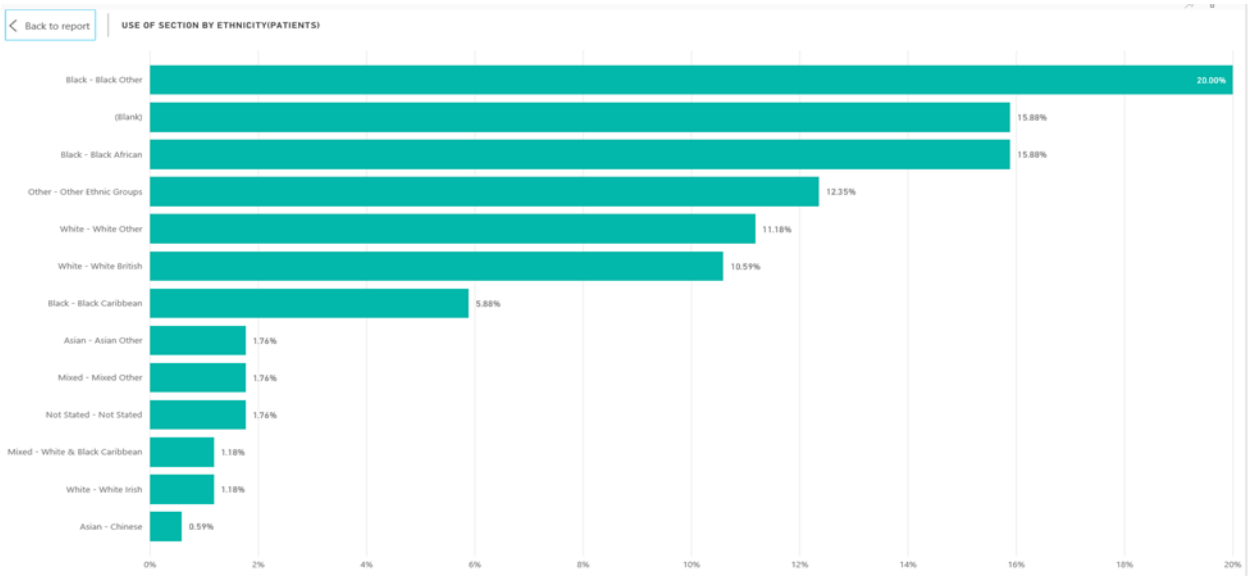
[1] Racial disparities in mental health: Literature and evidence review , Race Equality Foundation 2019

ethnicity profile of 18-65 year olds in Southwark and the ethnicity of Friend and Family Test respondents to these services (between April 2016 and March 2019).This shows the disproportionate proportion of black people using these services:



Locally black people are also disproportionately sectioned:

Briefing to the Commission, 21 January 2020, appendix A,



- **Nationally black and minority ethnic people are less likely to be referred to talking therapies and more likely to be medicated for ill mental health[2].** Locally there is an under representation of the BAME population in SLaM CAMHS provision. This group makes up 59% of Southwark's population, but only 42.4% of patients (under the age of 18)[3].

- **National and local evidence indicates that black and minority ethnic people want the impact of racism and wider inequalities on their mental health to be addressed in the treatment for their mental illness and in preventative work.** National research suggests that matching the cultural, linguistic religious and/or racial identity between service users and practitioners can improve

[2] Racial disparities in mental health: Literature and evidence review , Race Equality Foundation 2019
[3] Briefing note to the Commission 21 January 2020.

treatment duration and outcomes[4]. Black Thrive, working with a similar community in Lambeth, identified institutional racism as one of the reasons that black people have poorer outcomes from services. The local friends and family data provided on SLaM CAMHS service is more positive with that black people frequently more satisfied with service, although this data shows lower satisfaction from other 'other ethnic' groups.

Black, Asian and Minority Ethnic access to mental health services indicative review, provided to the Commission September 2020, paragraph 4.5

How likely are you to recommend Southwark Assessment and Liaison and Integrated Psychological Therapy services to friends and family if they needed similar care or treatment?						
Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses in 18/19	Positive responses in 18/19
Asian	10	90.0%	20	90.0%	12	91.7%
Black	33	93.9%	46	91.3%	35	94.3%
Mixed Race	24	95.8%	29	93.1%	13	92.3%
Other ethnic group	Under 10	100.0%	Under 10	100.0%	Under 10	66.7%
White	177	94.4%	184	88.6%	146	85.6%
Overall	274	93.1%	320	88.1%	227	88.1%

How likely are you to recommend Southwark CAMHS community services to friends and family if they needed similar care or treatment?						
Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses in 18/19	Positive responses in 18/19
Asian	18	83.3%	Under 10	100.0%	Under 10	80.0%
Black	81	92.6%	65	87.7%	37	89.2%
Mixed Race	32	93.8%	19	89.5%	23	95.7%
Other ethnic group	Under 10	75.0%	Under 10	71.4%	Under 10	50.0%
White	149	87.9%	129	90.7%	97	84.5%
Overall	324	86.1%	242	89.7%	181	85.1%

- **Nationally people from African Caribbean communities are three times more likely to be diagnosed and admitted to hospital for schizophrenia than any other group.** Locally black people are disproportionally diagnosed with schizophrenia and psychosis, though the picture is complex [5]. Black Thrive, and national research, has raised concerns that racism impacts on the over diagnosis of psychosis and schizophrenia, which can negatively impact on treatment trajectory [6].

- **Educational achievement is a protective factor however Black Thrive told us young black people are more likely to experience institutional racism in school** with children less likely to receive a

[4] Racial disparities in mental health: Literature and evidence review , Race Equality Foundation 2019
[5] See Briefing to the Commission, 21 January 2020, appendix A, slide 10, Top Diagnosis by Ethnicity.
[6] https://diversityhealthcare.imedpub.com/schizophrenia-and-psychosis-the-magical-and-troubling-disappearance-of-race-from-the-debate.php?aid=3730

positive response to distress and more likely to experience punitive behaviour managing techniques such a detention and exclusion.

Recommendations

The final meeting of the Commission received a helpful and extensively researched paper from council officers and the CCG, conducting an indicative review of Black, Asian and Minority Ethnic access to mental health services. The Commission's first two recommendations reflect this report's conclusions, which recommended mandating the collection of comprehensive ethnicity data and to improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities.

The Commissions first two recommendations are:

1 **Take action on better collation of data on sex and different black and minority ethnic groups' usage of mental health services, including CAMHS, the work that Southwark will fund in schools and The NEST open access service, to enable specific research and actions to address barriers to accessing services by the BAME community and ensure equitable access by sex and gender.**

2 **Provide better access to talking therapies according to local need. Conduct engagement with black and minority ethnic communities to ensure the therapies are culturally appropriate and geographically accessible.**

The third recommendation is informed by the work of Black Thrive, which works strategically with partners to co-design services with the BAME community to tackle the causes of mental distress, including racism and the wider determinants of mental health.

The Commission's third and last recommendation is:

3 **Adopt a Race Equality Framework in the delivery of Southwark 100 % universal reach target.**

The Commission would like to take this opportunity to thank you, council officers and the CCG for their input into the review.

We hope that the above summary of the reviews findings and our recommendations are informative and will be helpful in shaping the delivery of Southwark's programme to provide appropriate and timely support to a 100% of Southwark's children and young people in need of Mental Health provision.

Yours sincerely,

Councillor Victoria Olisa

Chair, Health and Social Care Scrutiny Commission

Cc

Genette Laws, Director of Commissioning, Southwark Council

Sam Hepplewhite, Director of Commissioning, Southwark NHS CCG

Jean Young Associate Director of Healthy Populations and Community Based Care, NHS South East London Clinical Commissioning Group (Southwark)

Southwark Child and Adolescent Mental Health Commission:

Rt Hon Harriet Harman QC MP

Emily Barlow

Louise Bauer

David Brindle

Andy Elvin

Peter Hay CBE

Nancy Hey

Karen Mellanby

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Dr Matthew Patrick

John Poyton

Emma Thomas

Rianna Walcott

Peter Wilson

Cassie Buchanan

Rikie Salman

A REVIEW BY

BARONESS DOREEN LAWRENCE

AN AVOIDABLE CRISIS

The disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities

CONTENTS

ACKNOWLEDGEMENTS

In April, Keir Starmer appointed me as race relations adviser and asked me to launch a review into the impact of coronavirus on black, Asian and minority ethnic communities.

Since the launch of the review in April 2020, we have received over 200 submissions and met with over 300 people as part of a programme of online roundtables. I have met with frontline workers including doctors and nurses, trade unions, local government, faith leaders, high profile campaigners, SMEs, think tanks, voluntary sector organisations and bereaved families. The submissions have been wide ranging and included reports, studies, recommendations and personal testimonies.

I would like to thank everyone who has taken the time to contribute to this report, and everyone who has helped shape it. In particular, I would like to thank Sir Keir Starmer MP and Marsha De Cordova MP for their support throughout.

BARONESS DOREEN LAWRENCE

1 FOREWORD

In the early weeks of the Covid pandemic, as mounting evidence began to show that Black, Asian and minority ethnic communities were dying at a disproportionate rate, I was asked by the Leader of the Labour Party, Sir Keir Starmer, to lead a review to investigate the reasons.

It was immediately apparent that the impact on people's health was inseparable from economic prospects and experiences of discrimination.

It is often said, but perhaps not fully appreciated, that behind each statistic is a human story. For me, amplifying the voices of those who are all too often invisible has been the driving force behind my many years of campaigning.

So this review is not mine. It belongs to the hundreds of people I have spoken to: doctors, nurses, parents, teachers, faith leaders, councillors, activists and, most importantly, those who have lost loved ones. It is based on hundreds of submissions, full of expert opinions, recommendations and heart-wrenching stories.

The overwhelming message was that this must be a watershed moment for change. Black, Asian and minority ethnic people have been overexposed, under protected, stigmatised and overlooked during this pandemic – and this has been generations in the making. The impact of Covid is not random, but foreseeable and inevitable – the consequence of decades of structural injustice, inequality and discrimination that blights our society. We are in the middle of an avoidable crisis. And this report is a rallying cry to break that clear and tragic pattern.

It will require systemic solutions to systemic problems. It is not enough for policymakers to know that ethnic inequalities exist. We need to honestly confront how inequalities at all levels of society have come to exist and the intersectional impact it has on each ethnic group. This means recognising the interaction of faith, class, gender, disability, sexuality, ethnicity and culture in order to truly understand that no community is ever one homogeneous group.

Only then will we be able to respond effectively. We need bold, joined-up policies and an approach that encompasses tackling ethnic disparities, from housing to employment and health.

This report gives just a snapshot of the impact of Covid-19 so far and the structural inequalities faced by Black, Asian and minority ethnic people. It makes immediate recommendations to protect those most at risk as the pandemic progresses and presents next steps for beginning to tackle the underlying causes.

I first met Keir campaigning on these very issues decades ago, and I would like to thank him for commissioning this important review. I would also like to thank Marsha de Cordova MP, Labour's Shadow Secretary of State for Women and Equalities, for her tireless support over the last few months, hosting roundtable discussions, pressing the Government to go further and faster on protecting those most at risk from this virus, and for her friendship and wise counsel.

The coronavirus crisis has brought us all together in many ways. But it has also exposed our faults.

This must be a turning point. We have heard enough talk from the Government. It is now time to act. In the words of one submission we received: we created this system; we need to fix it.

BARONESS DOREEN LAWRENCE

EXECUTIVE SUMMARY

Covid-19 is having a disproportionate and devastating impact on ethnic minority communities. Not only are Black, Asian and minority ethnic people dying at a disproportionate rate, they are also overexposed to the virus and more likely to suffer the economic consequences. Despite repeated warnings, the Government has failed to take sufficient action.

Covid-19 has thrived on inequalities that have long scarred British society. Black, Asian and minority ethnic people are more likely to work in frontline or shutdown sectors which have been overexposed to Covid-19, more likely to have co-morbidities which increase the risk of serious illness and more likely to face barriers to accessing healthcare. Black, Asian and minority ethnic people have also been subject to disgraceful racism as some have sought to blame different communities for the spread of the virus.

This virus has exposed the devastating impact of structural racism. We need immediate action to protect people this winter, but we must also fix the broken system that has left ethnic minority people so exposed.

THE URGENT NEED FOR ACTION

Despite being aware of the disproportionate impact of Covid-19 on the UK's Black, Asian and minority ethnic communities, the Government has not done enough to protect people ahead of the second wave. As transmission surges once again across the country, the need for this action could not be more urgent.

The Government must set out an urgent plan for tackling the disproportionate impact of Covid on Black, Asian and minority ethnic people this winter.

TIME TO TACKLE HEALTH INEQUALITIES

Black, Asian and minority ethnic people face significant barriers to accessing healthcare. These barriers include a lack of cultural and language-appropriate communication; not being taken seriously when presenting with symptoms; a lack of clinical training on the presentation of different illnesses across communities; and the 'no recourse to public funds' rule which prevents migrants accessing state assistance. Black, Asian and minority ethnic people are also under-represented across the senior leadership of the NHS.

Suspend the 'no recourse to public funds' rule during the pandemic and initiate a review on its impact on public health and health inequalities.

OVEREXPOSURE TO COVID-19

Black, Asian and minority ethnic workers have suffered disproportionately from the Government's failure to facilitate Covid-secure workplaces. Many respondents told us about inadequate PPE, failures to implement and access risk assessments and insufficient government guidance on their protection.

Ensure Covid-19 cases from the workplace are properly recorded by confirming that employers must report occupational infections of Covid-19 in line with health and safety law.

The Government should introduce a legal requirement for employers to publish their Covid-19 risk assessments on a central Government portal.

The Government should improve access to PPE in all high-risk workplaces where a risk assessment requires it and advise employers that they should provide PPE that is appropriate for all staff, such as those who wear hijabs, turbans or have beards for religious reasons.

Black, Asian and minority ethnic people are more likely to live in poor quality and overcrowded housing. Both are significant risk factors for Covid and also affect the ability to self-isolate. Poor-quality housing has not been sufficiently considered when providing guidance for minimising transmission, nor has adequate support and resources been given to local authorities to tackle this problem.

Give targeted support to people who are struggling to self-isolate at home, including a package of resources to enable local authorities to identify and support people who may not be able to self-isolate. The Government should also review the current financial support package for those who need to isolate to ensure it supports all those who need help.

The Government's decade-long failure to build social rented housing has pushed many families into the less regulated and less secure private rented market. Black, Asian and minority ethnic households are also disproportionately affected by the affordability crisis in housing.

Research by Shelter has found that four in 10 landlords admitted that "prejudices and stereotypes" come into letting decisions.[1] This is exacerbated by the Government's right to rent policy, which has been found to lead to discrimination in the housing market.[2]

The Government should urgently bring forward emergency legislation to protect renters in this crisis, and ensure that its Renters Reform Bill includes measures to tackle racial discrimination in the private rental market.

The Government should raise the local housing allowance to the level of local average rents, to ensure low-income households are not forced into debt eviction and homelessness during the crisis.

The economic impact of the pandemic is disproportionately affecting ethnic minority communities. Black, Asian and minority ethnic workers are over-represented in shutdown sectors, and Pakistani and Bangladeshi workers are also overwhelmingly more likely to be self-employed.

Conduct and publish equality impact assessments on the Government's support schemes to make sure Black, Asian and minority ethnic people are able to access the support they need.

[1] https://england.shelter.org.uk/__data/assets/pdf_file/0004/1236820/Landlord_survey_18_Feb_publish.pdf

[2] https://www.jcwi.org.uk/passport-please

END THE STIGMATISATION OF COMMUNITIES

The Covid-19 pandemic has fuelled racism as some have sought to blame Black, Asian and minority ethnic communities for spreading the virus. Despite SAGE having warned the Government in July of a risk that local restrictions could lead to racial stigmatisation and discrimination, little has been done to counter these narratives.

This also appears to be feeding into the enforcement of restrictions by public authorities. Liberty has found that police forces in England and Wales are up to seven times more likely to fine Black, Asian and minority ethnic people for violating lockdown rules.[3]

The Government must develop a clear plan to combat stigmatisation of communities during the Covid-19 crisis.

Urgently legislate to tackle online harms by bringing forward the much-delayed Online Harms Bill.[4]

IMPROVE COMMUNICATION AND ENGAGEMENT

The Government has been criticised for its poor communication during this pandemic. To date there have been few community-specific awareness raising campaigns or materials distributed by local and central government.

We also heard that the use of the term BAME can mask the ethnic identities and realities of the very people it seeks to represent, and it is important that Government communication and engagement recognises this.

The Government should remove linguistic, cultural and digital barriers to accessing public health information. The Government should work with all relevant bodies, including faith and community groups, to identify effective channels to disseminate information and provide support.

PLUG THE GAPS IN DATA

A recurring and frustrating theme of this review has been the lack of reporting of ethnicity data, not just in relation to Covid-19 but more widely.

The Government should take immediate action to ensure comprehensive ethnicity data collection across the NHS and social care. The Government should also ensure all appropriate data collected and released by Government and public bodies is disaggregated to include a demographic breakdown.

[3] https://libertyinvestigates.org.uk/articles/police-forces-in-england-and-wales-up-to-seven-times-more-likely-to-fine-bame-people-in-lockdown/

[4] https://committees.parliament.uk/publications/1954/documents/19089/default

END STRUCTURAL RACISM

There have been positive steps towards racial equality in recent decades. But racism and structural inequality still persist and some indicators have worsened. For example, the Lammy Review found that the proportion of Black, Asian and minority ethnic young offenders in custody rose from 25 per cent to 41 per cent between 2006 and 2016, despite the overall number of young offenders falling to record lows.[5]

In response to the Black Lives Matter movement, the Prime Minister announced yet another Commission on Race and Ethnic Disparities, and chose as its chair a man who has cast doubt on the existence of institutional racism.[6] This only adds to the feeling among some communities that this Government is simply not serious about tackling racism and persistent racial inequalities.

Implement a Race Equality Strategy, developed with Black, Asian and minority ethnic communities and with the confidence of all those it affects.

The Government should implement a national strategy to tackle health inequalities, with ministerial accountability and targets.

Equality impact assessments should be used much more effectively to shape and inform policy, and policymakers should seek to tackle structural racism with their decisions. The Government should also enact section 1 of the Equality Act which covers socio-economic disadvantage.

The publication of ethnicity pay gaps should become mandatory for firms with more than 250 staff, to mirror gender pay gap reporting. The Government has been consulting on this change for years but has failed to make any progress.

Since 2010 the Conservatives have implemented a range of policies to intentionally and openly create a 'hostile environment' for undocumented migrants in the UK, from blocking access to public funding to making employers, landlords and NHS staff, among others, check people's immigration status. This aggressive policymaking infamously culminated in the Windrush scandal, which saw people who had the right to be in the UK left in terrible circumstances. This has also contributed to the systemic discrimination experienced by migrants and the UK's Black, Asian and minority ethnic population.

The Government must commit to stopping the 'hostile environment', and reforming our immigration system so that it is fair and effective.

Societal prejudices are learned from a young age and fester when left unchallenged. The Macpherson Report called for improved diversity in the school curriculum, and the Windrush 'Lessons Learned' Review called for better understanding of Black British history, yet little progress has been made on diversifying the national curriculum. Action is also required to tackle the attainment gap.

The Government, working with the Devolved Administrations, should launch a review into the diversity of the school curriculum to ensure it includes Black British history, colonialism and Britain's role in the transatlantic slave trade.

The Government should implement a national strategy with clear targets to close the attainment gap at every stage in a child's development, enforced through an independent body, such as the Children's Commissioner.

[5] http://www.russellwebster.com/lammy-review-final/

[6] https://www.theguardian.com/world/2020/jun/15/dismay-over-adviser-chosen-set-up-uk-race-inequality-commission-munira-mirza
https://www.theguardian.com/world/2020/aug/11/race-equality-chief-tony-sewell-faces-legal-challenge-over-appointment

THE URGENT NEED FOR ACTION

> *"The impact of Covid on Black, Asian and minority ethnic [people] has been literally unimaginable… We need to find out why the BAME community has been so affected. We also need to put proper planning [and policies] in place for the future."*
>
> **Individual submission**

The coronavirus crisis has had a significant and often heart-breaking impact for everyone in this country. All aspects of life and work in the UK have had to adjust to new and unprecedented circumstances. But it was clear from the early stages of the pandemic that the crisis was taking a disproportionately high toll on ethnic minority groups in the UK.

On 10 April 2020, less than three weeks after the national lockdown was declared, the British Medical Association warned that the first 10 NHS doctors to die from the virus were from Black, Asian or ethnic minority backgrounds.[7] A subsequent analysis revealed that 68 per cent of the NHS staff that had died were from ethnic minority backgrounds.[8] Evidence of significant disparities in health outcomes continued to emerge over the following weeks, including the shocking revelation that over one third of patients in intensive care were from ethnic minority backgrounds.[9]

The hugely significant role of key workers in tackling the crisis and keeping the country going became increasingly obvious, with public transport and healthcare among those on the frontline. Both sectors include a significantly high number of workers from ethnic minority backgrounds – official data from 2019 indicated 20 per cent of over 1.2 million NHS staff were Black, Asian and minority ethnic, compared with 14 per cent of the general population of England and Wales. This increases to 44 per cent of medical staff.[10]

Research from organisations such as the Institute for Fiscal Studies, healthcare professionals and the Office for National Statistics further revealed the extent of both the health and economic implications on ethnic minority groups. This included the revelation that Black men are 4.2 times more likely to die from Covid-19 and Black women are 4.3 times more likely than white men and women.[11] In a recent report the Institute for Public Policy Research and the Runnymede Trust estimated that:

> "Over 58,000 and 35,000 additional deaths from Covid-19 would have occurred if the white population had experienced the same risk of death from Covid-19 as the Black and Asian and populations respectively."[12]

The Government published a review of the impact of Covid-19 on Black, Asian and ethnic minority groups in June.[13] It was hoped that Public Health England's review would provide a major insight into ethnic disparities of Covid-19 and put forward recommendations for action, but it did not. The report set out the disproportionate impact of Covid – the facts of which were already acknowledged and provided the basis for the review being commissioned in the first place – and made few recommendations for action. In doing so, the report failed to fulfil its terms of reference, to "suggest recommendations for further action that should be taken to reduce disparities in risk and outcomes from Covid-19 on the population".[14]

[7] https://www.theguardian.com/society/2020/apr/10/uk-coronavirus-deaths-bame-doctors-bma
[8] https://www.theguardian.com/world/2020/apr/16/inquiry-disproportionate-impact-coronavirus-bame
[9] https://www.icnarc.org/About/Latest-News/2020/04/04/Report-On-2249-Patients-Critically-Ill-With-Covid-19
[10] https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest
[11] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
[12] https://www.ippr.org/blog/ethnic-inequalities-in-covid-19-are-playing-out-again-how-can-we-stop-them
[13] https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[14] https://khub.net/documents/135939561/287909059/COVID-19+Impact+Review+ToRs.pdf/611bea2c-0cbe-4c71-57fe-abfeccdbf273?t=1588688788954

In addition, there was a highly unusual process of publication, with confused briefings about decisions to delay or publish the report. It was then rushed out with no public comments from Public Health England or the health experts. After publication it became clear that significant sections from the report, including key stakeholder and community voices and a list of recommendations, had been removed. The Government was then forced to publish the missing information in a subsequent PHE report.[15]

Zubaida Haque, then Interim Director of Race Equality at the Runnymede Trust, told the British Medical Journal that:

> "People are upset, angry, astonished, and appalled. It's completely lacking in any plan of action on how to save lives."

Many stakeholder organisations, including representative bodies, have emphasised the need for a clear action plan, which has not been delivered. The British Medical Association stated that: [16]

> "The Government who commissioned this review must now produce a clear action plan with timescales of how these recommendations will be implemented. The time for reviews, reports and commissions is over."

Throughout this pandemic, the Government has shied away from taking action to mitigate against the impact of Covid-19 on Black, Asian and minority ethnic groups and the recent statement from the Minister for Equalities risks being too little too late. It also fails to address the systemic and structural drivers of the inequalities we have seen.

Recommendation 1: The Government must go further and set out an urgent plan for tackling the disproportionate impact of Covid on ethnic minorities this winter

Despite being aware of the disproportionate impact of Covid-19 on the UK's Black, Asian and minority ethnic communities, the Government has not done enough to protect people ahead of the second wave or account for the significant disparities we've seen. As the country now faces rising Covid cases, hospital admissions, and deaths, the need for this action could not be more urgent.

The Government should set out a wider package of immediate measures to tackle the disproportionate impact of Covid on Black, Asian and minority ethnic people. This should include further steps to protect frontline staff and improve public health communication.

[15] https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

[16] https://www.bma.org.uk/bma-media-centre/bma-calls-for-tangible-and-urgent-action-in-response-to-public-health-england-s-latest-review-into-covid-19-impact-on-bame-communities

TIME TO TACKLE HEALTH INEQUALITIES

"I, like other members of the Black community, am waiting for the next wave of the virus to hit and wondering how many more family members will be lost."

Submission from a member of Wolverhampton Caribbean Community Memorial Trust

Unsurprisingly, health inequalities are a key driver of the disproportionate impact of Covid-19. Some ethnic groups are more likely to have underlying health conditions and find it more difficult to access medical care. Evidence also suggests that the social and economic inequalities faced by ethnic minorities can lead to poor health outcomes. The Marmot review describes this as the "social determinants of health". [17]

Public health challenges such as high levels of obesity, cardiovascular disease and diabetes disproportionately fall on some of the UK's Black, Asian and minority ethnic communities, and it is important for these differences to be understood.[18] There has also been considerable attention given to possible biological explanations for the disproportionate effect of Covid, but a recent paper from the ethnicity subgroup of SAGE argued that these are "unlikely to explain the ethnic inequalities".[19] As the Royal College of Nursing highlighted in a submission to this review:

> "Biology can also be a distraction and discussions around Vitamin D deficiencies do not fully explain the disparities between Black, Asian and minority ethnic groups contracting and dying from Covid-19; the true picture will not be understood by biology alone."

IPPR and the Runnymede Trust estimate that co-morbidities lead to the Black population being only five per cent more likely to die from Covid-19 than the white population, arguing:

> "The majority of the additional risk of death from Covid-19 experienced by minority ethnic communities is unexplained… Genetics cannot explain why every minority ethnic population, given huge genetic diversity within and between these groups, has a higher risk of death from Covid-19 than the white ethnic population. Instead, this inequality is likely to be driven by structural and institutional racism… and differential access to healthcare."[20]

One of the drivers of health inequality is the Government's failure to implement targeted public health strategies. Since 2015, £800 million has been taken out of public health grants to local authorities and this summer the Government announced Public Health England would be scrapped. These cuts have fallen most heavily on areas with high levels of deprivation and the negative relationship between deprivation, ethnicity and health outcomes is well documented. We consistently heard that targeted, culturally appropriate public health strategies to combat chronic conditions such as obesity, heart disease and diabetes, which feed more serious health complications, should be a priority for Government.

The NHS is our most treasured institution, and the heroism of doctors and nurses during this pandemic has cemented this fact in the hearts of people across Britain. The NHS was founded 75 years ago, as the Windrush arrived, and its story has always been entwined with Britain's growing diversity. Today, Black, Asian and minority ethnic people make up 20 per cent of its workforce.

[17] https://www.health.org.uk/news-and-comment/news/health-equity-in-england-the-marmot-review-10-years-on

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925135/S0778_Drivers_of_the_higher_COVID-19_incidence__morbidity_and_mortality_among_minority_ethnic_groups.pdf

[19] https://www.gov.uk/government/publications/drivers-of-the-higher-covid-19-incidence-morbidity-and-mortality-among-minority-ethnic-groups-23-september-2020

[20] https://www.ippr.org/blog/ethnic-inequalities-in-covid-19-are-playing-out-again-how-can-we-stop-them

But despite the huge contribution of our NHS, 64 per cent of Black Britons think the NHS does less to protect their health than that of white people, a perception substantiated by the health outcomes they experience.[21] Maternal mortality is five times higher for Black women than white women, and twice as high for Asian women. Black mums-to-be are eight times more likely to be admitted to hospital with Covid-19 than white pregnant women.[22]

We also heard that Black, Asian and minority ethnic people often experience barriers to accessing healthcare, including mental health services. This can often be caused by a lack of cultural and language appropriate communication, as well as digital exclusion. One submission reported the remarks of a junior doctor working in intensive care:

> "Language barriers for people who can't speak English, especially when you can't say if you're in pain or short of breath, can have a huge impact."

For migrants, requirements to show passports when seeking care and information passing between the NHS and the Home Office has created a significant barrier to accessing even emergency healthcare.[23] We heard that the 'no recourse to public funds' condition that prevents many migrants accessing social security and other state assistance was a factor in health inequalities experienced by many. In the context of Covid-19, the Coalition of Race Equality Organisation's submission highlighted that the vast majority of migrants were unaware of the Covid-19 exemption from charging and immigration checks, meaning many were avoiding seeking medical care out of fear.

Many submissions raised the lack of training for healthcare practitioners to enable them to fully understand inequalities in health outcomes, cultural differences and any unconscious bias. We heard that some Black, Asian and minority ethnic people are not being taken seriously when seeking care, or facing untrue stereotypes about pain thresholds which affect clinical decisions. Black Ballad highlighted some examples:

> "We've spoken to doctors and midwives who don't even know that Black women are five times more likely to die from pregnancy complications. If there is no awareness in the first place, and people don't know about it, then what can be done?"[24]

There is also a lack of medical training on the different presentation of medical conditions among different ethnicities, and a lack of Black, Asian and minority ethnic participants in medical trials. Scientists for Labour reported to us, for example, that:

> "Medical professionals have reported a lack of training on diagnosis of conditions for those with darker skin tones."

Finally, there is a lack of diversity in senior levels of the NHS. Black, Asian and minority ethnic staff make up around 20 per cent of the overall NHS workforce but just 6.5 per cent of senior managers. In London, almost half of NHS employees are Black, Asian and minority ethnic, but 92 per cent of NHS Trust Board members are white.[25] During a roundtable with NHS providers, Trust leaders highlighted the "critical need" for more diversity in decision-making positions, with nursing and management structures being particular examples of where the 'glass ceiling' needed to be broken.

Several respondents mentioned the NHS Workforce Race Equality Standard (WRES), which was introduced in 2015 to improve the diversity, progression and treatment of Black, Asian and minority ethnic staff. The

[21] https://www.theguardian.com/world/2020/sep/07/two-thirds-of-black-britons-believe-nhs-gives-white-people-better-care-finds-survey
[22] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf
https://www.bbc.co.uk/news/health-53191235s
[23] https://www.medact.org/wp-content/uploads/2020/06/Patients-Not-Passports-Migrants-Access-to-Healthcare-During-the-Coronavirus-Crisis.pdf
[24] https://www.huffingtonpost.co.uk/entry/shocking-healthcare-racism-endangering-black-mothers_uk_5f2d3a2dc5b6b9cff7f0a3ba
[25] Pg. 13 https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf; https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf

Seacole Group, the network for Black, Asian and minority ethnic non-executive directors in the NHS, told us that the requirement for healthcare organisations to provide WRES data was an important first step to reveal the scale of inequality and discrimination. However despite five years of data there has been no substantial change. They suggested improvements must be made to hold senior management to account on progress. A respondent said:

> "We have the data to prove inequality but we are not moving forward to see tangible improvements. As we approach the second wave it will be unforgivable if we have the same level of deaths."

This review also heard concerns about the impact on mental health as a result of the pandemic, particularly in light of the poor mental health outcomes Black people face and the barriers to accessing mental health services. For instance, a 2018 review into modernising the Mental Health Act found that "those of Black African or Caribbean heritage are over eight times more likely to be subjected to Community Treatment Orders than those of white heritage".[26] Dr Jacqui Dyer, Chair of Black Thrive, a London based partnership for improving Black mental health, stressed that "post treatment and bereavement counselling to support individuals in our community will be key".

To understand the disproportionate impact of Covid-19 on the UK's ethnic minority communities, we must look beyond Covid-19 to longstanding health inequalities and their causes. A number of organisations, including the Royal College of Nursing and the British Medical Association, called for a cross-governmental strategy to tackle health inequalities in their submissions to us. As the British Medical Association argued:

> "Over the longer term there must be a determined focus on interventions to narrow the longstanding health inequalities that Covid-19 has brought to the fore."

But the truth is the Government already knows this. Ten years ago the Marmot Review warned that a strategy was needed to reduce healthcare inequalities, but the Conservatives' record has been shameful. Austerity and a failure to provide for ever-increasing demand has seriously undermined our health service. The 2020 Marmot Review into Health Inequalities found that:[27]

> "Austerity has taken its toll in all the domains set out in the [first] Marmot Review. From rising child poverty and the closure of children's centres, to declines in education funding, an increase in precarious work and zero hours contracts, to a housing affordability crisis and a rise in homelessness, to people with insufficient money to lead a healthy life and resorting to food banks in large numbers, to ignored communities with poor conditions and little reason for hope. And these outcomes, on the whole, are even worse for minority ethnic population groups and people with disabilities."

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

[27] https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

Recommendation 2: A national strategy to tackle health inequalities

The 2010 Marmot Review set out six policy objectives to reduce health inequalities. Ten years on no action has been taken and the recently published updated Marmot Review has argued that many Government policies have run counter to its recommendations.

The Government should implement a national strategy to tackle health inequality as a matter of urgency. This strategy should be implemented in tandem with communities, and should include:

- Clear ministerial accountability and clear targets to close the gaps in negative health outcomes, such as the difference in mortality between Black and white women in pregnancy and childbirth
- Targeted public health action to help reduce instances of conditions such as diabetes and cardiovascular disease
- A review of clinical training to ensure all ethnicities get the best medical care
- Improved training for all health and care staff to tackle racism, challenge any unconscious bias and ensure good understanding of cultural differences
- Targets to improve the diversity of NHS governance, with clear ministerial accountability
- Improve the Workforce Race Equality Standard so that managers and the boards are held to account for a failure to make progress
- Support for every Trust to develop their own race equality strategy
- Steps to address racial inequality in mental health services, to ensure provision is widely accessible and support is culturally appropriate. Action should also be taken to address inequality in the detainment of people in crisis under the Mental Health Act
- A commitment to engage with staff on how the lessons from the pandemic can be applied to the future of the NHS

Recommendation 3: Suspend 'no recourse to public funds' rule during the pandemic and initiate a review

The Government should suspend 'no recourse to public funds' for the duration of the Covid-19 pandemic, and conduct a review of the impact of NRPF on public health and health inequalities.

OVEREXPOSURE TO COVID-19

There are many ways in which the UK's Black, Asian and minority ethnic people have been overexposed to the impact of Covid-19 – from being over-represented in industries that are overexposed to the health and economic impacts of Covid-19, through to environmental factors such as overcrowded housing and air quality.

OCCUPATIONAL EXPOSURE TO COVID-19

"I didn't come to work to die."

A nurse who contributed to the review

Black, Asian and minority ethnic workers are disproportionately represented in sectors where home working is not possible or in jobs that are low paid and insecure. This means ethnic minorities are more exposed to catching the virus and less able to self-isolate if they do catch it. Black, Asian and minority ethnic workers have suffered disproportionately from the Government's failure to facilitate Covid-secure workplaces.

The British Medical Association found in April that 64 per cent of Black, Asian and minority ethnic doctors had felt pressured to work in settings with inadequate PPE compared with 33 per cent of their white counterparts.

In the same survey a respondent said:

> "I am the only Muslim anaesthetist with a beard in my department…I am being forced to shave my beard due to unavailability of hood masks with respirator, and a bearded doctor can't pass a fit mask test."

Similarly, the Royal College of Nursing highlighted in its submission that:

> "Seventy per cent of Black, Asian and minority ethnic respondents said that they had felt pressured to care for a patient without adequate protection as outlined in the current PPE guidance, almost double the 45 per cent of white British respondents who had felt this pressure."

Alongside inadequate PPE we heard that for many Black, Asian and minority ethnic workers there has been a failure to implement and access risk assessments, insufficient Government guidance for their protection and for groups that have historically faced discrimination or feel like outsiders in UK workplaces[28], it can be particularly hard to raise health and safety concerns. The Seacole Group highlighted the need to equip managers with tactics and tools for how to protect all staff with high risks; to identify and plan for how Black, Asian and minority ethnic staff and those with underlying conditions can be redeployed; and to allow higher level of PPE for staff if they feel they need it. During a roundtable with trade unions as part of this review, we heard several accounts of the lack of protection for at-risk employees:

> "A survey carried out by the union has shown 80 per cent of members say no one has spoken to them about risk assessment." – Unison

> "There is a lot of anxiety and uncertainty for Black staff. There is not enough guidance and information out there for schools. Many Black staff are also community leaders and have double burden and responsibility." – NASUWT

> "Risk assessments need to be enhanced for Black, Asian and minority ethnic workers and it's been very difficult to get employers to understand this and approach it in that way." – Unite

[28] E.g. see GMC Fair to Refer report which identifies overseas-qualified doctors, locums and SAS doctors, all of whom are mainly BAME as being most likely to be 'outsiders' and lacking support at work and the BMA's findings from its survey of disabled doctors and medical students referenced below.

The TUC and other unions also raised the over-representation of Black, Asian and minority ethnic workers in low-paid and precarious work. These workers were the ones often overlooked in decisions about workplace protection, and many have felt unable to self-isolate due to the risk of financial loss.

These workers may also feel least able to raise concerns in the workplace and throughout this pandemic we have seen some horrifying examples of non-unionised and rogue businesses exposing their workforces to danger against government advice and, at times, the law. For instance, garment factories in Leicester were reportedly forcing people into work, even those with Covid-19, and locking the doors behind them to give the impression of compliance.[29]

Several NHS respondents told us about the importance of Black, Asian and minority ethnic networks in their workplace. Throughout the pandemic these groups have been a valuable means of communicating across the organisation and many expressed the need for them to be given more support from the top of the organisation. Trade unions also told us about the importance of creating a safe space for Black, Asian and minority ethnic staff members to express their concerns and advocate for change.

Recommendation 4: Ensure Covid-19 cases from the workplace are properly recorded

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) employers are legally required to report cases of diseases and deaths caused by occupational exposure.

However, employers have been advised by the Government not to register many occupational cases or deaths during the pandemic because it claims contact with the public is not "sufficient evidence" they could have resulted from the virus.[30]

As well as making it harder to track and tackle the spread of the virus, this will potentially deny workers and their families clarity, closure and justice. It will also undermine the Government's efforts to understand the impact on Black, Asian and minority ethnic communities, who are among those more likely to be exposed to the virus at work.

The Government should confirm that employers have a duty to report occupational infections of, and deaths from, Covid-19 in line with RIDDOR requirements. It should further take action to increase awareness of these requirements and call on the Health and Safety Executive to take action against employers failing to comply with them.

Recommendation 5: Strengthen Covid-19 risk assessments to ensure consistency and to give workers more confidence

All employers with more than five staff are required to produce written risk assessments and employers with over 50 staff are expected to publish their risk assessments on their own website. However, many employers failed to publish risk assessments on their websites despite having staff working onsite.

The Government should introduce a legal requirement that employers publish their Covid-19 risk assessments on a central Government portal, giving staff greater confidence in their safety at work.

Recommendation 6: Improve access to PPE in all high-risk workplaces

The Government should advise employers in high-risk settings that they should provide PPE for staff where a risk assessment requires it. The Government should also advise employers that they must provide PPE which is appropriate for all staff, for example for those who wear hijabs, turbans or have beards for religious reasons.

[29] https://labourbehindthelabel.net/wp-content/uploads/2020/06/LBL-Boohoo-WEB.pdf
[30] https://www.mirror.co.uk/news/politics/government-turning-blind-eye-workplace-22681684

ENVIRONMENTAL EXPOSURE TO COVID-19

Environmental factors such as housing and deprivation play a huge role in determining health outcomes. Poor quality and overcrowded housing are significant risk factors for Covid-19.

Between 2014 and 2017, 23 million households in England were overcrowded. While on average only two per cent of white British households experience overcrowding, the percentage is considerably higher for Black, Asian and minority ethnic communities.[31] Not only are Black, Asian and minority ethnic people more likely to live in overcrowded housing, their quality of housing is disproportionately poor as they are more likely to live in polluted areas and without outside space.

We heard that poor housing hampers an individual's ability to self-isolate within a household after being exposed to Covid-19, a particular risk for multigenerational households. Those living in overcrowded housing are also more likely to have existing health issues such as heart and respiratory problems, which exacerbate illness from Covid-19, and studies have suggested that long-term exposure to air pollution before the pandemic is associated with severe symptoms from Covid-19 and a greater risk of death.[32] Moreover, Aston University highlighted the strong association between area deprivation, ethnicity, ambient air quality and Covid-19 related deaths.[33]

We heard overcrowding and poor-quality housing has not been sufficiently considered when providing guidance for minimising transmission, nor has adequate support and resources been given to local authorities to tackle this problem. Friends, Families and Travellers told us shielding and self-isolation was a particular problem for some Gypsy, Roma and Traveller communities in cases where there is lack of access to water and sanitation.

A decade of poor housing policy and longstanding inequalities has left people overexposed to Covid-19. Since 2010, the number of new social rented homes has fallen by over 80 per cent, new homes for affordable home-ownership has fallen by 89 per cent and there are more than 800,000 fewer home owning households aged under 45. [34] With only 20 per cent of Black African households owning their own home, compared to 68 per cent of white households, this failure is particularly acute.

The Government's decade-long failure to build social rented housing has pushed many families into the less regulated and less secure private rented market. Research by Shelter has found that four in 10 landlords admitted that "prejudices and stereotypes" come into letting decisions.[35] This is exacerbated by the Government's right to rent policy, which has been found to lead to discrimination in the housing market.[36]

Beyond outright discrimination, Black, Asian and minority ethnic households are disproportionately affected by the affordability crisis in housing. Before Covid, ethnic minority communities were more likely to say they were "struggling financially" and to live in a household which was behind on bills or housing payments.[37] Black, Asian and minority ethnic people are more likely to have fallen behind as a result of the

[31] https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest

[32] https://www.ons.gov.uk/economy/environmentalaccounts/articles/doesexposuretoairpollutionincreasetheriskofdyingfromthecoronaviruscovid19/2020-08-13

[33] https://publications.aston.ac.uk/id/eprint/41460/1/Submission_of_evidence_for_Select_Committee_Aston_University_pdf.pdf

[34] MHCLG, Additional affordable homes provided by tenure, England, September 2020, https://www.gov.uk/Government/uploads/system/uploads/attachment_data/file/570005/Live_Table_1000.xlsx.; English Housing Survey 2018 to 2019: headline report, MHCLG, January 2020, https://www.gov.uk/government/statistics/english-housing-survey-2018-to-2019-headline-report; MHCLG, Additional affordable homes provided by tenure, England, September 2020,, Table 1000: additional affordable homes provided by type of scheme, England.

[35] https://england.shelter.org.uk/__data/assets/pdf_file/0004/1236820/Landlord_survey_18_Feb_publish.pdf

[36] https://www.jcwi.org.uk/passport-please

[37] https://www.ippr.org/blog/minority-ethnic-groups-face-greater-problem-debt-risk-since-covid-19

Covid crisis, with a shocking one in three Black people behind on their bills as a result of the crisis compared to one in eight white people.[38]

Local government respondents told us that housing benefit caps and the bedroom tax have had a disproportionate impact on Black, Asian and minority ethnic families. The Covid crisis has caused a huge 93 per cent rise in households hit by the benefits cap, from February to May this year.[39]

Black, Asian and minority ethnic households are also disproportionally represented at the most acute end of the housing crisis – homelessness. People who are homeless, including rough sleepers, are acutely at risk of Covid, but Black, Asian and minority ethnic households are over-represented in homelessness figures, in particular Black households who account for one in 10 homeless households, compared to one in 30 of the general population.[40] Rough sleeping has already risen sharply during the pandemic. This combined with the onset of winter and a second Covid spike, the effects of the Tories' job crisis and the end to the evictions ban, threatens to drive a homelessness crisis that will disproportionately affect Black, Asian and minority ethnic communities.

Recommendation 7: Give targeted support to people who are struggling to self-isolate at home

The Government should urgently work with local authorities to co-produce a package of resources to enable them to identify and support people who may not be able to self-isolate. This should include those with no recourse to public funds.

The Government should also review its current financial support package for those who need to isolate to ensure it supports all those who need help. No one should be forced to choose between isolating or putting food on the table.

If the Government or local authorities plan to provide a system of parcels of food and essential amenities during the second spike of Covid-19 then it must build into the contracts measures to ensure these are culturally appropriate and meet the dietary needs of all of our communities.

Recommendation 8: Ensure protection and an end to discrimination for renters

The Government should urgently bring forward emergency legislation to protect renters in this crisis, and ensure that its Renters Reform Bill includes measures to tackle racial discrimination in the private rental market.

Recommendation 9: Raise the local housing allowance and address the root causes of homelessness

The Government should raise the local housing allowance to the level of local average rents, to ensure low-income households are not forced into debt eviction and homelessness during the crisis. The Government's homelessness and rough sleeping strategy must address the causes of homelessness among Black, Asian and minority ethnic communities, and put forward a strategy to address the root causes of housing inequality, including the supply of good quality, secure affordable housing.

[38]https://www.citizensadvice.org.uk/Global/CitizensAdvice/Debt%20and%20Money%20Publications/Excess%20Debts_who%20has%20fallen%20behind%20on%20their%20household%20bills%20due%20to%20coronavirus%20plus%20methodology).pdf

[39] https://labour.org.uk/press/labour-calls-on-government-to-scrap-benefit-cap-to-avoid-evictions-crisis-after-latest-extension/

[40]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/923123/Annual_Statutory_Homelessness_Release_2019-20.pdf

Exposure to financial hardship

Not only have Black, Asian and minority ethnic people been overexposed to contracting Covid-19, the economic impact of the pandemic is likely to disproportionately affect these communities too. During this review we heard accounts from a range of people and organisations about the economic hardship affecting Black, Asian and minority ethnic communities alongside the health crisis.

The economic impact of coronavirus has hit some parts of the economy much more than others, and sectors such as hospitality were shut down to control the spread of the virus. Black, Asian and minority ethnic workers are over-represented in these sectors and are therefore likely to be disproportionately affected.[41] This is exacerbated by the fact that workers in shutdown sectors from Black, Asian and minority ethnic backgrounds are less likely to have a partner in paid work and are in general less likely to have savings to cover a period of financial hardship.[42]

Unite the Union highlighted how those who are already disadvantaged and face discrimination in the labour market will find it hardest to retrain and gain employment. BAME Labour highlighted in its submission that:

> "While in the population as a whole, women are more likely to work in the shutdown sectors, this is only the case for the white ethnic groups. Bangladeshi men are four times as likely as white British men to have jobs in shutdown industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and Black Caribbean men are both 50 per cent more likely than white British men to be in shutdown."[43]

Past economic crises have tended to exacerbate existing racial inequalities, with Black, Asian and minority ethnic workers bearing the brunt of job cuts. For instance, employment rates for Black workers fell by over 2 per cent during the 2007-08 financial crisis and by an astonishing 13 per cent during the recession of the early 1990s. There is already evidence of similar effects in this crisis, as some surveys have found Black, Asian and minority workers are more likely to report losing their jobs, losing hours or being furloughed.[44]

Concerns have also been raised around the almost 1.4 million people who do not have recourse to public funds – a high proportion of whom are from Black, Asian and minority ethnic backgrounds. Citizens Advice highlights that some of these people "have faced the impossible choice of returning to work while ill, shielding, or living with someone who is shielding or losing their income".[45]

Financial hardship also has serious consequences for remittances – financial support sent to family members in other countries. We heard from the Filipino community that:

> "Participants also struggled to remit money to the Philippines, at a time when relatives were also undergoing hardships associated with the global pandemic. Eighty per cent of participants supported loved ones abroad, including parents and children. Interviewees explained that relatives would be unable to access healthcare and medication, their children's education would be interrupted, and families would go into debt if remittances ceased."

[41] https://commonslibrary.parliament.uk/research-briefings/cbp-8898/

[42] https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some-ethnic-groups-more-vulnerable-to-COVID-19-than-others-V2-IFS-Briefing-Note.pdf

[43] BAME Labour submission to the Doreen Lawrence Review

[44] http://cep.lse.ac.uk/pubs/download/cepcovid-19-007.pdf; https://www.sheffield.ac.uk/news/nr/coronavirus-recession-threatens-worsen-racial-inequalities-youth-unemployment-black-lives-matter-1.890568) (https://www.politicshome.com/news/article/bame-brits-twice-as-likely-to-have-lost-their-job-during-furlough-new-study-finds

[45] Citizens Advice (June 2020) Citizens Advice reveals nearly 1.4m have no access to welfare safety net

Pakistani and Bangladeshi workers are also overwhelmingly more likely to be self-employed, with one in four working-age Pakistanis and nearly one in five working-age Bangladeshis in self-employment.[46] This leaves them particularly exposed to a downturn and will leave many who are sole traders struggling to pay back debt build up over the course of the crisis. It also leaves them overly exposed to the large and well-documented gaps in the Government's Self Employment Income Support Scheme, which Parliament's Treasury Select Committee estimates left around 1 million self-employed workers with no financial support.[47]

We also heard from Black, Asian and minority ethnic business owners and self-employed people that they were struggling to access government schemes such as the Coronavirus Business Interruption Loan Scheme for small businesses and the Self Employment Income Support Scheme. During our meeting with small and medium-sized business owners for this review, one said:

> "We did a recent survey which showed that 48 per cent of Black, Asian and minority ethnic-led businesses weren't even applying for government schemes because they didn't think they would qualify. We need to improve diversity data in business. The community urges the major banks, British Business Bank and government to improve their diversity data monitoring and reporting. You can't impact what you don't measure."

Recommendation 10: Urgently conduct equality impact assessments on the Government's support schemes to make sure Black, Asian and minority ethnic people are able to access the support they need

The Government has failed to conduct and publish equality impact assessments for its economic support packages. The Government should urgently conduct and publish equality impact assessments of all Covid-19 business support schemes. The audit should include but not be limited to the Coronavirus Large Business Interruption Loan Scheme, the Self Employment Income Support Scheme, the Bounce Back Loan Scheme, the Job Support Scheme and the Job Retention Scheme.

[46] https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some-ethnic-groups-more-vulnerable-to-COVID-19-than-others-V2-IFS-Briefing-Note.pdf

[47] https://committees.parliament.uk/publications/1446/documents/13238/default/

STIGMATISATION OF COMMUNITIES

The Covid-19 pandemic has fuelled racism as some have sought to blame Black, Asian and minority ethnic communities for spreading the virus.

At the start of the pandemic we saw shocking acts of hate crime against Chinese and East Asian communities, fuelled by the branding of Covid-19 as the 'Chinese Virus' from senior global figures, taken up by the UK far right. A survey carried out by psychologists at the University of Oxford in May found that nearly 20 per cent agreed to some extent with the statement that "Muslims are spreading the virus as an attack on Western values"[48] and the far right have spread conspiracy theories that mosques were illegally open during lockdown.[49] The Community Security Trust has highlighted an explosion of antisemitic conspiracy theories regarding the virus and we heard that the Gypsy, Roma and Traveller community had been the targets of excessive racialised media scrutiny during the Covid-19 pandemic.

Despite SAGE having warned the Government in July of a risk that local restrictions could lead to racial stigmatisation and discrimination, little has been done to counter these narratives and, in some cases, rather than being challenged by politicians, they have been reinforced. For example, Conservative MP Craig Whittaker tweeted:

> "If you look at the areas where we've seen rises and cases, the vast majority, but not by any stretch of the imagination all areas, it is the BAME communities that are not taking this seriously enough."[50]

This also appears to be feeding into the enforcement of restrictions by public authorities too. Liberty has found that police forces in England and Wales are up to seven times more likely to fine Black, Asian and minority ethnic people for violating lockdown rules.[51] Yvette Cooper, Chair of Parliament's Home Affairs Select Committee raised the fact that young Black men were stopped and searched by police more than 20,000 times in London during the coronavirus lockdown – the equivalent of more than a quarter of all Black 15 to 24 year olds in the capital. 80 per cent of those stopped were found not to have done anything that required any further action.[52]

The disproportionate number of fines and stop and search during this period reflects a broader disproportionality across the justice system. The direct and indirect effects of this disproportionality are to deepen financial hardship and raise employment barriers for ethnic minority groups. This is one of the reasons the Lammy Review recommended introducing a system for sealing criminal records, as used in several US states.

Any stigmatisation or discrimination must be challenged strongly whenever it rears its head. It is the responsibility of all those in positions of power to be absolutely clear that any disproportionate impact of this virus on Black, Asian and minority ethnic communities is not a result of choice but due to structural inequality, inadequate protective measures and Government inaction.

But while there are countless examples of racism and injustice during this pandemic, there has also been much to offer hope. We have seen worldwide solidarity with the Black Lives Matter movement, with people of all races lining the streets in support. In Surrey a hospital was named after Mary Seacole, in tribute to the Black, Asian and minority ethnic NHS employees, following campaigning from Patrick Vernon

[48] Newsweek (May 2020) One fifth of English people in study blame Jews or Muslims for Covid-19

[49] https://www.independent.co.uk/news/uk/home-news/coronavirus-muslim-lockdown-conspiracy-theories-tommy-robinson-katie-hopkins-a9471516.html

[50] BBC (July 2020) Craig Whittaker: MP defends saying some Muslims not taking covid seriously

[51] https://libertyinvestigates.org.uk/articles/police-forces-in-england-and-wales-up-to-seven-times-more-likely-to-fine-bame-people-in-lockdown/

[52] https://www.theguardian.com/law/2020/jul/08/one-in-10-of-londons-young-black-males-stopped-by-police-in-may

OBE and others. The Hindu Forum of Britain told us how temples across the UK provided support in the community and to frontline workers. Moving forward we must do more to publicly recognise Black, Asian and minority ethnic heroes if we are to change the narrative and tackle racial prejudice.

Recommendation 11: Develop and implement a clear plan to prevent the stigmatisation of communities during Covid-19

The Government must develop a clear plan, in conjunction with local authorities, to combat stigmatisation of communities during the Covid-19 crisis. The plan should include action to address the increase in hate crime and scapegoating seen during the pandemic, including online. As part of this plan the Government should provide clear guidance on the application of the law on inciting racial hatred, and political leaders should issue a joint statement to condemn any attempt to pit communities against each other.

Recommendation 12: Urgently legislate to tackle online harms

The Digital, Culture, Media and Sport Select Committee has warned that Covid-19 has "exacerbated online harms before the machinery to deal with them has been put in place". The Government needs to take this issue seriously and must urgently bring forward its much-delayed Online Harms Bill.[53]

[53] https://committees.parliament.uk/publications/1954/documents/19089/default/

IMPROVE COMMUNICATION AND ENGAGEMENT

The Government has been rightly criticised for its poor communication during this pandemic. While this affects everyone, it has been particularly acute for some of the UK's Black, Asian and minority ethnic communities.

During the review, local government leaders, who have consistently been overlooked and excluded from decision making, spoke about the impact this has had in communities, saying:

> "Mixed messages from central Government led to lack of trust from Black, Asian and minority ethnic communities."
>
> "The guidance at the beginning was not clear and many residents got in touch to ask what they should be doing to protect themselves."[54]

We heard from various community organisations that there were few community-specific awareness raising campaigns or materials distributed by local and central government. Many local authorities also highlighted a lack of guidance and support from the Government on how to best use their expertise and local knowledge to communicate national information and priorities. As Hackney Council noted: "We have the experience, expertise and knowledge of our local communities, and know the best channels to communicate with them."

The All Party Parliamentary Group for Africa, among others, said that improvements in communicating risks to Black, Asian and minority ethnic groups are essential, for example making key communications available in community-specific languages via a variety of media sources, including popular Black, Asian and minority ethnic radio and TV stations. We also heard how some groups have exploited this lack of communication from the Government to spread misinformation.

SAGE has highlighted the important role the faith sector had in sharing Covid-19 guidance. For example, it points out that for some Muslim communities public health information shared by a faith-based credible source such as the Muslim Council of Britain was more trusted than information received from the Government.[55]

The Government should do more to engage with and utilise grassroots organisations such as charities and faith groups. To quote the JAN Trust: "We know the importance of engaging with communities to determine what issues concern them, and developing culturally sensitive and appropriate solutions."

We also heard concern about the exclusion of certain faiths and denominations from Government consultation, leading to stress and anxiety and the spread of misinformation within communities, primarily the Jewish and Muslim communities in relation to funeral guidance. The Hindu Council also told us there were concerns in the community that Hindu funeral rituals could not be performed, causing further anxiety and guilt on not honouring the last wishes.

A respondent from Wightman Road Mosque told us:

> "There is…a sense that Government guidance has been lacking in clarity and this is needed urgently for religious groups."

The Evangelical Alliance stated:

[54] Roundtable participant

[55] Pg10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/914924/s0649-public-health-messaging-bame-communities.pdf

> "An enduring lack of religious literacy in Government has also resulted in the smaller forum which consults directly with the Prime Minister not having an evangelical voice in it...who are the fastest growing and most (socially and ethnically) diverse element of the church."

As the pandemic progresses, improving communication and engagement must be a priority for the Government. As part of this, the Government should utilise existing organisations such as Healthwatch England to reach out to communities and involve them in redesigning health and social care structures post-Covid.

Throughout the pandemic, small voluntary organisations have stepped in to support communities and plug the gaps, often ones left by Government cuts to local council budgets. The expertise, knowledge and value of Black, Asian and minority ethnic third sector organisations will be critical for on the ground recovery but many of these specialist charities and grassroots organisations are themselves suffering a lack of funding. Karl Murray, from the Ubele Initiative, a community-based organisation, warned that specialist organisations are lacking reserves and this could lead to their closure.

Research conducted by the Ubele Initiative at the beginning of lockdown also found that nine out of 10 Black, Asian and minority ethnic micro and small organisations were set to close if the crisis continued beyond three months.[56]

While we know this is a problem affecting the whole of the third sector, the APPG for Africa highlighted that:

> ''Historically Black, Asian and minority ethnic groups are promised better funding but there is a lack of transparency and data gathering which makes it difficult to monitor how resources are allocated and how decisions are made.''

Likewise, we heard from the Board of Deputies of British Jews that:

> ''Many charities are concerned about their future viability and are having to seriously consider closing or else seriously reducing their activities and staffing levels.''

It is clear that supporting smaller charities who work at a grassroots level in Black, Asian and minority ethnic communities is vital. As we saw in the aftermath of the Grenfell disaster, small community-led organisations are crucial to community recovery.

Finally, a message we repeatedly heard was about the unhelpful use of the acronym BAME. This wide-ranging term ignores the significantly different impact the virus has had on ethnic minority groups. For example, we heard that there isn't a specific ethnicity classification for Somalis and they can tick up to three boxes when asked for their ethnicity. Labour Latin American Councillors also highlighted concerns that an inquiry into the impact on Black, Asian and minority ethnic people would exclude the Latin American community and stressed the importance of the inclusion of Latin America in future ethnic monitoring. The use of the term BAME can mask ethnic identities and realities of the very people it seeks to represent.

Recommendation 13: Ensure everyone can access Covid-19 communication

The Government should remove linguistic, cultural and digital barriers to accessing public health information including accessing testing, use of the track and trace app and other health and care services. The Government should work with all relevant bodies including faith and community groups to identify effective channels to disseminate information and provide support to local authorities to deliver it on the ground. Communication must have the trust of all communities and be tailored to different communities.

[56] https://static1.squarespace.com/static/58f9e592440243412051314a/t/5eaab6e972a49d5a320cf3af/1588246258540/REPORT+Impact+of+COVID-19+on+the+BAME+Community+and+voluntary+sector%2C+30+April+2020.pdf

PLUG THE GAPS IN DATA

A recurring and frustrating theme of this review has been the lack of reporting of ethnicity data, not just in relation to Covid-19 but more widely. The Government has taken some steps to improve data collection and reporting, with the creation of the 'Ethnicity facts and figures' service, but there is much more to be done.

We know there has been a failure to collect and publish basic data by ethnicity, such as the number of health and care staff who have caught Covid-19 or whether they received treatment after a positive test. We heard from Dr Chaand Nagpaul, from the British Medical Association, who said:

> "Data is crucial. Unless we have the data we won't know what to do. Even within Black, Asian and minority ethnic communities there are different outcomes. Data needs to tell us: ethnicity, religion, job occupation, profile of that job, whether there was exposure, other medical conditions, info on if they had the right PPE – in order to make sense of this in real time, to understand what is going on."

Additionally, the Muslim Council of Britain highlighted the importance of "disaggregated data on Covid-19 mortality rates continu[ing] to be collected to better understand whether there are particular factors that put individuals at higher risk", and recommended that disaggregated data should be collected as standard practice, including data on faith. As well as disaggregated data we heard that multivariate analysis is important because it allows us to more clearly see inequalities.

The All-Party Parliamentary Group for Gypsies, Travellers and Roma stated that failure to include Gypsy, Roma and Traveller ethnicity categories in the NHS Data Dictionary meant that there was insufficient data available to carry out an analysis on the impact of coronavirus on members of these groups as part of the PHE review of disparities in risks and outcomes.

Recommendation 14: Collect and publish better ethnicity data

The Government should take immediate action to implement the PHE recommendation to "mandate comprehensive ethnicity data collection and recording as part of routine NHS and social care data collection systems".[57]

The Government should also ensure all appropriate data collected and released by Government and public bodies is disaggregated to include a demographic breakdown, which enables analysis of particular intersections of ethnicity with other characteristics, such as age or religion.

Part of this will require building trust with communities. The Government should support targeted outreach and consultation activities alongside trusted community leaders to make clear the purpose of data collection to mitigate the perception of risk.

[57] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

END STRUCTURAL RACISM

"Yes we must organise the immediacy of saving lives. But we must also have a grand plan for medium to long term so it can never happen again. Underlying fundamental elements that have caused this racial impact must be challenged."

Lord Simon Woolley, Founder Operation Black Vote

Covid-19 has thrived on structural inequalities that have long scarred British society. Black and minority ethnic people are more likely to work in frontline or shutdown sectors, more likely to live in poor quality or overcrowded housing and more likely to face barriers to accessing healthcare. Biological factors do not explain the disparity in deaths and infections; Black, Asian and minority ethnic people have been overexposed to this virus.

There have been positive steps towards racial equality in recent decades. Overt racism is now less acceptable than it used to be, and the grandchildren of Commonwealth migrants have wider opportunities than their grandparents and are achieving. But racism and structural inequality still persist and some indicators have worsened.

Between 2011 and 2016, the number of young ethnic minority people in the UK who were long-term unemployed almost doubled. The Lammy Review found that the proportion of Black, Asian and minority ethnic young offenders in custody rose from 25 per cent to 41 per cent between 2006 and 2016, despite the overall number of young offenders falling to record lows.[58] Since the Lammy Review this disproportionality has got worse, with the latest statistics from Her Majesty's Inspectorate of Prisons showing that 51 per cent of boys in young offender institutions are Black or from minority ethnic backgrounds.

Nine per cent of Black people are unemployed, more than double that of white people. Pakistani and Bangladeshi ethnic groups have the lowest hourly pay – £2 less than their white counterparts. And 18 per cent of people living in Asian households have a persistent low income compared with eight per cent of people living in white households.[59]

Many Black, Asian and minority ethnic people face barriers to progression in the workplace across our economy. In the public sector, Black, Asian and minority ethnic staff make up around 20 per cent of the overall NHS workforce but just 6.5 per cent of senior managers. In London, almost half of NHS employees are Black, Asian and minority ethnic, but 92 per cent of NHS Trust Board members are white.[60] Similarly, in the private sector, the Parker Review showed that 37 per cent of FTSE 100 companies had no board members of colour and across the FTSE 350, 59 per cent of companies had no Black, Asian or minority ethnic directors.[61]

Structural inequality is ingrained from a young age. A child's socio-economic status is too often a determinant of educational attainment and life chances. Across all ethnicities, eligibility for free school meals correlates with lower educational attainment, with white children performing the worst followed by mixed race and Black children.[62]

[58] http://www.russellwebster.com/lammy-review-final/
[59] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits
[60] Pg.13https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf;https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf
[61] https://www.ey.com/en_uk/news/2020/02/new-parker-review-report-reveals-slow-progress-on-ethnic-diversity-of-ftse-boards
[62] https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/gcse-results-attainment-8-for-children-aged-14-to-16-key-stage-4/latest#main-facts-and-figures

Wider trends show however that as early as primary education white British children are 10 per cent more likely to achieve the expected standard in reading, writing and maths and, at A-level, white British students are more than three times as likely to achieve high grades than Black Caribbean students.[63] By the time they reach university, there is a 13 per cent attainment gap between Black and white students.[64] These existing inequalities will inevitably be exacerbated by Covid-19.

Moreover, we must recognise that societal prejudices are learned from a young age and fester when left unchallenged. The Macpherson Report called for improved diversity in the school curriculum, and the Windrush 'Lessons Learned' Review called for better understanding of Black British history, yet little progress has been made on diversifying the national curriculum.

The Conservatives have also introduced a range of policies to intentionally and openly create a 'hostile environment' for undocumented migrants in the UK, from blocking access to public funding to making employers, landlords and NHS staff, amongst others, check people's immigration status. This aggressive policymaking infamously culminated in the Windrush scandal, which saw people who had the right to be in the UK left in terrible circumstances. This has also contributed to the systemic discrimination experienced by migrants and the UK's Black, Asian and minority ethnic population. As Liberty put it: 'If you seem visibly foreign, these policies create a mandate for racial discrimination against you."[65] Hostile environment policies have also put barriers in the way of access to healthcare, leading to poorer health outcomes.

One submission we received described the impact of structural racism. They argued the system "discriminates against Black people – the compounding effects of lower wages, worse job prospects, worse treatment from health practitioners, experiences of police violence, and others."

Throughout this review, we heard a real sense of frustration that despite the causes of racial inequality being well known, and report after report making recommendations on how to tackle it, little action has been taken. Over the last three years, there have been numerous Government-led reviews, which have cumulatively made over 200 recommendations which could significantly change the experiences of Black, Asian and minority ethnic people in the UK. Yet few of these recommendations have been taken forward effectively.

This sense of frustration is justified. Theresa May commissioned a race disparity audit in 2017 that led to no concerted Government action. In response to the Black Lives Matter movement, Boris Johnson announced yet another Commission on Race and Ethnic Disparities, and chose as its chair a man who has cast doubt on the existence of institutional racism.[66] This only adds to the feeling among some communities that this Government is simply not serious about tackling racism and persistent racial inequalities.

As Labour's Shadow Justice Secretary David Lammy said:

> "We do not need another review, or report, or commission to tell us what to do…It is time for action on the countless reviews, reports and commissions on race that have already been completed'."[67]

[63] https://www.ethnicity-facts-figures.service.gov.uk/summaries/black-caribbean-ethnic-group
[64] https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2019/bame-student-attainment-uk-universities-closing-the-gap.pdf
[65] https://www.libertyhumanrights.org.uk/fundamental/hostile-environment/
[66] https://www.theguardian.com/world/2020/jun/15/dismay-over-adviser-chosen-set-up-uk-race-inequality-commission-munira-mirza https://www.theguardian.com/world/2020/aug/11/race-equality-chief-tony-sewell-faces-legal-challenge-over-appointment
[67] https://www.theguardian.com/commentisfree/2020/jun/16/race-inequality-review-boris-johnson-black-lives-matter-david-lammy

Recommendation 15: Implement a race equality strategy

If we are to tackle the scourge of racial inequality, we need action not reviews from Government. This means the development of a race equality strategy, as called for by the Equality and Human Rights Commission, developed with Black, Asian and minority ethnic communities and with the confidence of all those it affects.

Any strategy should:

- Ensure all departments and public bodies conduct race audits and produce a roadmap to improve the recruitment, retention and progression of Black, Asian and minority ethnic people
- Support the implementation of the public sector equality duty to ensure proper compliance
- Have a strong mechanism for parliamentary accountability and clear milestones to measure success, including related to disparities outlined in previous Government reviews

Recommendation 16: Ensure all policies and programmes help tackle structural inequality

When the Government and political parties develop policies and programmes, racial equality must be a positive aspiration, not an afterthought or a tick-box exercise. Equality impact assessments should be used much more effectively to shape and inform policy, and policymakers should seek to tackle structural racism with their decisions. The Government should also enact section 1 of the Equality Act, which requires public bodies to reduce inequalities that result from socio-economic disadvantage.

Recommendation 17: Introduce mandatory ethnicity pay gap reporting

The publication of ethnicity pay gaps should become mandatory for firms with more than 250 staff, to mirror gender pay gap reporting. The Government has been consulting on this change for years but has failed to make any progress.

Recommendation 18: End the 'hostile environment'

The Government's 'hostile environment' policies have had far reaching consequences for migrants and the UK's Black, Asian and minority ethnic population – far beyond the stated intention of the policies. The Government must commit to stopping the 'hostile environment', and reform our immigration system so that it is fair and effective.

Recommendation 19: Reform the curriculum to fight the root causes of racism

The Government, working with the Devolved Administrations, should launch a review into the diversity of the school curriculum to ensure it includes Black British history, colonialism and Britain's role in the transatlantic slave trade. The school curriculum should include and inspire all young people.

Recommendation 20: Take action to close the attainment gap

The Government should implement a national strategy with clear targets to close the attainment gap at every stage in a child's development, enforced through an independent body, such as the Children's Commissioner.

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Health & Social Care SCRUTINY COMMISSION

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