INSTITUTE of HEALTH EQUITY

STRUCTURAL RACISM, ETHNICITY AND HEALTH INEQUALITIES IN LONDON

CONTENTS

ACKNOWLEDGEMENTS 4

FOREWORD 6

CHAPTER 1. INTRODUCTION 7

Framework and structure of the review 9
How is racism in London already being tackled? 10
Intended audiences 10
Definitions and terminology 11
Methodology 13
Limitations of the review 14

CHAPTER 2. LONDON'S DEMOGRAPHICS AND ATTITUDES TOWARDS IMMIGRATION AND ETHNICITY IN THE CAPITAL 15

London's ethnic composition 16
Culture and racism in london 28

CHAPTER 3. RACISM AND ETHNIC INEQUALITIES IN HEALTH 31

The experience of racism on health 32
Self-reported health by ethnicity 32
Causes of mortality by ethnic group 36
Ethnic inequalities in maternal and infant mortality and health 42
Mental health 45
Violence 49
Covid-19 and ethnicity 50

CHAPTER 4. RACISM AND ETHNIC INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH 55

4A. GIVE EVERY CHILD THE BEST START IN LIFE 56

Ethnic inequalities and early child development 56
Participation in early years services and take-up of freechildcare 58
Child poverty 59
Experiencing trauma during childhood 60
Experiences of racism and discrimination in the early years 61
RECOMMENDATIONS: GIVE EVERY CHILD THE BEST START IN LIFE 62

4B. ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES 63

Ethnicity and inequalities in education 63
Post-school education and training 78
Access to jobs and skills-building 80
Young people, safety and the criminal justice system 83
RECOMMENDATIONS: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THE LIVES 86

4C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL 87

Rates of employment and ethnicity 87
Pay and inequalities in pay 95
Quality of employment 98
RECOMMENDATIONS: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL 104

4D. ENSURE A HEALTHY STANDARD OF LIVING 105

Wealth and income inequality 105
Poverty 106
Food poverty and insecurity 107
Fuel poverty 109
Digital poverty 110
Debt 110
Welfare, benefits and financial support organisations 111
RECOMMENDATIONS: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL 114

4E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE COMMUNITIES AND NEIGHBOURHOODS 115
Housing and ethnicity in london 115
Places, health and ethnic inequalities 125
Crime and experience of the criminal justice system 130
RECOMMENDATIONS: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES 139
4F. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION 140
Smoking 140
Alcohol 140
Drug misuse 142
Obesity 143
Physical activity 145
RECOMMENDATIONS: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION 146
CHAPTER 5. RACISM AND ETHNIC INEQUALITIES IN HEALTH AND SOCIAL CARE 147
5A. NHS services 148
Detentions under the mental health act 152
Mental health services for young people 155
Experiences of racism in maternity services 155
Maternal mental health 157
Reducing ethnic inequalities in maternal and infant health services 157
5B. Racism and medical practice, technologies and research 160
Medical practice 160
Research 161
Treatments and new technologies 162
5C. Social care services 163
5D. Employment in health and social care and experiences of racism 164
Healthcare 164
Employment in social care 167
RECOMMENDATIONS: END RACISM IN HEALTH AND SOCIAL CARE 167
CHAPTER 6. TAKING ACTION ON RACISM – THE ROLE OF ORGANISATIONS AND SYSTEMS 168
6A. LEGISLATION, REGULATION AND ENFORCEMENT 169
The Equality Act 169
Hate crime legislation 171
Healthcare inequality duties 172
6B. ORGANISATIONAL ACTION ON ANTIRACISM 173
Leadership on antiracism 173
Organisational accountability for racism 179
6C. COMMUNITY CO-PRODUCTION 182
Working with voluntary, community, faith and social enterprise organisations 185
6D. RESOURCING AND INVESTMENT TO TACKLE RACISM 186
6E. DATA, RESEARCH AND EVALUATION TO IDENTIFY AND TACKLE RACISM 187
6F. NATIONAL ADVOCACY AND SOCIAL MOVEMENTS TO SUPPORT ANTIRACISM 189
RECOMMENDATIONS TOWARDS A MORE RACIALLY EQUITABLE SYSTEM: THE ROLE AND IMPACT OF INSTITUTIONS AND ORGANISATIONS 189
CHAPTER 7. REPORT CONCLUSIONS 190
RECOMMENDATIONS 192
APPENDICES 197
APPENDIX 1: ETHNIC CATEGORIES IN THE CENSUS 198
APPENDIX 2: LIFE EXPECTANCY BY ETHNIC GROUP 200
APPENDIX 3. ETHNIC INEQUALITIES AND COVID 202
REFERENCES 207

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FOREWORD

What kind of society do we want? That is the question to which this report provides important answers. The question was given new urgency in Britain, this summer of 2024, by the most appalling outbreak of racist-fuelled violence. Our answer is clear: we want a society where all its members, whatever their ethnic background and country of origin, have the conditions, the freedoms, to lead lives they have reason to value. One way we will know that is happening is all groups in society having the conditions for good health. It is those conditions for good health – the social determinants of health – that are the focus of this report.

The UK is remarkably diverse – London, the focus of this report even more so. London, as a great world city, has attracted people from all over the world to make lives here for themselves and their offspring and to contribute to the economy, culture and dynamism of London and the UK. It is a profound injustice if conditions for good health are unequally distributed, depending on ethnicity. Especially so, if that unequal distribution results from the evils of racism.

The UCL Institute of Health Equity (IHE) was funded by the Greater London Authority (GLA) to write this report. The IHE's modus operandi is to review evidence, synthesise it and make recommendations. It is a careful deliberative process. That process has been applied here – hence the lengthy report that follows from this Foreword. But racism, and its ill-effects, the damage it does to people's lives and hence their health, has leant an urgency to our deliberations. As has the testimony of those who have born its brunt. Racism is a scar on society. Social justice requires that we take the action necessary to deal with it and with its underlying causes.

In the IHE's previous reports, for example the 2010 *Marmot Review, Fair Society Healthy Lives*, and the 2020 *Marmot Review: 10 Years On*, there was a clear focus on socioeconomic inequalities in the social determinants of health. One approach to ethnic inequalities in health would be to continue that approach and reduce socioeconomic inequalities in conditions of life. To the extent, that particular ethnic groups had high levels of socioeconomic disadvantage, that would provide welcome benefits.

There are limitations to this approach. First it fails to address the question of why some ethnic groups are more likely to be in poverty, experience poor housing, suffer in the educational and criminal justice system, be low paid and experience racism and its effects in the labour market. Second, it fails to address the question of how racism directly damages health and well-being. Third, it does not deal with racism that limits access to health and other services. Fourth, there are the impacts of intersectionality. Being poor, Black, disabled, of particular gender, faith or sexual orientation, may be worse for health than being only one of those alone.

For all these reasons we gladly accepted the invitation from authorities in London to conduct this review and make recommendations for decision-makers and stakeholders across London. The fact that London wanted this report reflects the commitment, leadership and ambition to root out racism and prevent its health consequences, building on longstanding efforts. Indeed, we report on many welcome programmes, interventions and approaches in London on which future actions can build. We know that racism is a challenge that transcends boundaries and borders, and whilst this report is for London, we hope that it will have wider impact across the UK. Indeed, much of the data that we cite is for the UK as well as London.

Racism has deep historical roots; it is pervasive; and it is embedded in the structure of society. However, we now find ourselves at a pertinent point in history for our society. When we look back at this time, we hope it will be seen as the moment when London, and the nation, woke up to the scale of inequality – a moment when we decided the future would be different.

In this report, we make recommendations to bolster meaningful change in institutions. In our view it is an important step in removing the scourge of racism from our society and improving health for all.

Michael Marmot and Habib Naqvi (Co-Chairs)

CHAPTER 1

INTRODUCTION

Racism in the capital is widespread and persistent, causing damage to individuals, communities and society as a whole. Its impacts are experienced in different ways and to varying levels of intensity related to individual experiences, socioeconomic position and other dimensions of exclusion such as disability, age and gender. The intersections with other dimensions of exclusion can amplify the effects of racism. Our focus is on the effects of racism on health and its contribution to avoidable inequalities in health between ethnic groups – a particularly unacceptable form of health inequity. It is urgent that society tackle the damage to health and wellbeing as a result of racism.

Repeated exposure to racism leads to an accumulation of disadvantage and poorer health over the life course. (1) (2) (3) (4) Racism affects health in three, interrelated ways. Firstly, experiencing racism directly damages physical and mental health. Secondly, racism may be a cause of socioeconomic disadvantage and adverse exposure to the social determinants of health which undermine health. Thirdly, racism damages health through the operation of the health care system and other services.

Structural racism has its origins in historical influences and is embedded in economic, legal and political systems. It refers to the way racism is produced, embedded and normalised in societal structures, laws, cultures and institutions and relations between people, affecting the whole population. The welcome acknowledgement in London of structural racism and its effects has been accompanied by leadership and steps taken to address these ill-effects. More can be done. Much more. Racism is an unacceptable stain on society. Correcting it is a matter of social justice.

There is much to be learned from study of the historical, economic and cultural origins of racism. It underpins the way structural racism operates, but it is not the focus of this report.

Two concerns are central to this report. First, for those of us whose primary concern is health, we need to understand the structural causes of health inequalities which affect patterns of ill-health. Many of those patterns are judged to be inequitable and unnecessary - the result of unfair societal structural arrangements, policies and programmes. Second, by investigating ethnic differences in the social determinants of health, we understand more about how racism damages people's lives from birth, through the life-course. It is a contribution to understanding of an urgent social problem and strengthens advocacy and evidence for urgent action.

This review mostly focuses on racism perpetuated by institutions where you can see its impacts in London and it is where organisations, leaders and community groups in London have direct leverage. We recognise that institutional racism has its origins in societies' broad structures and action is urgently needed to change and influence those structures. The effects of structural racism are evident in ethnic inequalities in experiences in education, rates of poverty, employment, pay, career progression, experience of the criminal justice system, housing and health care services, particularly maternity and mental health services, as well as in experiences of racism between people. Institutions, communities, systems and leaders in London have the ability to influence those structures which embed racism; through representation, advocacy, leadership and supporting changes to legal systems, investment decisions, economic policies and shaping cultures and discourse.

We, at the UCL Institute of Health Equity, have been focused on inequalities in health between groups defined socioeconomically, according to income, education, work or level of deprivation. We have compiled the evidence for action on the social determinants of health to achieve greater health equity. (5) In our 2020 review, '*Health Equity in England: the Marmot Review 10 Years On*', we lamented the relative scarcity of systematic evidence on ethnic differences in both health and the social determinants of health which hindered efforts to understand or tackle ethnic differences and the impacts of racism on health. (6) The Race and Health Observatory was set up in 2021 with the mission to examine race and health with a particular focus on the health care system. (7) Recognition of differences in health between ethnic groups in Britain goes back some decades. (8) We draw, too, on understanding from the Americas where the role of racism in shaping health has had a much longer tradition of study and, regrettably, is much in evidence. (9)

A particular challenge is that there is not a simple one-to-one relationship: racism damages health. Some ethnic groups will, no doubt, have experienced racism but not have worse health, or have better health, than average. Some ethnic groups may have worse health than the British average but it would be wrong to jump to the conclusion that racism is the main cause. Examination of this question is a focus of this report and we conclude that racism has profound influence on health.

The approach taken in this report is that, in large measure, health inequalities between ethnic groups do not reflect biological properties of those groups but reflect the way structures and institutions interact with, and affect attitudes between ethnic groups and with other dimensions of inequality.

Going beyond this simple dichotomy, we examine intersectionality. Characteristics such as ethnicity, disability, gender, age and sexual orientation will have greater impact together on health than only one of those dimensions alone. They interact with social and economic disadvantage to damage health. For example, it was put to us that being disabled, from an ethnic minority group and disadvantaged economically is a potent health-damaging combination.

The GLA funded this report as part of a series of reviews focussed on building the health inequalities evidence base in London. The four commissioned reviews cover housing, the cost of living, adult skills and, in this review, the health and health equity impacts of structural racism. (10) While the focus of the series is London, the approach and recommendations in this and the

other reviews should be relevant to other places. The present report, responds to the need to examine ethnic differences in both health and the social determinants of health and explore the role that structural racism plays in generating observed inequalities between ethnic groups.

At the start of this review, an initial consultation with community groups was held in October 2022, led by the GLA. The participants emphasised the range of aspects of discrimination and racism they experienced in many of the key social determinants. These experiences informed the broader scope of this review. We took up the suggestion of involving community groups and representatives more centrally in the review. An Advisory Board was established, who requested that further steps be taken to bring in community expertise. The process to do this is described below.

The Advisory Board consists of representatives and leaders from a range of ethnic minority community groups covering key social determinants, senior leaders on antiracism and public health in London, and academic experts. The Advisory Board met four times and provided advice and input for the duration of the review.

FRAMEWORK AND STRUCTURE OF THE REVIEW

The review covers ethnic inequalities and racism in health and in six areas of social determinants of health that are the key drivers of health, as set out in the 2010 Marmot Review – *Fair Society, Healthy Lives* and again in *Health Equity in England: the Marmot Review 10 Years On*. (11) (6) The analysis and recommendations in this review are carried out against these six areas, which also form the basis of six policy objectives to reduce inequalities in health, as follows:

Following this introduction, Section 2 provides an overview of the demographic context in London and cultures that are relevant to understanding the impacts of racism on health. Section 3 sets out ethnic inequalities in health. Section 4 overviews the main social determinants of health according to the six policy objectives above. Section 5 covers racism within health and social care services. Section 6 sets out the principles for the development of antiracism approaches in organisations in order to reduce institutional racism and assesses current legal and regulatory mechanisms designed to prevent racism and hold organisations and individuals to account. Section 7 concludes and summarises the recommendations.

RECOMMENDATIONS FOR ACTION

Following overviews of the evidence in each section, recommendations for action are made covering each of the six social determinants policy areas in Section 4, health and social care services in Section 5 and for the legal and regulatory system and organisations in London in Section 6. The recommendations have been shaped by the views of the Advisory Board and as a result of the community engagement led by the Race Equality Foundation. The GLA commissioned a community engagement process to develop a short set of priority recommendations for action in London in response to the review drafts and recommendations. The process has involved community groups who represent some ethnic minority groups and who may also represent specific concerns, such as maternity services, disability and poverty.

High-level recommendations to tackle racism and its effects are not particularly sensitive to the different experiences of racism and differing impacts on individuals and between ethnic groups. This report shows varying health and social determinants of health outcomes between ethnic minority groups and there are also important nuances in experiences of racism among different age groups, genders, disability and socioeconomic position.

The intention is that more detailed recommendations for action which are sensitive to these important differences are made by organisations and sectors which have responsibility for those outcomes. The ambition for this report is that the public health system, the GLA and other organisations also take the recommendations and develop more detailed recommendations and implementation plans relevant to their sectors.

Our general approach in the recommendations is that of proportionate universalism: universalist policies with effort proportionate to need. Ethnic inequalities and the health effects of racism make a simple appeal to universalism insufficient. The following five principles apply:

1 Public health to take a leading role in highlighting the impacts of racism in health and the social determinants and in putting racial equity at the heart of policy and interventions.

2 Spending and resource allocation must be proportionate to the scale of inequities in health and its social determinants and address racism and its intersection with socioeconomic disadvantage and other dimensions of exclusion.

3 Services must be culturally appropriate and designed with minoritised ethnic communities that are most affected.

4 There must be effective action to combat racism with sufficient accountability and appropriate sanctions.

5 There must be appropriate data and evidence to strengthen accountability to enable the effects of racism to be monitored and anti-racism policies and interventions evaluated.

There are many data and evidence gaps related to ethnicity and racism and there are also recommendations to strengthen research and data in these areas.

HOW IS RACISM IN LONDON ALREADY BEING TACKLED?

There are ongoing and developing programmes to tackle racism in London and, in some arenas, strong antiracism leadership and community activity. This review includes case study examples of programmes developed by a range of sectors, organisations and services. Our desk research did not include evaluating the case studies ourselves but drew on any available evaluation or impact studies. Here we briefly introduce some of what is already being done in London with further detail in Section 6.

We acknowledge that while there are certainly reasons to be positive about antiracism in London, racism is still pervasive and, according to some reports set out in Section 2, may be increasing. Many of the mechanisms and programmes set up to challenge racism are only partially effective or are poorly or under-used. More positively, awareness of ethnic and racial inequalities in health has increased since the disproportionate impacts on some ethnic minority groups from the COVID-19 pandemic, the death of George Floyd and as a result of the Black Lives Matter movement. Understanding is also growing about the complex drivers of these differences. Inequities tracing back to colonialism have shaped and continue to drive racism in Britain today.

Influenced by this growing recognition, leaders across the GLA, London Councils, London boroughs, London's health and care system, public services and businesses have made public commitments to antiracism in the past few years alongside the community and voluntary sector, which are summarised in Section 6. Many of the antiracism programmes established in London are relatively new and therefore we have not yet seen their impact, but we hope that they will be developed with, and informed by the findings of this review.

It is important also to recognise the commitments and the hard work of many in the voluntary and community sector - and particularly those in London's race equity sector - who have long highlighted and fought against racism and provided support for groups who experience racism in their daily lives. Many community organisations have led the development of antiracism approaches which are now been adopted in many sectors. Some private sector organisations have also strengthened their focus on tackling racism, particularly in recruitment, pay and progression, and are strengthening partnerships with community organisations.

INTENDED AUDIENCES

The review is intended to support organisations in London and beyond to strengthen their understanding and action of racism and health by:

1. Developing the evidence base.
2. Proposing interventions to reduce racism and its impacts and for public health to have tools to strengthen advocacy with other sectors to tackle racism.
3. Recommending the strengthening and scaling up of antiracism approaches in London including in public health.

   Recommendations for action are highly relevant for the following sectors:

   - Local authorities
   - Regional and national government
   - Healthcare
   - Social care
   - Housing, planning and regeneration
   - Public services
   - The community, voluntary, faith and social enterprise sectors

- Businesses and economic sectors
- The research and information sector

In addition we hope that the analysis informs public debates about health and racism and makes a contribution to international work on health inequalities and the impacts of racism.

DEFINITIONS AND TERMINOLOGY

Broadly, health inequalities are systematic differences in health between social groups. Those inequalities that are avoidable by reasonable means are considered inequitable. (12) Health inequalities are largely driven by inequalities in the social determinants of health – these are the conditions in which people are born, grow, live, work and age – and the structural drivers of these conditions, namely the unequal distribution of power, money and resources. (13)

Language matters – it relates to power relations and cultural attitudes and impacts communities in tangible ways. For instance, collective terminology leads to policies that do not take account of differing ethnic groups and their specific histories, experiences and outcomes. Language used to describe ethnic minority groups in the UK is contested and is not universally understood nor agreed, and definitions change over time. We recognise the strong and sound arguments behind different uses of language in this important area. After consultations, we adopted the approach taken by the Race and Health Observatory – see below.

RACE AND RACISM

Race is a categorisation which purports to be based on physical characteristics, however, it is a social construct derived from discrimination and prejudice which is embedded in laws, histories and societal norms and which has been used to justify subjugation and discrimination of one race over another – hence the turn *racism*. (14) It leads to the unfair distribution of power, money and resources and inequalities in the conditions of daily life in education, employment and housing and experiences of services outlined in this report. *Ethnicity* is also a socially constructed categorisation, usually used to refer to race and shared cultural experiences, religious practices, traditions, ancestry, language, dialect or national origins (for example, African-Caribbean, Indian, Irish). (15) (16) The term differentiates among groups of people according to cultural expression and identification as well as physical characteristics. (17)

Separating racism into three different types of racism, as described below, can assist in action to reduce racism and indicates where action should be directed. These forms of racism are highly interrelated and interdependent and for those experiencing racism different forms of racism can be experienced at the same time and can be indistinguishable. Structural racism leads to and enables institutional/organisational and interpersonal racism.

Structural racism is racism that occurs systematically across society and is reflected in the practices, culture and traditions of social, economic, legal, educational and political systems in society which lead to unfair and inequitable distributions of power, money and resources which penalise ethnic minority groups. Racism embedded within societies' structures reflects historical power relations and attitudes, and are consequently entrenched within systems, policies, institutional practices and laws. Structural racism manifests in institutions and organisations and in racism between individuals. Structural racism drives and shapes cultural attitudes about race and enables and reinforces racism towards individuals and groups. The forces underlying structural racism are so embeded in daily life that they are seen as the inevitable order of things. (18) (19) White privilege is one of the ways structural racism is experienced and perpetuated in daily life and refers to the many advantages that White individuals experience, which they may not be aware of. White privilege is a result of a system that takes Whiteness as the norm and perpetuates this through the institutions, allocation of resources, systems and societal norms. (20) Examples include goods and services which are oriented towards White people, another example is not expecting to be discriminated against, feel uncomfortable or disadvantaged in public settings.

Institutional racism refers to discriminatory policies and norms rooted in institutions and organisations and comprises a broad range of practices perpetuating differential access to services, experiences and opportunities within institutions based on race, culture or ethnic origin. (21) Institutional racism is largely driven and shaped by structural racism and represents a failure of institutions to tackle racism. It can be experienced in processes, attitudes and behaviour which amount to discrimination, deliberately and through unwitting prejudice, ignorance, thoughtlessness and racial stereotyping. The levers of change, such as cultural shifts, policy and legal changes may feel beyond the capacity of individual institutions. However, there is much that institutions can do within their own organisational practices and processes. By developing clear antiracism approaches, individual institutions develop precedent and exemplars for others to follow and can directly challenge the structures that give rise to racism.

Individual or interpersonal racism can involve avoiding and ignoring people due to their ethnic background, discriminatory treatment during personal interactions, such as making racial slurs, stereotyping, making derogatory comments, 'microaggressions', violence, intimidation and other forms of exclusion, including lack of representation and feeling different or alone. Interpersonal racism is closely related to institutional and structural racism which enable or perpetuate interpersonal racism and does not hold individuals accountable.

INTERSECTIONALITY

Inequalities are not the result of single, or distinct factors or characteristics but are the result of overlapping discriminatory structures and processes that create inequitable outcomes. (22) Racism is one element of exclusion and discrimination and intersects with other contexts of people's lives and their characteristics. Socioeconomic position, gender, sexuality, age and disability are all dimensions of exclusion that frequently intersect with experiences of racism and often exacerbate the extent of exclusion and its impacts on health and on the social determinants of health. Ableism is another pervasive form of discrimination. Ethnic minority groups may experience multiple disadvantages that damage their health: for instance, experiencing racism, being socioeconomically disadvantaged, female, and disabled can lead to multiple and cumulative discrimination and disadvantage. The migration history of individuals also reflects their length of exposure to racism and discriminatory behaviour in the UK. In Section 3 we show how patterns of migration and length of stay in the UK affects health.

CLASSIFICATIONS OF ETHNICITY

The NHS Race and Health Observatory undertook a review of terminology about ethnicity in 2021. They were encouraged to conduct the review "by a resurgent Black Lives Matter movement which has led to a renewed scrutiny of the terms used to describe ethnicities in the UK". (23) Following consultation with stakeholders in 2021, its review concluded that there is no one term that is acceptable to all the diverse communities in England, and instead of recommending a particular term, recommended a set of principles: to be specific where possible, to not use acronyms, to specify context, to be transparent about language and to be adaptable as preferences and contexts change over time. (23) This review adopts these principles.

Increasingly organisations are using terms including 'minoritised groups', 'racially minoritised groups/ communities', or 'Black, Asian and minoritised groups'. The word 'minoritised' reflects that individuals have been minoritised through social processes of power and domination, rather than just reflecting that groups are numerical minorities. It also better reflects the fact that some ethnic groups that are minorities in London are majorities in the global population. While we are in agreement with the emphasis on minoritisation as an active process reflecting social constructs and power relations, this review, reflecting the RHO Review, uses the term 'ethnic minority' which encompasses all ethnic groups except the White British group. (23) The term minoritised is used in some of the case studies, reflecting the organisations' preference.

Where appropriate and the data are available we identify specific ethnic groups. The UK government prefers not to capitalise ethnic terms such as 'black' or 'white', unless the name includes a geographical place. However, following consultation with the Advisory Board and review of broader practices this report capitalises ethnic terms. Where data are presented, we follow the categories and terminology used by the authority that collected the data, rather than that which is self-identified, except where ethnic categorisation was expressed by those involved in the community engagement and in surveys. As this is a review of evidence and interventions, we also use the terminology that is used in the reports, evidence, interventions, policies and strategies and data we draw on, which is why there might be some inconsistencies in use of language in different parts of the report.

The ethnic groups and categories used in data collection have changed over time and therefore there is often discrepancy in the terms used. Accordingly, this review variously uses the 19 detailed ethnic groups, Box 1, or five higher level ethnic groups, used in the 2021 Census of England and Wales as well as more simple descriptions, Asian, Black, Mixed, White, Other. (20) A more detailed consideration of the classifications by ethnic group is in Appendix 1.

Box 1. 5 and 19 ethnic categories (ONS classification) (24)

1. **Asian, Asian British or Asian Welsh**
   Bangladeshi
   Chinese
   Indian
   Pakistani
   Other Asian

2. **Black, Black British, Black Welsh, Caribbean or African**
   African
   Caribbean
   Other Black

3. **Mixed or multiple ethnic groups**
   White and Asian
   White and Black African
   White and Black Caribbean
   Other mixed or multiple ethnic groups

4. **White**
   English, Welsh, Scottish, Northern Irish or British
   Irish
   Gypsy or Irish Traveller
   Roma
   Other White

5 **Other ethnic group**
   Arab
   Any other ethnic group

The use of summary classifications for ethnicity frequently masks the different experiences of many ethnic groups and means that their particular experiences are not represented in data and therefore overlooked. Many community groups work to highlight the experiences of particular ethnic groups and try to deal with the circumstances of underrepresented groups.

ASYLUM SEEKERS AND MIGRANTS

Migration policy shapes the health and social and economic conditions for those seeking asylum and can increase the extent of racism many ethnic minority groups experience. This report highlights how migration policy has shaped discrimination and racism towards ethnic minority groups in England.

The definition of a refugee according to the United Nations Refugee Convention is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of their nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (25)

A person seeking asylum, or an 'asylum seeker', is a person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded. (26) In terms of UK migration law a person becomes a refugee when an individual who has applied for asylum meets the definition in the Refugee Convention, and are then entitled to be issued with documentation as official recognition. (27)

METHODOLOGY

All the reviews in the series were commissioned as rapid desk reviews of evidence of effective interventions in specific areas. As a rapid evidence review this review captures evidence gathered via:

1. Literature searches of widely used databases
2. Searches in published and unpublished grey literature
3. Data
4. Advice and information from stakeholders and the Advisory Board
5. Information from community engagement

DATA

Health data. While reliable information on ethnicity is not directly available from many health records, longitudinal linkage of records often provides a more acceptable level of reliability. For example, the ONS can link ethnicity recorded in the Census to death and other health outcomes, and NHS England can link together successive hospital episode records to obtain a more complete picture of ethnicity than that provided at a single episode of care. Additionally, censuses and surveys can ask respondents about both their ethnicity and health status – although in the case of surveys, reliability and representativeness at the whole-of-London or borough level is dependent on sample size and design.

Social determinants data is available from the census or some administrative sources at a granular level such as Middle Layer Super Output Areas (MSOAs). These sources, as well as large surveys, also provide data at local authority level. We use data which is disaggregated, where possible, by ethnicity and Index of Multiple Deprivation (IMD). For many topics there are significant gaps in data by ethnicity and/or IMD which limits the analysis of inequalities related to ethnicity and is partly why those inequalities are overlooked.

Overall, there is a lack of large sample data that enables analysis by multiple characteristics associated with discrimination and disadvantage, such as disability, ethnicity and socioeconomic position. In this review we do provide some analysis to highlight these intersecting and cumulative disadvantages, but there is a need for more data to enable this analysis.

COMMUNITY ENGAGEMENT

Those experiencing racism are often not involved in its identification nor in development of actions to reduce racism and therefore the extent and effect of racism can be overlooked and remediating actions may not be well designed nor effective. Much can be gleaned by hearing from individuals and groups who have experienced racism and understand its impacts on their health and living and working conditions. Such accounts are essential in assessments of inequalities and their impacts and in the development of recommendations for action. It is also important to note that individuals experience ethnicity and racism in different ways and that use of the term 'community' or 'groups' at times, will be a simplification of the multiple experiences of individuals.

Community engagement was not originally planned for this work but community feedback in the early stages of developing the scope of the review deemed it essential. The decision was made to significantly extend the remit of the review and cover a full range of issues that shape health in London and involve community groups in the review. To this end there were three ways communities were involved, through:

1. Representation on the Advisory Board.
2. A set of meetings with community groups to explore themes and limitations of the review.
3. The establishment of a group of people with expertise and experience in the issues and areas covered by the review in order to assess the report and develop more detailed recommendations.

While the engagement has enabled a deeper understanding of key issues and experiences which fed into the review and recommendations, it was not a comprehensive consultation with all available and affected communities or people with lived experiences of the impacts of racism.

Six sessions were held, involving seven community voluntary sector organisations, each one used materials based on the July 2023 draft of this review, to discuss the groups' responses to the findings and recommendations. The feedback was then summarised for IHE by the GLA, reviewed and incorporated into the draft.

A further community collaboration was established in February 2024 to develop a shortlist of practical recommendations relevant to the London context, building on this review. This process, led by the Race Equality Foundation, involved health and care partners and race equity experts in the statutory and voluntary, community and faith sectors with three strands of activity. The Design Working Group with approximately 12 members comprising individuals with lived experience, representatives from voluntary, faith, and community organisations, and statutory health and care organisations. They held a number of meetings to take the draft recommendations and develop more detailed London context specific proposals. The process included reviewing and coproducing recommendations for the different areas the evidence review covers. The working group decided to take a life course approach leading to development of recommendations for each stage of life. These recommendations were tested through two strands of activity - a by invitation survey and two workshop events to consult more widely with attendees from across the health and VCS community. Participants were asked to assess the deliverability of the draft recommendations and to identify any omissions that must be addressed. The outputs are recommendations that cover stages across life and are relevant for London, supported by and actionable by London organisations.

Analysis for this review also built on other community engagement exercises undertaken including the Beyond the Data consultations during the pandemic and the London-wide follow-on carried out by the GLA's Health Equity Group consisting of health and care partners. (28) (29)

LIMITATIONS OF THE REVIEW

Ethnic minority groups have lived experience of racism and discrimination and a thorough understanding of how racism affects their lives – often overlooked by organisations and policymakers. This review provides context. Primarily, it is aimed at organisations and service providers. We make recommendations for the inclusion of community organisations in the design and delivery of policies and services in order to ensure that their experiences and views of how to tackle racism and ethnic inequalities are taken into account effectively.

The review does not include religious discrimination. Often discrimination on the basis of religion is an expression of racism, but it is not considered separately in this review. Even within London, there is considerable overlap between ethnicity and religion – among both those identifying with the Jewish and Muslim faiths, for example, every one of the 19-fold ethnic groups was represented – albeit with very different proportions seen in each ethnic group. These overlaps between ethnicity and religion are complex and not captured well in data or surveys. For instance, in the 2021 census 71,000 people in England and Wales self-identified as of Jewish ethnicity, while 270,000 people identified that they believed in Judaism. Also 3.4 million people declined to answer the question on religion in the Census and 20.7 million who did answer said they had no religion.

While we have drawn on available reports on experiences of racism within institutions and on analyses of structural racism, these are not comprehensive and not available for all sectors or services and they do not encompass the multitude of ways in which people experience racism. There are reports into racism, particularly in the contexts of education, health care and the criminal justice system, which add to the body of evidence about its extent and effects. We include evidence presented in many of these reports and build on existing analyses and campaigns for racial justice, particularly from community and voluntary sector organisations. However, analyses in this report are constrained by what is available.

Racism may be inferred by looking at the outcomes for specific ethnic minority groups where such data are available. However, not all ethnic differences relate to racism, so conclusions require careful analysis and consultation.

We give case study examples of actions to mitigate the impacts of racism and develop antiracism practices but this is in no way a comprehensive overview of all the interventions and approaches that have been developed in London, often by communities themselves.

CHAPTER 2

LONDON'S DEMOGRAPHICS AND ATTITUDES TOWARDS IMMIGRATION AND ETHNICITY IN THE CAPITAL

This section sets out London's demographics including ethnic composition, immigration patterns, length of stay in the UK and age structures of some of the largest ethnic groups in London. Different ethnic groups have different age profiles, migration histories and social class profiles. All these influence peoples' experiences and duration of exposure to racism and discrimination and therefore impact on health and the social determinants of health. The social and occupational classes of ethnic groups in London is explored in order to provide important context to subsequent discussions about the relationships between health, ethnicity and racism as social and occupational class are very important determinants of health.

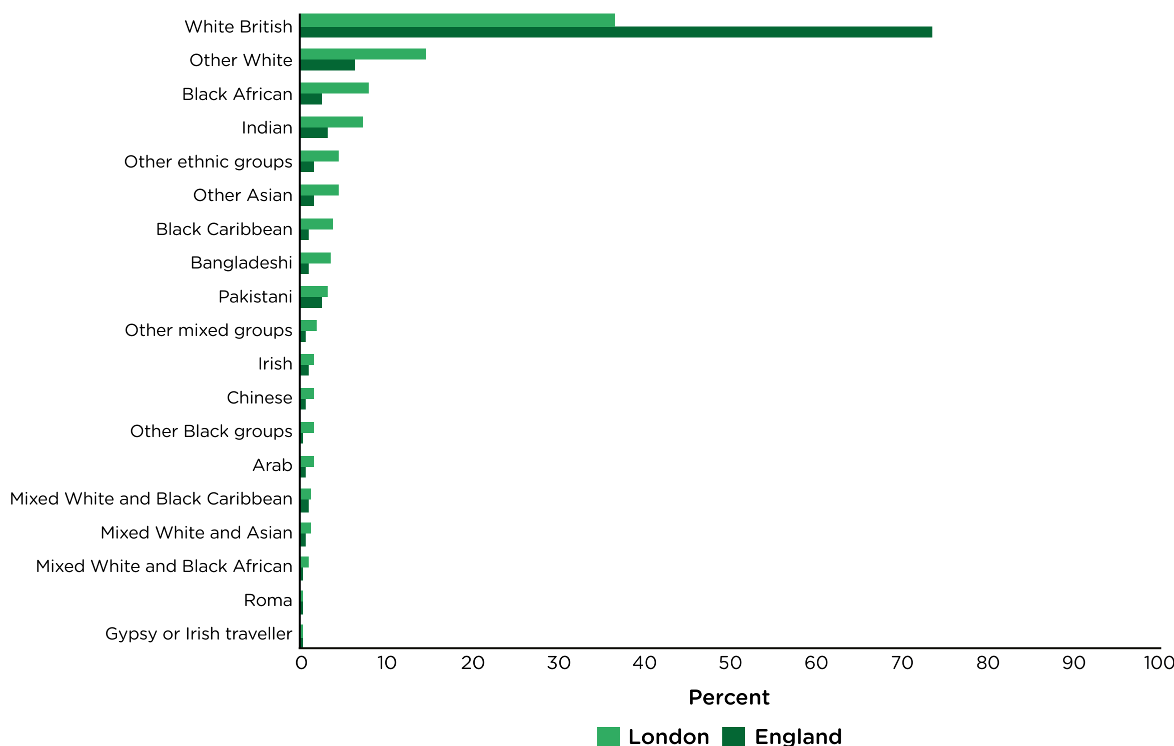
Migration policy is another important context in understanding the impacts of racism on health; it directly impacts the health of migrants, asylum seekers and refugees who become excluded from essential services. It leads to racial profiling and discrimination towards ethnic minority groups who are seen by service providers and employers as potentially being 'illegal immigrants', and hence to exclusion from services and employment to which they are entitled. Finally, in this section, reports of unfair treatment related to ethnicity are set out along with reports of surveys about how life in London is experienced by various ethnic groups.

LONDON'S ETHNIC COMPOSITION

The population of the London Region is estimated at 9 million. Between 2011 and 2021, London's population grew at a higher rate than the England population as a whole, at an estimated 7.7 percent in England compared with 6.6 percent. (30)

London is an ethnically diverse city. Overall, White groups comprised 53.8 percent of the population of London in the 2021 Census, compared to 81 percent in England as a whole. (31) Asian, Black and Mixed groups comprised 20.7, 13.5 and 5.7 percent, respectively, of London's population. For England as a whole, the corresponding figures were 9.6, 4.2 and 3 percent. A more detailed breakdown of ethnic groups in the 2021 Census is shown in Figure 2.1. The largest ethnic group was those who self-identified as White from one or other part of Britain - 36.8 percent in London compared to 73.5 percent in England as a whole. Aside from a number of other White groups (e.g. Irish, 1.8 percent, Gypsy, Irish Travellers and Roma, 0.5 percent and the residual 'other White' group, 14.7 percent), the largest detailed ethnic minority groups in London were those who self-identified as Black African or Indian, at 7.9 and 7.5 percent, respectively, compared to 2.6 and 3.3 percent in England as a whole. (31)

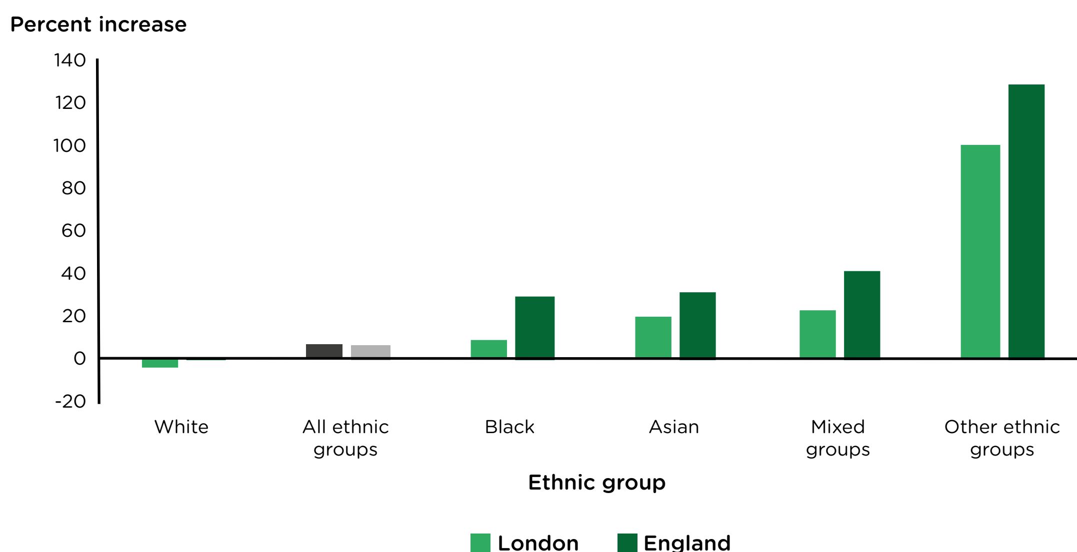
Figure 2.1. Percent of population by ethnic group, London and England, 2021



Source: *Census 2021 (31)*

London and England both became more ethnically diverse between 2011 and 2021. While the White group population in London decreased by around three percent, it increased slightly, by one percent, in England as a whole (Figure 2.2). Population growth was mainly driven by other ethnic groups in both cases. As ethnic minority groups formed a smaller proportion of the population in England as a whole than they did in London in 2011 (14.6 and 40.2 percent, respectively), the relative increases in each ethnic group were larger in England than in London. Those of Asian ethnic origin formed the largest broad ethnic group in 2011 (18.5 and 7.8 percent in London and England as a whole, respectively) and experienced the next highest relative increases (22.7 and 40.9 percent, respectively).

Figure 2.2. Percent increase in ethnic group populations between 2011/12 and 2021/22, London



Source: *ONS (32)*

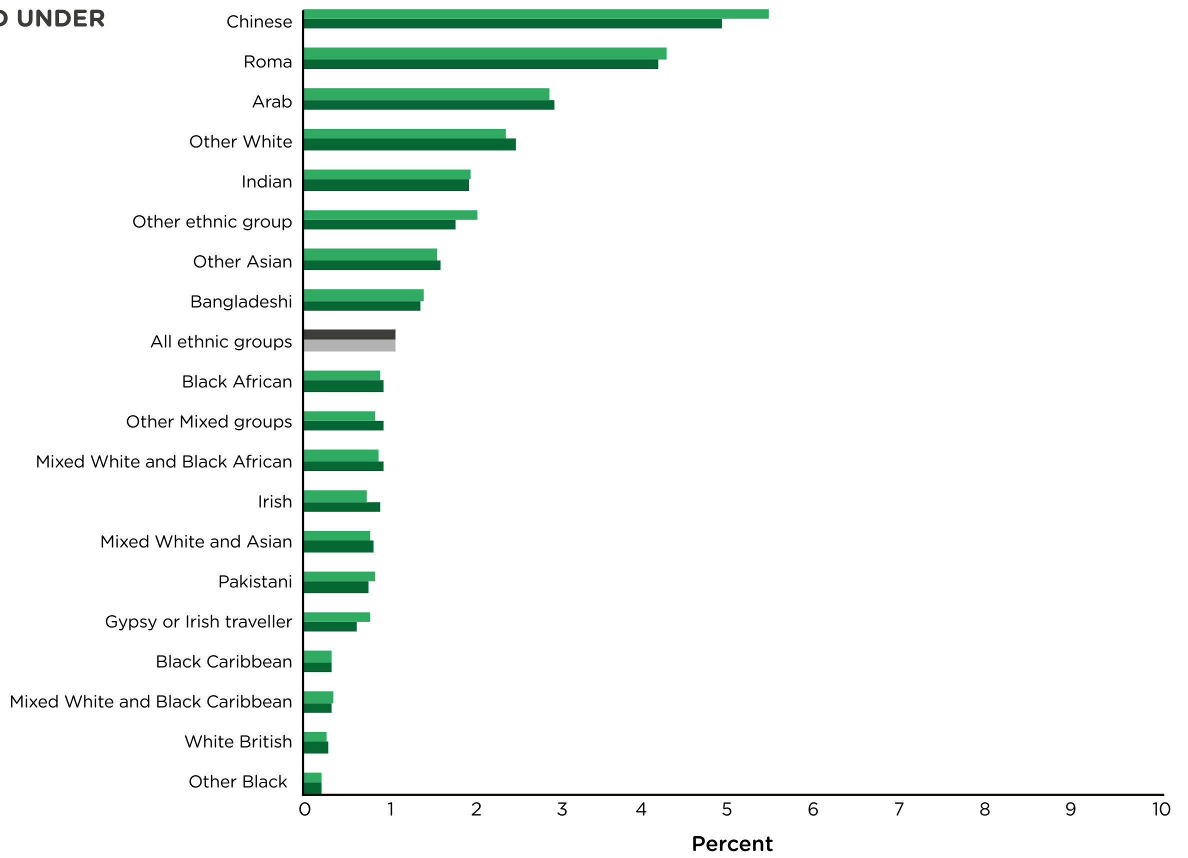
The Borough of Newham was the most ethnically diverse local authority in London in 2021, with people from the Asian, Black, Mixed and Other ethnic groups making up 69.2 percent of the Borough's population, compared with 46.2 percent for London as a whole. (33) Tower Hamlets, Redbridge, Brent and Harrow all also have ethnic minority populations of over 60 percent. (33) These areas all have high concentrations of particular ethnic minority groups. For example, in Tower Hamlets 34.7 percent of the population identifies as Bangladeshi or British Bangladeshi and in Harrow 28.8 percent of the population identifies as Indian or British Indian. (33) The least ethnically diverse borough is Richmond upon Thames, with 19.5 percent of ethnic minority populations who do not identify as White, followed by Bromley, Havering and Bexley, all with under 30 percent. (33)

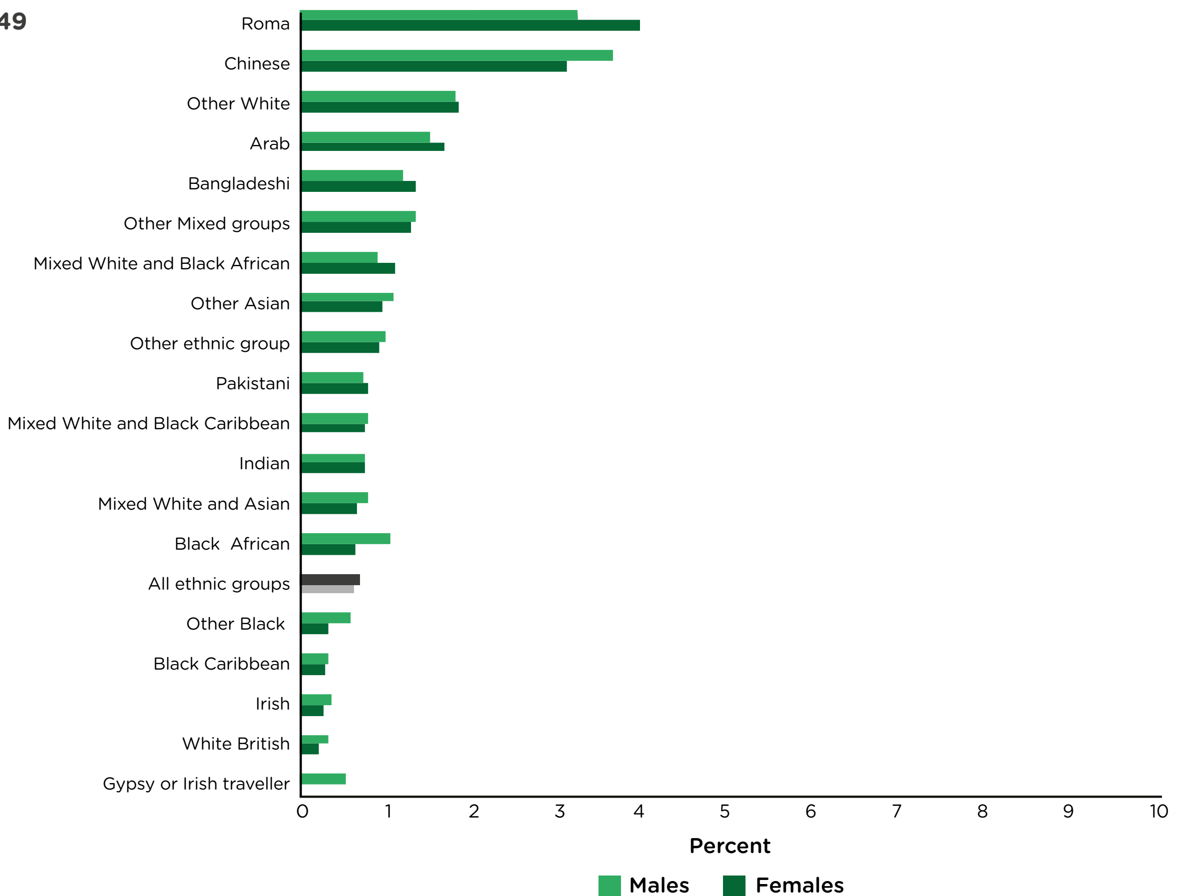
There is some correlation between ethnic diversity of neighbourhoods and deprivation. None of London's 10 percent least-deprived neighbourhoods has a Black African population of higher than 5 percent but all of London's most deprived, apart from one, do. In Bromley, for example – one of London's least deprived and least diverse boroughs – there are only four neighbourhoods in the 20 percent most deprived neighbourhoods in London. These four neighbourhoods are four of the five neighbourhoods in Bromley with the highest proportion of residents with Black African backgrounds. (33)

IMMIGRATION INTO LONDON

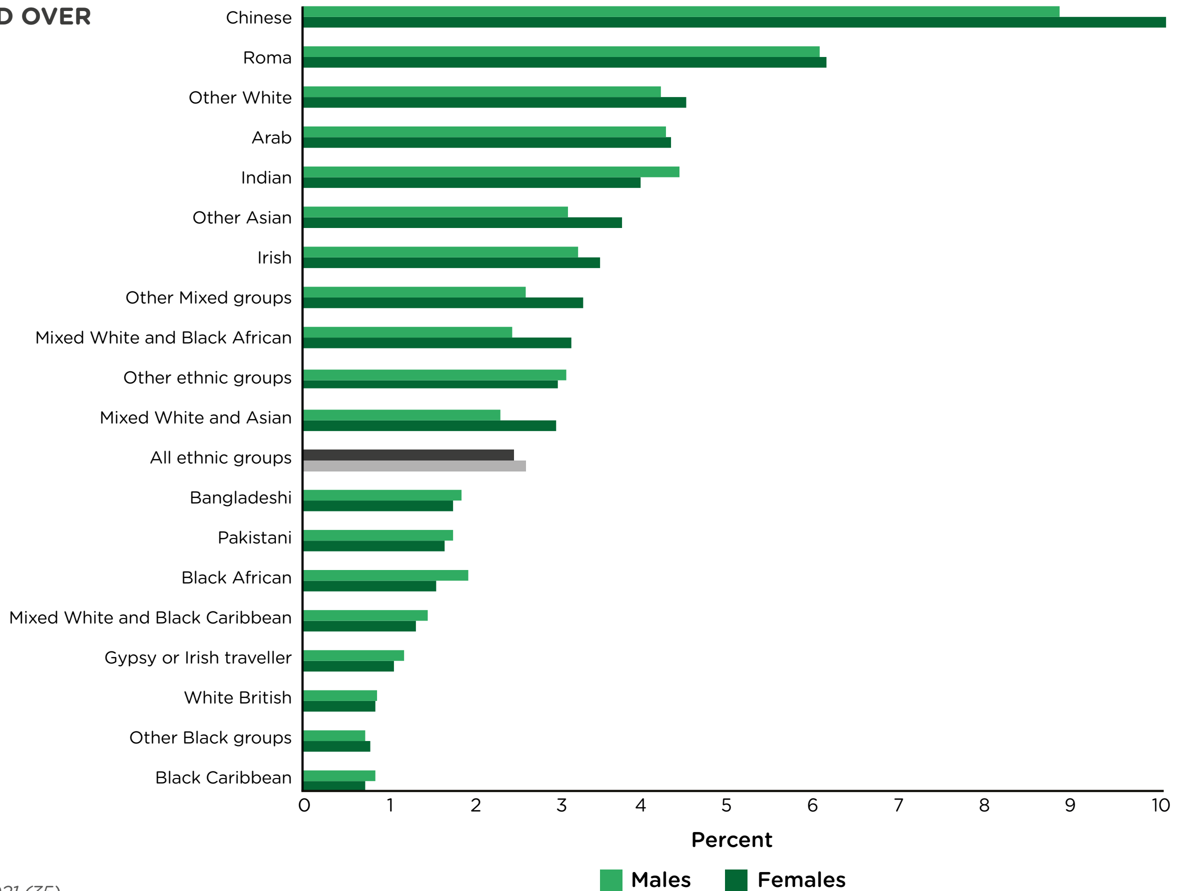
The 2021 Census shows that one in three London residents was born outside the UK. (34) The highest proportion of arrivals from outside the UK in 2021 were Chinese people, including from Hong Kong under the British National Overseas Scheme, and Roma, in each age group (Figure 2.3).

Figure 2.3. Percent of London residents with an address one year ago outside the UK by ethnic group, sex and broad age group, 2021





C. AGED 50 AND OVER



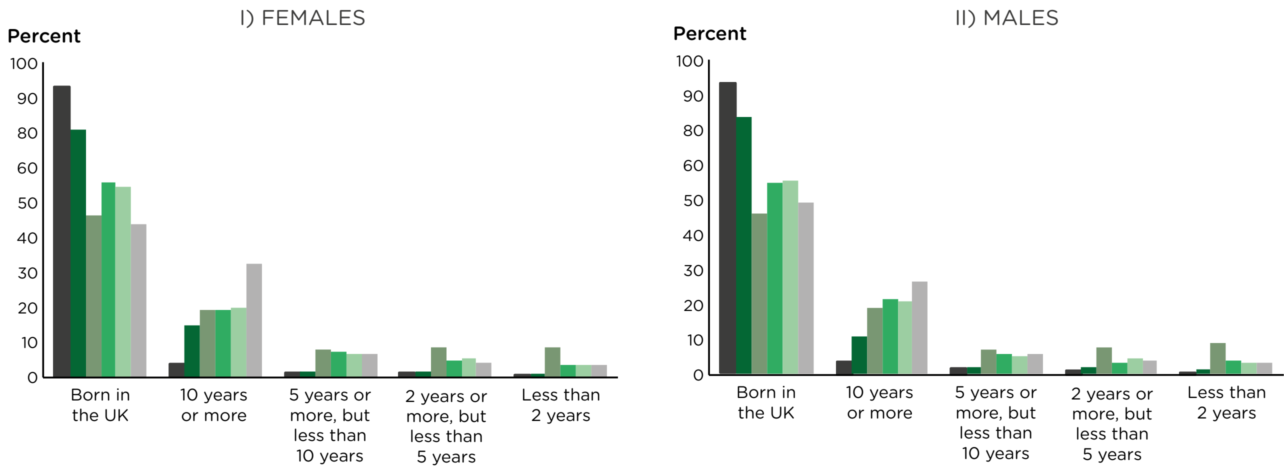
Source: *Census 2021 (35)*

Figure 2.4 provides an indication of duration in the UK by ethnic group and broad age group. For those who have only recently arrived in the UK, most of the accumulated advantage and disadvantage that influences their health would have been experienced prior to arrival in the UK. The risk that exposure to racism in the UK had adversely affected their health could be argued to be less than if the same individual had spent a greater proportion of their life here. Of course, other factors, such as ethnic group, socioeconomic position and age affect experiences and impacts of racism. (36) (37)

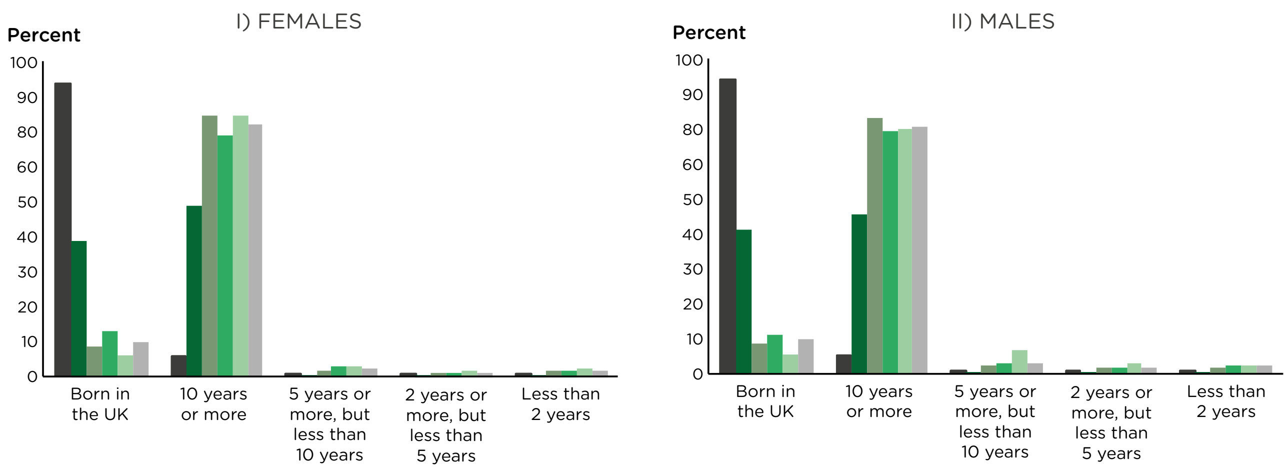
Among those aged under 50, around half of the larger ethnic groups were born in the UK, with the exception of Black Caribbeans and White British (around 80 and 92 percent UK born, respectively). For those who were not born in the UK, the time since arrival varied considerably – although in each case the majority had been in the UK 10 years or more. Shorter durations in the UK were more common among those of Indian origin than any other ethnic group. At ages 50 and over, for most of the larger ethnic groups, only between 6 and 15 percent were born in the UK. The exceptions are again Black Caribbean (43 percent of women and 47 percent of men, respectively) and White British (93 percent of both sexes). In this age group, within each ethnic minority group shown in Figure 2.4, the most common duration was arriving in the UK more than 10 years prior to 2021.

Figure 2.4 Distribution of each large ethnic group by whether born in the UK and, if not, length of residence in the UK, London, 2021

A) AGE UNDER 50



B) AGE OVER 50



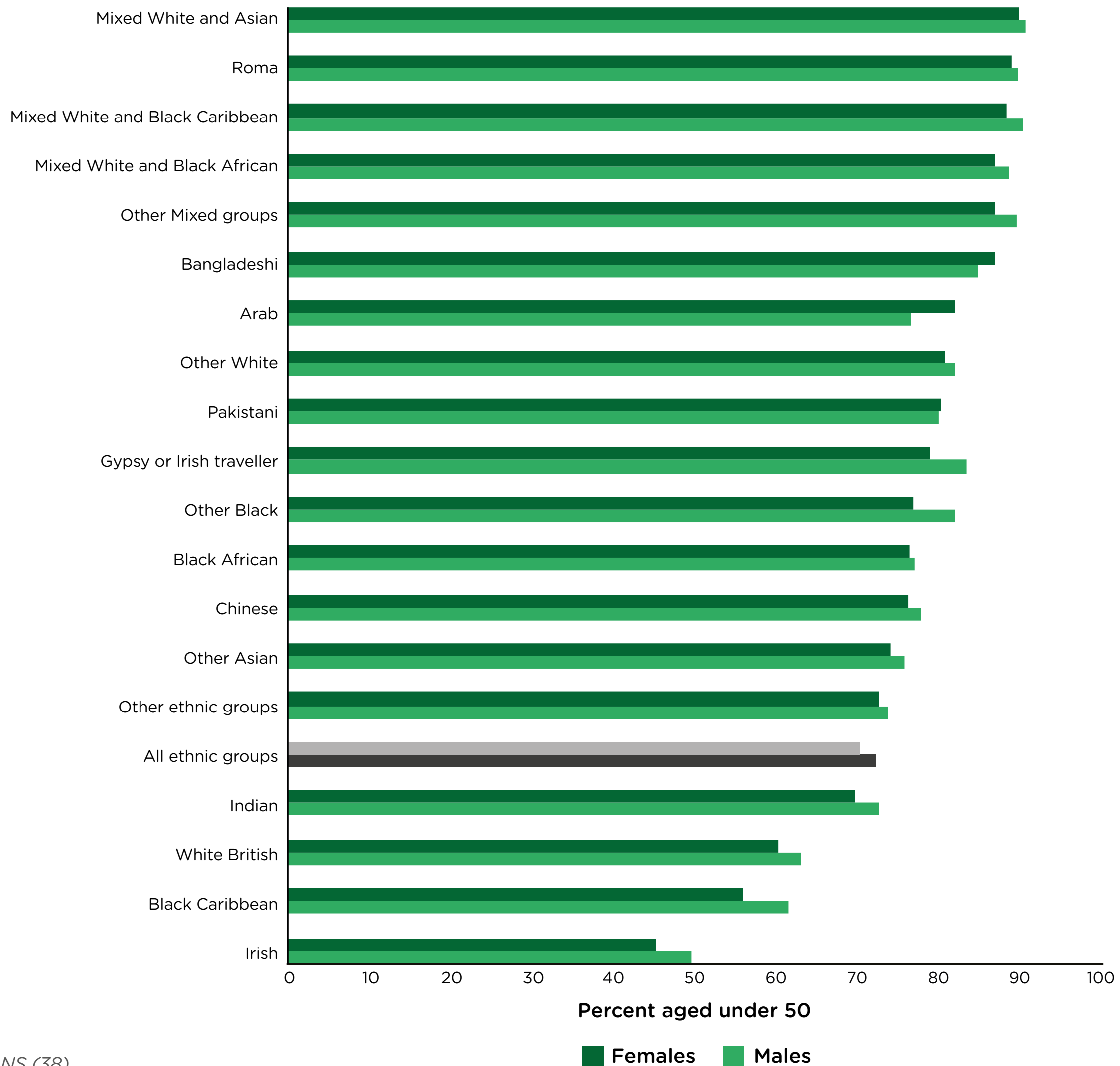
White British Black Caribbean Indian Pakistani Bangladeshi Black African

Source: *ONS (35)*

AGE STRUCTURE AND ETHNICITY

There are differences in the age structure of the population in London by ethnicity. Most ethnic minority groups have a relatively young age profile. The main exceptions are those identifying as Irish, Black Caribbean or of Indian background (Figure 2.5), likely due to these groups being involved in earlier waves of immigration into London in the 20th Century. These differing age structures by ethnicity point to a need to design for services to be more sensitive to the ethnic and age profiles of the populations they serve. Recommendations to this effect are made for health and social care services in Section 5.

Figure 2.5. Percentage of population of London aged under 50, by ethnic group, 2021



Source: *ONS (38)*

SOCIAL CLASS AND ETHNICITY

There are differences in how long individuals can expect to live, related to their occupation in England and Wales. (39) There are many factors that contribute to these differences and many reasons why an individual might or might not attain a class that indicates a longer life. Some of these apply equally across all ethnic groups, for example, social disadvantage, disability, gender. Others will vary between ethnic groups, for example, proportion of working life spent in the UK, and impacts of racism experienced including in education, employment and/or occupational progression. Differences in the social class structure of ethnic groups therefore provides important context to the analysis of health inequalities in Section 3 and of the social determinants in Section 4.

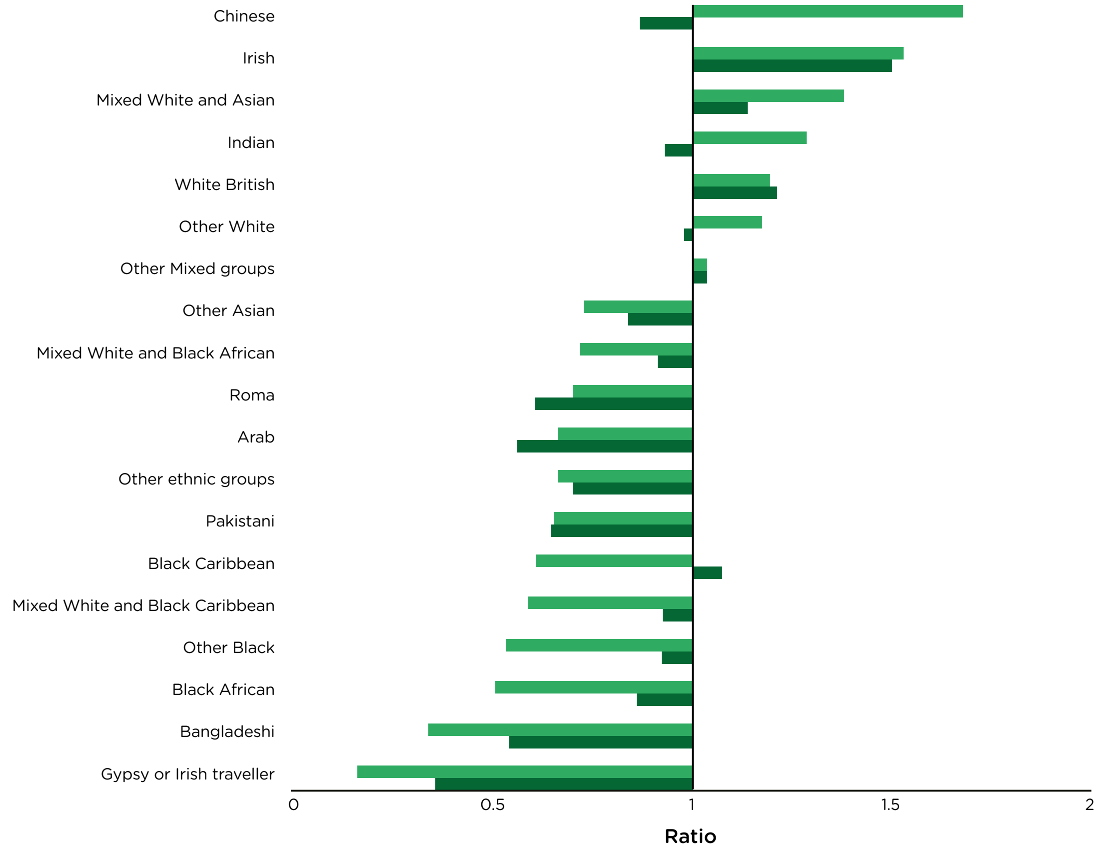
Managerial, administrative and professional occupations are generally the most advantageous for health and are jobs either at the highest levels of organisations or requiring specific advanced professional skills. As Figure 2.6(A) indicates, those of Chinese, Irish, Indian, Mixed White and Asian origin, White British and Other White groups are more likely to be in a higher managerial, professional or administrative job than the average Londoner, among both men and women aged 16 to 64. Among both men and women, Gypsy and Irish Travellers, Bangladeshis and most Black groups are the least likely to be in managerial, administrative and professional jobs. While being younger means that an individual is unlikely to be able to obtain such a job, racism will also reduce the opportunities for such employment.

Lower managerial, administrative and professional classes have a different profile. Those of Irish, White British and Mixed White and Asian origins are more likely to be in these jobs than the average Londoner while Gypsy and Irish Travellers and Arabs are least likely. Additionally, Roma and Bangladeshi women are also least likely to be in this class.

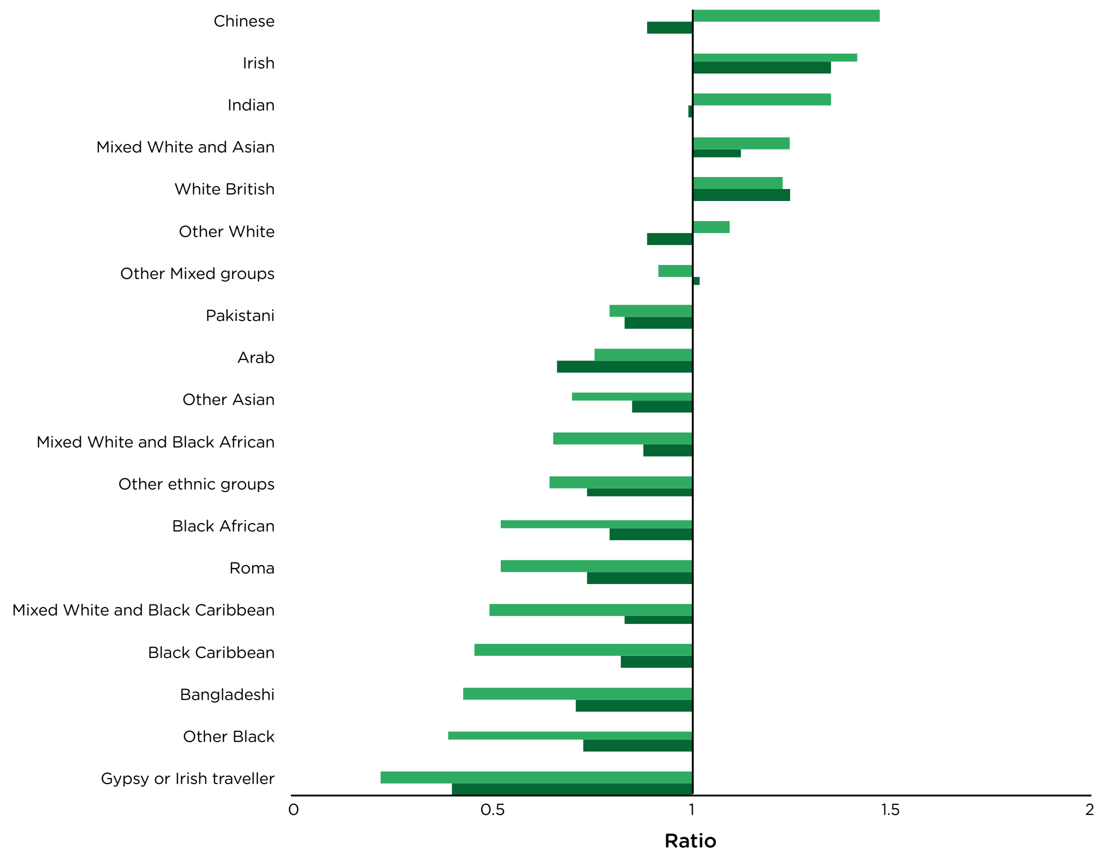
Figure 2.6 Ratio of the percent of those aged 16 to 64 in each ethnic group at Census who were in selected occupational classes (NS SEC) compared to the corresponding percent for all Londoners at that age, London, 2021

(A) MANAGERIAL, PROFESSIONAL AND ADMINISTRATIVE OCCUPATIONS

I) FEMALES

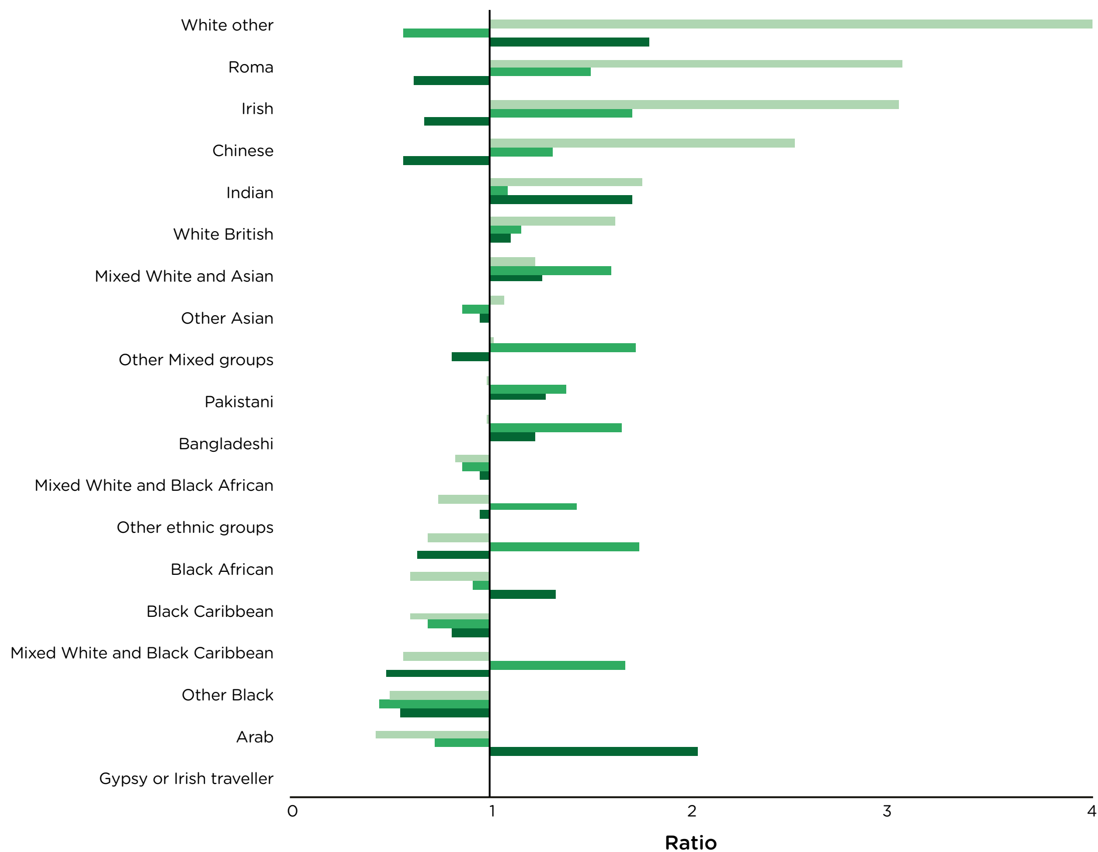


II) MALES

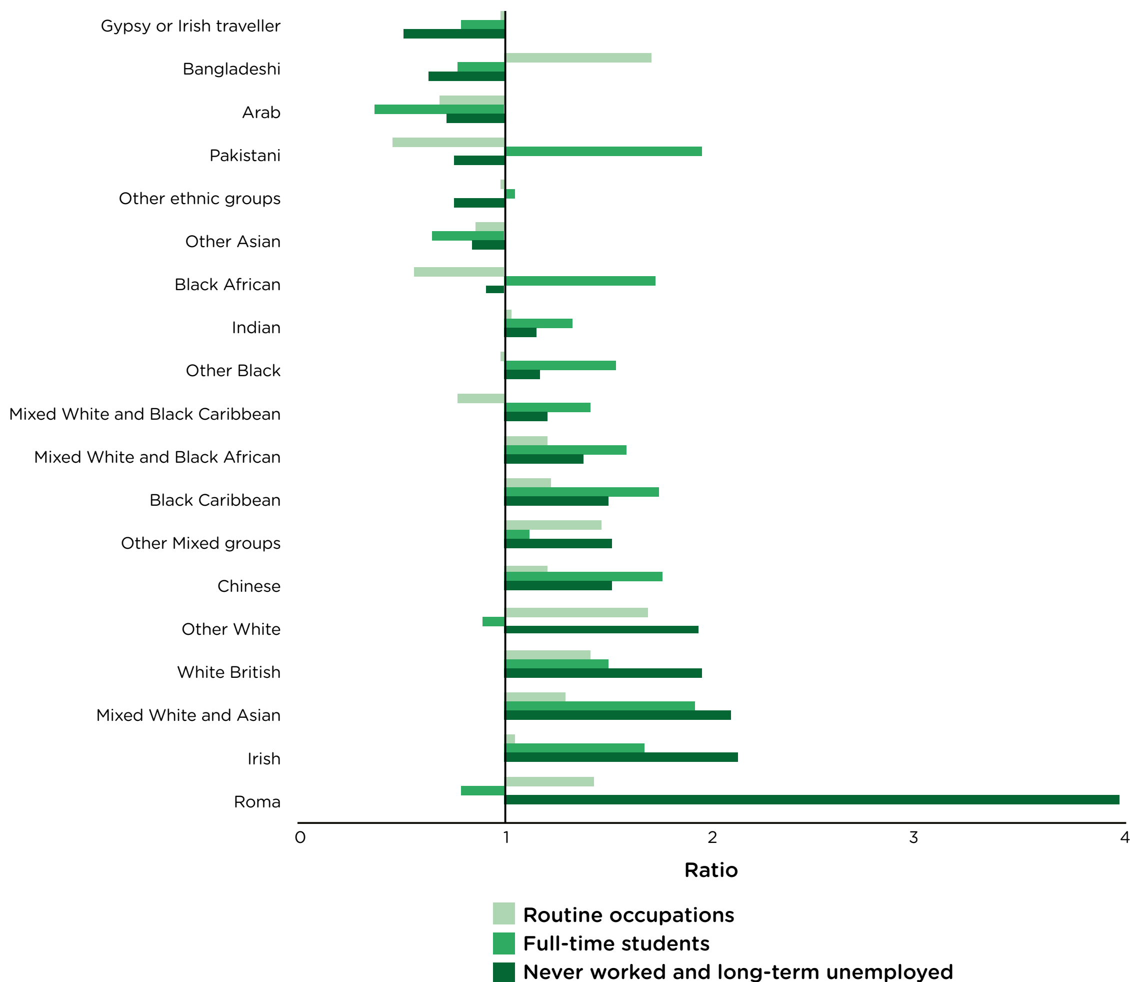


(B) NEVER WORKED, LONG-TERM UNEMPLOYED, STUDENTS AND ROUTINE OCCUPATIONS

I) FEMALES



II) MALES



Source: *ONS 2021 Census customised dataset (35)*

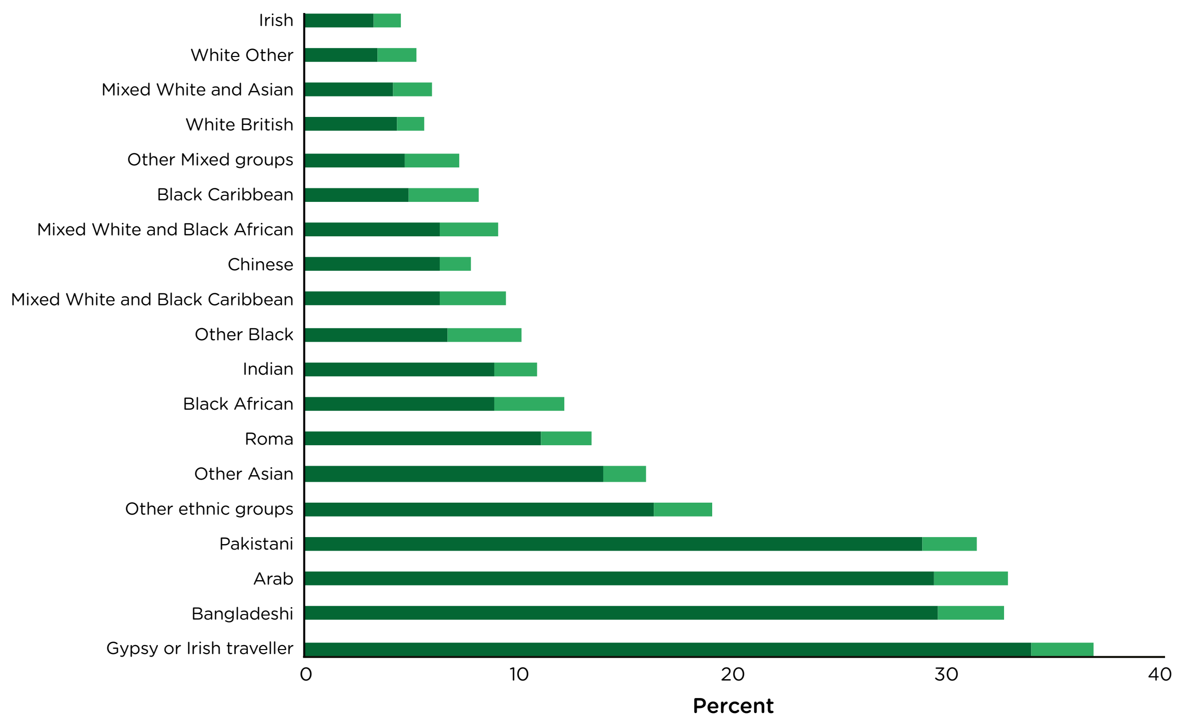
In contrast to Figure 2.6(A), Figure 2.6(B) highlights those who were either in the least skilled routine occupations and those who were not in employment at Census, either never having worked, being long-term unemployed or being a student. Each of these situations clearly has a different implication for life chances and health. In both sexes, it was Gypsy and Irish Travellers who were most likely to be in the 'never worked and long-term unemployed' class at age 16 to 64 in London. Bangladeshi, Arab and Pakistani women were also more likely than others to have never worked or be long-term unemployed, while rates were higher among men for Arabs and some Black groups.

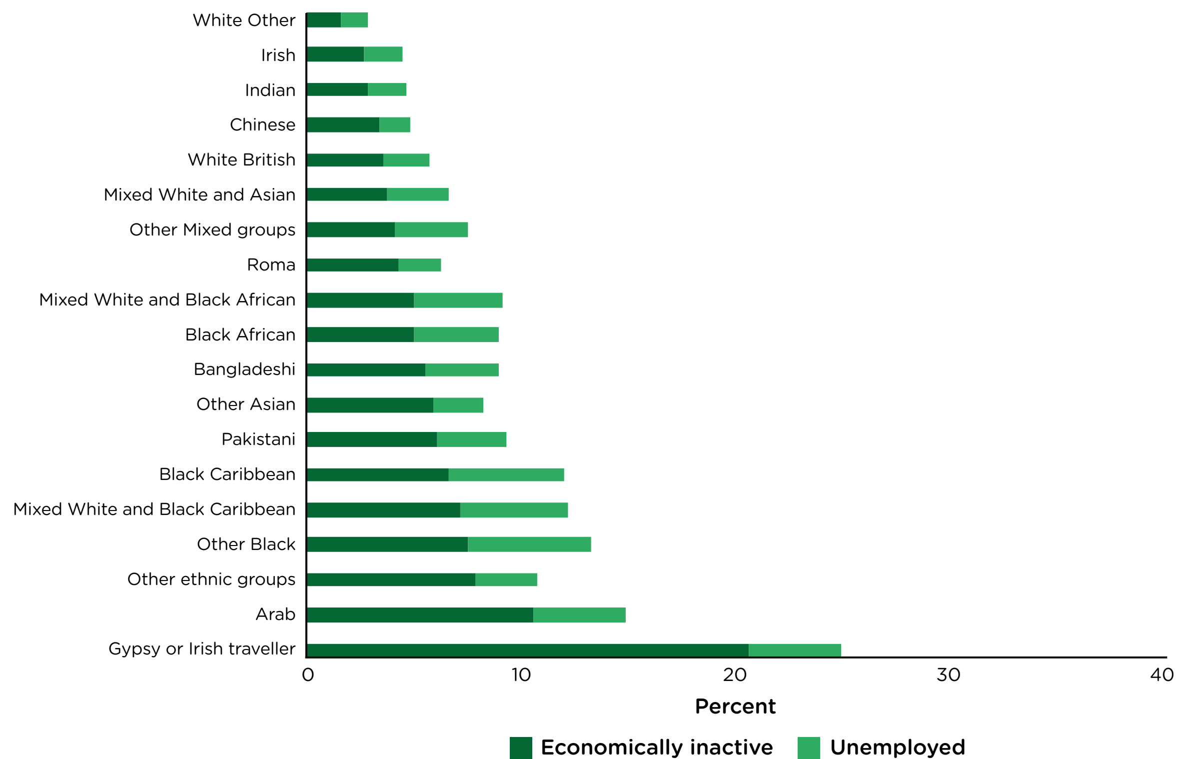
Among women, Gypsy and Irish Travellers, Roma and 'Other' ethnic groups were more likely than others to be in routine occupations in London. Among men, it was Roma and those of Black Caribbean origin who were more likely to be in these occupations.

Many, but not all, ethnic minority groups included a higher proportion of students than the average for London in both sexes, reflecting both a younger age profile and pointing to a healthy migrant profile, as their numbers would have included international students who might only be in London for the duration of their course.

One important inference it is not possible to draw from Figure 2.6(B) is the distinction between those who had never worked, that is those who are economically inactive and the long-term unemployed. Unfortunately, due to ONS disclosure rules, we cannot make this distinction ourselves for London. However, Figure 2.7 indicates this distinction for England as a whole and shows that the largest proportions, around 30 percent, of women who reported that they were economically inactive i.e. had never worked, were in the same ethnic groups as those identified in Figure 2.6(B). The largest long-term unemployment rates were between three and four percent for women from Arab and various Black ethnic groups. Among men, a smaller proportion than women reported never having worked and a larger proportion were long-term unemployed – peaking at 5.4 and 5.7 percent for Black Caribbean and 'Black other' groups, respectively. Long-term unemployment is particularly harmful for health.

Figure 2.7 Percent of each ethnic group at ages 16 to 64 at Census who had never worked or were long-term unemployed by whether economically inactive or unemployed by sex, England, 2021





Source: *ONS 2021 Census customised dataset (35)*

The differences in occupational class and unemployment and economic inactivity by ethnicity provide important insights into the likelihood of poor health, further set out in Section 3 and also into the extent of ethnic inequality and racism in employment in London, in Section 4C.

LANGUAGES

More than 300 languages are spoken across London. The 2021 Census showed that the proportion of the population with main languages other than English was three times as high in London as in the rest of England. And 1.83 million people in London, around 22 percent of residents aged three and above, compared with 7 percent in the rest of England, reported that English was not their main language. (35) (40) For those in London whose main language was not English, most reported speaking English 'very well' (46 percent, or 840,500 residents), or 'well' (35 percent, 636,200 residents). Four percent of residents in London whose main language was not English (355,000 residents) were recorded by the 2021 Census as not speaking English well or at all, up from 320,000 in 2011. (35) (40)

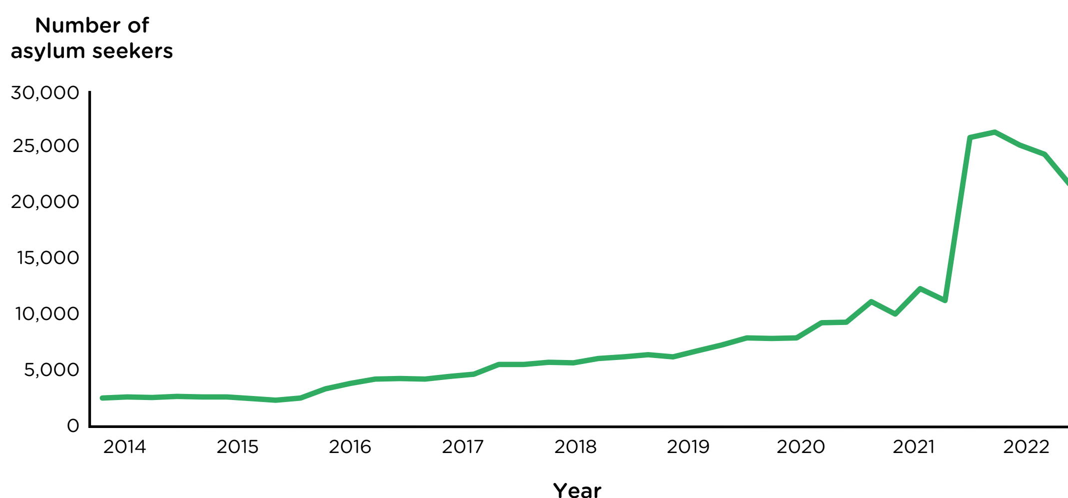
Boroughs with high rates of residents not speaking English well or at all include Newham (with 8 percent or 27,300 residents), Brent (6 percent, 24,700 residents), Ealing (6 percent, 22,900 residents) and Enfield (6 percent, 21,000 residents). (41) The coverage of courses in English for Speakers of Other Languages (ESOL) is shown in the ESOL Provision Planning Map which provides detailed information derived from the 2021 Census about areas with potentially high demand for English language tuition. (42) English language provision was highlighted during the community engagement for this review as being too short-term given the length of time it takes to gain proficiency. In Sections 4C we highlight the importance of good English language skills for educational attainment, employment outcomes and access to services. There are some inadequacies in the provision of ESOL in London and in particular courses are not always accessible to carers, people with disabilities, parents and those with full time jobs. (43)

ASYLUM SEEKERS

The annual number of asylum applications to the UK peaked in 2002 at 84,132. The number then fell sharply to reach a 20-year low of 17,916 in 2010. It rose steadily throughout the 2010s, then sharply from 2021 onwards, to reach 81,130 applications in 2022, not far off the 2002 peak. (44) This corresponds to a national and global increase in the number of refugees, with 2021–2022 seeing the largest annual increase ever recorded worldwide. (45)

Not all asylum seekers receive support and the number of those qualifying for support relates both to the numbers of asylum applications and to the criteria for eligibility. The number of asylum seekers in receipt of government support has grown in London, to over 26,000 in 2023, falling slightly to 20,114 in March 2024. (Figure 2.8).

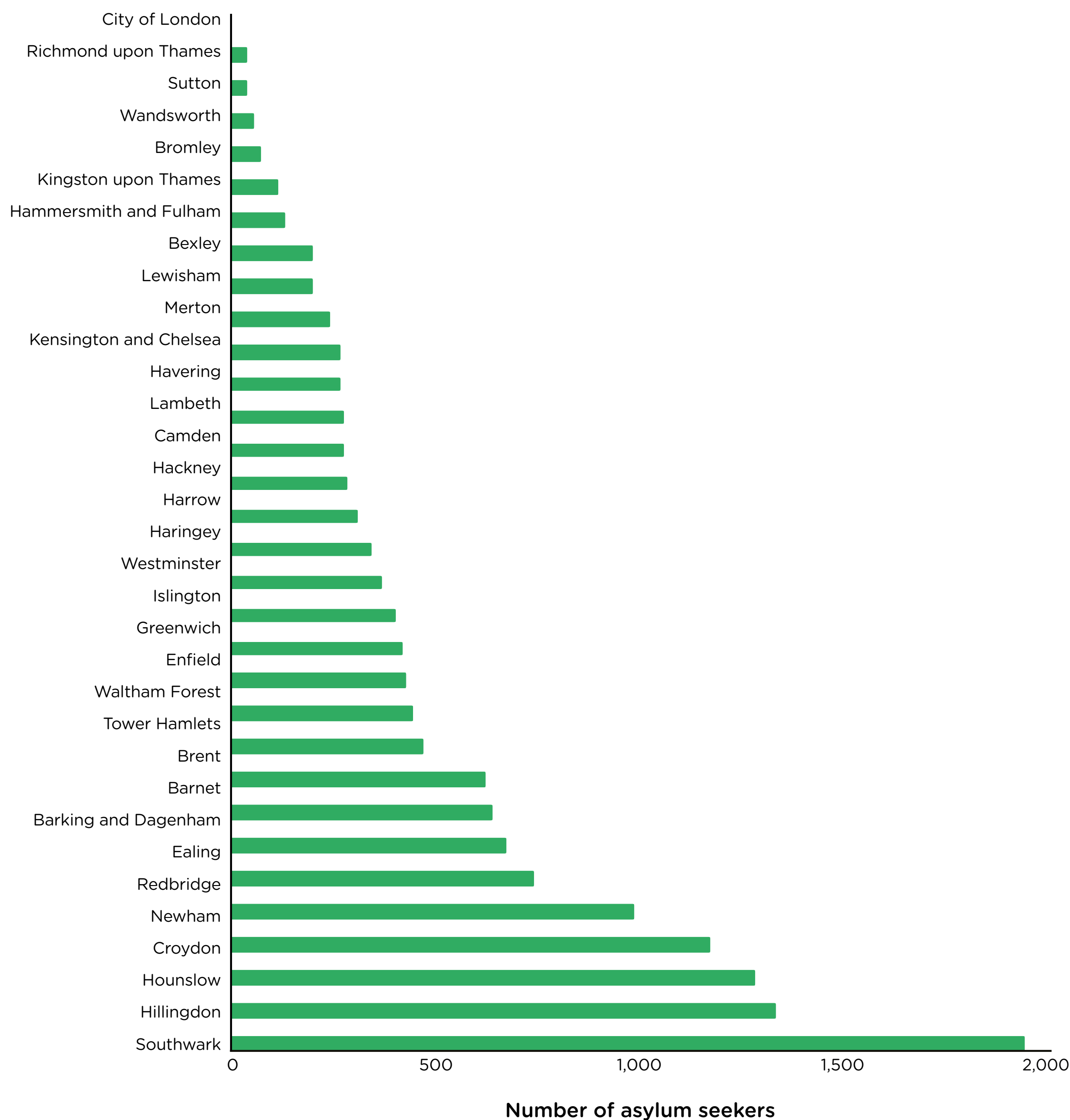
Figure 2.8. Number of asylum seekers in receipt of government support by quarter, London, 2014 to 2024



Source: *Home Office (46)*

London has recently seen a significant growth in the number of asylum seekers accommodated in contingency hotel accommodation, with this number reaching a high of 15,434 in June 2023, before falling to 12,545 in March 2024. (46) (26) The numbers of asylum seekers in receipt of support varies significantly across Boroughs, with Southwark home to the largest number in 2022, Figure 2.9.

Figure 2.9. Average of quarterly numbers of asylum seekers in receipt of support by local authority, London, 2022



Source: *Home Office (46)*

MIGRATION POLICIES AND THE HOSTILE ENVIRONMENT IN THE UK

Current and longstanding migration policies negatively affect new and established migrants and those without secure immigration status. Migration policy is one of the ways structural racism manifests in institutions, policies and attitudes towards established and undocumented, irregular migrants in London, harming the health of both groups. Many ethnic minority British nationals are treated with hostility and suspicion as a result of punitive policies and damaging narratives about immigration. An example is the recent Windrush scandal in which many British citizens were unable to work, find housing or access health care and were wrongfully deported.

The No Recourse to Public Funds (NRPF) policy, applies conditions to certain visas or grants of limited leave to remain and restricts affected migrants from accessing welfare benefits. It is estimated to affect over 2 million people in the UK according to analysis conducted by the London School of Economics and Political Science for the GLA. (47) The impact has been highlighted as particularly punitive. Examples include the inability to access publicly funded domestic violence shelters

or homelessness assistance. There are also long-term and hard-to-capture impacts of stress and poor health resulting from navigating the complex and expensive route to access services. In 2015 the Immigration Health Surcharge was introduced which applies to all those applying for a UK visa for longer than six months and who are not exempt. Charges increased from £200 per person per year in 2015 to £624 in 2020, with a further increase to £1,035 in 2024, which increases poverty and associated harms to health. (48) (49)

The 'hostile environment' policies have been central to the UK's immigration policy since 2012. The set of policies making up the 'hostile environment' intend to exclude undocumented or irregular migrants, who cannot prove their right to be in the UK with documentation. Estimates indicate there were around 397,000 irregular migrants including children in London in 2017. (50) (51) Central to the hostile environment is deterrence and it is designed to make life difficult for individuals without permission to remain in the UK, so that they leave voluntarily. (52) The hostile environment blocks migrants who do not have secure immigration status from accessing essentials including housing, employment, banking, free secondary health care and legal representation. (53) (54) The hostile environment has led to health services being delayed and withheld. (55)

The hostile environment has also been shown to create new forms of racial profiling that negatively affect ethnic minority groups in the UK. Service providers are tasked with checking immigration status and there are reports of those perceived to be foreign, due to factors such as skin colour and accent, being asked to prove their eligibility to access services. (56) Pushing the complex task of checking immigration status onto untrained people perpetuates racism and discrimination, noted further in Section 4E related to housing providers. (56)

The community engagement for this review raised issues around the conditions and situations for asylum seekers and for people without recourse to public funds and the impact this has on so many aspects of life and health. The engagement raised the following issues:

- Waiting for a decision or response from the Home Office causes distress and ill-health.
- Many asylum seekers are unable to make decisions about children's education as they may be moved at short notice, with education suffering as a result.
- During the period of uncertainty while awaiting a decision about status, being left in limbo and unable to work or choose accommodation, leaves people feeling unsafe, scared and stressed.
- Standards of accommodation for those awaiting decisions are poor, often overcrowded and poor quality especially for children in hotels.

CULTURE AND RACISM IN LONDON

Cultural attitudes are highly relevant to health and the social determinants of health for London's ethnic minority groups. Particularly relevant for this review are the ways cultural attitudes are shaped by and reinforce racism embedded in systems, structures and organisations which perpetuate and enable racism and resulting exclusions and harm. Cultural attitudes about racism and ethnicity are complex and varied, shaped by both historical and present societal conditions, colonialism, policies and institutions which reinforce racist narratives about other ethnicities and immigration, including those originating in political and media discourse. In addition to affecting health and wellbeing for ethnic minority groups through policies and legislative frameworks, political leadership has a significant role in shaping cultural attitudes towards migration and towards ethnic minority groups and influences levels of racism and discrimination experienced.

Most analyses of health and health inequalities do not consider cultural attitudes as a factor shaping health. Interventions to support health and the social determinants of health are mostly based on services and organisations rather than being designed to influence and shape cultural attitudes. Cultural attitudes

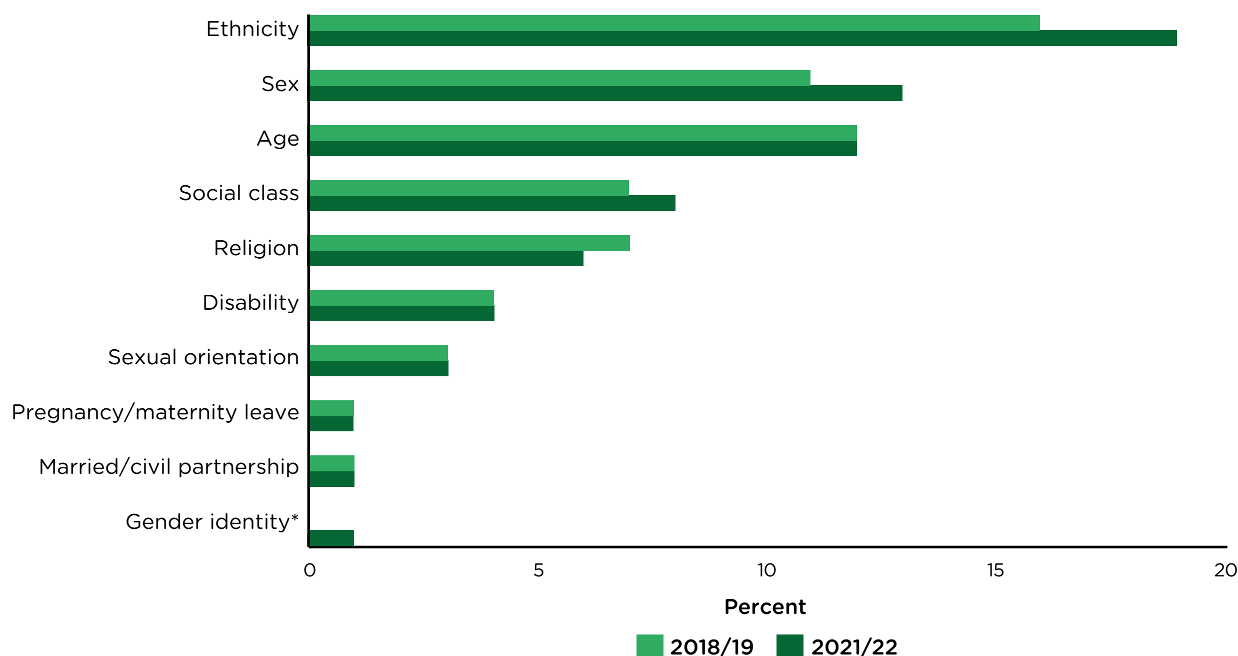
and particularly the recent negative discourse around equality and diversity policies and legal mechanisms contribute to failures to tackle and address racism. The importance of strengthening these mechanisms, and leadership to tackle racism are set out in Section 6.

Key points of relevance to London were highlighted in discussions with communities and the Advisory Board:

- The cultural landscape is highly complex and fluid and cultural attitudes, including those leading to racism, shift quite rapidly.
- Particular ethnic groups are subject to higher levels of racism.
- There are clear interrelationships in experiences and impacts of racism which are related to socioeconomic position, disability, age, sexuality and gender.
- Experiencing or anticipating racism 'knocks confidence', particularly for women, which in turn leads to unfulfilled potential, stress and anxiety and reduced opportunities for employment and progression.
- Trust in governance systems, institutions and services has been undermined by racism and the lack of accountability for it.
- Lack of substantive engagement with communities also undermines trust and confidence in the policies, services and interventions that affect communities and means that services provided may be ineffective or not well-designed to meet the needs of ethnic minority groups. Effective engagement and coproduction are essential to reduce ethnic inequalities, racism and its harmful impacts.
- Public health requires strong leadership on antiracism and the strengthening of positive narratives about ethnic diversity.
- Leadership is important in making the cultural shifts required for reducing racism.

The Survey of Londoners reports that London residents are more likely to be treated unfairly because of their ethnicity than any other characteristic, and that this likelihood increased between 2018/19 and 2021/22, with 19 percent of Londoners reporting being treated unfairly due to their ethnicity in the later survey, Figure 2.10. (57) Other main forms of unfair treatment associated with protected characteristics include age, sex, social class, religion, disability, sexual orientation. Reported discriminatory treatment due to ethnicity increased by 3 percent between 2018/19 and 2021/22.

Figure 2.10. Percent of Londoners who reported being treated unfairly by the type of protected characteristic or social class considered responsible, London, 2018/19 and 2021/22

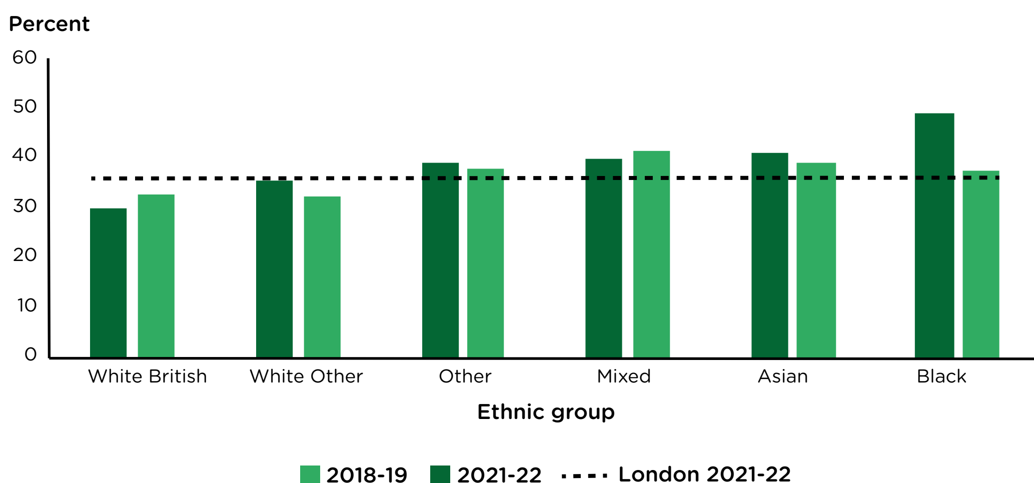


Source: *GLA (57)*

Note: ** This characteristic was labelled 'gender identity' in the 2021-22 survey, and as 'being or becoming a transsexual person' in the 2018-19 survey. Therefore, these are not wholly comparable labels.*

Figure 2.11 summarises how different groups of London residents experience different forms of unfair treatment based on their age, sex and ethnicity. (57) The data from the GLA Survey of Londoners 2021-22 provides a detailed ethnic breakdown of those reporting they had been treated unfairly. In 2021–22 nearly half of Black Londoners, 41 percent of Asian Londoners and 40 percent of Mixed Londoners reported unfair treatment – and for Black Londoners that proportion had increased by 11 percent since 2018–19.

Figure 2.11. Percent of Londoners who reported being treated unfairly because of either a protected characteristics or their social class by ethnic group, London, 2018/19 and 2021/22



Source: *GLA (57)*

Among many ethnic minority groups there are reports of strong ties and affiliation to London. The 2021/22 Survey of Londoners showed that around 80 percent of respondents felt 'very or fairly strongly' that they belonged to London, with the highest rate of 85 percent applying to Asian Londoners. Amongst this group, those of an Indian ethnic background (90 percent) and Bangladeshi ethnic background (88 percent) exhibited the highest rates of feeling that they belonged to London. Overall, there is little divergence in attachment to London by ethnicity, with a range of 78–85 percent of respondents across ethnic groups feeling they 'very or fairly strongly' belonged to London. (57) However, also notable from the Survey of Londoners is that White residents are the least likely to mix with other ethnic groups. Social mixing can positively shift cultural attitudes and reduce racism.

There are less hostile attitudes towards migrants in the Capital than in other places in Britain. The British Social Attitudes (BSA) Survey from 2014 looked at attitudes towards immigration and the effects of immigration. (58) Fifty-four percent of London-based respondents had more positive than negative views about the effects, compared with 28 percent of respondents from all other regions; 55 percent of London-based respondents thought immigration had a positive cultural impact, compared with 31 percent for all other regions. Because London is more ethnically diverse than other parts of the UK, these results suggest that people who have experience of migration and migrants in their everyday lives are more likely to have positive views about the impact of immigration on the UK's economic and cultural landscape. (59)

The 2021 BSA survey and other recent surveys also suggests that nationally, public attitudes to the impacts of immigration have become more positive in recent years. (60) Those who viewed immigration as having a negative impact fell from around 40 percent in 2011 to around 20 percent in 2021. (61) As there is no regional breakdown in the latest BSA survey, it is unclear if this national increase in positive attitudes is mirrored by a similar increase in positive attitudes in London.

CHAPTER 3

RACISM AND ETHNIC INEQUALITIES IN HEALTH

This section provides an overview of health by ethnicity and the social, economic and demographic factors influencing the health of ethnic groups. It is essential that healthcare, public health and organisations providing services related to the key social determinants are more sensitive to the varying risk of ill health by all the dimensions identified in this and subsequent sections.

Evidence shows that being subjected to racism negatively affects mental and physical health and these impacts last throughout life. (36) (37) In this context, it is worth noting that duration of stay in the UK varies considerably within and between ethnic groups in London and hence this affects the possible duration of exposure to the experience of racism in the UK, but not, of course, the timing or intensity of the experience. As outlined in Section 2, there are substantial differences in the age structure, immigration history and occupations of ethnic groups in London which impact on exposure to racism and health.

Health differences among ethnic groups are difficult to interpret for several reasons. A healthy migrant effect has long been recognised among those who were not born in the country to which they migrated. In general, people who migrate are healthier than both the average of the country they left, and of the country to which they migrated. We have shown this in the past. (62) Second, the substantial differences in the age structure of the various ethnic groups in both London and England makes realistic comparisons difficult. Third, socioeconomic differences, also related to experiences of immigration and racism between groups will have substantial impacts on health. We have performed extensive and detailed analyses of the factors that make life expectancy differences between ethnic groups difficult to interpret, which are presented in Appendix 2.

THE EXPERIENCE OF RACISM ON HEALTH

As we have made clear, differences in health among ethnic groups do not, by themselves, indicate that racism is the cause. That said, there is evidence racism has direct and long-term impacts on mental and physical health.

Direct health impacts include psychological distress, poorer self-rated health and hypertension. (63) A study using data from four waves of the UK Household Longitudinal Study (UKHLS) between 2009 and 2013 found that those who reported racial discrimination had poorer mental functioning scores four years later. In particular, fear of racial discrimination, expressed through reporting feeling unsafe or avoiding spaces or places, had the biggest cumulative effect on the mental health of people from ethnic minority groups. Further, exposure over the life course, together with vigilance and the anticipatory stress of possible future racist encounters, is likely to continue affecting the mental health of people from ethnic minority groups long-term. (64) We present further evidence on mental health in a later section.

A 2022 study using 2009-2019 UK Household Longitudinal Study Data investigated how racism affects health over time, by age, and through its impacts on socioeconomic inequality. (36) (37) The authors examined the accumulation of impacts over the life course and conclude that repeated exposure to racism leads to an accumulation of disadvantage and poorer health outcomes throughout life. (36) (37)

In these analyses, the strongest direct effect of racism on mental and physical health was when racism was reported at the same time as these health outcomes. However, they describe two longer term indirect effects. First, when racism directly affected income, this had a persistent longer term effect on physical and mental health Second, when racism had a direct effect on physical health, this had a longer term indirect effect on mental health. In relation to mental health specifically, the effects of racism are not significantly different by age group, suggesting that the effects of racism are consistent throughout life. The effects of racism on physical health were significantly different by age group, with slightly different patterns of effects for the under 30s compared with those at older ages. This is in line with previous literature demonstrating that ethnic inequalities in physical health outcomes increase after the age of 30. (65) (37)

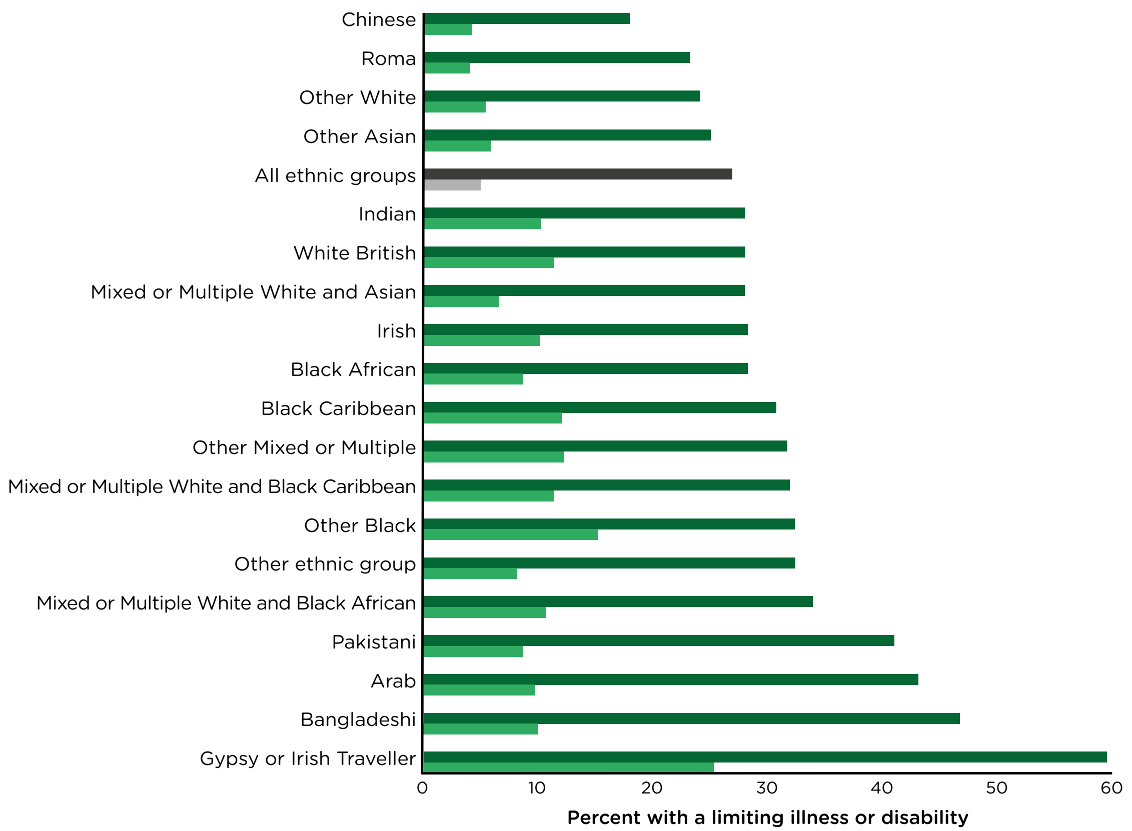
SELF-REPORTED HEALTH BY ETHNICITY

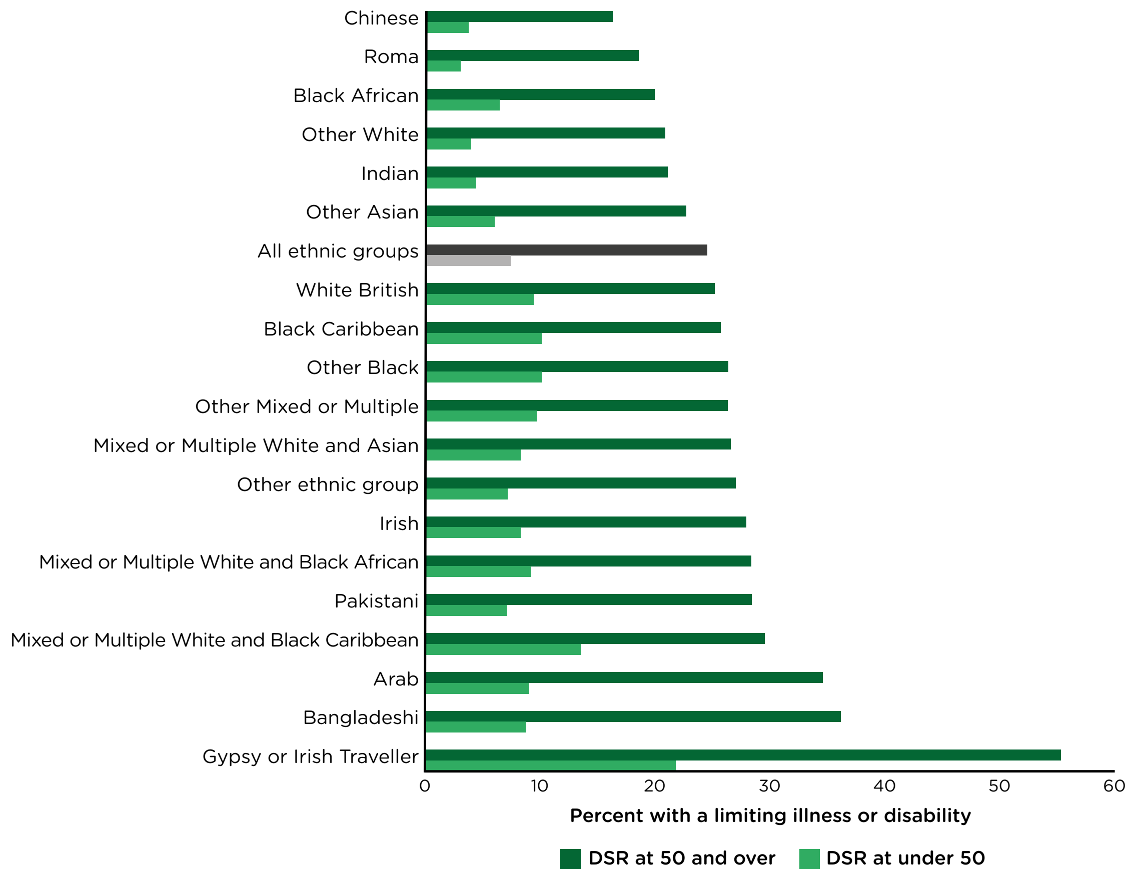
Self-reported health has been included in questions in every UK population census since 1991. In our 2020 Review, *The Marmot Review 10 Years On*, we reported that disability-free life expectancy had stopped improving in England and, for women, was getting worse. (6) In London, there are ethnic inequalities in the percentage of people reporting that have a limiting illness or disability at every age. (6) Based on the analysis of age structures in Chapter 2, we calculated age standardised rates of limiting illness above and below the age of 50 for males and females separately. In both age groups and for both sexes, the highest rates of reported limiting illness or disability were for Gypsy and Irish Travellers, while the lowest were for Chinese and Roma groups, figure 3.1.

For other ethnic groups, reported rates varied by age and sex. At ages 50 and above, Bangladeshis and Arabs had markedly higher rates of limiting illness or disability for both sexes, as did Pakistani women. A number of other ethnic groups also had slightly higher rates than White British for both sexes. This pattern is not seen at below the age of 50, where highest rates were seen in Black and Mixed groups. Figure 3.1 makes clear a pattern to which we will return throughout the discussion of social determinants of health in Section 4 – there are marked differences between ethnic groups, at least in part reflecting the very different social class distributions highlighted in Chapter 2.

It is quite possible that the reasons why levels of limiting illness or disability between ethnic groups vary by age is associated with their different demographic structures. For example, reflecting the higher proportions of students in some ethnic groups than others, as discussed in Chapter 2.

Figure 3.1. Age-standardised percent reporting that they have a limiting illness or disability by broad age group and sex, London, Census 2021





Source: *ONS (2023) (38)*

Note: *In this graph DSR is the directly age-standardised rate of reporting a limiting illness or disability, expressed as a percent of population*

SELF-REPORTED HEALTH AND LENGTH OF RESIDENCE IN THE UK

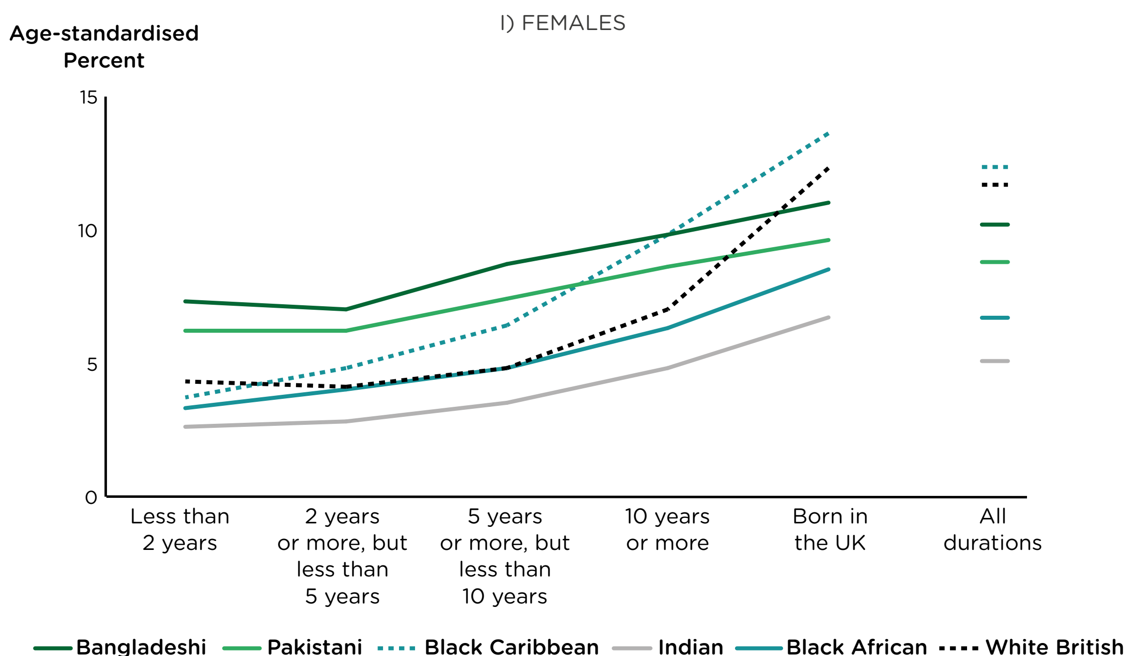
As indicated in Section 2, there are substantial differences in the proportion of each ethnic group born in the UK and the time that those not born here had been resident in the UK in 2021. For those who have only recently arrived in the UK, most of the accumulated advantage and disadvantage that influenced their health would have been experienced prior to arrival in the UK. There are multiple processes by which initial good health deteriorates. One is the various influences associated with aging. The other is exposure to the accumulation of negative influences such as those associated with racism and low income. The risk that length of exposure to racism in the UK had adversely affected their health could be argued to be less than if the same individual had spent a greater proportion of their life here. The relationship between limiting long-term illness or disability, age group, duration of time resident in the UK and ethnicity for Londoners is shown in Figure 3.2. The first point to note, is that while rates are, of course, much lower at younger ages than at older ages for every ethnic group, within the younger age group those born in the UK have higher rates in every ethnic group than those born abroad.

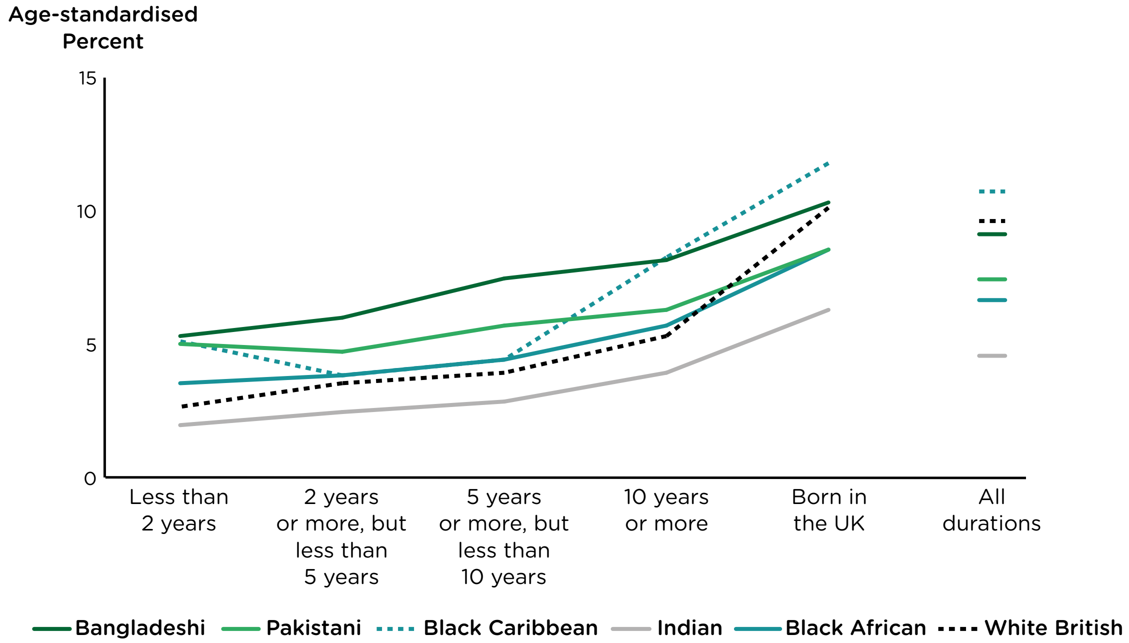
Among those aged under 50 who were born in the UK, age-standardised rates of limiting long-term illness or disability were highest for Black Caribbean groups (13.7 and 11.4 percent for females and males, respectively), followed by White British (12.4 and 10.2 percent for females and males, respectively) and Bangladeshis (11.1 and 10.4 percent for females and males, respectively). Lowest age-standardised rates are for those of Indian origin (6.8 and 6.3 percent for females and males, respectively). Among those who were born abroad, with minor exceptions, age-standardised limiting long-term illness rates at ages under 50 increase with length of time resident in the UK for every ethnic group. With the exception of Black Caribbeans, for whom the proportion arriving in the UK less than 10 years prior to Census Day 2021 is very small, all other ethnic groups saw very similar rates of increase in ill-health over time since arriving in the UK.

At ages 50 and over, there are increases in illness with duration of time in the UK, but the increase with duration is less steep and is not seen for Black Caribbean and Pakistani groups, possibly due to very small numbers with shorter durations. Of course, the scales used in Figure 3.2 differ and as illness rates at older ages are much greater than at younger ages a small difference in the ratio of two percentages at older ages can represent the same percentage point increase in the absolute number as a larger ratio at younger ages.

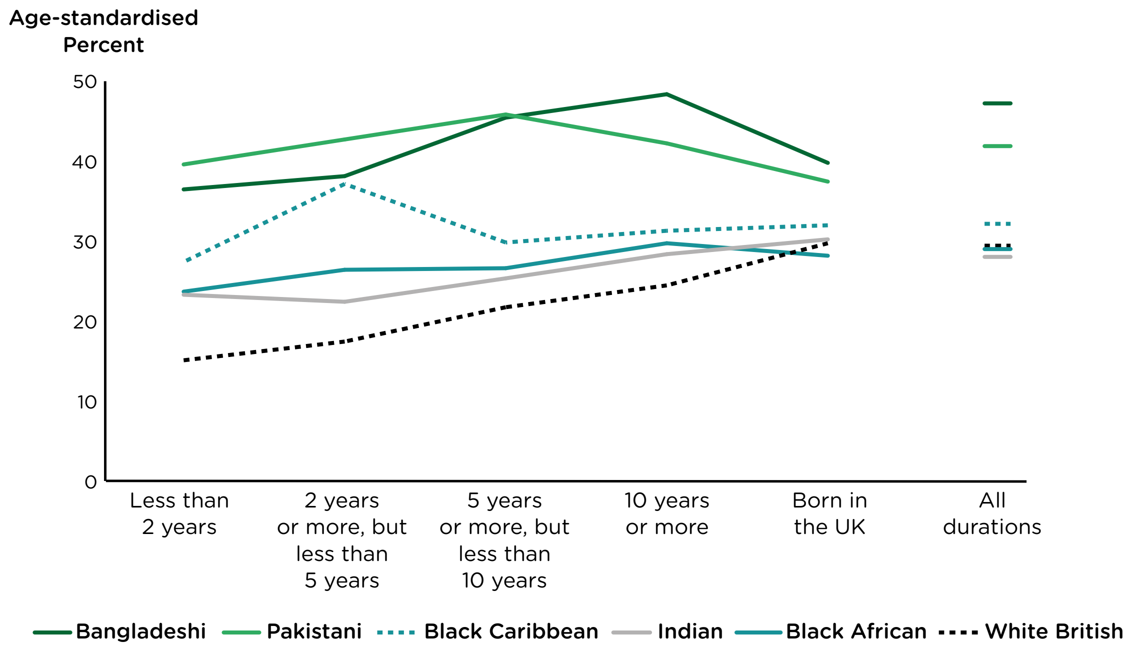
Figure 3.2 Age-standardised percent reporting that they have a limiting illness or disability by broad age group, sex, ethnic group, whether born in the UK and, if not, length of residence in the UK, London, Census 2021

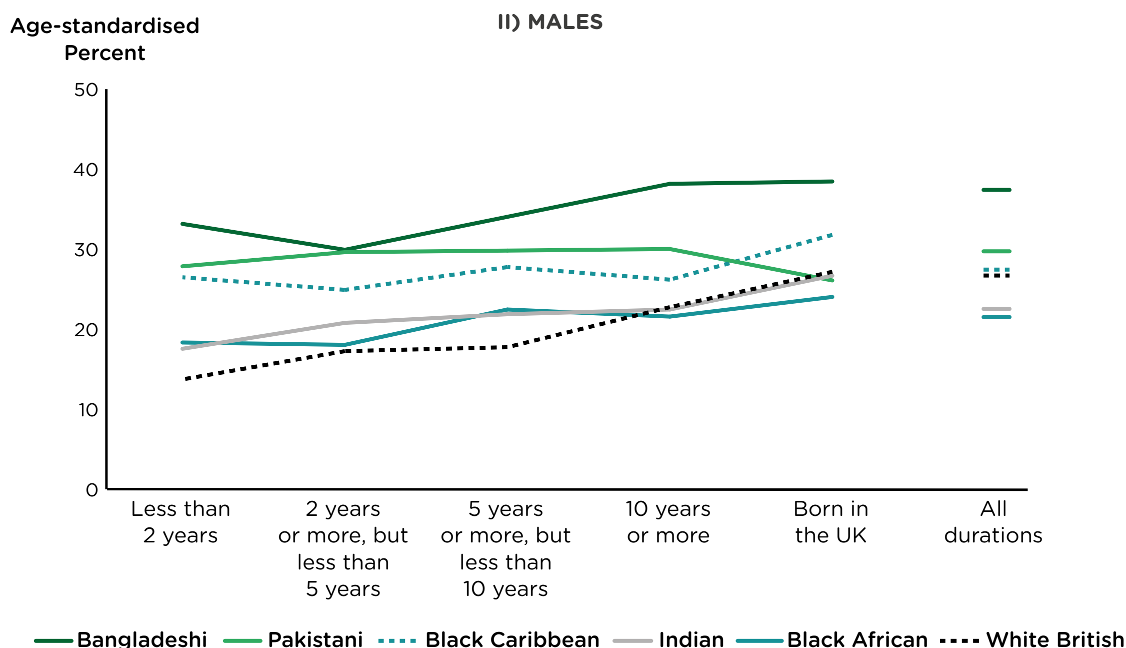
A) AGE UNDER 50





B) AGE 50 AND OVER





Source: *ONS (2023) (38)*

There are several possible explanations for increasing ill health with duration of residence in the UK. The first, as hypothesised above, is that duration of exposure to racism and the conditions of daily life that followed from discrimination leads to a deterioration in health. The counterargument to this hypothesis is that White British born abroad experience the same increase in ill health as others and, among those born in the UK, only Black Caribbean and Bangladeshi groups have consistently worse health than White British in both age groups and both sexes.

A second hypothesis is that the different durations in the UK correspond to changes in the entry requirements to the UK (e.g. in the points-based system introduced in 2008 and subject to frequent changes since then) and that this resulted in a systematic change in the social composition of new migrants, with more recent migrants more likely to be professionals. However, again, this argument may not apply to those White British born outside the UK if they had a right to remain and did not rely on the points-based system. It would also not apply to those entering the UK under family reunion.

A third hypothesis is that the pattern seen across most ethnic groups reflects some form of health selection, whereby those undertaking long-term migration are less likely to have pre-existing health conditions than those born in the UK, but that this advantage wears off with time as they develop the normal health problems for their age group. Selection processes like this are well-documented in relation to both employment, the healthy worker effect and marriage. (66) (67) (68) (69) (70) Both of these are particularly relevant to those aged under 50, since the ability to take up employment or migrating to get married are common at younger ages. It is also possible that long-term migration itself requires a degree of good health.

The convergence of mortality levels to those of each ethnic group born in the UK, including White British, might also suggest a fourth hypothesis – that simply living in the UK is bad for health. Set against this hypothesis is the very high levels of ill health in many of the countries of origin of migrants.

It may, of course, be that all four hypothesised mechanisms play a part – further investigation of the characteristics of the White British group who were born abroad is needed to clarify this. However, what is clear is that there are substantive differences in ill health between ethnic groups born in the UK, with worse health among Black Caribbean, Bangladeshi and Pakistani groups than other ethnic minority groups.

CAUSES OF MORTALITY BY ETHNIC GROUP

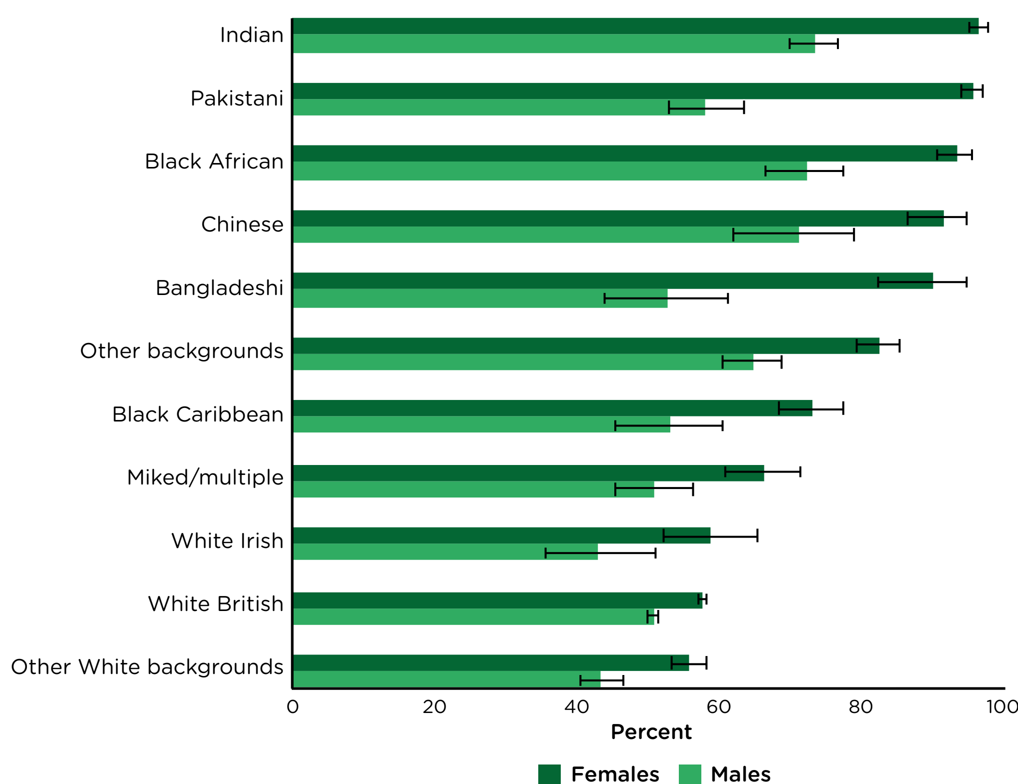
ONS have published several studies based on data by ethnicity and cause of death recorded on death certificates. The first accompanied the life expectancy results described in Annex 2 and looked at eleven selected groups of underlying causes of death in 2011-14 that had been shown by previous research to vary by ethnic group or country of birth. (71) The second looked at the five most common leading underlying causes of death for each ethnic group in their study population in 2011 to 2019. In total this involved examining seven underlying causes – heart disease, dementia, respiratory diseases, lung cancer, influenza and pneumonia, cerebrovascular diseases and prostate

cancer. (72) The final one used a long list of more specific diseases mentioned anywhere on death certificates between March 2021 and January 2023 among those in the 2021 Census. This study looked at 15 cancer sites, eight cardiovascular disease conditions, chronic kidney disease, dementia, diabetes, and four types of respiratory disease (including COVID-19). (73)

The first of these ONS studies indicated significant differences by ethnicity between broad causes of death in 2011 to 2014. (74) In particular, males in the White ethnic group had a significantly higher mortality rate from cancer than males in all other ethnic groups except for the mixed ethnic group. Cancer mortality was lowest among males in the Indian and Asian other ethnic groups. Females in the White ethnic group had a significantly higher mortality rate from cancer than females in all other ethnic groups while females in the Pakistani, Indian and Asian Other ethnic groups had the lowest rates.

In this context, the Annual Population Survey indicates that current cigarette smoking among Asian, Black and Chinese groups was around half that in White groups in the years 2012 to 2019. (75) (76) While this does not take account of age or past cohort smoking patterns, Figure 3.3 shows age-standardised percentages who had never smoked. For women of Indian, Pakistani, Bangladeshi and Black African origin this figure of non-smokers exceeded 90 percent, compared to below 60 percent of White groups, i.e. representing in excess of a fourfold difference in never smokers. Among men the differences were less extreme. After adjustment for age, slightly over 70 percent of Indian, Black African and Chinese men had never smoked regularly, compared to 50 percent or less among White groups. Bangladeshi, Pakistani and Black Caribbean men were only marginally more likely to have never smoked regularly than White British men. Section 4F emphasises the need for smoking prevention services to be better related to particular ethnic groups and genders as well as socioeconomic position.

Figure 3.3. Age-standardised percent who had never smoked regularly by ethnic group and sex, England, 2011-19



Source: *Health Survey England (77)*

Notes: *Bars represent 95 percent confidence intervals*

There is also evidence that many minority ethnic groups are less likely than the White ethnic groups to drink alcohol, set out in Section 4F. (78)

The ONS report on deaths in 2011-14 indicated that males in the Bangladeshi, Indian and Mixed ethnic groups had statistically significantly higher mortality rates from circulatory diseases, as underlying causes, than males in the White ethnic group and most other groups while females in the Pakistani ethnic group had the highest mortality rate from these causes, followed by those in the Mixed, Indian and Black Caribbean groups. (71)

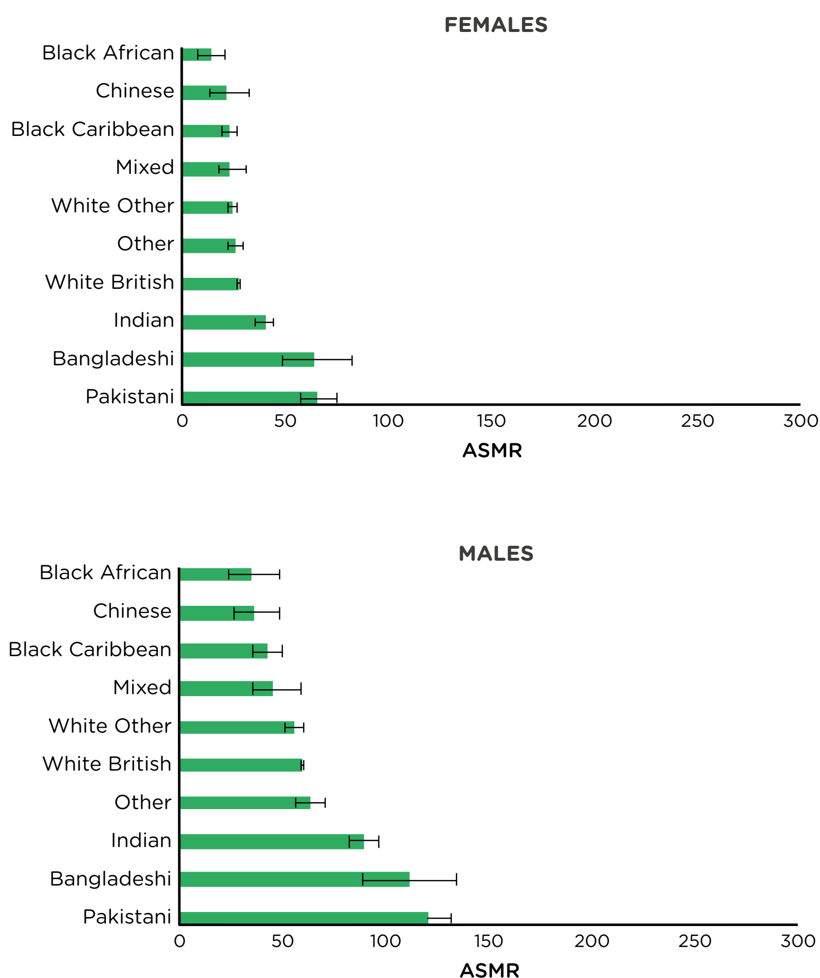
These findings on mortality rates, which reflected what was already known about disease prevalence in these groups, have shown that people in the South

Asian ethnic group (including Bangladeshi, Indian and Pakistani ethnic groups) had higher ischaemic heart disease, hypertension and diabetes prevalence than those in the White ethnic group. (79) (80) (81) This is also consistent with an earlier analysis by country- of-birth of immigrants. (62) Conversely, those in the Black ethnic group had lower ischaemic heart disease than those in the White ethnic group. While cancer incidence registration is generally lower among ethnic minority groups compared with the White ethnic group, there is a higher level of registering prostate cancer in the Black ethnic group. (82)

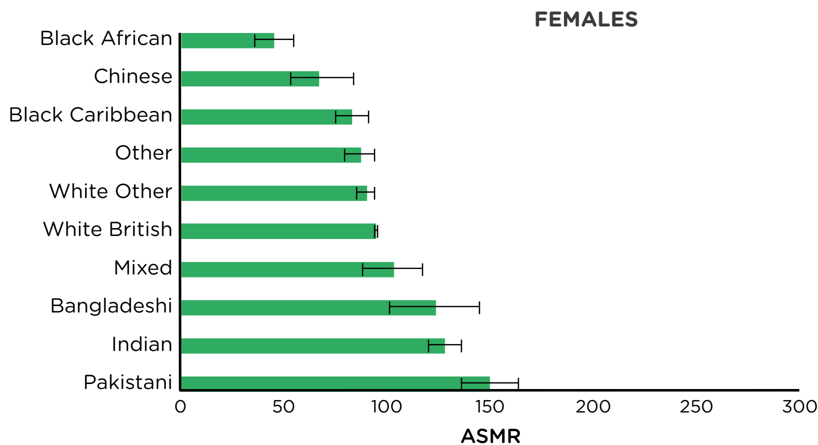
As mentioned earlier, ONS have supplemented the underlying cause of death data in Figure 3.4 with more recent data on conditions on the death certificate that contributed to the death. Figure 3.4 shows that heart conditions (both myocardial infarctions and chronic ischaemic heart disease) were more commonly mentioned at death among Pakistani, Bangladeshi and Indian men and women than in any other ethnic group. While strokes were also mentioned more commonly among these groups than among White groups, they also contributed to deaths of both men and women from Black Caribbean and Black African groups more than those from White groups. Most ethnic minority groups, with the principal exception of Chinese groups, were more likely than White groups to have diabetes and chronic kidney disease mentioned at death. These two conditions were particularly associated with a raised risk of death from COVID-19 (discussed below). By contrast, among women, breast cancer and lung cancer were more frequently recorded at death among White British women than any other ethnic group. Consistent with the data on smoking in Figure 3.3. And with the 2011-14 data on all cancers, lung cancer was mentioned more among Bangladeshi men than White British, but rates were a particularly low (for both sexes) among Indian and Black African groups – providing a good indicator of low levels of the cumulative effects of tobacco use in these two ethnic groups.

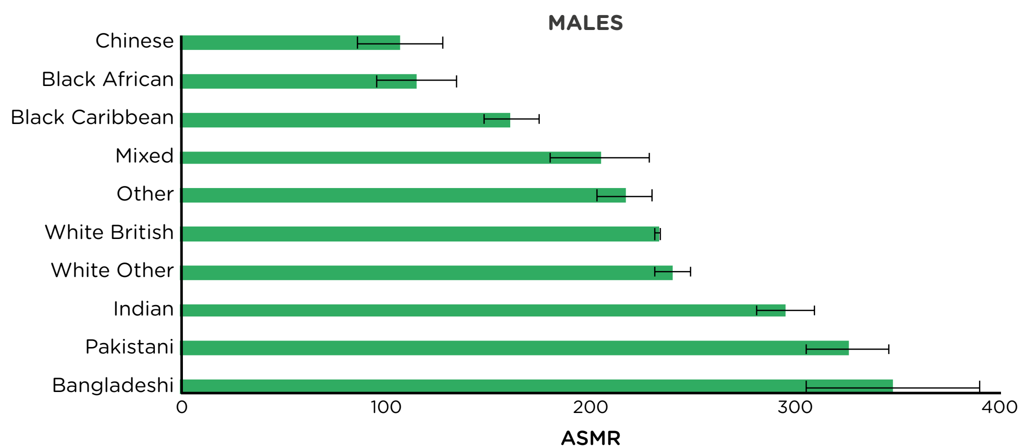
Figure 3.4. Age-standardised mortality rates by mentions of selected health conditions by ethnic group, England, 21 March 2021 To 31 January 2023

MYOCARDIAL INFARCTION

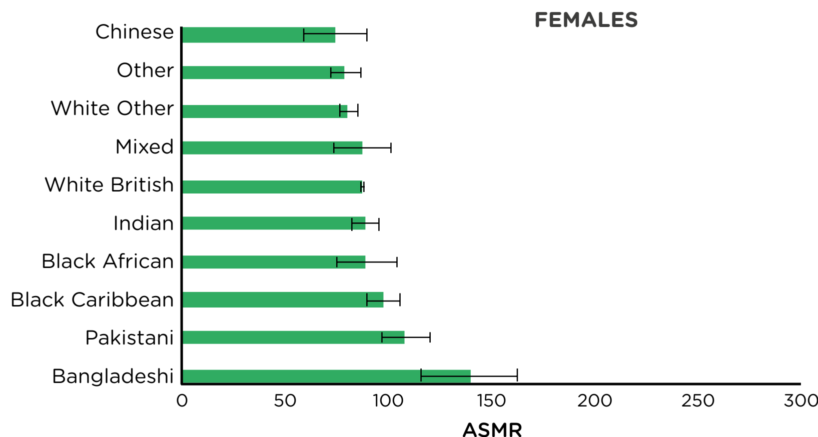


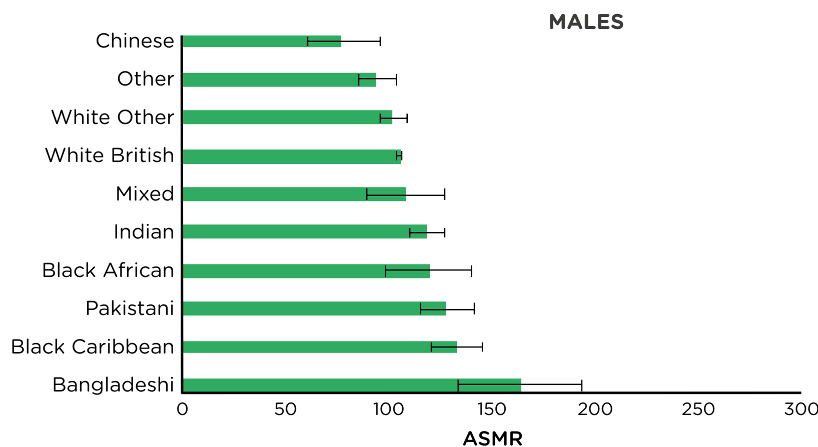
CHRONIC ISCHAEMIC HEART DISEASE



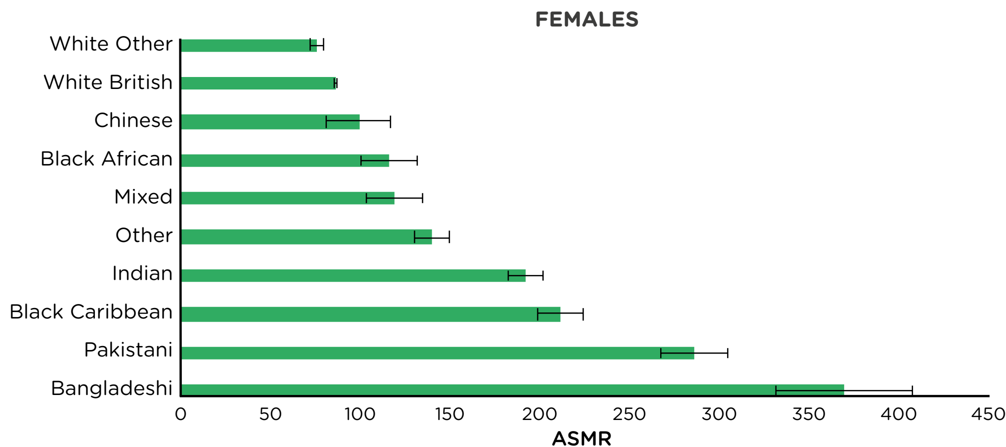


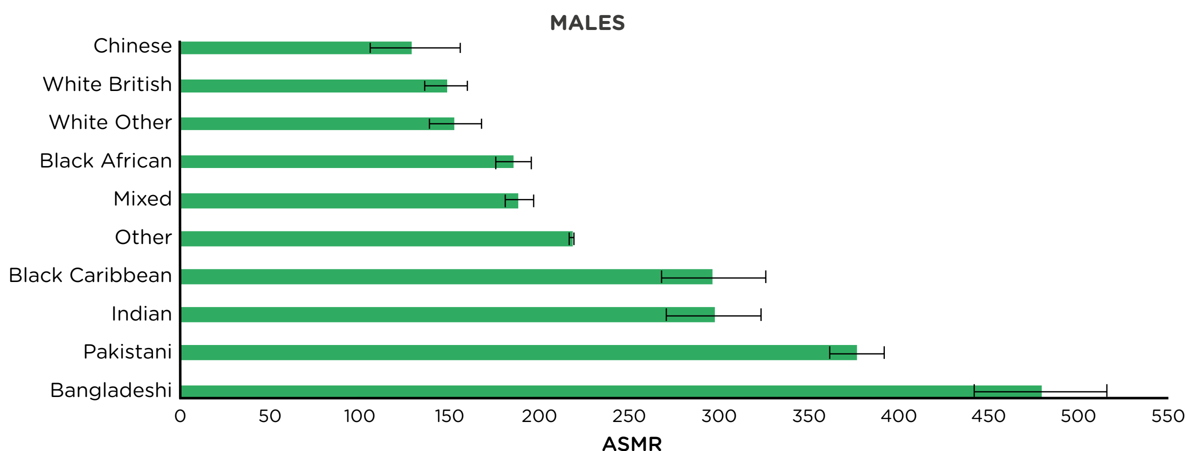
STROKE



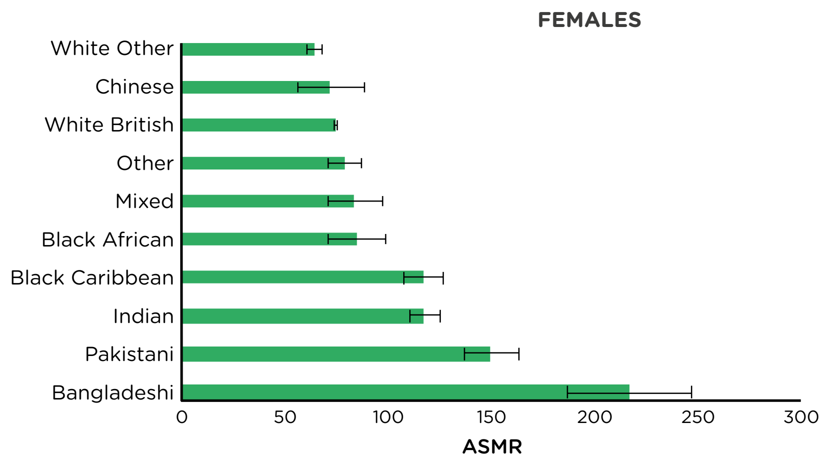


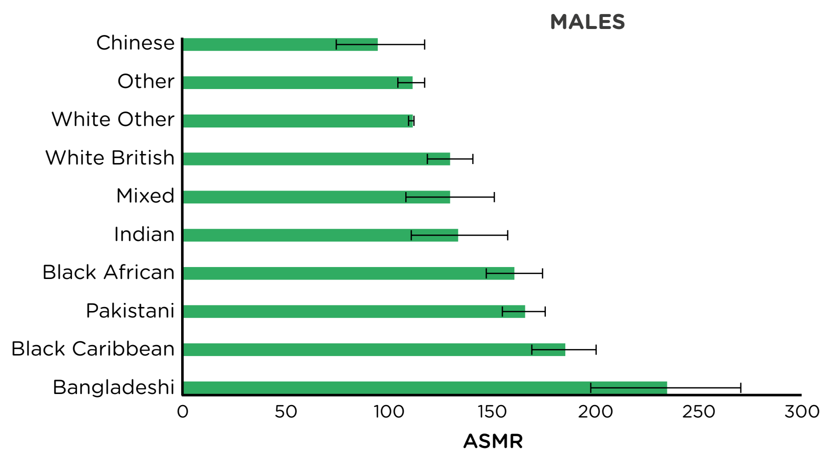
DIABETES



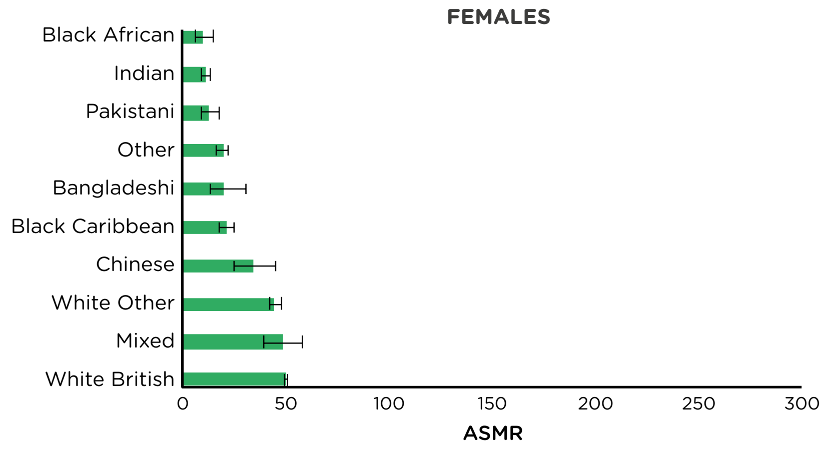


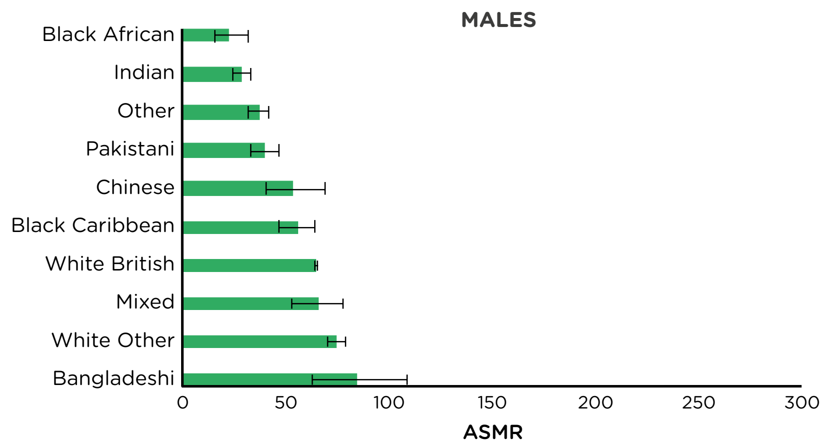
CHRONIC KIDNEY DISEASE



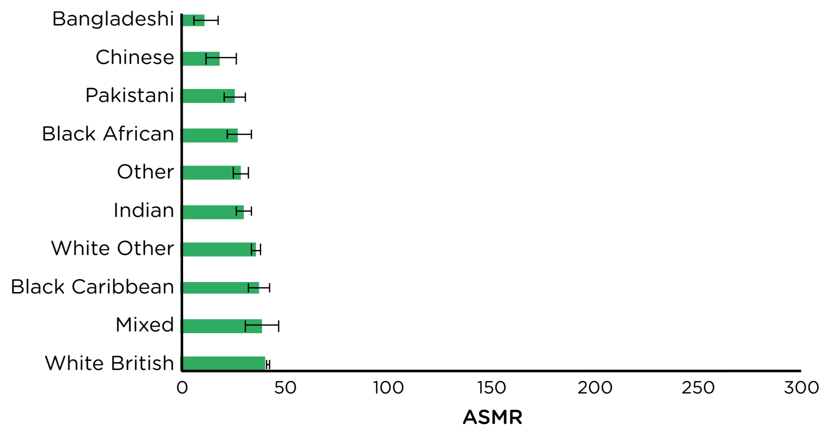


LUNG CANCER

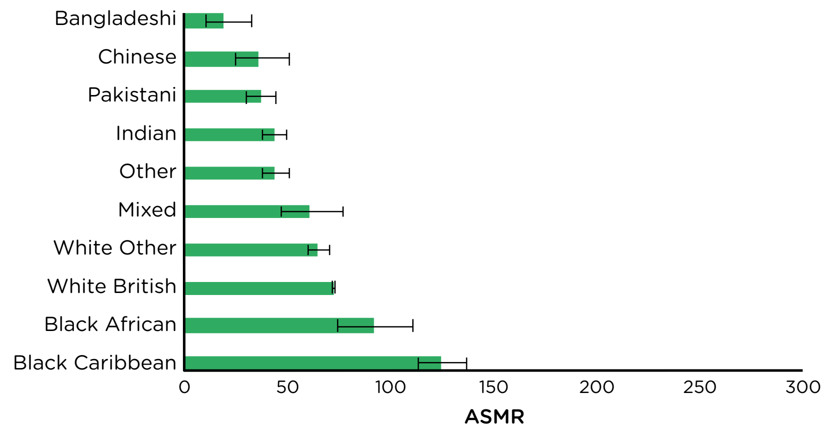




FEMALE BREAST CANCER



MALE PROSTATE CANCER



Source: *ONS (2023) (73)*

The analyses by cause of death confirm clear differences by ethnicity in both underlying and mentioned causes of death, indicating much higher risk of specific diseases among different ethnic groups, based on well recognised risk factors (e.g. diabetes in South Asians and hypertension in Afro-Caribbeans). (83) This highlights again the need for disease specific and prevention services to be more tuned to the needs and to the risk factors among different ethnic groups with proportionate resources.

ETHNIC INEQUALITIES IN MATERNAL AND INFANT MORTALITY AND HEALTH

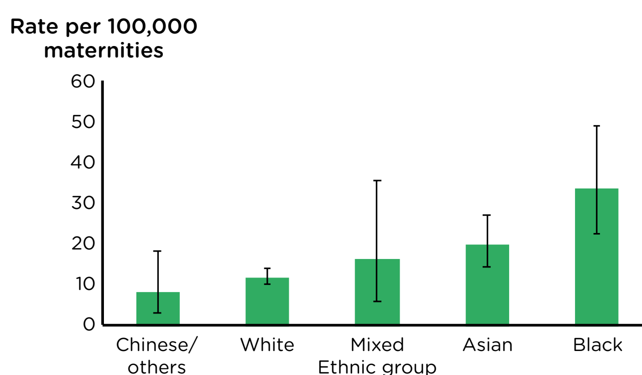
There are clear and persistent ethnic inequalities in maternal and infant health; and particularly concerning are high maternal and infant mortality rates for many ethnic minority groups. There are also repeated reports of racism and lack of culturally appropriate maternal and postnatal care for many ethnic minority groups in England, discussed further in Section 5. (84)

MATERNAL MORTALITY

The 2024 *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* [MBRRACE] report found that Black women are almost three times more likely to die from pregnancy and childbearing-related complications than White women, while women from Asian ethnic backgrounds are almost two times more likely to die. (85) MBRRACE also reported that women from ethnic minority groups are at higher risk of experiencing premature birth, stillbirth or neonatal death. A review of UK maternal mortality between 2009–2017 found that this inequality between Black and White women is widening. However, according to MBRRACE in 2020-22 there was a statistically non-significant decrease in the difference in maternal mortality rates between Black and White women from 2019-21, largely due to an increase in the maternal mortality rate for White women . (84)

Figure 3.5 shows the clear ethnic inequalities in maternal mortality 2020-2022 with much higher rates for Black women than for women of other ethnicities and over four times the rate compared to women of Chinese/other ethnicities.

Figure 3.5. Maternal mortality rates per 100,000 maternities by ethnic group, England, 2020–22



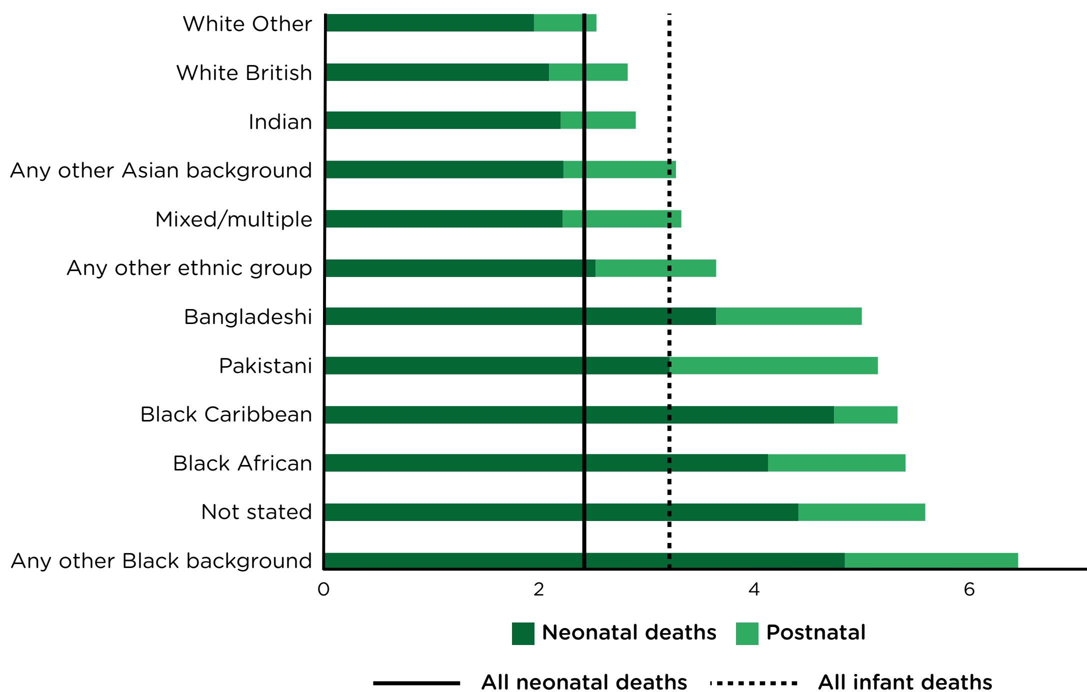
Source: *MBRRACE-UK (85)*

The role of racism in driving these stark ethnic inequalities in maternal mortality is overviewed in section 4A.

NEONATAL AND INFANT MORTALITY

As well as ethnic inequalities in maternal mortality, Figure 3.6 shows that, in 2020, rates of infant mortality were high for many ethnic minority groups, particularly Black, Pakistani and Bangladeshi groups, both in the neonatal and post-neonatal periods, except that the post-neonatal rate was low for the Black Caribbean group, although the neonatal rate was particularly high. Babies from Indian, White British and Other White backgrounds have lower than average rates of both neonatal and post-neonatal mortality. Even though rates of neonatal mortality were low by historical standards, socioeconomic and ethnic inequalities indicate issues with living and working conditions for pregnant women, maternal health, access to maternity and obstetric services and the appropriateness of those services.

Figure 3.6. Infant mortality rate per 1,000 live births by ethnic group and whether in the first 28 days or not, England and Wales, 2020



Source: *ONS (86)*

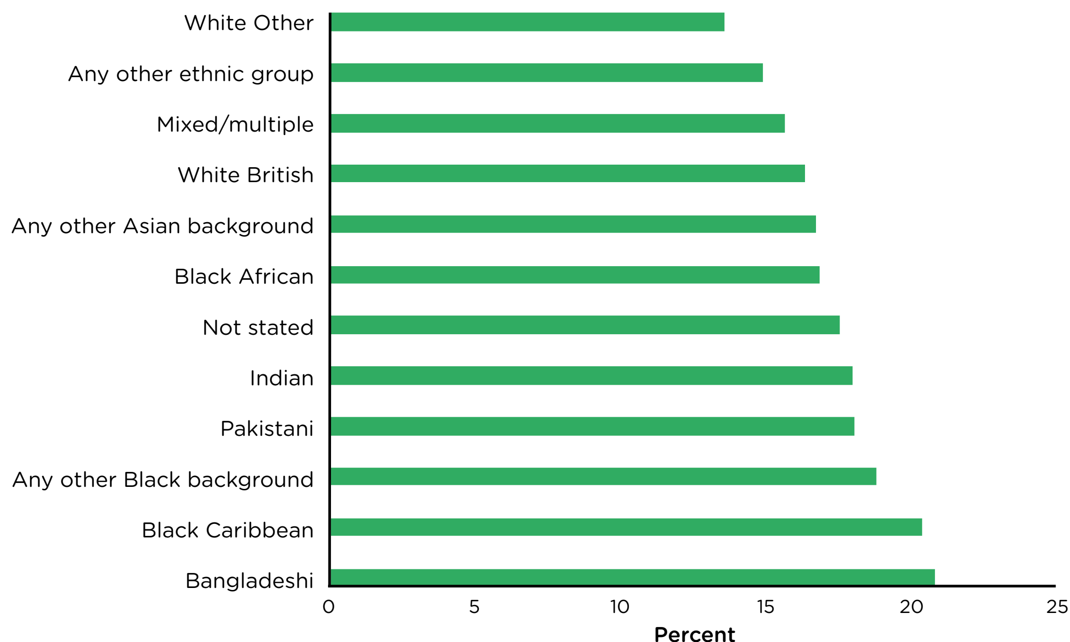
Note: *Neonatal deaths are those occurring during the first 28 completed days of life per 1,000 live births. Post-neonatal deaths are those occurring subsequently, in the first year of life.*

PRETERM AND LOW BIRTHWEIGHT LIVE BIRTHS

There are also clear ethnic inequalities in the proportion of babies born alive at 37 weeks of gestation or earlier in England and Wales, Figure 3.7. Prematurity rates among most ethnic minority groups are higher than those for White British. As a result of a shortened period of in-utero organ development, premature infants who survive are at higher risk of chronic respiratory, cardiac, renal, and endocrine system disorders later in life. (87) This has significant implications for chronic disease development, as well as cognitive, physical and emotional development.

Bangladeshi, Indian and Black Caribbean babies are more than twice as likely to be born low birthweight than White British babies. (88) Low birthweight is related to deprivation and parental low income as well as lack of access to appropriate pre-natal services. (89) (90) (91) (92) A review found that improving income levels by increasing minimum wage and longer parental leave decreases the number of low birthweight births and infant mortality. (93)

Figure 3.7. Percent of live births born preterm by ethnic group, England and Wales, 2021



Source: *ONS (2023) (94)*

The first stage of the Nurture Early for Optimal Nutrition (NEON programme) ran from 2015-2018, focused on Bangladeshi children living in East London, who are at higher risk of poor nutrition and obesity than the average child in the UK. It specifically focused on Bangladeshi communities, as previous efforts to address child nutrition have often considered all South Asian populations together, limiting their effectiveness, Box 2.

Box 2. Neon Programme (95) (96)

NEON is a community-based approach to help improve nutrition when a child is between 6 months - 2 years old. The programme uses the WHO-recommended Participatory Learning and Action approach, which involves the community in interventions. Community members, trained as community researchers recurited, interviewed and interpreted findings from other members of the community. This involved training local, bilingual women and introducing them to women's groups as community facilitators, reducing language barriers and allowing communities to receive health advice they understood. 141 people from the British-Bangladeshi community in Tower Hamlets were interviewed.

The impacts of the first stage of the project included improved nutrition and feeding practices. It found that community consultation led to more appropriate and better-quality interventions than interventions designed at a distance and imposed on the community.

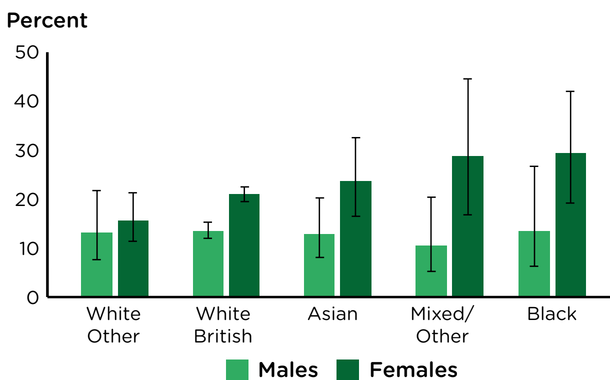
Due to the success of the first stage of the programme, it was funded and expanded further, with the second phase starting in December 2019 and running till May 2023. The second phase involved developing the intervention for further South Asian communities across more boroughs in East London.

This programme was funded by the NIHR Academy in partnership with the Tower Hamlets GP Care Group CIC and the London Boroughs of Tower Hamlets, Newham, and Waltham Forest, and supported by ARC North Thames. In 2021 the programme was awarded a Royal Society for Public Health and Wellbeing Award for empowering communities and individuals and addressing the population health and the wider social determinants of health. (97)

MENTAL HEALTH

There are stark ethnic inequalities in common mental disorders in England for women, Figure 3.8. Rates are higher for women than men in all ethnic groups and highest for Black and Mixed/Other groups and lowest among White British and White Other groups. Among men, rates are lowest among the Mixed/Other group, while other ethnic groups have similar levels to each other.

Figure 3.8. Percent of adults who experienced a common mental disorder in the past week by sex and ethnic group, England, 2014

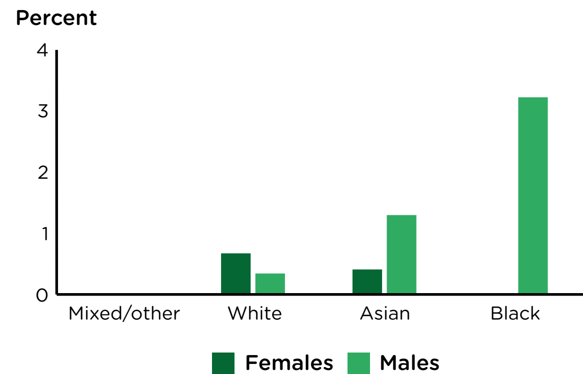


Source: *NHS Digital (98)*

The authors of the Adult Psychiatric Morbidity Survey (APMS) report highlight several common mental disorders linked to the social determinants of health. Debt and financial strain are associated with depression and anxiety, with increasing evidence suggestive of a causal association. (99) (100) They also point to a range of other known associations, including work stress (101); social isolation (102); poor housing and fuel poverty (103) (104); negative life events (such as bullying, violence, bereavement, job loss); childhood adversity including emotional neglect, physical and sexual abuse (105), institutional care, low birth weight (106), poor interpersonal and family relationships, a partner in poor health, being a carer (107) and problems with alcohol and illicit drugs. (108) Being exposed to racism also directly impacts mental health. (64) Therefore, higher rates of poor mental health among many ethnic groups relate to racism in at least three ways; through direct experience of racism, through racism which affects the social determinants of health (Section 4) and through experiences of mental health in relation to access and experience of mental health services (Section 5).

Severe mental illness diagnosis is particularly pronounced in each of the Black groups - Black Caribbean, Black African and Black British groups. (109) Studies indicate high rates of psychosis among Black Caribbean men are not present in the Caribbean (110) indicating the increased risk is context dependent. Studies point to worse outcomes in the social determinants of mental health, social and cultural exclusion and not having control over ones life, trauma, misdiagnoses, poor quality and inappropriate medical care as reasons for higher risk. (110) (111) In the APMS, psychotic disorder was found to be higher among Black men (3.2 percent) than men from other ethnic groups; Psychotic disorder did not vary significantly between ethnic groups among women (Figure 3.9). This was consistent with previous analyses of APMS (112) as well as with findings from other surveys. (113) (114)

Figure 3.9. Psychotic disorder in the past year by ethnic group and sex, 2007 and 2014 combined

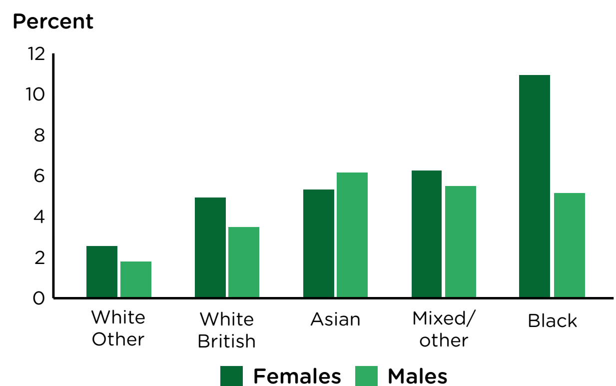


Source: *NHS Digital (2016) (115)*

Note: *there were no cases identified in the survey for Black females*

Although the age-standardised rate of trauma in adulthood did not vary significantly by ethnic group in the APMS, variation by ethnic group in the rate of screening positive for post-traumatic stress disorder (PTSD) did approach significance with more Black women than any other group screening positive (10.9 percent – Figure 3.10).

Figure 3.10. Age-standardised percent screening positive for post-traumatic stress disorder, by ethnic group, 2014



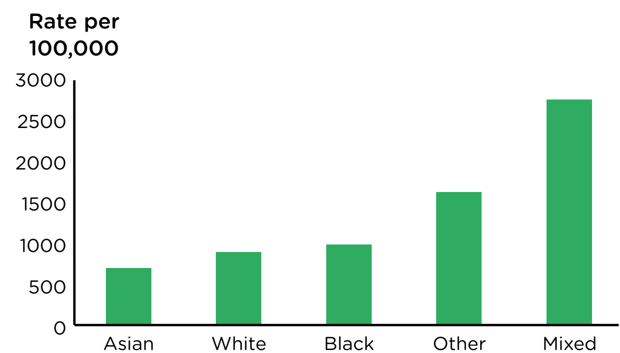
Source: *NHS Digital (2016) (116)*

YOUNG PEOPLES' MENTAL HEALTH

The outcome of household poverty, trauma, and many of the stresses experienced during early life may be poor mental health, which can have repercussions for the whole of life. (117) (118) Evidence shows clear deteriorations in young people's mental health in England and in London between 2017 and 2022. (119) A study of young people attending secondary schools in inner London found that there is a higher prevalence of mental health problems in London than is estimated nationally. There was some variation by ethnicity, with lower rates of mental health problems among Indian/Bangladeshi/Pakistani adolescents and higher rates among those from other mixed ethnic backgrounds. (120)

Figure 3.11 shows that for under 18s there are clear inequalities in contact with NHS mental health services, with young people of Mixed ethnicity having rates of contact over 2.5 times that of White and Asian young people, although it is unclear whether this is due to higher need, differential access to services or disproportionate diagnoses. There is likely to be a large excess of mental illness which is currently untreated.

Figure 3.11. Crude rate per 100,000 of those aged under 18, supported through NHS funded mental health, with at least one contact, England, April 2021 to March 2022

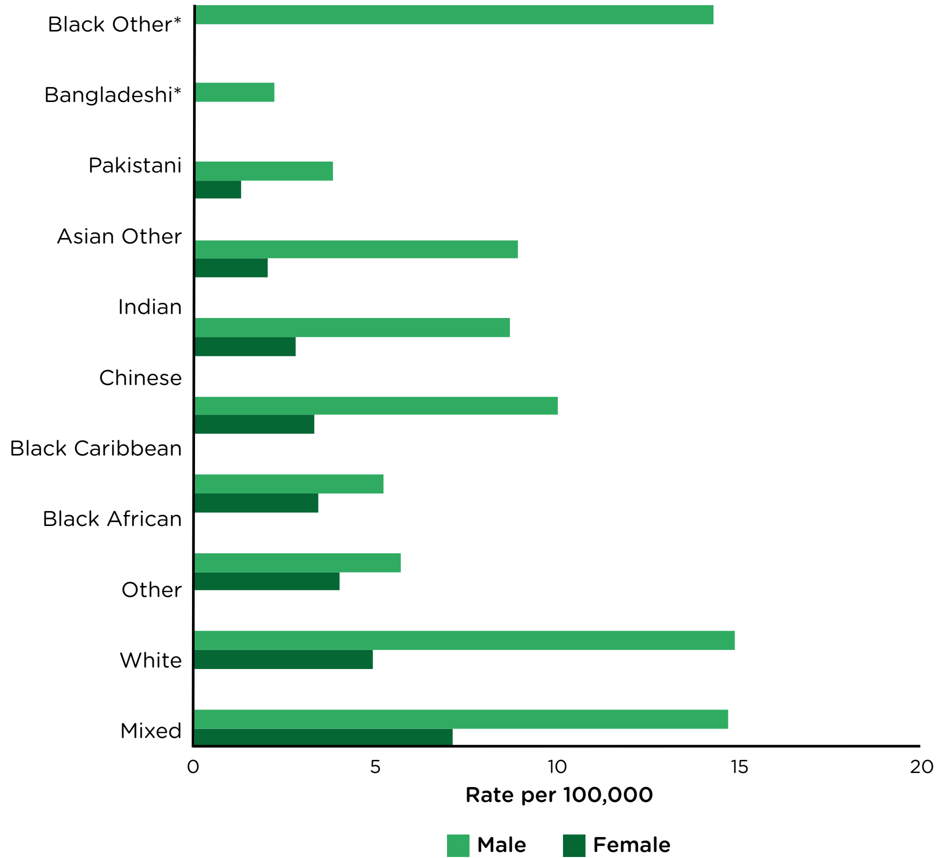


Source: *NHS Digital (121)*

SUICIDE RATES

Suicide rates are much higher for men than women among all ethnicities in England and Wales, with the highest rates among males for those who are from White, Mixed/multiple ethnic and Black Other groups - Figure 3.12. Among women rates are highest among Mixed ethnic groups.

Figure 3.12. Age-standardised suicide mortality rates at ages 10 and over by ethnic group and sex, England and Wales, 2017-19



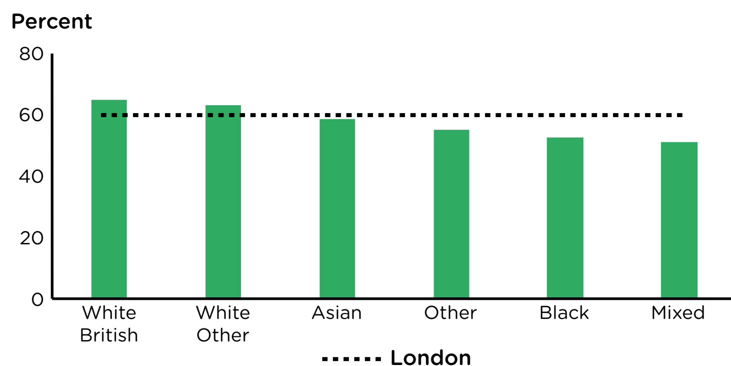
Source: *ONS (72)*

Notes: **Rates not calculated due to low numbers*

WELLBEING AND LIFE SATISFACTION

Figure 3.13, based on the GLA survey for London in 2021, shows that White British and White Other groups have higher life satisfaction than other ethnic groups. Mixed ethnic groups have the lowest according to this survey.

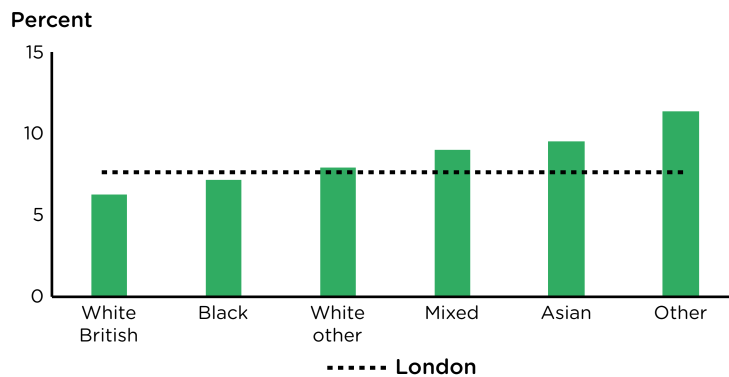
Figure 3.13. Percent of people with high or very high life satisfaction by ethnic group, London 2021/22



Source: *Survey of Londoners (57)*

There are clear ethnic inequalities in loneliness according to the Survey of Londoners with over 11 percent of Other ethnic groups often or always feeling lonely compared with just over 6 percent of White British Londoners – Figure 3.14.

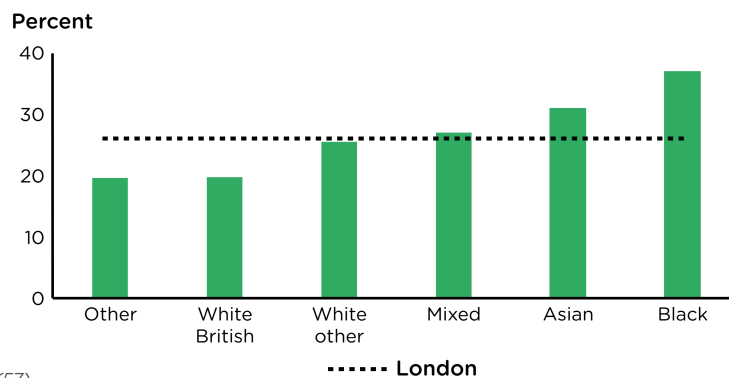
Figure 3.14. Percent of people who often or always feel lonely by ethnic group, London, 2021/22



Source: *Survey of Londoners (57)*

While social isolation does not necessarily lead to loneliness, it is an indicator for loneliness and is associated with a range of other poor physical and mental health outcomes. As Figure 3.15 shows, over 37 percent of Black/African/Caribbean and Black British people are socially isolated according to the survey of Londoners, compared with just under 20 percent of White British and Other ethnic groups. These figures are not age standardised and this may therefore, at least to some extent, reflect the differences in age structure shown in Figure 2.5 and migration history, shown in Figures 2.3 and 2.4.

Figure 3.15. Percent of people socially isolated by ethnic group, London, 2021/22



Source: *Survey of Londoners (57)*

Inequalities in mental health among some ethnic and more deprived groups highlights the importance of taking a social determinants approach with an equity lens to the design and delivery of policies and interventions to reduce inequalities in mental and physical health. Similarly, considerations of ethnicity as well as gender and socioeconomic position must be at the heart of effective and accessible services to prevent and treat mental disorders.

VIOLENCE

Violence takes many forms including domestic violence, gang violence and aggressive behaviour to neighbours or strangers, and has many causes. These causes include:

- Learned patterns of thinking, behaviour and feelings from early life experiences. (122)
- A wide array of neurological, physiological, or chemical influences that promote aggression and violence – including brain damage resulting from a variety of environmental or early life factors. (123)
- Developing ideas, beliefs, and patterns of thinking that emerge as a result of interactions throughout life – in particular perceiving hostility in others even when none exists.
- Social and environmental conditions where violence is normalised and widespread.
- There is evidence that inequality can increase the frequency of violence. (124)
- The characteristics of the situation in which violence occurs, such as stress or aggression in others and the availability of weapons such as knives, that encourages or engenders violent behaviour. (125)

The intersection between racism, social and environmental conditions can heighten propensity towards violence noted above, leading both to violence by members of disadvantaged groups to one another and racially motivated violence to members of other groups. Sections 4B and 4E overview the systemic racism which has undermined trust in the criminal justice system among many ethnic minority groups. The work of the London's Violence Reduction Unit is also highlighted in these sections.

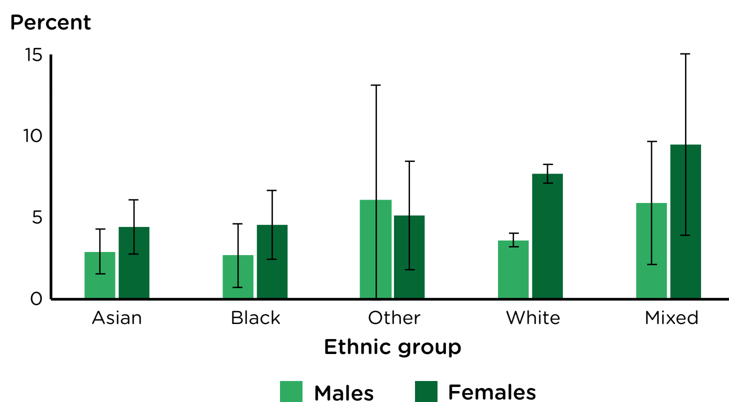
DOMESTIC VIOLENCE

The ONS Crime Survey for England and Wales showed that for both sexes combined, the prevalence of domestic violence in 2022 was highest in the Mixed group (8.7 percent), followed by 5.9 percent in the Black group, 5 percent in the White group and 3.9 percent in the Asian group. Figures for women were made available for three of these groups - Black (10.2 percent), White (7 percent) and Asian (3.2 percent. (126)

Figures for some more detailed ethnic groups in which large numbers of cases were reported were made available from the Crime Survey 2020. In the year covered, April 2019 to March 2020, the prevalence for both sexes combined in the Mixed White/Black Caribbean group was 10.6 percent, followed by Mixed White/Asian group (8.8 percent). Among women in the in the Mixed White/Black Caribbean group the figure was 11percent.

Results from the Crime Survey of England and Wales also show that reporting of domestic abuse by Asian and Black women in the survey is significantly lower than by White women – Figure 3.16. It may be that this reflects an unwillingness to report abuse, even in a highly confidential survey. No other differences were statistically significant due to small numbers of ethnic minority groups in the survey. The data is not available for London.

Figure 3.16. Percent of adults aged 16 to 74 years who were victims of domestic abuse in the last year, by ethnic group and sex, England and Wales, year ending March 2020



***Source:** ONS Crime Survey for England and Wales (127)*

***Notes:** Bars represent 95 percent confidence intervals*

Underreporting of domestic abuse is common; however, it is even more acute within ethnic minority groups. Women from ethnic minority groups are found to be more likely to stay in abusive relationships due to the barriers associated with leaving. (128) Research by domestic abuse charity Safelives shows that victims from ethnic minority groups suffered abuse for 1.5 times longer before getting help compared to those who identify as White British or Irish. (129)

Low level of reporting domestic abuse among women from ethnic minority groups is exacerbated by distrust of the police force as well as cultural norms. Disclosing abuse is often seen as bringing shame to the family and to the community. 'Honour-based violence' is a collection of practices used to control the behaviour of women and girls within families or social groups to protect religious and cultural beliefs and values, and it includes incidents of forced marriage and female genital mutilation. Data on police reporting of 'honour-based violence' offences in the UK have been collected by the Home Office on a mandatory basis since April 2019, although they are not available by ethnicity. As indicated, these figures on recorded offences understate the level of violence experienced. In the year April 2021 to March 2022, there were 2,887 offences involving 'honour-based' abuse reported by police in England and Wales, including 77 female genital mutilation offences and 141 forced child marriage offences. A total of 427 offences were reported by the Metropolitan Police. (130)

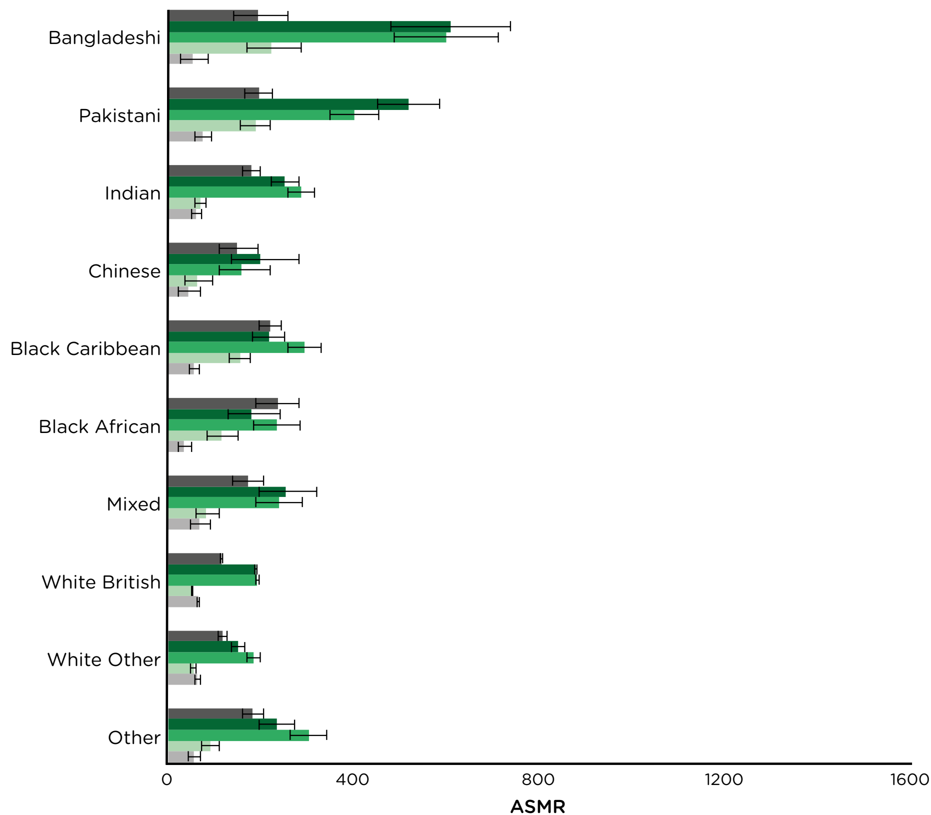
Further, issues related to racism, such as stereotyping, have been found to impact the likeliness of reporting domestic abuse. (128) Safelives' research has found immigration status to be a barrier to leaving domestic abuse by ethnic minority groups, as many fear deportation. Immigration status and financial vulnerability are often used to control the victim by the abuser as it increases the feeling of isolation and further impedes help-seeking. (129)

COVID-19 AND ETHNICITY

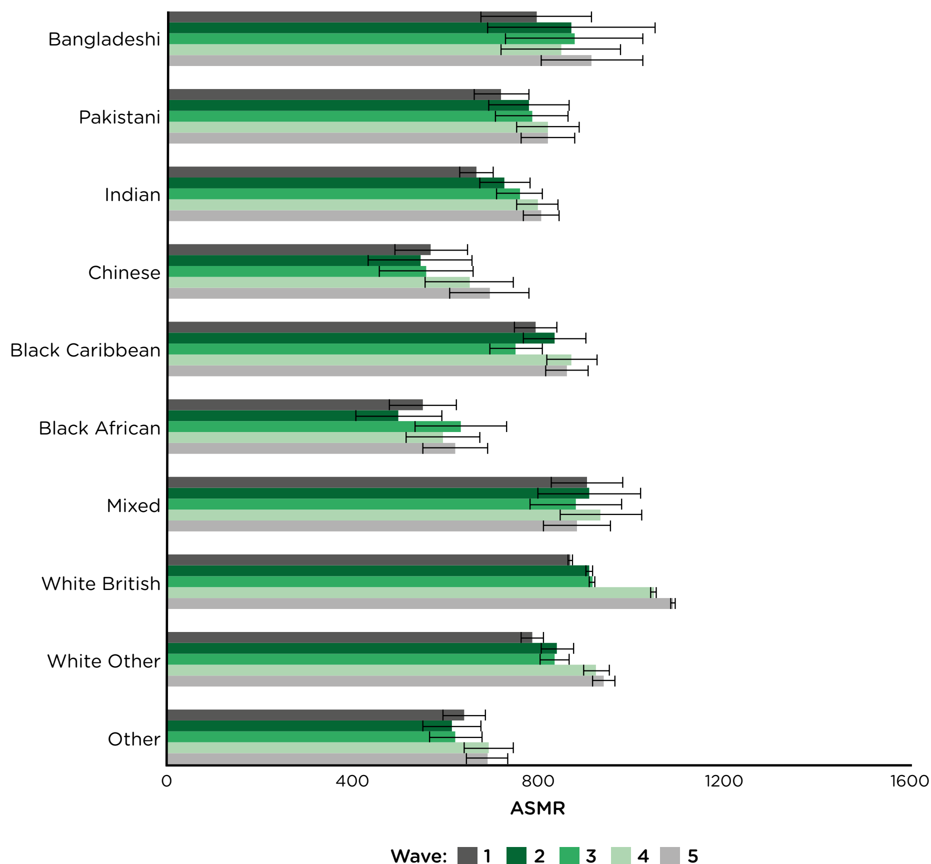
Mortality rates from COVID-19 were much higher among many ethnic minority groups than the White British group in England in the early stages of the COVID-19 pandemic, with a changing pattern as the pandemic progressed, according to ONS 2011 Census-based analyses, Figure 3.17. Specifically, during Wave 1 of the pandemic COVID-19 mortality rates for all ethnic minority groups (except Chinese and White Other) of both sexes were significantly higher than that for the White British group, while none were significantly higher during the fifth (Omicron) wave. During the intermediate waves, COVID-19 mortality rates were consistently significantly higher for Indian, Pakistani and Bangladeshi males and females, as well as Black Caribbean males. Further analysis details are in Appendix 3.

Figure 3.17. Age-standardised death rates from COVID-19 and non-COVID-19 causes by ethnic group and sex, England, 24 January 2020 to 23 November 2022

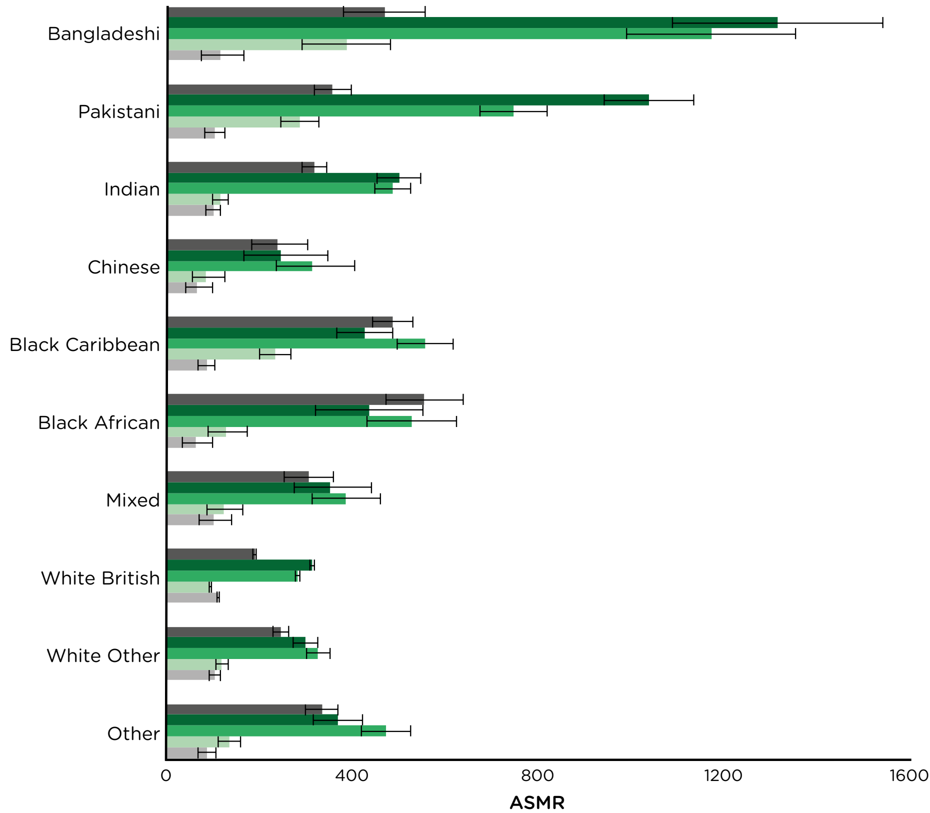
COVID-19 MORTALITY



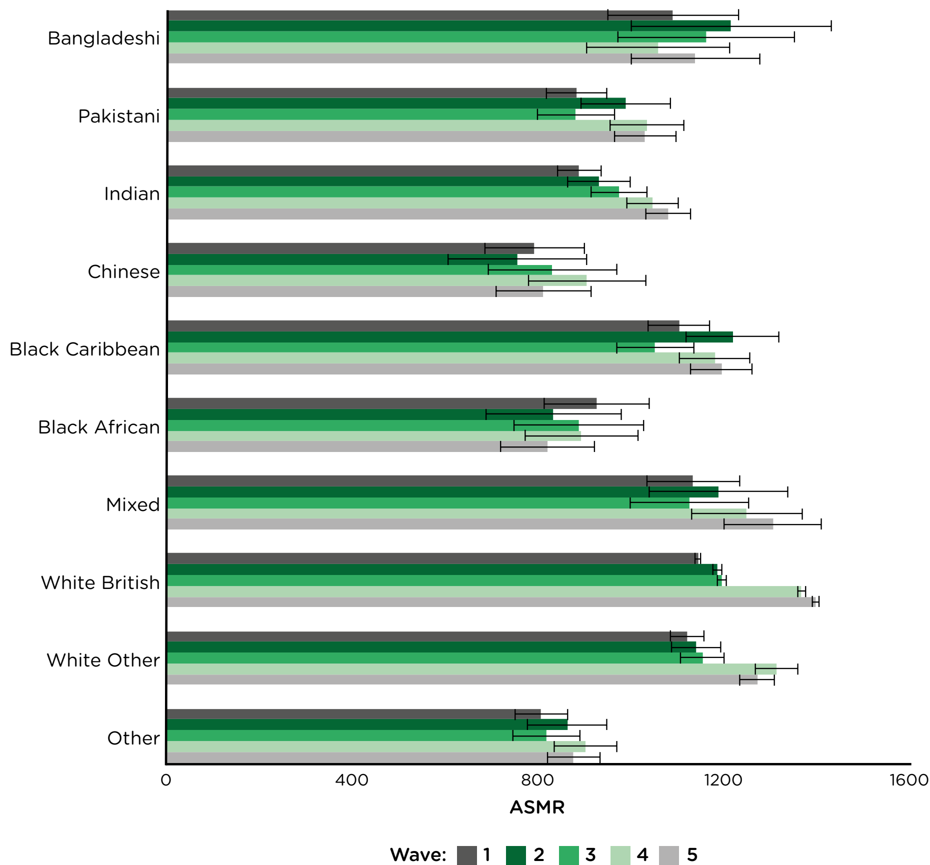
NON-COVID-19 MORTALITY



COVID-19 MORTALITY



NON-COVID-19 MORTALITY



Source: *ONS (2023) Updating ethnic contrasts in deaths involving the Coronavirus (Covid-19), England (131)*

Notes: *1) Ethnicity was recorded using the 2011 Census question.*

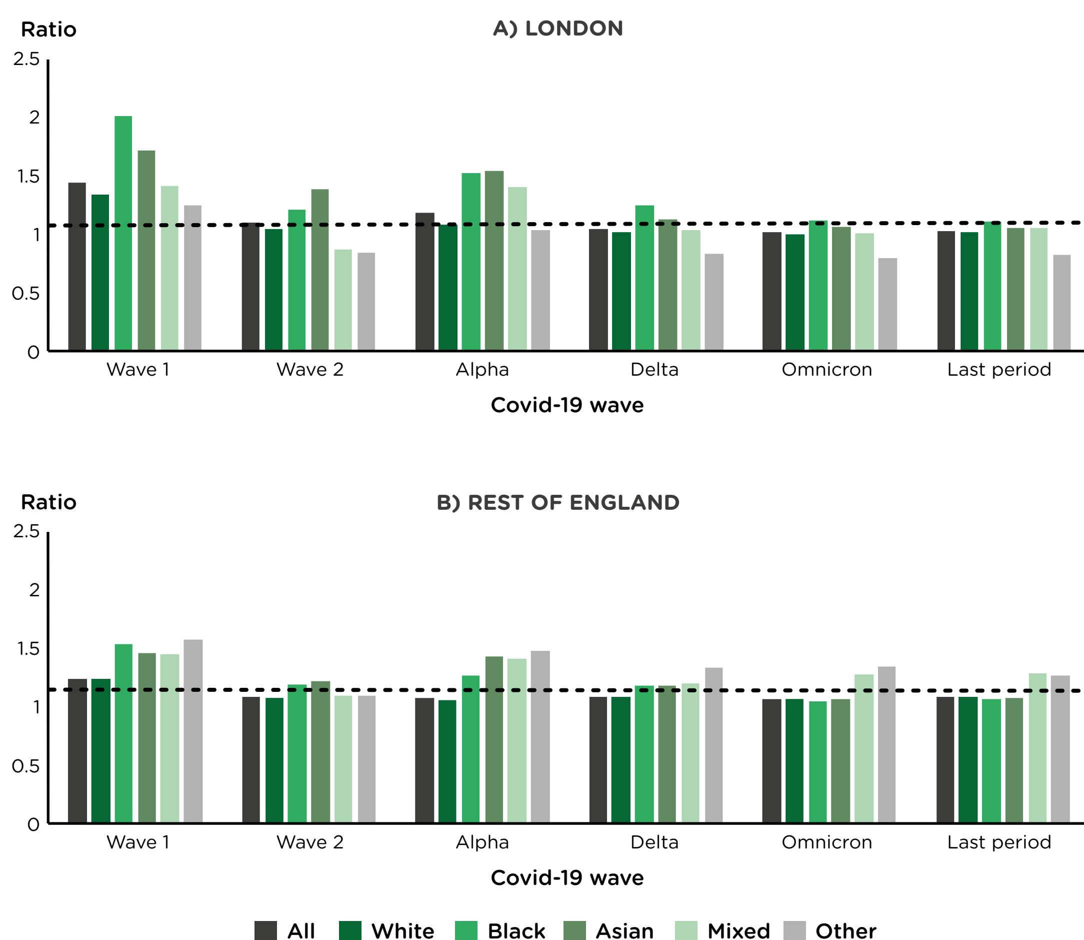
2) Covid-19 waves: The first COVID-19 variant period was defined by ONS as being is from 24 January 2020 (the date when the first COVID-19 case was reported in the UK) to 11 September 2020 (when wild-type was the dominant variant); the second period is from 12 September 2020 to 8 January 2021 (when wild-type was the main variant); period three ONS defined to be from 9 January 2021 to 12 June 2021 (when Alpha was dominant); period four ONS defined to be from 13 June 2021 to 9 January 2022 (when Delta was dominant); period five ONS defined to be from 10 January 2022 to 23 November 2022 (when Omicron was dominant).

3) Bars represent 95 percent confidence intervals.

Data for London on mortality during the COVID-19 pandemic by ethnicity is available from the Office for Health Improvement and Disparities (OHID), but on a substantially different basis to that used by the ONS – see Appendix 3 for details. (132) The OHID analysis shows a marked difference in the pattern of excess in all cause mortality rates between ethnic groups in London and those in the rest of the England during the period March 2020 to June 2023 (Figure 3.18). For all ethnic groups combined, there was an overall excess of deaths in London in Waves 1 and 3 (the Alpha Wave) but not in other waves, with the larger excess in Wave 1. However, the pattern varied by ethnic group in London. Excesses were seen among Black groups in London in Waves 1 to 4, but not subsequent waves, with this group having the largest excess of all groups in Wave 1. Asian groups experienced excess mortality only in Waves 1 to 3. While the excess in Asian groups was greater in Wave 1 than in subsequent waves, their excess in Wave 2 was higher than in each of the other ethnic groups during that wave. There were excess levels of mortality among those of mixed origin only in Waves 1 and 3 but not in other waves.

Outside London, a different pattern of excess mortality was seen. The only overall excess was in Wave 1, during which ethnic groups other than White groups had similar levels of excess mortality, higher than that for White groups . Outside London, Black and Asian groups also had similar raised levels of mortality in Waves 2 to 4 but not subsequently. By contrast Mixed and "Other" ethnic groups had excess levels of mortality in every wave except Wave 2

Figure 3.18. Ratio of all registered deaths to those expected, by ethnic group, London and the rest of England, 21 March 2020 to 23 June 2023



Source: *OHID (2023) (133)*

Notes *a) Ethnicity was derived from the linked HES-ONS mortality data file.*

b) Covid-19 waves: wave 1 is from 21 March to 28 August 2020; wave 2 is from 29 August2020 to 8 January 2021; the Alpha wave (wave 3) is from 9 January 2021 to 4 June 2021; The Delta wave (wave 4) is from 5 June 2021 to 7 January 2022; The Omicron wave (wave 5) is from 8 January 2022 to 18 November 2022 and the last period is from 19 November 2022 to 23 June 2023

To attempt to understand the factors contributing to these mortality patterns by ethnicity, wave and geography, ONS-derived statistical models summarised waves into three time periods between March 2020 and December 2021. Briefly, the first model, which relates to deaths occurring between 2 March and 28 July 2020 showed that accounting for population density and local authority of residence comprised a substantial part

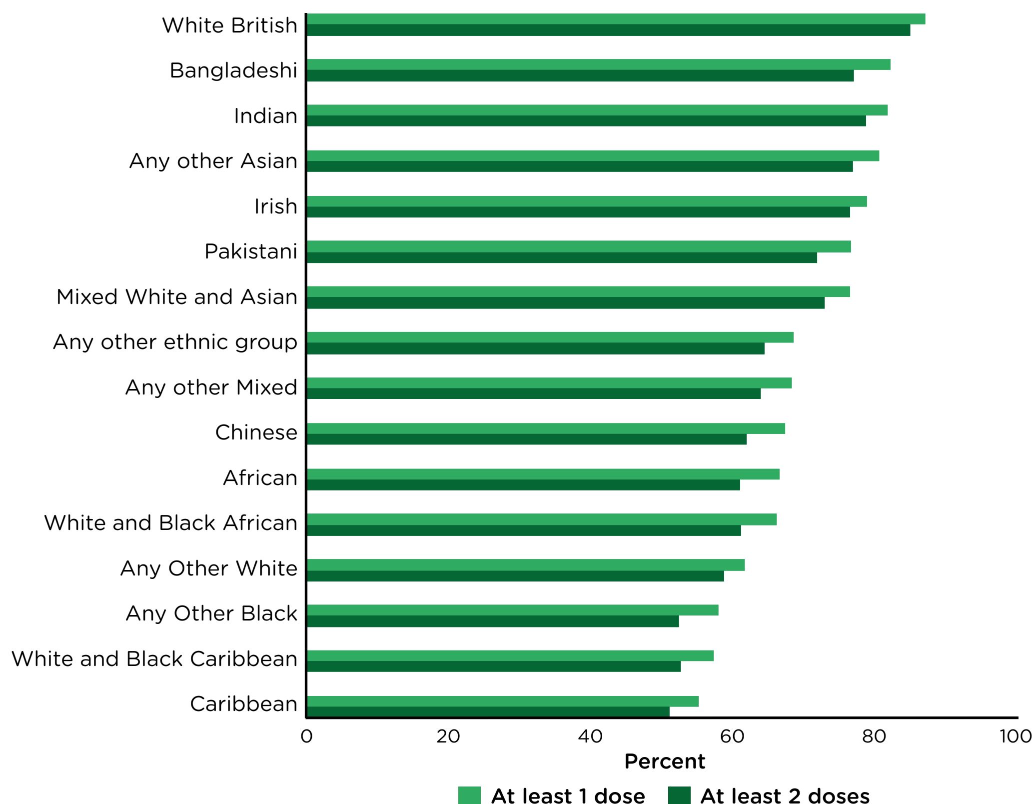
of the excess risk experienced by most ethnic minority groups. However, it only fully accounted for excess risk among Chinese and Mixed groups of both sexes and females in the Indian and Other ethnic groups. Adding additional socioeconomic factors and self-reported health into the models further reduced the magnitude of the excess in most other groups, However the only additional group for which these factors fully accounted for the excess was among females in Pakistani and Bangladeshi ethnic groups. (134)

Of course, all the factors in the different models are interrelated. The cumulative occupational, living and environmental conditions experienced by many ethnic minority groups related to racism and discrimination, plausibly contributed to the disproportionately high mortality rates from COVID-19. For example, people from several ethnic minority groups are more likely than White people to live in an overcrowded household with several generations, or in a household of multiple occupation (135) (136) (137) (138) which have been shown to increase the risk of COVID-19 infection and mortality. (139) Many ethnic minority groups are also more likely to live in deprived urban areas (140) (141) (142), with higher rates of air pollution (143) (144), which increases the risk of COVID-19 infection and mortality.

It should also be noted that all the exposure variables relied on individual information supplied in the 2011 Census and may not have accurately described people's situation in 2020. In particular, the only health status information available to the ONS in 2020 was self-reported general health and limiting long-term illness in 2011. It became evident, from research over the course of the pandemic, that specific health conditions increased the risk of severe outcomes from COVID-19 infection and, as discussed earlier in this section, some of these were particularly prevalent in some ethnic minority groups e.g. chronic kidney disease, diabetes and sickle cell disease. (145)

In the later waves of the COVID-19 pandemic, the importance of vaccination status in reducing excess mortality became paramount once the programme was rolled out after January 2021. However, vaccination rates differed in London up to March 2022 (Figure 3.19). All ethnic minority groups had lower rates than the White British group – with Caribbean groups having the lowest rates, 55 percent with at least one dose and 51 percent with at least two doses. This vaccine hesitancy among ethnic groups was an important contributor to mortality risk in waves two and three of the COVID-19 pandemic (Appendix 3). This 'vaccine hesitancy' reflects a combination of factors – perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders. (146) (147) Vaccine hesitancy relates to peoples' wider experiences more broadly, where they have experienced racism, exclusion, lack of representation and lack of cultural relevance from healthcare and other service providers.

Figure 3.19. Percent of people vaccinated for COVID-19, by dose and ethnic group, London, 8 December 2020 to 31 March 2022



Source: *NHS digital (148)*

CHAPTER 4

RACISM AND ETHNIC INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH

This section sets out the way particular minority ethnic groups can be disadvantaged with respect to the social determinants of health. To the extent possible we examine the way that racism plays a role in generating these disadvantages. As outlined in Section 1, these cover the six key social determinants of health and policy objectives in the original Marmot Review (11) and subsequent reviews from IHE. (149) (6) Two caveats are in order. First, as set out at the beginning of this report, ethnic differences and the effects of racism are not synonymous. In some cases racism is playing a role; in others the evidence is lacking, or racism is not implicated. But the evidence compiled here should contribute to the debate about racism and inform action for organisations responsible for the various social determinants. The second caveat is that, in large measure, the evidence base is inadequate to be able to state with certainty which social determinants most contribute to the ethnic health patterns laid out in Section 3. It is likely that there will be more than one influence, starting with early life through working life and into older ages and in a variety of settings. We are concerned with the cumulative impacts and intersections with other dimensions of exclusion and inequality on health.

4A. GIVE EVERY CHILD THE BEST START IN LIFE

This section sets out ethnic inequalities in levels of development among young children and inequalities in rates of child poverty, which have particularly harmful impacts on health and the social determinants of health throughout life. The section also reviews ethnic inequalities in access to maternal and newborn healthcare services and reports of racism affecting access, experiences and outcomes from those services which contribute to the unequal rates of maternal and infant health reported in Section 3.

ETHNIC INEQUALITIES AND EARLY CHILD DEVELOPMENT

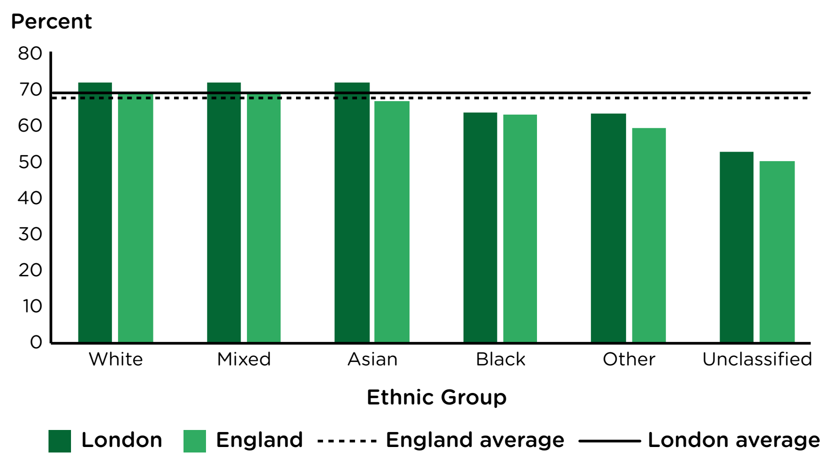
Children's experiences during their early years have lifelong impacts. Evidence has repeatedly shown that positive experiences and good development in the early years are closely associated with a range of beneficial long-term outcomes, including higher levels of attainment at school, better social and emotional development, improved employment outcomes, higher income and better lifelong health, including longer life expectancy. (11) (150) (151) (152) Conversely, less positive experiences early in life, particularly experiences of poverty, adversity and trauma, relate closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health. (11) (150) (153) (154) (155) (156).

Socioeconomic inequalities in child development are already recognisable by the second year of life. (11) (6) These inequalities have an impact by the time children enter school and persist and deepen during their school years. (157) There is some limited data by ethnicity available for some outcomes in the early years. One way to measure the level of development by ethnicity in England is to use data from the Department for Education (DfE) based on teacher assessments at the end of Reception year; recognising that these assessments may reflect teacher and wider school and education system biases about various characteristics of children and their families, including ethnicity. (158) We are acutely aware that there may be need to develop measures of early child development that are sensitive to cultural differences.

Across England in 2021/22, 71.7 percent of pupils aged 4-5 from the Chinese ethnic group met the expected standard of development – the highest percentage out of all ethnic groups. Followed by 69.5 percent among Mixed White/Asian children, 69.1 percent Indian children, 68.4 percent White Irish and 65.5 percent among White British children. The lowest proportion of children meeting the expected standard was among White Gypsy/Roma children with 29.9 percent. (159) Levels of development among children and young people are closely related to structural societal structurs including socioeconomic infactors as well as racism and other forms of discrimination.

Overall, young children in London have slightly higher levels of development at the end of Reception than in England as a whole. Among Asian, Mixed and White children, more than 70 percent reach a good level of development at the end of reception. On average, Black children do not meet the average level of development in London, but still have slightly higher development rates than children of comparable ethnicities across England, a likely result of socioeconomic disadvantage. Those children classified as 'Other' ethnicity or not classified by ethnicity at all have the lowest rates of good levels of development in London and England.

Figure 4.1. Children reaching a good level of development at the end of reception, London and England, 2022/23

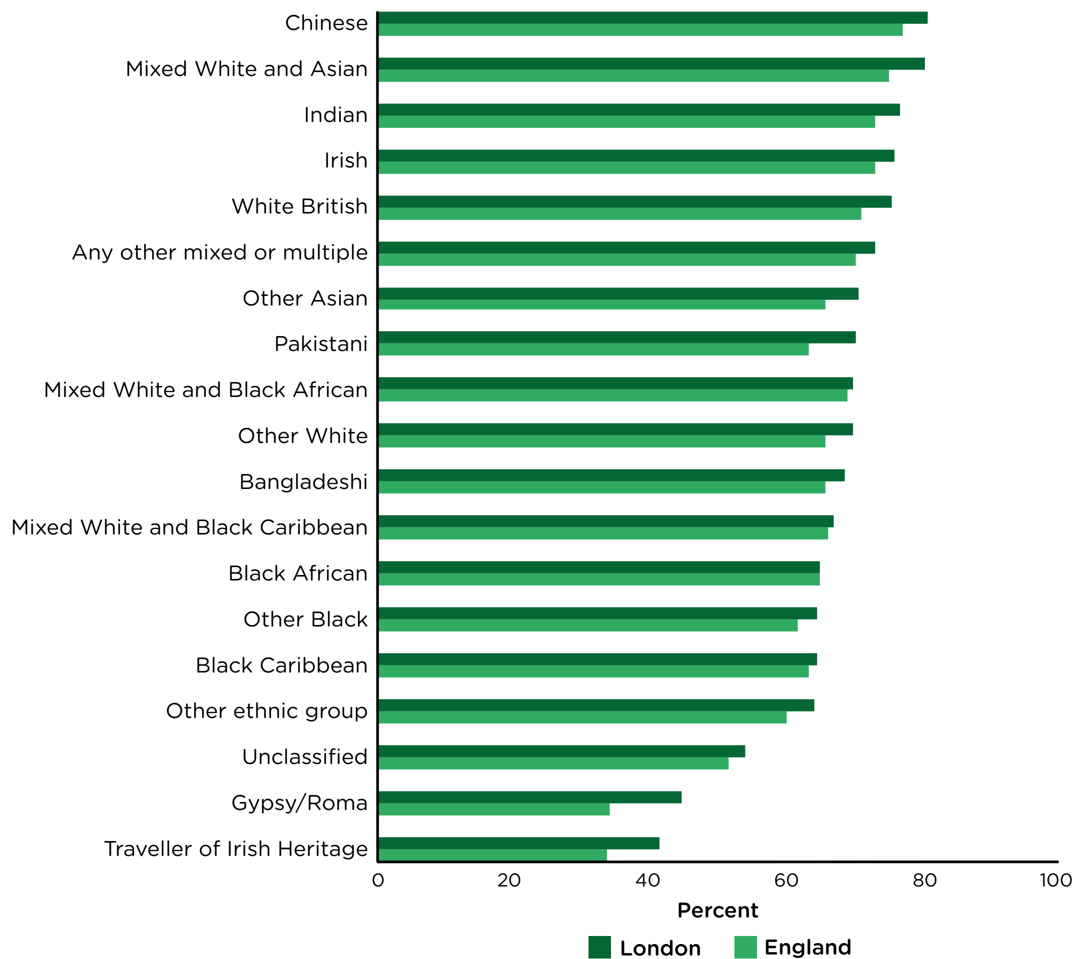


Source: *Department for Education (160)*

SPEECH AND LANGUAGE DEVELOPMENTAL DELAYS

There is evidence showing that early language delay is associated with poor academic attainment and lower socioemotional wellbeing and worse socioeconomic outcomes. (161) (162) A study of children from an ethnically diverse and deprived area in the UK found that children from low-income and bilingual backgrounds, were more likely to experience early English language delay, although a limitation of this study is that it did not include any families who could not complete the assessment in English. (163) In London children of all ethnicities are more likely to reach expected levels in communication, language and literacy than children in the rest of England during foundation stage (ages 2-5), Figure 4.2. (164) Chinese and Indian children do as well or better compared to White British children; children of other ethnicities do less well on this measure.

Figure 4.2. Percent of children aged 4 to 5 at the expected level in the communication and language and literacy areas of learning by ethnic group, London and England, 2022/23



Source: *Department for Education (165)*

Notes: *The 'unclassified' ethnic group category describes cases where a child's ethnicity was refused or not obtained. These children are included in the 'Total' numbers.*

PARTICIPATION IN EARLY YEARS SERVICES AND TAKE-UP OF FREE CHILDCARE

Participation in good quality early years services and childcare is particularly beneficial to the levels of development among young children in more disadvantaged households and is an important way to reduce inequalities in early years development. (166) There are inequalities by ethnicity in take-up of the free childcare offer.

A 2018 DfE report on the take-up of free early years education entitlements in the UK found that take-up was lower for children from Bangladeshi, Gypsy/Roma/Traveller, Black African and Pakistani backgrounds according to a study in 2010/11. (167) (168) The highest rates of formal childcare take-up were for Black Caribbean, White British, and mixed White and Black children, and lowest among children from Bangladeshi, Pakistani 'other Asian backgrounds. (169) Children who spoke English as an additional language were nearly three times as likely not to take up their full five terms of pre-schooling compared with children who spoke English as their first language. (169) The report referred to a perception among local authority leads and providers in London that there is a preference for some parents from some ethnic groups to keep their child at home rather than have them attend childcare settings, and a cultural preference for family members to care for the children over formal provision. (169) Interviews with parents from ethnic minority groups showed mixed responses, with those preferring informal childcare stating their motivations included teaching children about cultures and religion from an early age, instilling values they felt would not be provided via formal childcare, teaching children language to communicate with older relatives, and concerns over childcare providers' inability to cater to religious needs, such as food. In some cases, parents were unaware of the entitlements for free childcare or early years services. (169) In particular, a

lack of awareness of the entitlement for some free provision for two-year-olds led to lower participation from Bangladeshi, Somali and Polish groups. There is a need for good quality and culturally appropriate early years services which specifically address concerns about taking up the entitlement to childcare and for the offer and benefits of participation to be much better articulated for Londoners from ethnic minority groups.

CHILD POVERTY

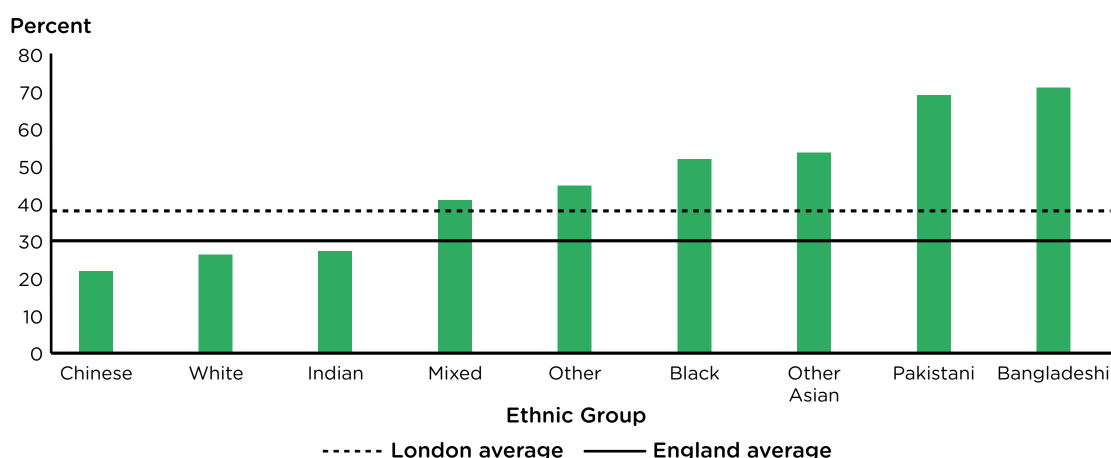
The experience of living in poverty as a child has multiple harmful impacts on health and the social determinants of health. (170) (171) Drivers of child poverty include parental unemployment, low pay, social protection which is too low to meet essential needs and the two-child benefit cap, housing costs and the rising cost of essentials such as heating. Child poverty is not an inevitability, but largely the result of political and policy choices in areas including social protection, taxation rates, housing and income and minimum wage policies and many countries in the Organisation for Economic Co-Operation and Development have considerably lower rates of child poverty than England. (6) According to the UNICEF Innocenti report, in 2019-2021, the UK ranked 28th out of 39 OECD and EU countries for rates of child poverty. Notably, it had the highest increase in child income poverty rate, of 20 percent, from 2012-14 to 2019-21 out of all the OECD countries. (172)

A child is defined as living in relative poverty if they live in a household whose equivalised net income is less than 60 percent of median equivalised net household income for that financial year. This is measured both before and after housing costs, with the after-housing cost figures taking into account essential housing costs including rent, mortgage interest, council tax, water bills and so on, but not including fuel bills. (173) (174) Across the UK 30 percent of children live in relative poverty after housing costs.

In 2021/22 Tower Hamlets was the borough with the highest proportion of children in poverty in London, both before and after housing costs, at 27 percent and 48 percent respectively. (175) (176) In London 24 percent of children were living in severe poverty after housing costs in 2019/20–2021/22, which is defined as living in a household with less than half of median income. (174)

There are clear ethnic inequalities in rates of child poverty in London: 42 percent of Pakistani children are living in low-income before-housing-costs, double the average for London and nearly triple the rate of White, other Asian and Indian children. The figures after housing costs are higher still, Figure 4.3. Over 70 percent of Bangladeshi children and nearly 70 percent of Pakistani children in London live in low-income households after housing costs, which is nearly 44 percentage points higher than the rate for White children. The rate for children from Indian households is close to that of White children. Children from Chinese households have the lowest rates, around 22 percent. Food insecurity, poor quality housing including cold and damp conditions and air pollution are all impacts of poverty, covered in, which harm health and are most likely to affect Bangladeshi, Pakistani children, those from other Asian backgrounds and Black children.

Figure 4.3. Percent of children living in low-income households (after housing costs) by ethnic group of head of household, London, 2017/18 to 2019/20



Source: *DWP (177)*
Note: *A household is in low income if they live on less than 60 percent of the UK's median income.*

There are a range of programmes in London provided by the GLA, local authorities and the community, voluntary, faith and social enterprise (CVFSE) sector which try to tackle child poverty and mitigate its impacts. These must take into account the clear ethnic inequalities in rates of child poverty and be designed appropriately for the differing needs of different ethnicities. More broadly, ethnic inequalities in household income and poverty rates, set out further in Section 4D, are related to lower pay, employment rates and levels of seniority, affected by racism among employers.

Parenting approaches are often seen as key to children's development in the early years but it is important to note that parenting is closely related to families' social and material circumstances. Put simply, it is easier to parent more effectively when social and economic circumstances are favourable and when stress and anxiety are lower; although, of course, positive and negative approaches to parenting apply across the socioeconomic gradient. Parenting is influenced, although not determined, by parents' own childhoods and their current lives, including their own mental wellbeing, their social and material circumstances and their networks of support. (151) (152)

Children whose parents have 'no recourse to public funds' (NRPF) are more likely to be destitute, live in poor and overcrowded housing and experience food poverty and housing precarity. (178) (179) (180) Furthermore, children in households with NRPF do not have access to state-sponsored childcare, (181) thus missing out on the developmental benefits of early years education facilities. These inequities negatively impact children's development, hold them back from achieving their potential and ultimately undermine their health and future prospects. An Association of Directors of Children's Services' research report identified the increasing numbers of families with NRPF as one of their top safeguarding pressures. (182) (183)

EXPERIENCING TRAUMA DURING CHILDHOOD

One clear impact of poverty is an increase in the likelihood of experiencing trauma including adverse childhood experiences (ACEs). There is growing evidence linking experience of trauma and subsequent risk of mental health conditions. (184) Common types of ACEs are abuse and neglect; living in a household where there is domestic violence, drug or alcohol misuse, mental ill health, criminality, divorce or separation; and living in care. (185) Children growing up in deprived areas and those from families with low socioeconomic position are more likely than their more advantaged peers to experience ACEs. (155) (186) (187) ACEs elevate the risk that children and young people will experience damage to health, or to other social outcomes, across the life course. Those who experience multiple ACEs have an increased risk of disease, including heart disease, cancer, lung disease, liver disease, stroke, hypertension, diabetes, asthma, arthritis and mental health problems throughout their lives. (6)

Providers of children's social care in England and Scotland set out that family poverty and inequality are damaging children. (155) (188) Children in Need are a legally defined group of children, assessed as needing help and protection because of risks to their development or health. This group includes children on child in need plans, children on child protection plans, children looked after by local authorities, care leavers and disabled children. (189) There were over 403,000 children identified as children in need in 2023 in England with the proportion of those identified as being from ethnic minority groups increasing since 2015. (189)

London data on ACEs by ethnicity is not available but as many ethnic minority children in the capital are living in poverty, it is likely that there are relatively high rates of ACE experience among these groups. The experience of racism by children should be recognised as an ACE due to the resulting trauma. (187) Programmes designed to reduce the likelihood and impact of ACEs on health and other outcomes throughout life should develop culturally informed practices, relevant for different ethnic groups and which take account of experiences of racism. (187)

Trauma-informed practice is a way of working that acknowledges that people may have experienced trauma and takes this into account when interacting with them and treating them. It emphasises the safety of survivors and creates opportunities for them to rebuild control and empowerment. (190) Trauma-informed approaches in child services can improve outcomes for young people, including reduction in post-traumatic stress symptoms and behavioural problems. (191) The key principles of trauma-informed approaches are:

1. Recognition (understanding and acknowledgement that people may have experienced trauma)
2. Resist retraumatisation (some services, particularly inpatient settings can retraumatise people as they mirror the lack of control and restraint some may have experienced)
3. Cultural, historical and gender contexts (ensure services are culturally appropriate and view contexts with an intersectional lens)
4. Trustworthiness and transparency
5. Collaboration and mutuality (recognise the power imbalance between staff and survivors and ensure relationships are based on mutuality, trust and respect)
6. Empowerment, choice and control
7. Safety
8. Survivor partnerships (peer support and coproduction)
9. Pathways to trauma-specific care (192)

EXPERIENCES OF RACISM AND DISCRIMINATION IN THE EARLY YEARS

Some of the ethnic differences in experiences in the early years may be explained by higher levels of deprivation and poverty among many ethnic minority groups, itself partly related to experiencing racism during recruitment and employment. There are other additional impacts from racism including in access to and experience of services. In 2022 the Early Years Foundation, in partnership with the Race Equality Foundation and Action for Children, published a report exploring the experiences of families from ethnic minority groups in accessing and receiving family support in England. (193) The review highlighted that racism was commonly reported when trying to access family support services and one in three survey respondents felt they were treated unfairly when seeking or receiving support for their family. (193)The review found that families from ethnic minority groups were proactively seeking help and support, but that they often encountered multiple barriers in doing so, including racism and discrimination leading to, inappropriate information, difficulties finding appropriate services, insufficient service capacity and long waiting lists. Some parents also had negative experiences of the first point of contact with services, including them or their children being 'pathologised' by providers. Parents and young people also identified a lack of cultural sensitivity within family support services. They found that services were not representative of the communities they worked with, and that practitioners did not always display cultural sensitivity or an understanding of cultural or religious influences on family dynamics. (193)

While evidence of the impact of racism on access to early years settings is scarce, research funded by the Nuffield Foundation in 2022 on the impacts of the COVID-19 pandemic on early childhood education and care shows that children from ethnic minority groups were more negatively affected than their White counterparts. (194) Based on analysis of national data, the study finds that areas with large ethnic minority populations were particularly likely to experience temporary closures of services during the first year of COVID restrictions. Between January 2020 and January 2021, there were large declines in take-up of funded entitlement places for disadvantaged two-year-olds (a drop of 7 percent, from 69 to 62 percent) and three-year-olds, particularly in areas with large ethnic minority groups and limited labour market participation. Children from ethnic minority groups and those diagnosed with Special Educational Needs (SEN) were most likely to be impacted. (194)

In some instances, racism and discrimination in childcare settings discourage parents from taking up services their children are eligible for. Guilaine Kinouani, a psychologist and author, recounts direct and indirect racism in nurseries in the UK. She reports her own experience having seen the lack of attention, care and warmth towards her child. Kinouani reports that Black children are subtly excluded and treated differently and discusses how her child was left unchanged for hours. (195) Another concerned mother felt compelled to set up the 'Dope Black Mums' Facebook group to gather opinions from other Black mothers in the UK, who spoke of experiencing everyday 'microaggressions' that affect Black children's confidence and performance. (195)

Some studies explore the relationship between ethnic and cultural differences in parenting styles and child development outcomes and show there are challenging intersections of race, culture and child welfare policies. (196) Based on interviews and discussions with Nigerian parents' about their experiences of the British child welfare system suggest that social workers perpetuate the British public's misrecognition of Nigerian parents through uncritical social work practices, which are implicated in further disempowerment of Black African parents, to the detriment of the families' well-being. (197)

Generalising parenting practices is problematic as these differ culturally and also relate to socioeconomic circumstances, with parenting often being more challenging when also dealing with poverty and debt. (198) Moreover, processes of acculturation may shift what are seen as traditional parenting practices towards adopting some from the dominant culture. Research has also indicated that parents from ethnic minority groups have to adapt parenting practices to try to protect their children from racism by being prepared to encounter bias. (199) A study assessing adolescent mental health in London found that low care and high control parenting is associated with poorer mental health within each ethnic group in a sample of 11- to 13-year-olds. (187) (200)

A qualitative study in the UK from 1999 found that parents whose children had suffered racist attacks had less freedom to move about the neighbourhood on their own. (201) The research was carried out in Belfast, Cardiff, Glasgow and Hounslow with an involvement of 74 people in focus groups and in-depth interviews to express their experiences of racism and racist victimisation in and around the home. The study reports parents and children being too scared to leave their homes and the cumulative effect of their racist encounters leading to a deterioration of physical and mental health, including depression, insecurity, stress, and lack of sleep. In one case, a woman reported having a miscarriage due to the stress.

RECOMMENDATIONS: GIVE EVERY CHILD THE BEST START IN LIFE

1. Increase the spending on early years provision at a minimum meeting the OECD average and ensure allocation of funding is proportionately higher for more deprived areas and excluded ethnic groups.

2. Reduce levels of relative child poverty in all ethnic groups to 10 percent – level with the lowest rates in Europe.

3. Ensure programmes that tackle child poverty and mitigate its impacts are designed appropriately to meet the needs of different ethnic groups.

ADDITIONAL RESEARCH AND EVIDENCE

- Carry out routine collection of data by ethnicity to establish the extent of ethnic inequalities in the early years.
- Analyse whether early years services and assessments of levels of development are culturally appropriate for the diverse populations and wide range of socioeconomic background in London.
- Undertake further studies on the experiences of racism and their effects among parents and children in the early years and ensure these are incorporated into actions to tackle racism and improve outcomes.

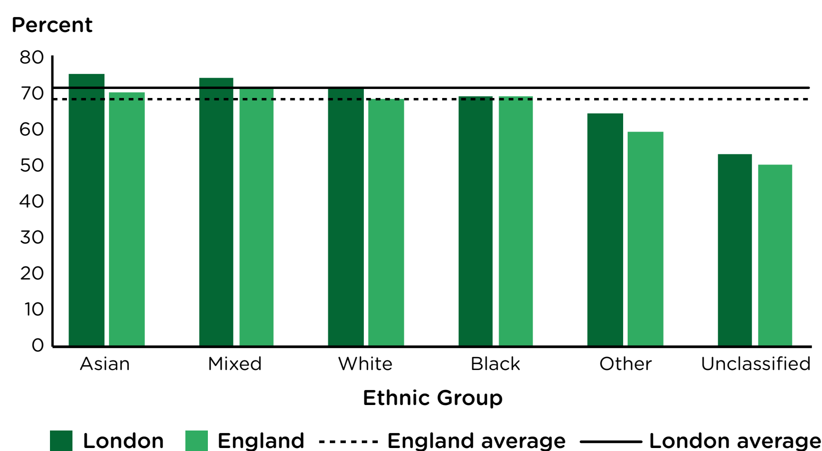
4B. ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

There is a clear and close relationship between health in adulthood and experiences in education and as a young person. In the UK, those who have no qualifications are more than twice as likely to have a limiting illness in adulthood as those who achieved university level (or equivalent) education. (202) Reducing inequalities in educational attainment and experiences for young people are effective interventions for reducing health inequalities and should be considered as such by all relevant stakeholders.

ETHNICITY AND INEQUALITIES IN EDUCATION

The rate of pupils aged six to seven years meeting the expected standard of reading at the end of Key Stage 1 in 2022/23 was higher for all ethnicities, other than Black pupils where it was the same in London compared with the rest of England, Figure 4.4. Asian pupils in London were most likely to reach the expected standard. Those who were not classified by ethnicity in the data, and those classified as 'Other' ethnicity, were least likely to reach the expected standard.

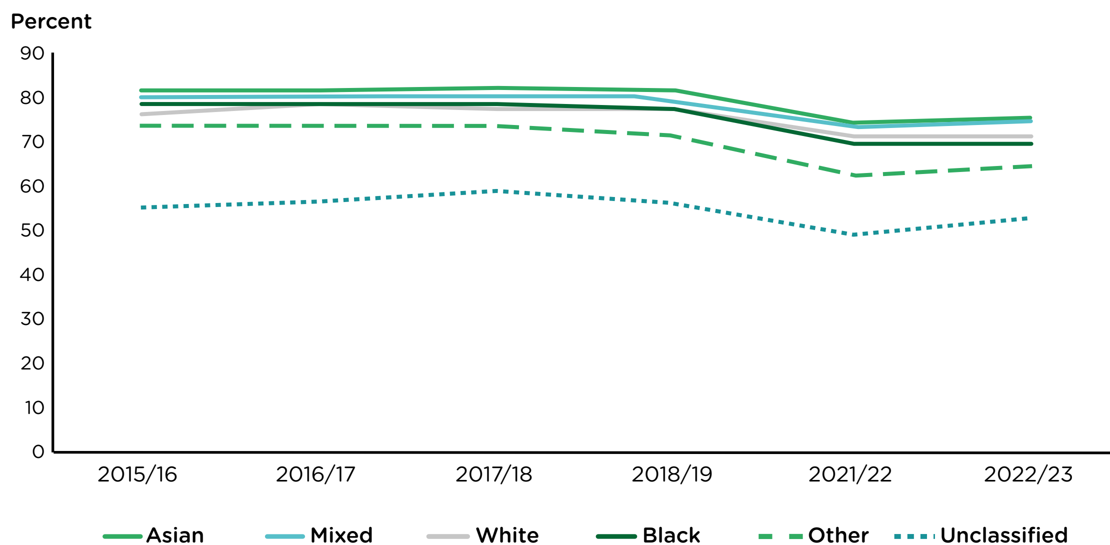
Figure 4.4. Percent of pupils meeting the expected standard of reading at the end of Key Stage 1 by ethnic group, London and England, 2022/23



Source: *DfE (203)*

Since 2015/16 the rates of all pupils meeting the expected reading standard has declined in London and the decline has been slightly steeper for Black pupils and those of other ethnicities than for Asian, Mixed and White students, Figure 4.5. In 2022/23 the rates improved slightly for all ethnicities other than Black and White pupils, which have remained the same.

Figure 4.5. Percent of pupils meeting the expected standard of reading at the end of Key Stage 1 by ethnic group and year, London, 2015/16 to 2022/23

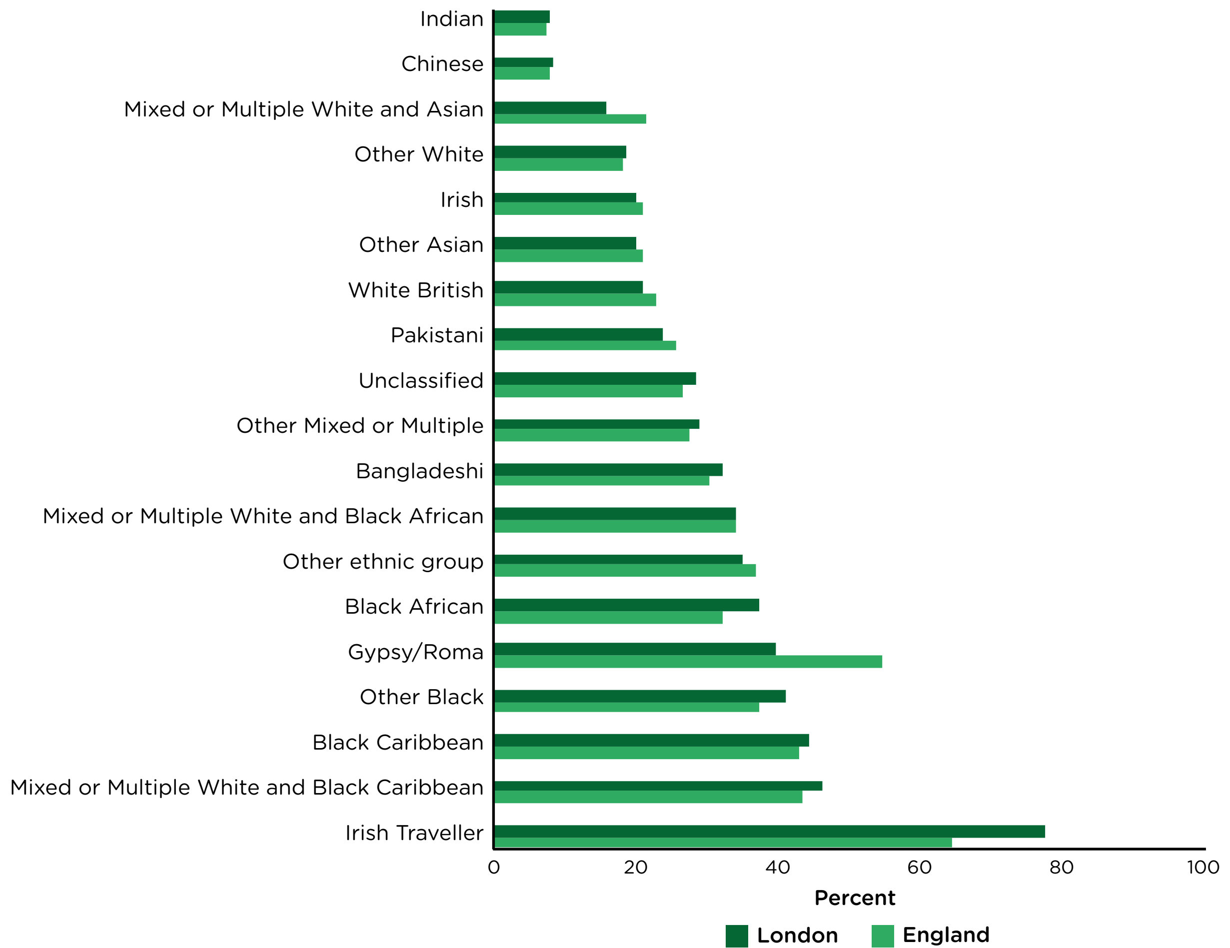


Source: *DfE (203)*

Across England, children in lower-income households have lower levels of attainment than their peers in wealthier households. Free school meal eligibility is used as an indicator of poverty when assessing educational performance. In 2020, the difference between pupils eligible for free school meals and those not eligible was a GCSE score on average 1.24 grades lower. This situation has changed little since 2017. (204)

Figure 4.6 shows that across both London and England as whole, most pupils from ethnic minority groups have higher rates of free school meal eligibility than White British pupils, except for Indian, Chinese, Mixed White and Asian, Other White and Asian, and Irish pupils.

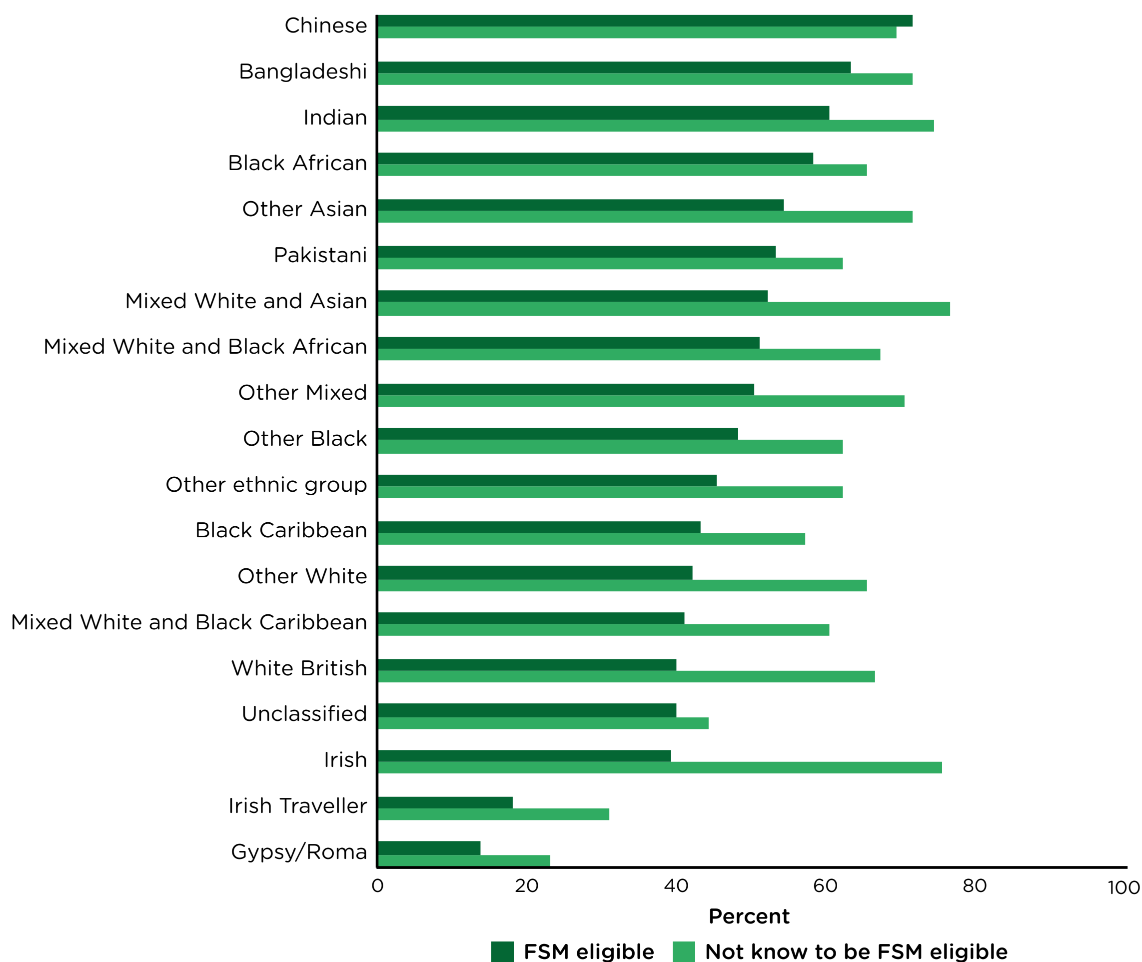
Figure 4.6. Percent of pupils with free school meal eligibility by ethnic group, London and England, 2022/23



Source: *Department for Education (205)*

There are widespread ethnic inequalities in attainment at Key Stage 2 (aged 11) related to eligibility for free school meals (FSM) in England, shown for 2021/22 in Figure 4.7. Among every ethnic group included in the data, except for Chinese pupils, pupils eligible for free school meals have lower attainment in reading, writing and maths than pupils who are ineligible. The attainment gaps between eligible and ineligible pupils are particularly wide for White Irish and White British pupils and White British pupils eligible for free school meals perform worse on these tests than pupils from most ethnic minority groups. Although for both these ethnic groups those who are not eligible for free school meals have relatively high proportions meeting the expected standards. This data is not available for London.

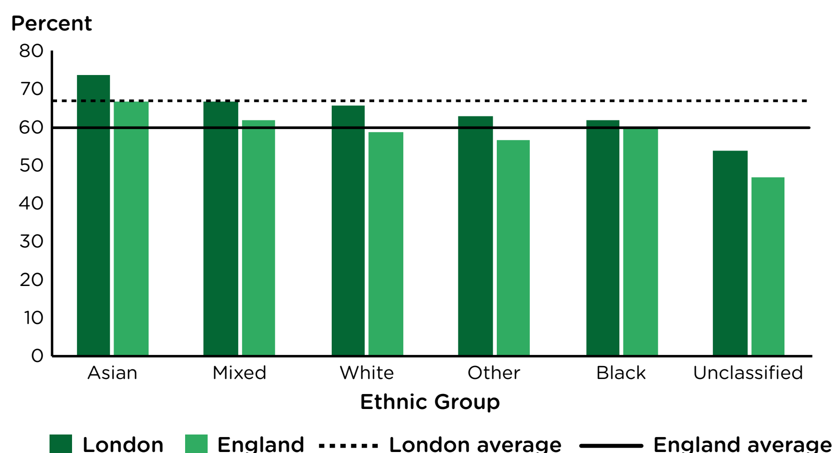
Figure 4.7. Percent of pupils meeting the expected standard of reading, writing and mathematics at the end of Key Stage 2 by ethnic group and free school meal eligibility status, England 2022/23



Source: *Department for Education (206)*

While data is not available by ethnicity and free school meal eligibility in London, overall, pupils in London perform well compared with the rest of England at KS2 (Figure 4.8). At the end of KS2, in 2021/22, Asian pupils in London and in England had the highest proportion of pupils meeting the expected standard in reading, writing and maths. The London advantage is less marked for Black pupils, although they still have higher levels of attainment than the average for all pupils in England and higher than White pupils across England at this stage.

Figure 4.8. Percent of pupils meeting the expected standard of reading, writing, and mathematics at the end of Key Stage 2 by ethnic group, London and England, 2022/23

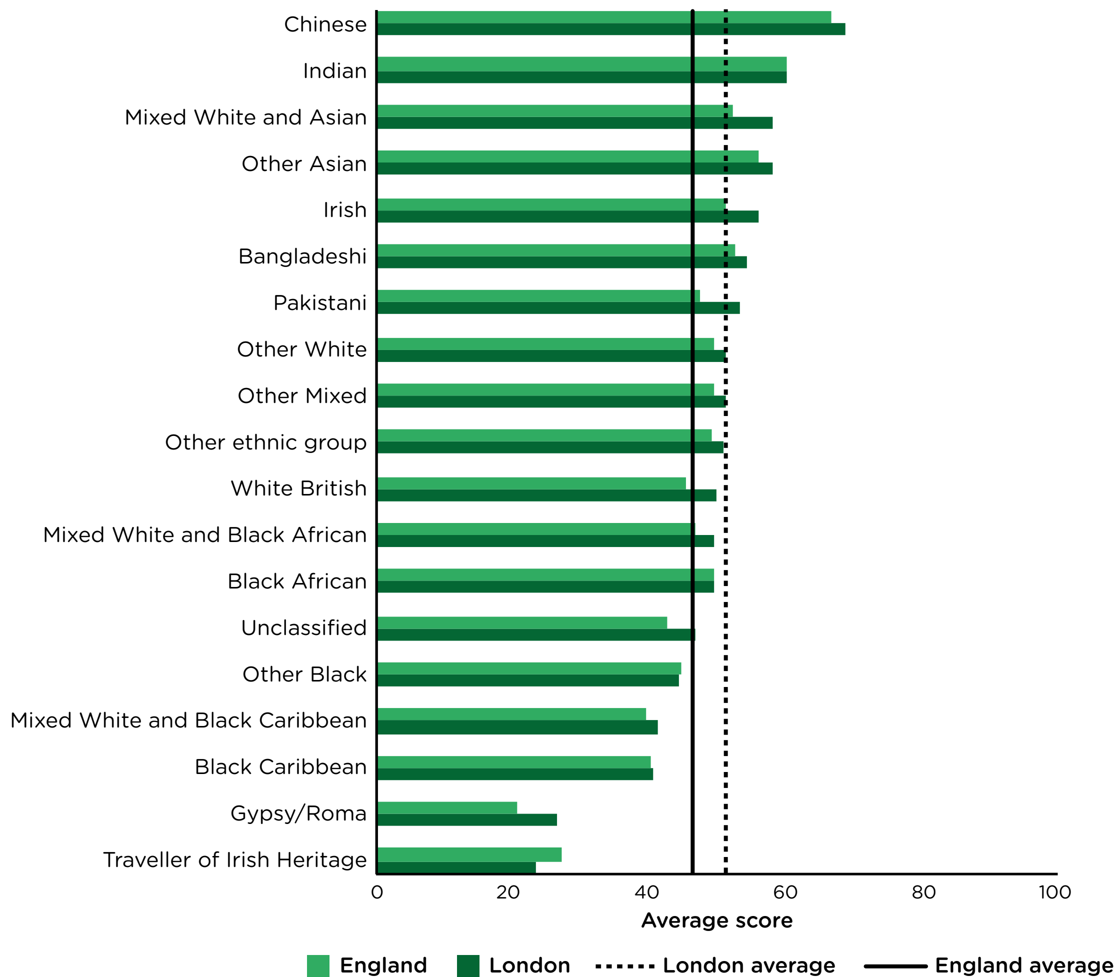


Source: *Department for Education (206)*

Progress 8 is a measure collected by the Department for Education, to identify the progress a student makes between ages 11 and 16 compared with other students with similar starting points. It compares, their Attainment 8 score, a measure of performance at the end of KS4 (GCSEs) across eight core subjects, to a national average of children with similar Key Stage 2 results. Overall in the UK Chinese, Indian, Other Asian pupils had the highest Progress 8 scores. (207) FSM. Measured by Progress 8 scores pupils eligible for FSM made less progress between 11 and 16 years than those not eligible. In 2016-18 Chinese, Indian, Asian other and Bangladeshi children who were eligible for FSM still had higher Progress 8 scores than the national average. (207)

London has the highest Attainment 8 scores of any region in England. (208) In London, students eligible for free school meals achieve higher Attainment 8 results than similar students elsewhere in England and the gap between students eligible for free school meals and those who are not is also narrower in London than in the rest of England. (204) Again, showing the higher and more equitable educational attainment for pupils in London. As at other stages of education, at age 16, however, there are inequalities in attainment by ethnicity and the London advantage noted at KS1 and for KS2 (Figure 4.9) is no longer present for Black African students or students classified as 'any other Black background' and Travellers of Irish heritage. Several studies indicate that underachievement is a particular issue for Black Caribbean students, more than Black African students and data shows a nine-point difference in average Attainment 8 scores between Black Caribbean and Black African students. The average score for Black Caribbean students in London is 10.4 points less than the London average for all groups. (209)

Figure 4.9. Average Attainment 8 score by ethnic group, London and England, 2022/23



Source: *Department for Education (160)*
Note: *The maximum achievable attainment 8 score is 90*

These ethnic differences at age 16 may relate to schools not catering to the particular needs of these students and unconscious, or even conscious, bias among teachers, which leads to low expectations for students that hinders their performance in school. (210) (211) While London has higher educational attainment compared with the rest of England, there are particular areas of concern, including for lower income pupils (by FSM eligibility) and for some ethnic groups – particularly many Black students and Gypsy/Roma and Travellers of Irish Heritage (where this data is available), for whom the London advantage is less apparent. Lower levels of attainment as well as higher rates of exclusion, set out below, indicate that secondary schools and broader education policies are systematically not meeting the needs of Black Caribbean, Black African and Gypsy, Roma and Travellers of Irish heritage students in London.

RACISM IN SCHOOLS

There are many reports of racism within schools, including from teaching staff and between pupils, which need to be more effectively addressed with stronger and better enforced accountability measures with appropriate sanctions. As well as levels of attainment there are ethnic inequalities in SEN diagnoses, school absences and exclusions in London and reports of racism in these areas.

Racism in schools can manifest in many ways, including conscious or unconscious differential treatment as a result of stereotyping and labelling by teachers. (212) (213) This affects a teacher's perceptions of children's behaviours and personalities, including the educational expectations teachers have. (213) In turn, incidents of racism and discrimination affect a child's self-esteem, mental health, aspiration and attainment, impacting their behaviour, which can become more disruptive or contribute to an increase in school absences and exclusions. (214) (213) Unconscious biases are influenced by background, experience, social and

cultural environments and can lead to non-intentional automatic judgements of those in the group they are biased towards. (215)

There is only limited research into unconscious bias in the UK education system. However, there is a fair amount on staff expectations and perceptions of students. Ethnic inequalities in teachers' judgments on performance may be partially explained by unconscious bias. A Dutch study found that teachers with negative unconscious bias are more likely to have low expectations of students from ethnic minority groups' academic performance. (216)

In the UK, a study examining teacher biases for seven-year-olds, found that children from low-income families, boys, students with SEN diagnoses, and children who speak languages in addition to English are less likely to be judged 'above average' at reading by their teacher, despite scoring the same as their counterparts in the reading test. They also found that all students from ethnic minority groups are less likely to be judged 'above average' at reading than White students. (217) A 2019 study looking at maths set allocation in 46 secondary schools found inequalities in relation to ethnicity, with Black and Asian students more likely to be misallocated to lower sets in maths than White students. The key findings from their analyses were that Black students are over 2.4 times more likely than White students to be misallocated to lower maths sets than their prior attainment would warrant and Asian students 1.65 times more likely. Conversely, White students are 2 times more likely than Black students to be misallocated to a higher set in maths, and 1.72 times more likely than Asian students. (218) Negatively biased teacher expectations have been found to have a detrimental influence on student achievement, with students from low-income families and ethnic minority groups seemingly more susceptible to these effects. (219)

A 2020 report from the YMCA looking at experiences of young Black people in the UK found that 95 percent of young Black people reported hearing and witnessing the use of racist language at school, while 49 percent felt that racism was the biggest barrier to attaining success in school, and 50 percent said the biggest barrier was teacher perceptions of them. (220) To inform its report, the YMCA held focus groups with young Black individuals. In the education focus group, participants shared experiences of White students telling them in the presence of teachers that "Black skin is not desirable" as well as calling them derogatory names. Further, participants reported being affected by 'subtle racism', where students and teachers would joke about stereotypes associated with young Black people. (220) The report showed that Black students felt they were 'labelled' as underachievers, aggressive or less capable by teachers. Participants shared instances where despite their academic attainment, they were placed in the lowest ability groups in school. Black students felt teachers actively disempowered them at times. National data show higher rates of exclusions for students from ethnic minority groups and this was confirmed in the focus groups when young Black people reported feeling that this higher exclusion rate could be linked to stereotyping and racial bias from teachers. (220)

In 2020 the Runnymede Trust published a report exploring race and racism in England's secondary schools, drawing on data from interviews with 24 secondary school teachers from across Greater Manchester. The report identified issues with low levels of racial literacy among school staff; a lack of diversity in the teacher workforce and school curricula; increased policing activity in schools being concentrated in areas with higher deprivation, which also tended to have larger Black and ethnic minority populations and 'race-neutral policies', such as uniform policies, which in fact, discriminated against pupils from ethnic minority groups. (221) In particular, the Runnymede Trust reports instances of Black students being excluded because their natural hair did not conform to uniform policy standards as it was not seen as 'tidy' and 'neat'.

Hair discrimination is a form of racial discrimination, protected under the Equality Act 2010. According to the Equality and Human Rights Commission (EHRC), hair discrimination ranges from describing someone's hairstyle as 'inappropriate' or 'exotic', through to bullying and banning certain hairstyles. The YMCA paper also reports that 70 percent of participants felt the need to change their hair to look more professional and fit in. (220) The experience of Ruby Williams in 2017 highlighted the issues. Ruby, then 15 and a student at the Urswick school in east London, was repeatedly sent home because the school claimed her hair breached its policy of Afro hair needing to be of a reasonable size and length. The three-year legal battle supported by the EHRC led to Ruby Williams receiving an £8,500 out-of-court settlement from the school, although the school did not accept liability. (222) Research from World Afro Day Hair showed that of parents who reported their children as having had a bad or very bad experience at school with their Afro-textured hair and identity, 82.9 percent had their hair touched without consent, and 58 percent experienced being on the receiving end of uncomfortable questions. (223) The research also found that only 12 percent of teachers surveyed across the UK said they had received equality and diversity training that included policies on hair, and an even smaller number of teachers were aware that equalities legislation applied to their school's hair policy. This points to a lack of education regarding what hair discrimination is and how it manifests itself. (224)

The Halo Code (Box 3) was created to combat hair discrimination. Initiatives like this are an important first step in tackling racial discrimination in schools, particularly in the absence of legal mechanisms. Unfortunately, as school policies are ultimately in the hands of individual institutions, it remains challenging to ensure change at structural level. Even more challenging is measuring any impact of campaigning initiatives such as the Halo Code. Schools and institutions can sign up, but commitment and action cannot be guaranteed.

Box 3. The Halo Code (225)

The Halo Code is the UK's first Black Hair Code. It was founded by 30 activists from The Advocacy Academy, a social justice youth organising movement dedicated to creating a more fair, just and equal society, and the Halo Collective, an alliance of organisations cooperating to combat hair discrimination. The Halo Code explicitly protects students and staff who come to school with natural hair and protects hairstyles associated with their racial, ethnic and cultural identities. By adopting the Halo Code, schools are proactively taking a stand to ensure that no member of their community faces barriers or judgement because of their hair texture. *Sutton High School* in Greater London was the first school in the UK to sign up to the Halo Code.

There is some research into the underperformance of Black Caribbean students in school in the UK. This suggests that some of the key factors leading to this underachievement are low teacher expectations, stereotyping, curriculum relevance and institutional racism. (211) A paper from 2022 on low teacher expectations suggests that low expectations can lead to subsequent underachievement from the students, and primarily manifests as being overlooked for answering questions, harsher reprimands, racist stereotyping and low ability grouping. (210) These reports recommend targeted interventions, inclusive curriculum development and improved teacher training to address these issues and to further promote educational equity for Black Caribbean students. (211) (210)

A report from 2018 focuses in particular on the underachievement of Black Caribbean boys in London's schools. They highlight the importance of mentorship, tailored support and a culturally responsive curriculum as interventions that could help improve their educational outcomes. (226) A 2020 paper investigating the criminalisation and exclusion of Black working-class young people in education with a focus on London, highlights the higher numbers of students in Pupil Referral Units and Alternative Provision than in the rest of the country and that young boys of Black Caribbean heritage in particular are overrepresented. (227)

There are reports of an 'adultification' of Black children, in particular teenage Black boys. Adultification harms Black children, with research showing that they are often viewed as both older and less innocent than their White peers. Adultification means that children do not receive the care and protection appropriate to their age and leads to excessively punitive treatment. The case of Child Q, a Black girl in a school in Hackney is an example of adultification of a Black teenager within a school setting and relates racism within the police force as well as within schools, set out further below. (228)

Gypsy, Traveller and Roma groups are often not included in a separate ethnic category in education and attainment data, so it is difficult to have accurate and up-to-date estimates of their level of educational participation and attainment. This lack of data might be partly attributed to a lack of self-identification due to fear of discrimination and racism in revealing their ethnicity, and a mistrust of the use of data collection. (229) The data that is available shows that Gypsy, Traveller and Roma children leave school at a much earlier age than children from other ethnic groups, and have low rates of participation in universities. (230) In England in the eight academic years to July 2018, the percentage of pupils going into education, apprenticeships or employment increased in every ethnic group except for White Gypsy and Roma. (231)

From the mid-1970s until 2008 there was a network to encourage the inclusion of Gypsy, Traveller and Roma children into education and to advise schools on ways to promote their achievement and opportunities. This involved parents working with the Traveller Education Support Service (TESS) to ensure their children were receiving an education. These services were part of local authority provision, grant aided by central government. Lack of funding from the Government means that many local authorities no longer offer dedicated services to promote the inclusion and achievement of Gypsy, Traveller and Roma pupils, although some local authorities in London do offer such services. (232) (233) (234) In some areas outside London there are pilot programmes to support educational attainment, reduce exclusions and drop-out rates and improving pathways to employment for Gypsy, Roma and Traveller children. (235)

The Education Support Project tackles the social exclusion of Roma children and young people aged 8–25 across six London boroughs and aims to increase their academic attainment, box 4.

Box 4. Education Support Project (236)

Two education support workers are assigned to provide support, advice and advocacy for over 100 Roma children and young people, enabling them to access and progress within primary, secondary, further education and vocational training. This includes helping with registration and transition at school, addressing truancy, challenging behaviour and exclusion, negotiating additional teaching support, supporting victims of anti-Gypsy racism in school, and referring beneficiaries to after-school activities. The project also runs mentoring schemes that offer one-to-one support through home tuition, emotional support and guidance.

The project has established links with education authorities such as the Travellers Education Services (TES) and collaborated in facilitating educational work in school to promote understanding of Roma culture and history in an attempt to reverse and combat bullying and anti-Roma prejudice.

The project's staff also work with approximately 50 Roma parents with the aim of facilitating communication between parents, school authorities, teachers and children.

Photo courtesy of the © Roma Support Group

The Guardian newspaper reported in 2021 that there had been over 60,000 racist incidents in schools in England between 2016 and 2021. (237) These incidents were defined as any situation perceived to be racist by the alleged victim or any other person. The information was uncovered using Freedom of Information requests sent to 201 councils and around a fifth of England's multi-academy trusts. However, they suggest that the true extent of the problem may be far greater as schools do not have a legal duty to report racist incidents to local authorities, or an obligation to record forms of bullying. (237) The lack of requirement to report racist incidents within schools means that many incidents are not known about, and racism can go both unrecorded and unpunished. The reliance on ad hoc reports to try and uncover the extent of racism in school highlights the need for legal report and accountability mechanisms.

POPULATION WITH NO FORMAL QUALIFICATIONS

Figure 4.10 shows proportions of each ethnic group in London with no formal qualifications among various age groups. (238) In each of the age groups Gypsy or Irish Traveller women are most likely to not have any qualifications. Among younger age groups, for every ethnicity except Gypsy and Irish Travellers, men are more likely to have no qualifications than women. This indicates the importance of taking gender as well as ethnicity into account in approaches to support qualification and provision of education and training for adults. For older age groups, there are also high rates of Bangladeshi and Pakistani people, particularly women (over 35 percent) with no qualifications; the proportion with no qualifications is much lower at younger ages than at older ages for all ethnicities. There has been progress in reducing the proportion of the population in London with no qualifications for all ethnicities, but there is more action required even among those under 24, where rates for Gypsy or Irish Traveller and Roma people with no qualifications remains over 10 percent.

Figure 4.10. Percent of population having no qualifications by ethnic group, age and sex, London, 2021

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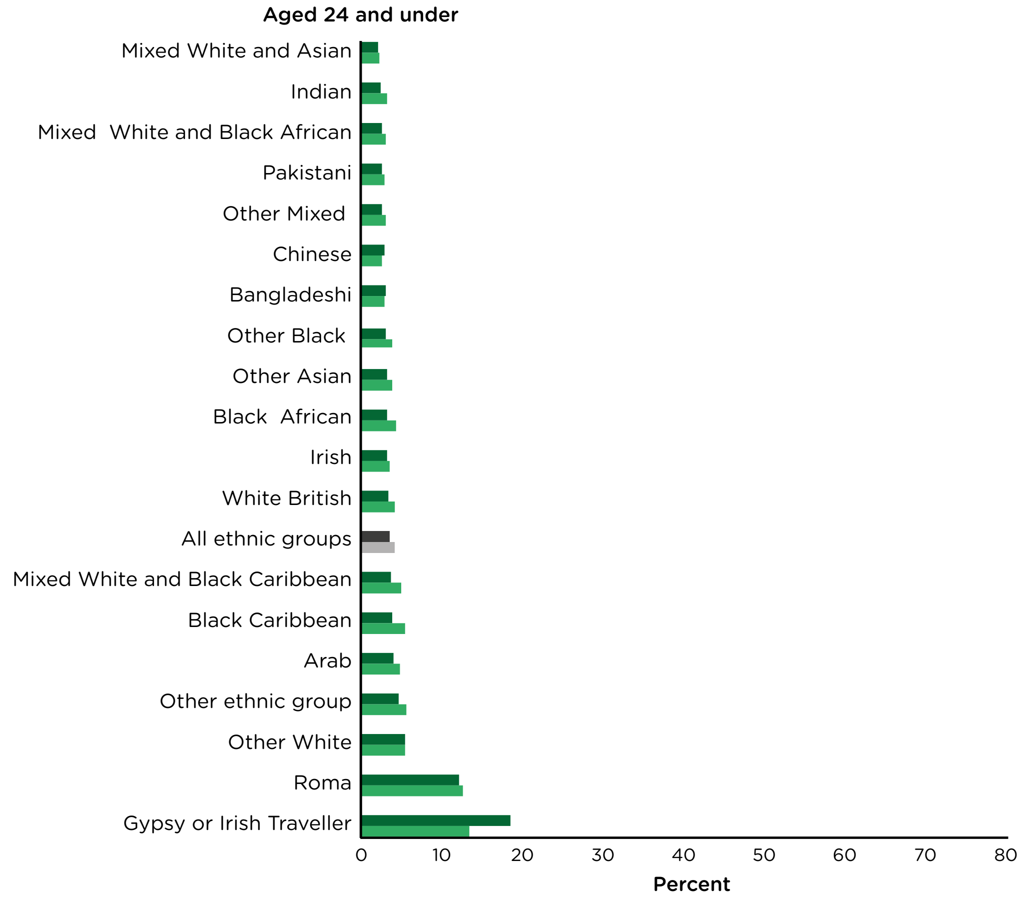
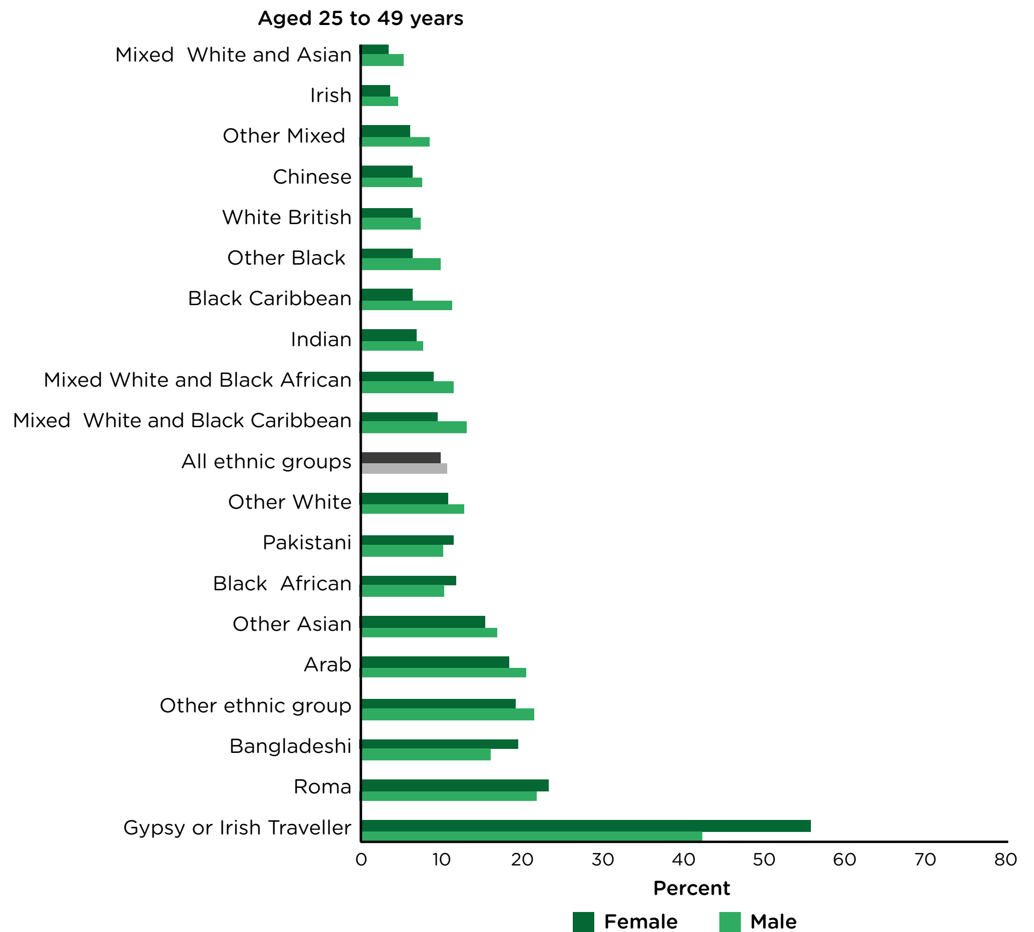
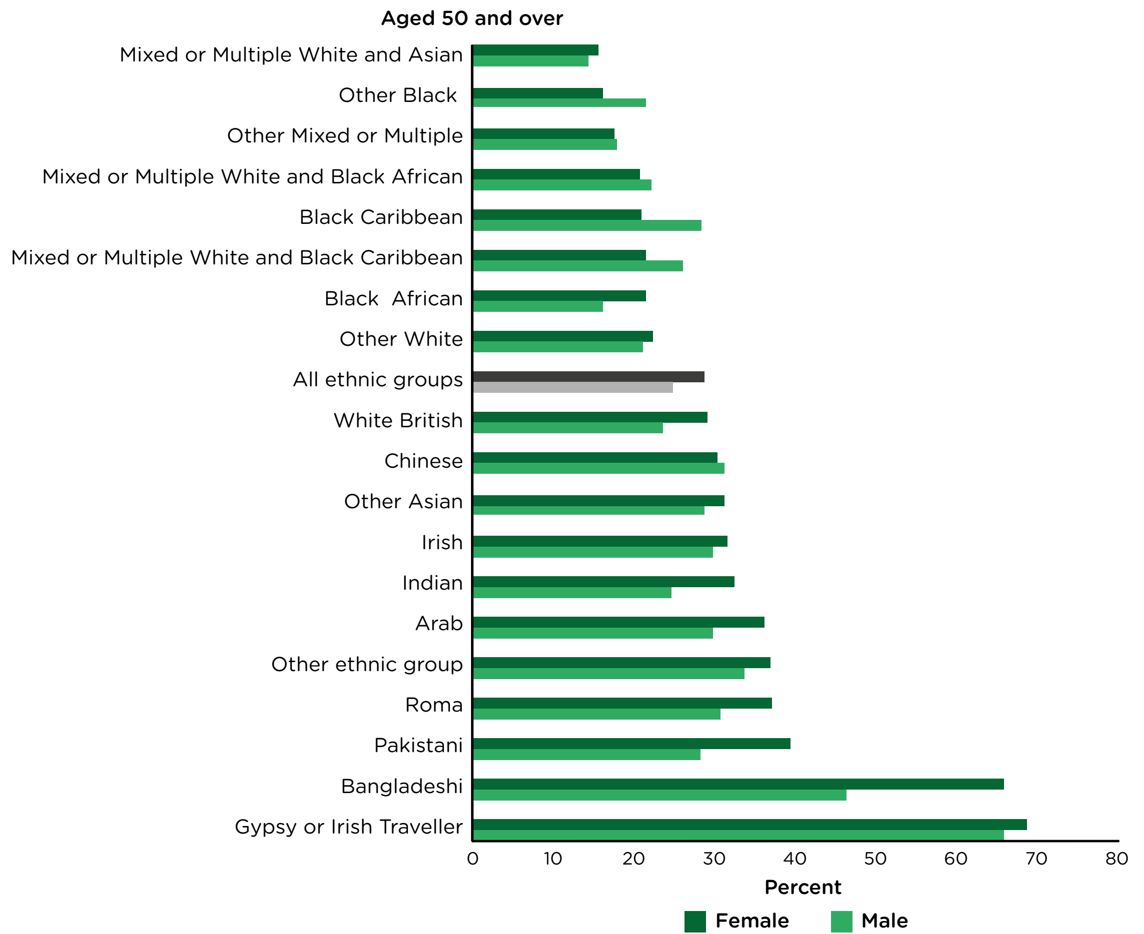


B) AGED 25 TO 49



C) AGED 50-PLUS



Source: *Census 2021 (238)*

London's Adult Education Budget (AEB), held by the GLA, funds the majority of skill provision initiatives across the capital, targeting groups facing inequalities in access to provision and obtaining qualifications. (43) The GLA conducted an assessment of local needs based on qualification levels by local authority district and allocated proportionally higher funding and support to local authorities where data highlighted local skills need, particularly in more disadvantaged areas and for London residents with protected characteristics. (239) There are many programmes specifically oriented towards ethnic groups with lower employment rates, particularly Black ethnicities. There is a need for greater focus on skills programmes for carers and women with children, particularly from South Asian ethnicities.

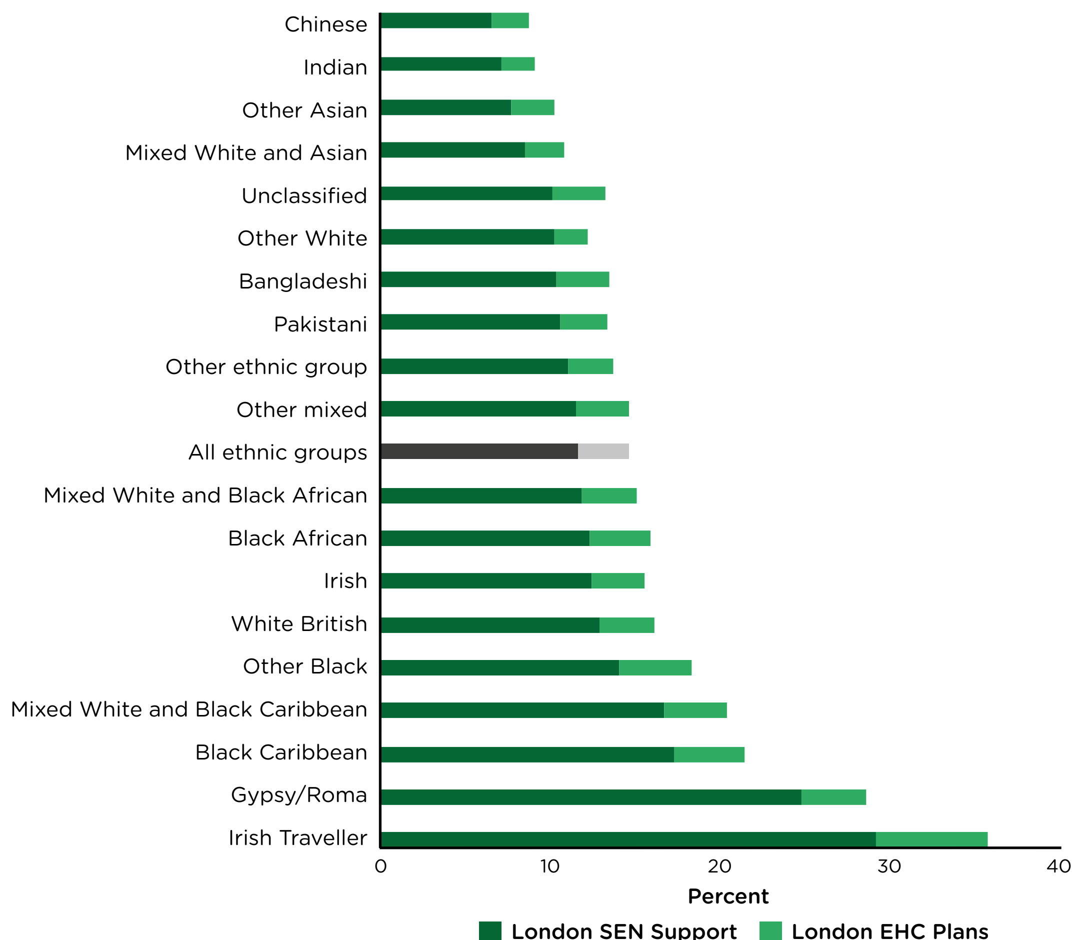
SPECIAL EDUCATIONAL NEEDS AND ETHNICITY

In England and London there are clear ethnic inequalities in pupils diagnosed with special educational needs (SEN). (240) SEN identification can support positive outcomes by providing targeted specialist support. However, when SEN is incorrectly identified or attributed, there can be negative consequences, such as pupils being given a narrowed curriculum, restricted opportunities due to reduced expectations and feelings of stigmatisation.

Using data from the 2016 England National Public Database (NPD), alongside an analysis of trends in NPD datasets dating from 2005 and longitudinal analyses, a 2018 Oxford University study showed unequal representation of ethnic minority groups identified with SEN in England. In particular, research finds that Black Caribbean and Mixed pupils are twice as likely to be identified as having a social, emotional or mental health need as their White British counterparts. (240) Further, Black Caribbean and Pakistani pupils are overrepresented (in relation to their numbers) in identification of moderate learning difficulties. Asian pupils are underrepresented in the identification of social, emotional or mental health problems and autistic spectrum disorders, which may mean they face barriers in accessing adequate specialist support. (240) Unconscious bias from teachers, racism, a lack of understanding of cultural differences and ineffective classroom management are among possible factors cited in the report behind this disproportionate representation in being identified as requiring SEN support, as well as higher levels of deprivation and poverty which increases risks of developing social, emotional or mental health problems and moderate learning difficulties. (240)

Figure 4.11 shows data for those diagnosed as requiring SEN support or EHC plans for England and London by ethnic group. Irish Traveller, Roma, Black Caribbean and Mixed White and Black Caribbean pupils are more likely to be diagnosed as requiring SEN support or EHC plans than other ethnic groups. From this data it is unclear whether ethnic differences in diagnoses are a result of discrimination or whether these diagnoses are appropriate, indicating that more research is needed.

Figure 4.11. Percent of pupils with any special educational need support or EHC plan by ethnic group, London, 2021/22



Source: *Department for Education (241)*

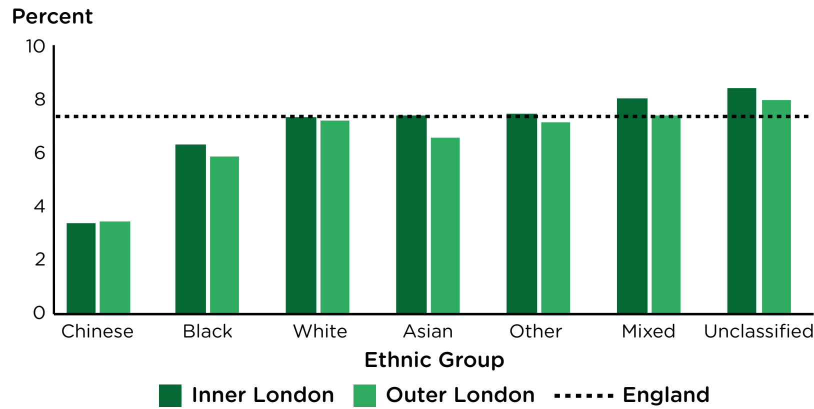
A paper from the London School of Economics, published in 2023, showed that while proportionally more children eligible for FSM and more children living in deprived areas receive SEN provision, there were lower chances of children having a statutory Education and Health Care Plan and also of specific conditions being diagnosed in areas that are more deprived. This suggests there is unmet need for support and provision among children living in more deprived areas. (242)

ABSENCE FROM SCHOOL

Absence from school is associated with lower educational attainment and also with a higher risk of being a victim of violence, of being involved in criminality and of reduced employment prospects. (243)

In London there are clear inequalities in absence from secondary school by ethnicity, with the rates being higher than the average for England among those unclassified by ethnicity, and for <ixed pupils in inner London. For all ethnic groups other than Chinese rates are higher in inner London than outer London.

Figure 4.12. Secondary school overall absence rate by ethnic group, inner and outer London, and England, 2022/23



Source: *Department for Education (160)*

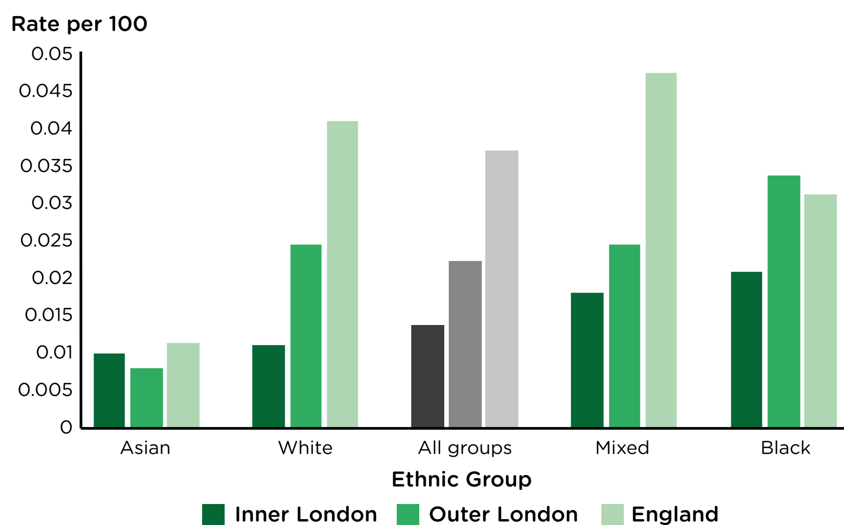
SCHOOL EXCLUSIONS

Although London has lower rates of permanent exclusions than England as a whole, schools in London still issue tens of thousands of formal exclusions every year. Pupils can be 'suspended' on a fixed-term basis for a maximum of 45 days in a year, or permanently expelled. School exclusions can have wide-ranging and long-lasting impacts on educational attainment and the likelihood of being involved in crime. Being excluded can aggravate existing mental ill health and can trigger long-term psychiatric illness and affect self-esteem and wellbeing. (214)

Factors that increase the likelihood that a pupil will be excluded include being supported by social care, having special educational needs including social, emotional and mental health needs, being a boy, living in poverty, and being from some ethnic minority groups. (244)

As Figure 4.13 shows in London Black pupils have the highest rates of permanent exclusion from school while in England Mixed pupils have the highest rates.

Figure 4.13. Rate of permanent exclusions in state primary, secondary and special schools per 100 pupils by ethnic group, inner and outer London and England, Autumn term 2022



Source: *Department for Education (245)*

In London in 2019 Travellers of Irish Heritage children were four-and-a-half times more likely than average to receive a fixed-term exclusion, while Gypsy and Roma children were nearly four times more likely. (244)

The Timpson review into school exclusions in 2019 was commissioned by the Government as a result of the publication of the Government's 2017 Race Disparity Audit, which revealed ethnic inequalities in education and found that Gypsy or Roma pupils are the most likely to be excluded and Black Caribbean pupils are around three times more likely to be permanently excluded than White British pupils. (246) The Timpson review shows inequalities in exclusion practices with higher exclusion rates for Black Caribbean and Mixed White and Black Caribbean pupils, as well as among those with SEN and those eligible for free school meals. The review set out 30 recommendations for Government, including updating statutory guidance, improving training on behaviour management, increasing investment and support for schools to support for children with behavioural difficulties, increasing recognition for those schools which create positive and inclusive cultures and introducing clear safeguarding mechanisms to ensure that no child misses out on education. (214)

The London Violence Reduction Unit's Inclusive and Nurturing Schools Programme is a three-year programme aimed at reducing school exclusions by strengthening inclusive and nurturing practice and tackling sexual harassment and abuse in schools and colleges. (247) The inclusion strand of the programme takes a school nurturing approach to improving children's mental health and emotional wellbeing. Schools in seven London boroughs will receive continuous support spanning training for staff, group-based support for pupils who are identified as being vulnerable, and optional pathways such as parental engagement, decolonising the curriculum and peer supervision. (248)

Football Beyond Borders (FBB) is an education and social inclusion charity that uses football as a tool to tackle the root causes of low educational attainment, poor school attendance, challenging behaviour and school exclusions. While not specifically designed for young people from ethnic minority groups, FBB has many participants from ethnic minority groups who are at risk of exclusion from school (Box 5).

Box 5. Football Beyond Borders (FBB) (249)

FBB works with Key Stage 3 pupils (11–14 year olds) in 45 secondary schools across London, Essex and Greater Manchester. The programme uses a football-themed learning and literacy curriculum and intends to build social and emotional skills, which FBB believes are key to overcoming the barriers to success in school for their at-risk young people.

The charity has been working with more than 1,000 young people each week, since September 2019. Pupils selected for the programme are those under-performing at school and many are at risk of school exclusion. A majority of the participants come from ethnic minority groups backgrounds. The 2019–20 cohort consisted of 29 percent White British participants, 25 percent Black African, 11 percent Black Caribbean, and 7 percent Pakistani participants.

The intervention runs for a minimum of two years and is delivered to groups of up to 16 pupils, combining weekly two-hour sessions: one hour in the classroom; one hour on the football pitch. Year 1 focuses on teaching Social and Emotional (SEL) skills. Year 2 builds on this knowledge and focuses on mastery of SEL skills. FBB coaches also attend parents' evenings to ensure the programme is embedded within the life of partner schools. Individual participants are set targets and continuation on the programme is dependent on meeting these.

School-wide achievement is rewarded by participation in trips, such as meeting Premier League footballers, attending international and Premier League matches, or visiting inspirational professionals in their place of work for career-based experiences. For the most vulnerable students, FBB provides one-to-one therapeutic support to support the development of their social and emotional learning. In 2019–20 FBB introduced Therapeutic Wellbeing Practitioners (TWPs), with a tailored one-to-one model of support for at-risk participants. TWPs were offered to young people who had had adverse childhood experiences, experienced a fixed-term or permanent exclusion, or had SEN identified. This enabled participants to engage with the underlying causes of their disruptive behaviour with a trained adult in an unconventional therapeutic setting.

In 2019–20, 98 percent of the students who were at risk of exclusion at the start of the year finished the year still in school. Nationally, school exclusions increase annually between the ages of 10 and 14, but this is not the case for FBB participants, whose exclusion and manage-moved rates decline as they spend more time with FBB. (250)

Box 6. Black Learning Achievement and Mental Health (BLAM) (251)

BLAM is a not-for-profit organisation in London that provides free advocacy at school exclusion hearings, with legal advisers who are committed to understanding the African and Afro-Caribbean community and experience. If it is unable to provide support, it refers cases to other organisations with whom it works closely. BLAM is currently partnered with Southwark, Islington, Newham and Hounslow Youth Offending teams to take on direct referrals for young people subject to school exclusions. (251)

REDUCING RACISM IN SCHOOLS

Nationally, guidelines are available for dealing with racial discrimination in schools. (252) (253) School leaders of state-funded schools are responsible for having anti-bullying and behaviour policies in place. Further, they must comply with the Equality Act 2010 and the Public Sector Equality Duties. However, there is a lack of clarity about when incidents should be reported by schools, as reporting guidance varies by school and local authority. (237) In 2012 the Government stated that schools have no legal duty to report racist incidents to local authorities, unless the incident is a crime, and in 2017 it issued further guidance advising schools that they had no obligation to record any form of bullying. (254) This presents serious limitations in tackling racism and quantifying the number of racist incidents affecting pupils from ethnic minority groups in schools.

Many individual schools across London have made steps towards becoming antiracism organisations and in the absence of a national policy regarding a Black curriculum, grassroots groups have offered schemes to help schools improve their curriculum, to which hundreds of schools across London have signed up. In January 2022, for example, more than 2,000 schools signed up to the *Diverse Curriculum – the Black Contribution*, and began reforming their curriculum. Reforms include reflecting the achievements of Black and ethnic minority people and addressing the legacy of colonialism. The programme, from Hackney, was developed by teachers and local council staff and provides students with nine six-week lessons on subjects including the Windrush generation. Initiatives such as this challenge the view that decolonising school curriculums results in less added-value material or misalignment with the national curriculum. (255) (256)

Other initiatives are also being delivered by local authority partners, such as the Towards an Anti-Racist Curriculum Tower Hamlets (TARCTH). Tower Hamlets is one of London's most diverse boroughs and as part of the Council's Tackling Race Inequalities Plans it has partnered with Global Learning London to develop and intensify schools' antiracist knowledge and commitment in 25 schools across the borough. TARCTH began in September 2021 and is presently in its second year of delivery. The programme has expanded from whole school antiracism training to include wellbeing sessions for people of colour, senior leadership team surgeries, and the development of an Antiracist Educators Network. (257) The Erith-based Active Horizons scheme, which offers leadership training in schools to equip young people as 'youth ambassadors' to help them to challenge racism, is another example. (258)

There are a range of approaches to build support for antiracism approaches in school and develop stronger relationships between ethnic minority pupils and schools and teachers. Many local authority and charity/voluntary sector organisations work to mitigate some of the harm experienced by young people as a result of racism.

A National Education Union (NEU) report from 2020 suggests that from primary to higher education stages, a sense of belonging within school is a reliable predictor of attainment outcomes and is characteristically lower among students from marginalised ethnic groups. (259) The authors show that a stronger sense of belonging is linked to: increased student motivation, increased staff wellbeing, motivation and retention, reductions in student absenteeism, improved academic achievement, and other positive social outcomes such as better health and wellbeing. (259) According to the report, three ways to build a sense of belonging are through leadership shaping culture, culture shaping learning and behaviour, and culture and leadership shaping agency and belonging. School leaders' attitudes and practices create the conditions needed for school belonging or send the message to some that they do not belong. It is important that they recognise the importance of leadership in order to foster an environment of inclusivity for students from ethnic minority groups.

Having a more diverse teaching workforce has been shown to help students from ethnic minority groups in school. However, a recent report from the Institute of Education highlighted that teaching is still a predominantly White profession, even in schools in areas with diverse communities. (260)

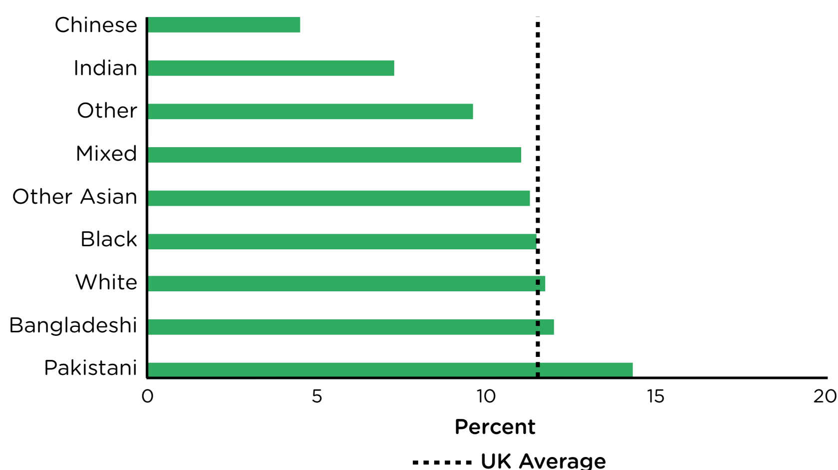
POST-SCHOOL EDUCATION AND TRAINING

While there has been progress in London in reducing ethnic inequalities in educational attainment, there are persistent issues, as set out above, and continuing reports about the impacts of racism in schools. This section overviews ethnic inequalities in post-school outcomes in London, where some of the progress which has been made in reducing ethnic inequalities during school years is lost as young people move into employment.

YOUNG PEOPLE NOT IN EDUCATION, EMPLOYMENT OR TRAINING

Data from the Annual Population Survey shows that in the UK from 2017–19, young Pakistani people (aged 16 to 24) were the most likely to not be in education, employment or training (NEET) at 14.3 percent of all NEETs, followed by Bangladeshi young people, then White young people. Chinese young people were the least likely to be NEET, Figure 4.14. (261) As with many of the other ethnic inequalities indicated in this section, services which respond to those most affected need to be more sensitive to the differing needs of ethnic groups and to challenge the drivers of those differences, including the effects of racism in education and among employers.

Figure 4.14. Percent of young people aged 16 to 24 not in employment, education or training (NEET) by ethnic group, UK, 2017–2019



Source: *Source: ONS (262)*

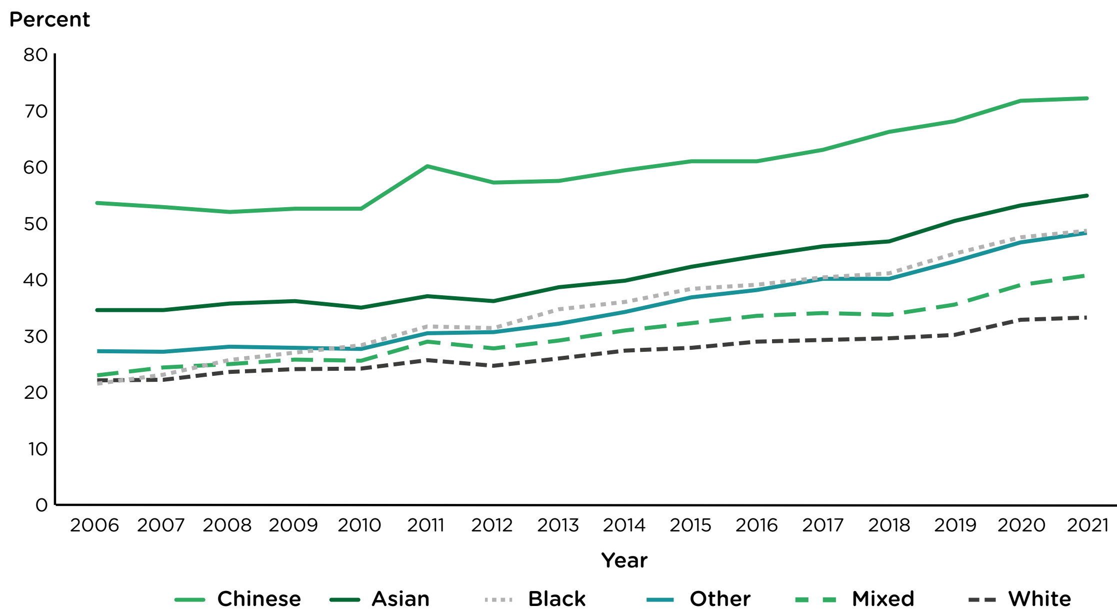
London's Violence Reduction Unit is funding Stronger Futures: a fund for grassroots and community-led organisations, designed to support vulnerable young Londoners in the hours after school and at weekends. The investment is for community-led groups to support those young Londoners most in need, targeting schemes that evidence how they will improve 1) educational outcomes; 2) employment opportunities; 3) welfare/support. (263)

HIGHER EDUCATION

Typically, university graduates earn more money in their lifetime, face less time in unemployment and live longer and have better health than those without a university education. (264)

UCAS data for England (Figure 4.15) show that the rate of Black school students entering higher education in England increased from 21.6 percent of in 2006 to 48.6 percent in 2021, the largest increase among all ethnic groups. (265) According to data from the Office for Students, London has the highest rates in England of state school students entering higher education at 54.2 percent compared with the national rate of 42.2 percent. (266) White students have the lowest rate of transitioning from state school to higher education in the UK. This data does not take into account students from private schools transitioning to higher education. Privately educated students comprised 6.4 percent of all students in 2021, with approximately as many as 18 percent of pupils aged 16–19 in the private sector. Privately educated students have a disproportionate presence at Oxbridge and other high-status universities. (267) According to a survey in 2022, approximately 40 percent of privately educated pupils in England and Wales are from ethnic minority groups, rising to 60 percent in London. (268)

Figure 4.15. Percent of state school students aged 18 securing a higher education place, by ethnic group and year, UK, 2006 to 2021



Source: *University and Colleges Admissions Services (UCAS) (269)*

While overall rates of participation in higher education are high among students from ethnic minority groups in the UK, issues related to ethnicity and racism have been identified in access to the more prestigious universities and while White students from state schools are least likely to transition to higher education in England, when they do they are more likely to be offered a place at high ranking universities. A 2016 paper exploring ethnic inequalities in admission to Russell Group universities, using UCAS individual-level applicant data from 2010–2013, found that while applicants from ethnic minority groups were more likely than White applicants to choose oversubscribed courses, therefore partly justifying lower levels of acceptance, applicants from ethnic minority groups were less likely to receive offers from Russell Group universities than comparably qualified White applicants. The rate of White applicants receiving offers to Russell Group Universities was 54.7 percent. Offer rates for applicants from ethnic minority groups were significantly lower: Indian – 43.1 percent, Chinese – 49.6 percent, Mixed – 47.8 percent, and other – 34.9 percent. The lowest offer rates were for applicants from the following backgrounds: Black Caribbean – 29.6 percent, Black African – 21.9 percent, Pakistani – 30.3 percent and Bangladeshi – 31.2 percent. (270)

Many London Universities provide grants or have schemes in place to encourage participation from students from ethnic minority groups. This includes Kings' College London, which gives these groups priority places on their programmes and extra support for students who join, and Goldsmiths which offers equity awards designed to help students from ethnic minority groups. (271) Kings College London aims to eliminate the gap in attainment between White and ethnic minority students and has set a specific target to close the widest ethnic gap in attainment – that of Black students - by 2024-5, by promoting and developing inclusive practices and attitudes across the institution (see Box 7).

Box 7. King's College London – an institution-wide approach to eliminating the attainment gap for ethnic minority students (272)

KCL has put in place different projects, interventions, strategies and policies to support diverse ethnic student groups and tackle the structural causes of differences in attainment.

All academic faculties identified priority actions. Some of the activities that have been implemented include: support for transition into university; development of an inclusive curriculum; assessment and feedback review and redesign of assessment formats; personal tutoring; supporting students' wellbeing and mental health; student co-creation and development; and piloting a cultural competency module for all students.

To support action to address racial inequalities and embed inclusive education at KCL, it established a Race Equality and Inclusive Education Fund. The fund has been essential to progressing action plans to close differences in attainment and supporting cross-faculty collaborations. For example, funding was awarded for a collaborative project to create and collate interprofessional teaching resources supporting inclusive curricula in healthcare programmes.

KCL's focus on addressing differences in the attainment of a 2:1 honours degrees by ethnicity has seen the rate among ethnic minority students obtaining this level increase to 93 percent in 2019–20 from 78 percent in 2014–15. Further, the gap in securing a 2:1 between Black and White students decreased over the same period from 26 percent to 4 percent. (272)

The Gypsy, Travellers, Roma, Showmen and Boaters (GTRSB) into Higher Education Pledge consists of a firm commitment by a university, college or educational institution to undertake certain steps to support GTRSB students into and within higher education (Box 8). Institutions that have adopted this pledge include Anglia Ruskin University, Nelson College London, Northumbria University, St Charles Catholic Primary School in Ladbroke Grove and others, but there has been relatively low uptake in London. Nelson College London has committed to putting into place cross-college mechanisms to support current and potential staff and students from GTRSB groups, but more institutions need to take on this commitment. (273)

Box 8. GTRSB into Higher Education Pledge (274)

The Gypsy, Travellers, Roma, Showmen and Boaters Pledge, developed in 2019, is designed to support GTRSB students and potential students through the development of widening participation practices, better monitoring of data, inclusive pedagogy and representation in the academy. (274)

The Pledge was developed in consultation with graduates, students and academic staff from GTRSB groups, civil society organisations, university representatives, and education policy specialists. It is underpinned by evidence and consideration of effective widening participation interventions in supporting members of the groups into and within higher education.

Institutions that sign up must establish a named contact point for GTRSB students and work towards creating the most appropriate and welcoming environment and conditions in which these students can stay resilient and thrive, both academically and personally. The institution is also required to develop processes to identify GTRSB students and monitor their progress.

The Pledge provides a catalyst for promotional work to foreground GTRSB inclusion and positive representation, while encouraging and increasing self-identification for both staff and students.

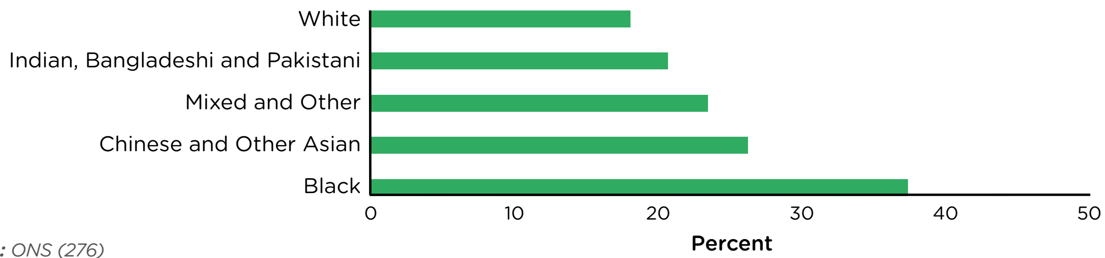
ACCESS TO JOBS AND SKILLS-BUILDING

EMPLOYMENT RATES

During the decade 2010–20 and then during the pandemic, the development of skills, particularly skills for work, among young people was harmed as a result of cuts due to austerity. The rising cost-of-living crisis is also negatively affecting the development of skills, as many young people cannot afford the time or cost of developing skills and staying on in education. (275)

Despite ethnic minority students' relatively strong educational attainment, there are clear ethnic inequalities in unemployment among young people. In London, young Black people aged 16–24 have more than double the unemployment rate of young White people, the ethnic group with the lowest unemployment rate (Figure 4.16). Reports show that some employers have unfair and racist recruitment practices, covered further in Section 4C.

Figure 4.16. Unemployment rate among young people aged 16–24 by ethnic group, London, July 2020 to June 2021



Source: *ONS (276)*
Note: *Figures not seasonally adjusted.*

The Centre for Social Investigation at Nuffield College, Oxford ran a test between November 2016 and December 2017 in which they sent out 3,200 applications with identical CVs that differed only in the ethnic background of the applicants. The study found that ethnic minority applicants had to send 60 percent more applications to get a positive response from an employer than a White British person. Black and South Asian applicants were especially heavily penalised and found that labour market discrimination levels have not changed since the late 1960s and 1970s. (277) (278)

The most important way to reduce these stark inequalities in employment rates is to ensure non-discriminatory recruitment practices, adhering to equalities legislation, and building capacity among employers to understand and tackle racism and discrimination in all areas of their organisations (see Sections 4C and 5). To this end, St George's, University of London, developed a Fair Recruitment Specialist Initiative in 2020.

Box 9. Fair Recruitment Specialist Initiative – St George's, University of London (279)

St George's, University of London created this recruitment initiative to address issues of underrepresentation of global majority candidates in its recruitment activities and mitigate the potential impact of unconscious bias. The initiative provides development opportunities for those who become 'Fair Recruitment Specialists', including comprehensive training, networking opportunities and experience taking part in recruitment panels. It provides a pool of staff volunteers from global majority backgrounds to be available to join interview panels across the university.

The need for the initiative was indicated by analysis of the university's recruitment data from 2016 to 2020, which showed that the majority of its interview panels were not representative in terms of ethnicity. Over this period, 66 percent of interview panels consisted only of White staff members. Since November 2020 there has been a significant reduction in the number of unrepresentative panels. (279)

SKILLS PROGRAMMES

In response to evidence of ethnic inequalities in employment rates, the GLA, local authorities and some employers in London have focused on developing skills-building programmes. Young Black men have often been prioritised in many of these interventions, but it is important to note that many other ethnic groups, disabled people and women, also have below-average employment rates and to enter work they need additional support, particularly affordable childcare. (43)

The Adult Education Budget was originally nationally managed by the Education and Skills Funding Agency (EFSA) but was devolved to the GLA in 2019. It funds the delivery of education and training for adult learners aged 19-plus in London, aiming to equip them with the skills and learning needed for work, apprenticeships or other

learning. Overall, the delegation of the Adult Education Budget to the Greater London Authority has led to some positive steps in improving accessibility to skills programmes for particular groups who are currently disadvantaged in education and employment (Box 10). Specifically, there has been increased participation among learners from minority ethnic groups, particularly among those earning below the London Living Wage or receiving out-of-work benefits.

Box 10. GLA Adult Education Budget (AEB) – impact on ethnic minority groups (280)

The Mayor's Adult Education Budget has supported many Londoners paid below the London Living Wage to develop their skills and access fully funded courses. In 2021/22 there were 23,590 learners who are in work and earning below the London Living Wage as an annual salary who participated in the Adult Skills stream of the AEB programme, a 17 percent increase from the previous year (280). Nevertheless, some groups still face low participation rates. These include single parents and carers, Londoners with disabilities, ethnic minority groups, and older Londoners. In 2021/22 62 percent of AEB learners were not in employment, 59 percent were from a minority ethnic background (compared to 63.2 percent in London), 27 percent were aged 50-plus (compared to 29 percent in London), and 13 percent declared a disability or health problem (compared to 15.7 percent in London) (281) (280). The background characteristics of the learners in academic years 2020/21 and 2019/20 are largely similar.

In 2019/20 AEB fully-funded courses were extended to London residents earning below the London Living Wage, enabling people in low-paid employment to participate (282). This change removed a barrier to accessing adult education and the funding helped about 10,780 (42 percent) more learners than in 2018/19. Although data is not available on the ethnicity of those additional learners accessing courses, it is likely to favour ethnic minority groups due to their disproportionate overrepresentation in low-paid employment. It is important that ethnicity is included in the collection of data about who accesses courses. (283) (284)

The Mayor developed a programme to support ethnic minority groups and women to develop skills in the digital sector (Box 11).

Box 11. The Mayor's Digital Talent Programme (285)

The London Economic Action Partnership (LEAP) is the local enterprise partnership for London that brings together entrepreneurs and business with the Mayoralty and London Councils to identify strategic actions to support and lead economic growth and job creation in the capital.

The Mayor's Digital Talent Programme was launched in October 2017 to offer training opportunities for young people. It focused on supporting women and people from ethnic minority groups to gain the skills needed to find employment within London's digital, technology and creative sectors. The programme particularly aimed to help increase the proportion of women working in these industries, currently 17 percent, to increase opportunities for residents from disadvantaged groups, and increase the number of Black, Asian and other ethnic minority groups working within these sectors.

The programme was intended to support 1,500 young people by offering work placements, creating tailored learning opportunities, assisting university students and helping businesses access the skills they need. (285)

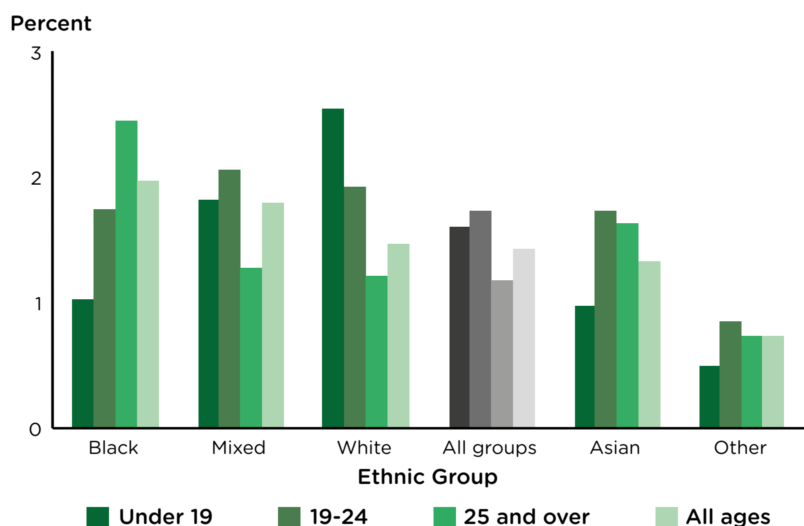
The extent and persistence of ethnic inequalities in employment rates are largely not the result of a lack of skills or academic attainment, and while skills-building programmes can help mitigate some of the impacts of racism on employment in London, they do not get to the source of the inequality. The source of ethnic inequalities in employment rates is related to racism and discrimination among employers and barriers to progression in employment, covered further in Section 4C. There needs to be a focus on the role of employers in the development and perpetuation of discriminatory and racist hiring practices and better enforcement and strengthening of existing equality legislation.

APPRENTICESHIPS

Apprenticeships are an important route to gaining skills, further education and access to good quality employment. Data on apprenticeship-starts from the 2021 Census show that across the UK, between 2011 and 2021 the percentage of apprenticeships started by people from ethnic minority groups increased from 10 to 14.3 percent. (286) Figure 4.17 shows that in London

there is fairly good representation of ethnic minority groups among those starting apprenticeships in 2019/20 and people from Asian, Black and Mixed ethnic groups start more apprenticeships than might be expected from the size of their populations in London.

Figure 4.17. Apprenticeship-starts as a percent of 2021 Census population by age and ethnic group, London, academic year 2021/22



Source: *DfE (287)*

Notes: *Census populations used to calculate rates are those at ages 16 to 34. For starts at ages under 19, the populations used are those at ages 16 to 18. For starts at ages 25 and over, the populations used are those at ages 25 to 34.*

While the proportion of people from ethnic minority groups starting apprenticeships is higher in London than in England, Census data show that in England, in the 10 years to July 2021, the number of apprenticeships started by Asian people and people of Mixed ethnicity decreased, albeit only slightly, and for Black people the number decreased from 17,350 to 13,000. However, the largest decrease was registered for the numbers started by White people, falling from 464,960 to 269,170 between the two Censuses.

Released prior to the latest Census data, a 2021 Action for Race Equality (ARE) briefing paper discusses the disparities faced by young people from ethnic minority groups in participating in apprenticeships in England. The analysis found that there are few apprentices from ethnic minority groups in the construction and engineering sectors. In 2021, the Hamilton Commission, set up to improve the representation of Black people in UK motorsport, found that in 2019/20 out of 58,890 apprenticeship starts in engineering across all skill levels, just 2 percent were taken up by Black students and 3 percent by Asian students. (288)

Employers are key actors in improving access to apprenticeships among ethnic minority groups. ARE has set up the Employer Champions network, for employers working to advance equity, diversity and inclusion across their firms. These employers partner with schemes such as Moving on Up (MoU), the Mayor of London's Workforce Integration Network (WIN) and the 10,000 Interns Foundation, which includes the 10,000 Black Interns and the 10,000 Able Interns programmes, to help reduce inequalities for Black and disabled people (289) by reducing barriers to access and reinforcing equitable recruitment practices.

YOUNG PEOPLE, SAFETY AND THE CRIMINAL JUSTICE SYSTEM

There is clear and substantive evidence about racism in the criminal justice system which affects all age groups in London. This is further covered in Section 4E. This section provides a brief overview, on the experiences of the criminal justice system among younger people where data is available by ethnicity.

FEELINGS OF SAFETY

Across London, young people report that they do not feel safe in their local area and that a lack of community spaces and safety are significant issues of concern. These views are more apparent among young people from ethnic minority groups. (290) (291) (292) In 2018, The London Mayor's Office for Policing and Crime (MOPAC) conducted an online survey aiming to gather the views of young Londoners about crime and safety issues that affect them. (293) Only 76 percent of Black young people reported feeling safe at school, compared with 89 percent of young White people. (293)

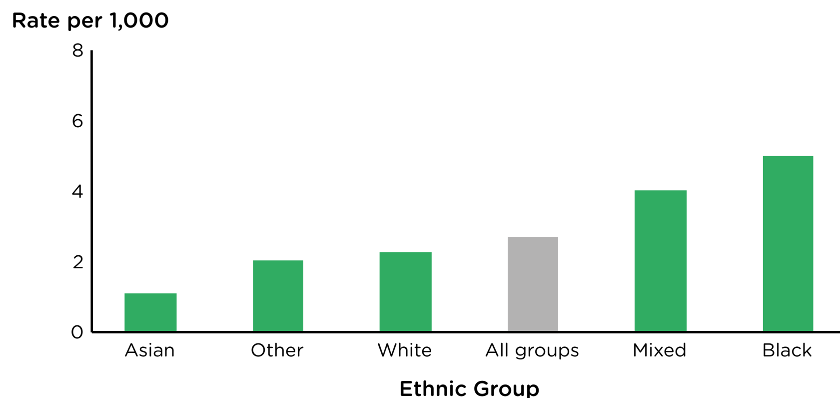
In 2020–21 the Mapping Young London survey of 1,623 young people aged 16–25 asked what they thought the best and worse things about living in London were. (294) They named "the mixture of people living here" as the best thing and "safety and the police" as the worst issue. Less than half, 41 percent, of young people said that they felt either quite, or very safe in London. Young women reported feeling less safe than young men and were far more likely to cite a fear of sexual assault and going out at night (68.2 percent versus 11.2 percent, and 68.1 percent versus 28.6 percent, respectively). The reasons for feeling unsafe included 60 percent saying they were fearful of mugging and physical attack, and 53 percent citing knife crime. However, different groups had different issues that made them feel unsafe. Asian young people were more likely to feel unsafe because of people being drunk/rowdy (44 percent), and Black young people were more likely to mention knife crime (66 percent).

The most popular suggestion for improving safety in London reported in the 2021 Mapping Young London survey was to improve street lighting, followed by improving relations between the police and community. The preferred solutions also differed by ethnicity, with providing young people with more things to do being more important to Black young people than the average of all respondents (47.9 percent compared with 36.1 percent). Asian young people responding to the survey were also more likely than average to choose 'more police' (33.7 percent compared with 24 percent), while young Black people were less likely to choose this (13.8 percent), likely related to experiences of racism from the police. (294) A 2018 report from the charity London Youth interviewing 10 youth professionals from 10 different organisations also finds that young Londoners report that youth organisations provided safe spaces for them in their community, representing a place where people could make connection while maintaining their cultural identity. (295)

THE CRIMINAL JUSTICE SYSTEM

It is clear that disproportionate outcomes exist for Black children in relation to many aspects of policing and the wider criminal justice system. Further work is needed to understand how much this is driven by wider structural inequalities that disproportionately disadvantage Black children compared to the actions of policing and the criminal justice system more broadly, but some will be attributable to racism from the police and the criminal justice system, section 4E. Across London there are large ethnic inequalities in the proportion of young people aged 10–17 who are cautioned or sentenced. Figure 4.18 shows this occurs far more for Black and mixed ethnicity young people than for young people who are white, other or Asian.

Figure 4.18. Rate per 1,000 of children aged 10 to 17 cautioned or sentenced by ethnic group, London, April 2021 to March 2022



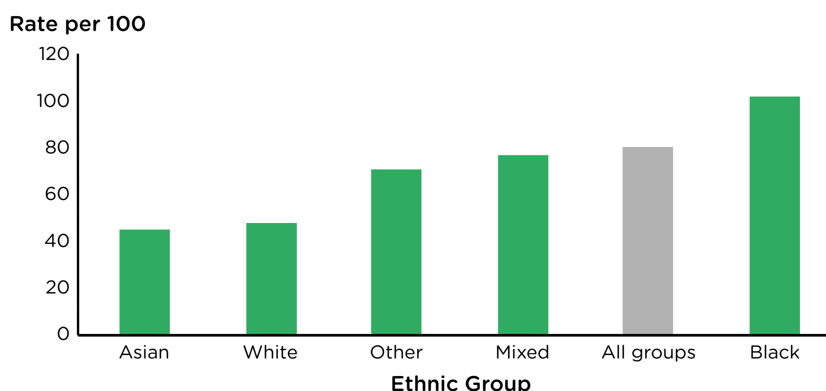
Source: *Youth Justice Board for England and Wales ONS (296)*

Notes: *(1) A youth caution is a formal warning given to people under the age of 18 who have committed a criminal offence and is kept on record by the police. Sentencing for children and young people under 18 is different to adult sentencing. It can include detention, training orders and, in some cases, custodial sentences or even life sentences for the gravest of crimes.*

(2) Rates are based on the 2021 Census population aged 10-17 in each ethnic group. Those cautioned or sentenced with unknown ethnic group have been redistributed in proportion to numbers with known ethnic group.

In 2022, the Youth Justice Board reported that young people within Young Offender Institutions (YOI) who are Black or Black British experience more force than other ethnic groups relative to the size of the Black population within those institutions (Figure 4.20) – 52 percent of all incidents of force were against Black British young offenders in Feltham who make up 45 percent of the population of inmates.

Figure 4.19. Average monthly rate of use of force incidents per 100 children and young adults in custody in Secure Training Centres and Young Offender Institutions by ethnic group, England and Wales, April 2021 to March 2022



Source: *Youth Justice Board for England and Wales ONS (296)*

Notes: *1. Secure Training Centres (STC) are custodial institutions for boys and girls aged 12-17 and Young Offender Institutions (YOI) are custodial institutions for boys aged 15-17.*

2. The numerator is number of incidents. One person may have multiple incidents, so 10 children in every hundred, each with 10 incidents, will give a rate of 100 incidents per 100 children

London's Violence Reduction Unit (VRU), was set up by the Mayor of London in 2019 to pioneer a partnership approach to tackling violence through prevention and early intervention. The approach is based on data and speaking to diverse communities to build on what works. The VRU focus on preventing harm and exploitation of young people, improving access to positive opportunities, working with educational settings, families and communities, as well as taking a whole-system approach to partnership working. Community and place-based approaches are key.

Box 12. MyEnds (297)

MyEnds is a programme funded by the GLA's London's Violence Reduction Unit which supports local, place-based approaches to reducing violence. The programme ran from April 2021 until 31 June 2024. The programme provides research, money, capacity for local neighbourhood areas that have had high and sustained levels of violence. Local consortia were invited to present the challenges and potential of their area and to articulate a vision for improving community resilience, outreach and interventions that will bring about change and provide better opportunities for young people. It is non- prescriptive and intends to empower voluntary and community sector (VCS) providers to develop locally-tailored approaches that meet the needs of the local community and help address the causes of young people becoming involved in violence.

THE CHILD FIRST APPROACH

The 2016 'Youth Justice Review' for England and Wales recommended creating 'a new system in which young people are treated as children first and offenders second' this has developed into the Child First Approach. (298) The Child First Approach is based on evidence on what is effective in addressing offending behaviour in children within the youth justice system, and what will help prevent those likely to enter the system from doing so. (299) The approach can help reduce some of the issues with adultification, particularly of Black children, within services, which was also highlighted earlier in section 4B on education. The key principles identified by the Youth Justice Board are to treat children as children, to build pro-social identity, to collaborate with children and to divert from stigma. (300) (301)

RECOMMENDATIONS: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THE LIVES

1. Reverse the cuts that have happened since 2010 in per pupil funding in schools and youth services.
2. Schools to strengthen antiracism approaches through capacity building and enforcement of legal obligations and additional duty to report and to act on racism in school settings.
3. Strengthen enforcement of legal requirements for non-discriminatory recruitment.
4. Increase the number of programmes to support young people's mental health and fund youth services and safe spaces that are culturally appropriate.

ADDITIONAL RESEARCH AND EVIDENCE

- Conduct further research into why many Black pupils do not benefit from being at secondary school in London as much as other ethnic groups.
- Assess why some young people from ethnic minority groups do not continue the good levels of attainment in primary school into secondary school and into good quality employment.
- Assess SEN diagnoses and referrals and support by ethnicity in London.
- Carry out further research into racism and discrimination by employers in London and their impact.
- Strengthen data on young people's mental health and wellbeing by ethnicity in London.

4C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Work and employment are of critical importance to the health and wellbeing of individuals in several interrelated ways and participation in, or exclusion from, the labour market determines a range of life chances. (302) (303) The health of working-age people and their families is negatively affected by: being unemployed, especially long-term; earning a low income; poverty associated with unemployment, economic inactivity or low-paid jobs; feelings of being unfairly treated; exposure to physical, ergonomic and chemical hazards in the workplace; physically demanding or dangerous work; long or irregular work hours, shift work and prolonged sedentary work; working in an adverse psychosocial environment defined by high demand and low control; and experiencing an imbalance between effort spent and reward received. (304) (305) (306)

This section provides an overview of the wide and persistent ethnic inequalities in London in rates of employment, levels of pay, quality of work and career progression. Multiple reports and surveys conducted over many years attest to the extent and pervasiveness of racism experienced in employment and is evident in discriminatory recruitment, reduced opportunity for progression, lower pay and poor working conditions and racist abuse at work from other employees or the public. There are also many accounts about a lack of redress and organisational accountability for racism. Racism in the labour market damages mental and physical health and impacts on other key social determinants of health, including income, housing, living conditions and social isolation.

RATES OF EMPLOYMENT AND ETHNICITY

Despite having positive educational outcomes and higher rates of educational attainment on average than White students (Section 4B), many ethnic minority groups in London experience lower rates of employment than White people, due at least in part to the impacts of racism. (307) (308) Research shows discriminatory hiring practices and that applicants from ethnic minority groups are less likely to be successful in the pre-interview stage of recruitment than White candidates. (309) (310)

In London in the 2021 Census there were substantial differences in the percent in employment at working ages between both women and men (66 and 74 percent in employment, respectively), with the White British group having substantially higher employment rates for both men and women than the average for London (72 and 77 percent, for women and men, respectively). Figure 4.20 shows how large were the differences between the White British group and most ethnic minority groups for both sexes in 2021. The largest differences were for Gypsy and Irish Travellers (43 and 29 percent for women and men, respectively). However, differences in excess of 25 percent were also seen among women with Arab, Bangladeshi and Pakistani ethnicity and for men identifying as "Black Other". On the other hand, several groups had slightly higher levels of employment than the White British group – Irish and "Other White" women and men as well as men identifying as Roma and Indian.

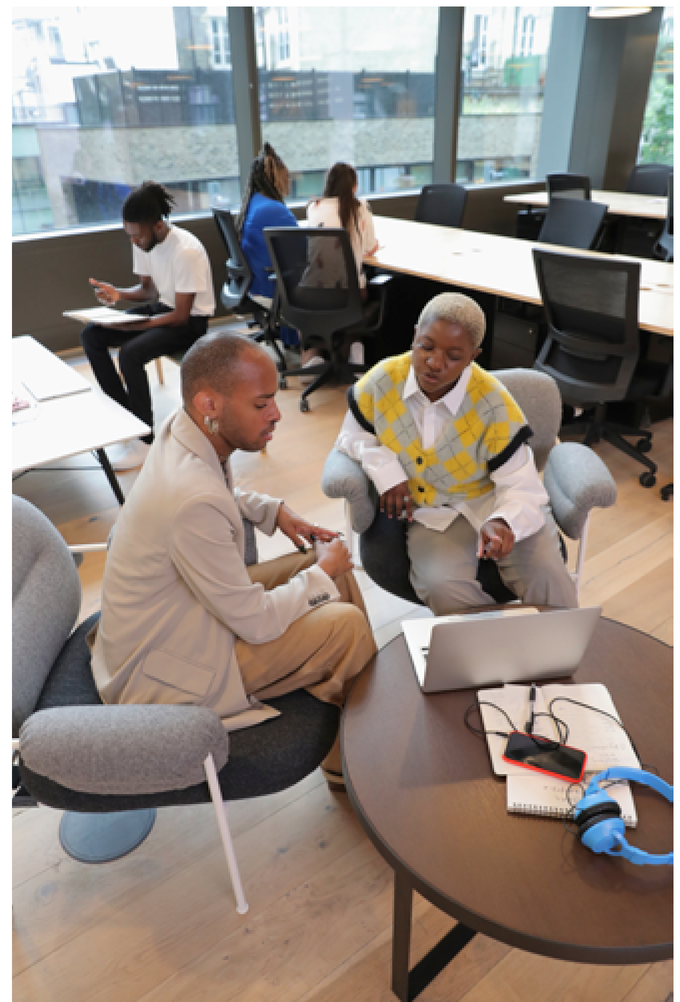
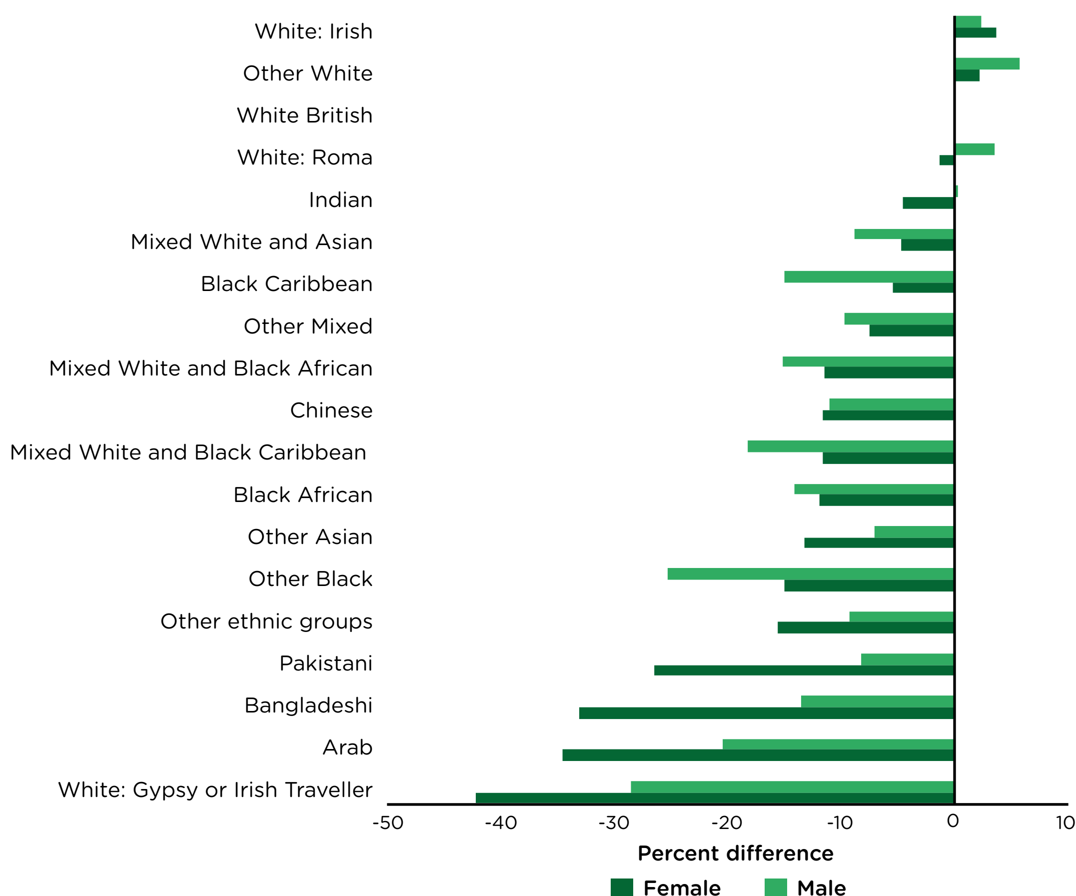


Figure 4.20 Difference in percent employed between each ethnic group and the White British group at ages 16 to 64, by sex, London, 2021



Source: *Census 2021 (238)*

The difference in employment rates between White British and many ethnic minority working-age people highlight the diversity of employment experience of men and women and each ethnic group. However, they also mask important differences between socioeconomic groups and between opportunities for work across local authorities in London and the type of work available to people in diverse circumstances (e.g. full or part time or on zero hour contracts). These multiple dimensions need to be considered when looking at programmes to support people into good quality employment. Programmes that are not sensitive to differing needs are unlikely to significantly reduce inequalities in employment rates.

For every ethnicity except for the Black Caribbean, Black Other and Mixed White and Black Caribbean groups, women had lower employment rates than males. This gender inequality was particularly marked for Bangladeshi, Pakistani, Arab and Gypsy and Irish Traveller ethnic groups (25, 24, 20 and 19 percentage point differences, respectively). Several factors are likely to account for these differences, including women's significant role in the informal or 'hidden' economy, as well as socio-cultural norms around caring and home-making responsibilities.

Employment rates do not give an indication of who is looking for employment. Many people, particularly those with caring duties or ill health, do not work but are not registered as unemployed nor actively seeking work. There are cultural differences in the propensity for women in particular to take on full-time responsibility for care and domestic duties.

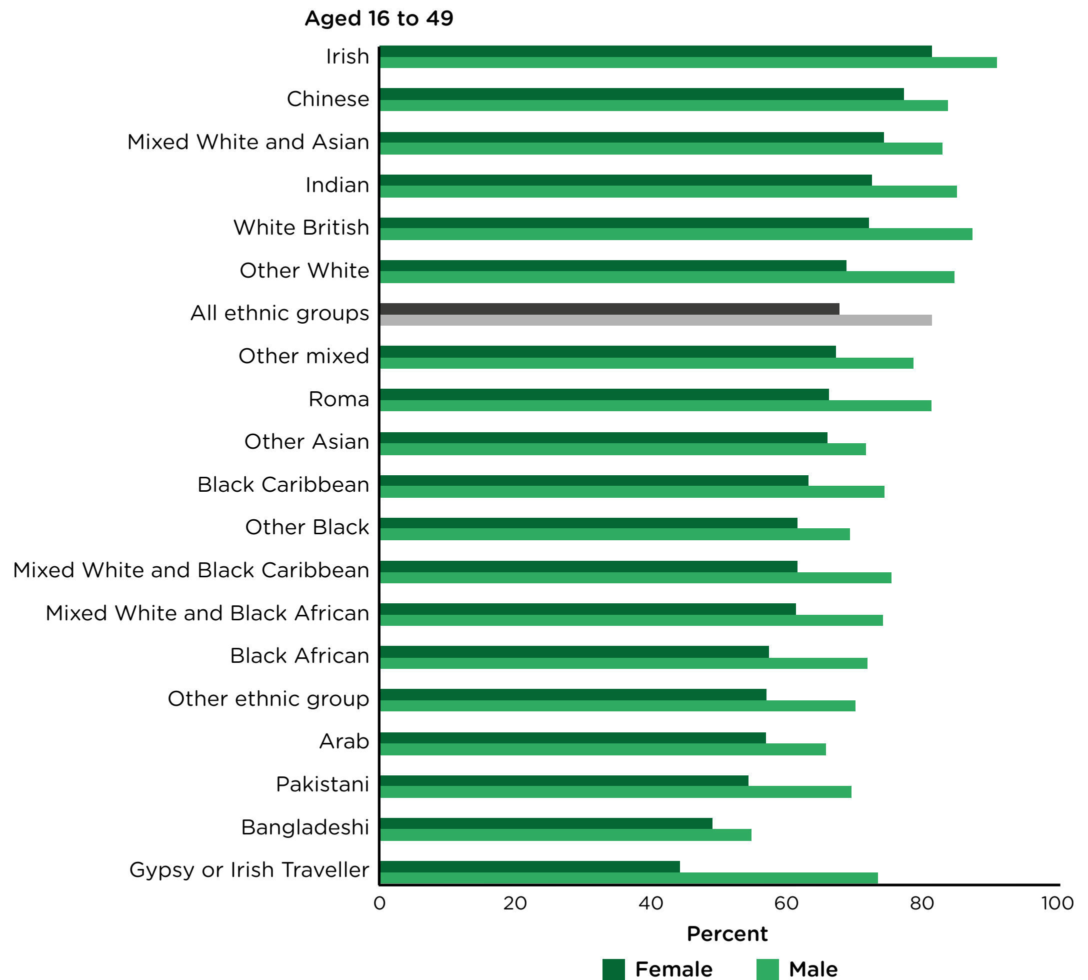
It is important to also establish whether ethnic inequalities in employment are changing with time. One way to do this is by looking at employment rates by ethnicity at different ages. The impacts of different migratory patterns, changing demographics in London and improving educational attainment among ethnic minority groups can be assessed for their effect on employment rates within different age groups. Figure 4.21 shows that among men in 2021, in each age group Irish and White British men had the highest rates of full-time employment in London, while in each age group Bangladeshi men had the lowest employment rates.

Among women, the picture is more mixed. In the 16 to 49 age group, Irish and Chinese women have the highest rates of full-time employment, and Gypsy/ Irish Travellers the lowest at 45 percent, followed by

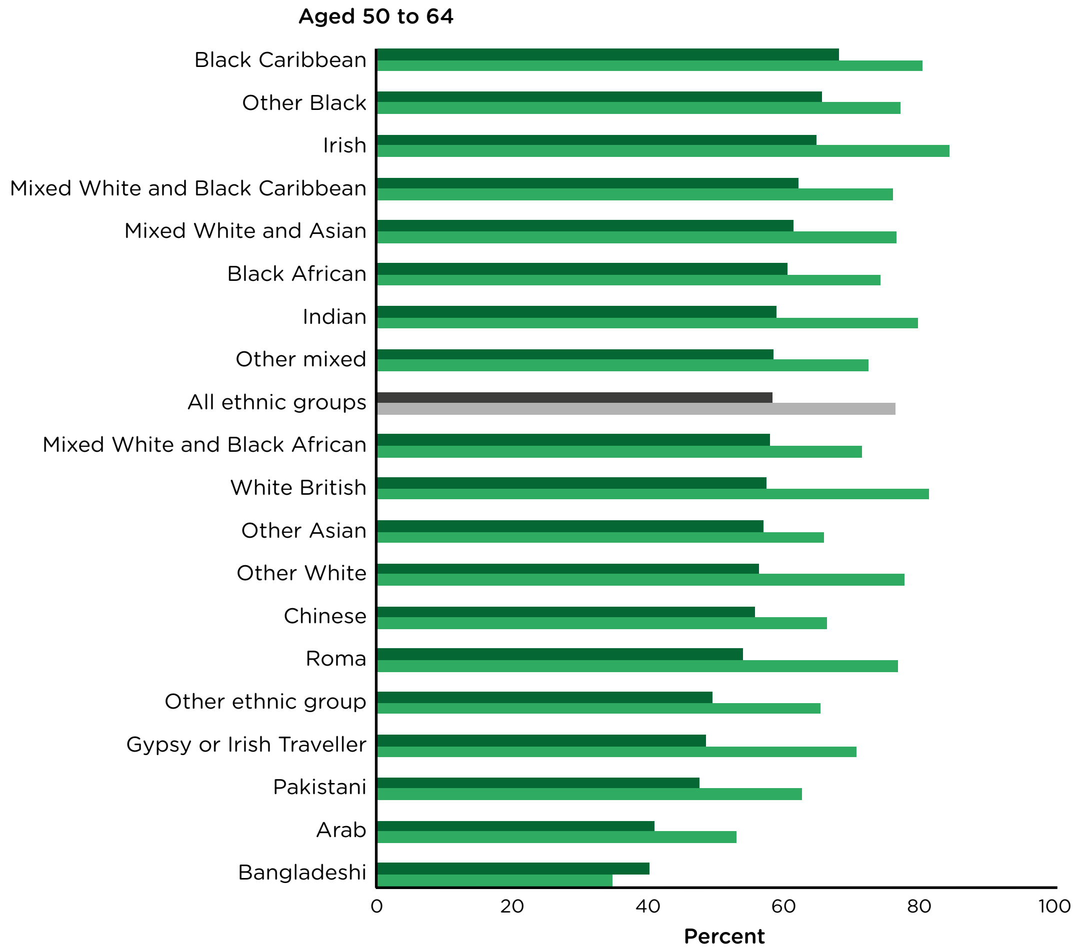
Bangladeshi women at 48 percent. Among women aged 50 to 64, Black Caribbean and Other Black women have the highest rates of full-time employment and Bangladeshi women the lowest, and among those aged 65 and over, Black African and Black Caribbean women have the highest rates of employment and White British women the lowest. The relatively low proportion of White British women working over the age of 65 may indicate that they are economically secure enough to retire while Black women continue working longer. In each age group women are much less likely than men to be in full-time employment.

Figure 4.21. Percent in full-time employment (31 hours or more per week) by ethnic group, age and sex, London, 2021

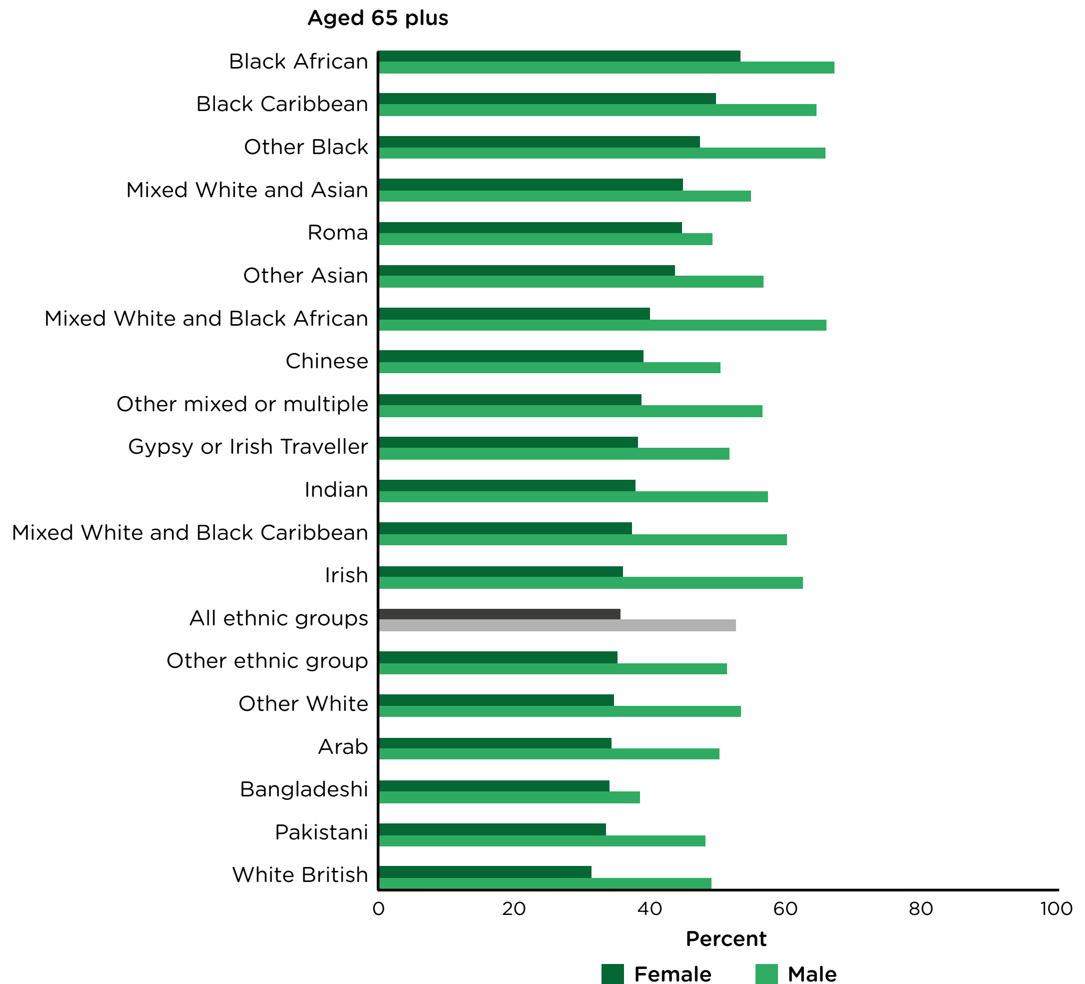
A) AGED 16 TO 49



B) AGED 50 TO 64



C) AGED 65-PLUS



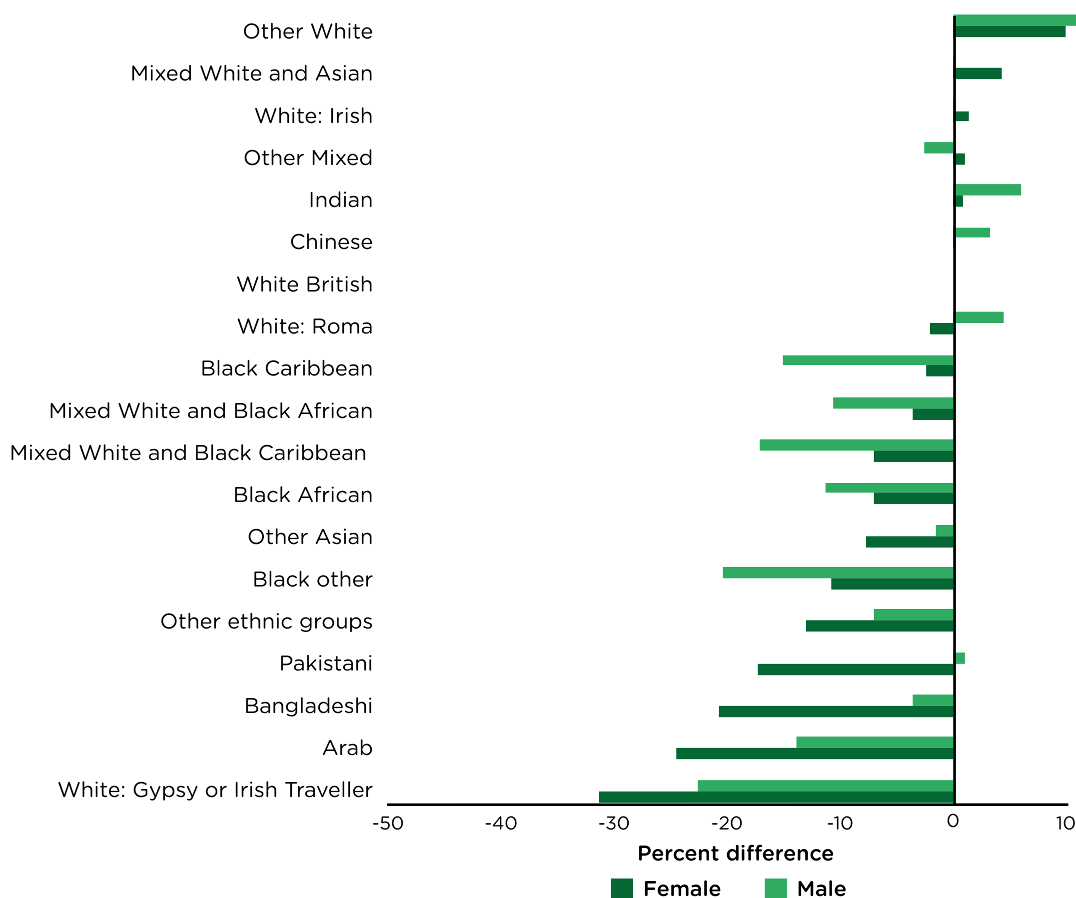
Source: *Census 2021 (311)*

Barriers to employment facing Gypsy and Travellers in England and Wales were set out in the ONS Lived Experience Survey. (312) Literacy skills and low educational attainment were identified as issues that had a significant impact on the employment opportunities available to some. Discrimination was noted as a barrier too, with many employers having preconceived ideas about Gypsy and Travellers, some of whom said they felt they had to hide their identity in order to get a job. Discriminatory behaviour in the workplace was also described. Some positive examples were described in which Gypsy and Travellers found rewarding work in environments where they had equal opportunities without having to hide their identity. Many respondents said that self-employment was preferable to working for an employer, due both to a desire for self-sufficiency and to avoid discrimination. (312)

EMPLOYMENT RATES, DISABILITY AND ETHNICITY

In London employment rates for those reporting having a limiting long-term illness or a disability under the Equality Act were 41 percent for both women and men of working age in the 2021 Census. (238) Although the figures for White British women and men are only slightly higher than this average figure (44 and 43 percent, respectively), there are substantial differences in employment between ethnic groups, Figure 4.22, As was the case for overall employment rates, among women, the differences in employment compared to White British, were greatest in the Gypsy and Irish Travellers, Arab, Bangladeshi and Pakistani ethnic groups. Among men, the largest differences were in the Gypsy and Irish Travellers, Black Other, Black Caribbean and Mixed White and Black Caribbean ethnic groups. On the other hand, several groups with disabilities had higher employment rates than their White British peers. For both women and men, the largest positive difference was for the Other White group. Cumulative disadvantage related to many minority ethnic group's experience of disability leads to specific barriers to employment, meaning a tailored approach is required.

Figure 4.22 Difference between each ethnic group and the White British group in the percent of those with a long-term illness or disability who were employed at ages 16 to 64, by sex, London, 2021



Source: *Census 2021 (238)*

PROGRAMMES TO SUPPORT EMPLOYMENT AND REDUCE RACISM IN RECRUITMENT

The Moving On Up programme (Box 13) was developed to educate employers and build capacity to overcome discriminatory organisational and to help potential employees to gain skills.

Box 13. Moving on Up (MoU) (313)

Founded in 2014 by Trust for London and City Bridge Foundation, in partnership with Action for Race Equality, MoU has the goal of increasing employment rates among Black men aged 16 to 24 in London. (314) (315) (313) MoU funds initiatives that provide support and increase their ability to get a job. Between 2015 and 2017, funding was allocated to six projects including recruitment agency models, which focused specifically on the skills required to successfully apply for jobs, on-the-job experience and group-based support to improve skills. An Inclusive Employers Toolkit was developed, which aims to help companies increase recruitment, retention and progression of young Black men within their workforces. (316) The toolkit is for use by senior leaders and recruitment staff within the construction and digital technology industries, and their suppliers. It equips employers with practical tools and examples of good practice from within these sectors.

In 2017, The Social Innovation Partnership (TSIP) conducted an evaluation of Phase I of the initiative. (317) The findings showed that 271 young Black men were in paid work following MoU, a job entry rate of 40–60 percent. A limitation of this finding is that the data covered only two thirds of the participants. The evaluation found that the greatest impacts of the initiative were on participants' attitude, confidence and understanding of work and that the programme gave participants greater awareness of what employers seek in terms of skills and behaviour, while increasing their motivation and self-assurance. The participants also felt empowered by having a programme designed to mitigate issues specific to young Black men. This shows the importance of tailoring initiatives and policies to underrepresented groups.

Phases II and III ran from October 2017 to the end of 2022, focusing on testing new, replicable approaches for delivering better local coordination and employer engagement to support more young Black men into quality jobs and careers. In particular, the programme tested if a collective impact model (CIP) focused on young Black men, which involves a network of partner organisations working collaboratively to achieve shared goals, could improve employment support and their outcomes. (318)

A 2021 interim evaluation found that the collaborative approach had positive impacts on some young Black men's employment journey. (319) A 2024 evaluation of the MoU programme focused on the collective impact approach between December 2021 and December 2023. (320) It focused on three questions:

1. How effective was the MoU collective impact approach?
2. Is the collective impact approach more effective in achieving direct outcomes for young Black men than 'business as usual' delivery?
3. What changes in wider systems has the programme contributed to?

Overall, the evaluation found that core groups of funded partners worked well together, sharing learning and understanding of the goal to improve outcomes for young Black men, with some practices extending to partners' own organisations. The MoU CIPs did quite well in achieving job outcomes for young Black men, over four years, the collective impact partnerships engaged with 902 young Black men, of which 302 got jobs, with 81 percent at salaries on or above London Living Wage. The evaluation did not find that there were significant differences between the CIPs and 'business as usual' delivery. It did note that limited funding and focus may have impacted implementation, and that the model may develop further. It was too early to see evidence of significant change in wider systems. (320)

Two programmes that specifically focus on building skills among women from ethnic minority groups are described in Boxes 14 and 15. These programmes aim to combat the disadvantage arising from a mismatch between cultural background and mainstream society and are not explicitly dealing with racism.

Box 14. The SWEET Project (321)

The SWEET project was designed for women from ethnic minority groups in West London who seek to enter sustainable employment. The project ran from 2016 until June 2023, funded by the European Social Fund and the Big Lottery Fund. The Paddington Development Trust was the lead coordinating partner. The partners worked with women from the boroughs of Hammersmith and Fulham, Harrow, Brent, Ealing, Barnet, Hillingdon and Hounslow, (321) targeting groups that have particularly high levels of female economic inactivity and worklessness. Key elements involved outreach to engage economically inactive women, providing culturally sensitive information, advice and guidance, making referrals to English language classes, giving support to access childcare and providing activities to link participants to the labour market, including voluntary work experience, open days to meet employers, skill development and confidence-building via one-to-one appointments, help with CV generation, community groups with other women, and workshops within the community.

Outcomes included social inclusion and poverty reduction. In 2019-20 737 economically inactive women engaged with them, with 124 getting into jobs and 100 moving into training. (322)

Box 15. You Make It (323)

Founded in 2011, You Make It is a programme initially focused on providing employment and skills support for women from Black and Asian backgrounds in East London. The 2021–22 programme was funded by multiple charitable grant foundations and trusts and supported unemployed and underemployed young women to build skills and gain employment. It ran a four-month programme that included group learning, one-to-one mentoring, work experience with local employers and start-up support; it also provided counselling and pastoral care. (323)

Between 2011 and 2021 it delivered 16 programmes and worked with 383 women, 89 percent of whom were from ethnic minority groups. The programme asked participants to measure the impact on a scale from 1 to 5 across 26 indicators, which they scored at the outset and on completion. In the 2022 evaluation of the previous two programmes, across all indicators there was an average increase from 2.99 at entry to 4.29 at the end. The proportion of participants claiming benefits fell from 70 percent to 55 percent, and the proportion who reported themselves unemployed fell from 68 percent to 38 percent. (324)

You Make It clients report that it provided valuable support, increased confidence and wellbeing and increased employment opportunities. However, the programme was small scale, and its impact only measured by self-evaluation.

Box 16. Barclays' Race at Work (325)

Barclays launched the Race at Work agenda in October 2020, which aims to close the ethnicity gap in workforce diversity and underrepresentation of certain groups across the bank in both the US and the UK. The Race at Work approach is grounded in four key areas: a metrics-driven approach focusing on data to progress the agenda, measure success and ensure transparency and accountability; colleague hiring and development to progress initiatives to attract, develop and retain racially diverse talent; strategic partnerships that increase brand visibility and the diversity of candidate pools; and equitable investments in minority-owned businesses. Through this initiative in the UK, Barclays aims to increase the number of underrepresented minority employees by 25 percent by the end of 2025, taking the overall percentage to 5 percent. In the UK and the US, Barclays aims to at least double the number of Black employees at Managing Director level by the end of 2022. (325)

MIGRANTS, ASYLUM SEEKERS AND EMPLOYMENT

Whether or not someone has the right to work in the UK depends on their immigration status. People automatically have the right to work if they:

- Are a British or Irish citizen
- Have pre-settled or settled status from the EU Settlement Scheme, or have applied and are awaiting a decision
- Have a family permit from the EU Settlement Scheme
- Have indefinite leave to enter or remain in the UK
- Have right of abode in the UK.

A person might have the right to work if they have a visa with a time limit. This is called having 'limited leave to enter or remain'. Someone does not have the right to work if they entered the UK illegally, or if their leave has ended. (326) As part of the hostile environment immigration policies most asylum seekers are prohibited from working (327), despite evidence challenging the efficacy of this approach. (328) (329) A report commissioned by the Mayor of London, published in 2023 highlighted poor working conditions experienced by many migrants in London, including abuse of labour rights, exploitation and modern slavery experienced by some migrants and high levels of bullying, discrimination and sexual harassment. Migrant workers also experience barriers to accessing advice and support.

The Work Rights Centre works in London and Manchester to support access to employment justice for migrants and disadvantaged Britons, Box 17.

Box 17. Work Rights Centre (330)

The Work Rights Centre (WoRC) is a charity with funding from the National Lottery Community Fund, Justice Together, the Tudor Trust and local government, amongst others. (330) The centre runs multilingual advice clinics weekly and helps its service users fight employment rights breaches, provides advice on employment and benefits and helps secure immigration status.

A high proportion of the centre's clients are engaged in precarious work, with over two-thirds lacking a written confirmation of payment. Informal work arrangements are not illegal but can make it harder for individuals to access and build a case for work protections.

The centre reports its outcomes for 2023 on its website. (331) In 2023 it worked with 1,333 new clients. (331) In 2023 immigration and employment enquires accounted for 39 percent and 33 percent of cases, respectively, with other cases related to welfare, housing and benefits. Most immigration issues related to making an application for immigration status. In relation to employment enquiries, unpaid wages and dismissals were the primary issues faced by clients. The centre routinely assisted clients in recovering unpaid wages and seeking compensation. The centre also helped with more complex discrimination and victimisation cases.

Its publications aim to challenge these systemic barriers and inequalities that lead to employment instability and financial exclusion migrants face in the UK and bring them to the attention of policymakers. (332)

In 2014 and 2016, the Immigration Acts introduced stricter penalties for employers who hire workers who lack permission to work, including fines of up to £20,000 per employee, prison sentences of up to five years, and the potential seizure of property and closure of businesses. (333) (334) Migrants who are found to be working without permission may also face wage confiscation, detention or deportation. To enforce these sanctions, the Immigration Compliance and Enforcement Department conducts raids on businesses that are suspected to be non-compliant. (335) While punitive sanctions may discourage some employers and migrants from working or hiring without legal permission, research suggests that for many, the benefits outweigh the potential risks. (336) (337) The PEW Research Center estimated that there were approximately one million migrants working in the UK without legal permission in 2017 (338) (although this is difficult to measure accurately) and many migrants seek work in the informal and unregulated shadow economy. (339) Without the right to work, individuals are denied basic protections such as health and safety standards, maximum working hours, sick pay, minimum wage and job security and also lack the power to demand better conditions or report violations. (340) (341)

'Right to work' enforcement intersects with racial discrimination. In the latest inspection of the Home Office's approach to illegal working by the Independent Chief Inspector of Borders and Immigration (in 2019), it was declared that half of all fines were administered to South Asian and Chinese restaurants and takeaways, on the basis that workers were 'believed to be removable', demonstrating the disproportionate targeting of specific ethnic groups. (342)

Breaking Barriers works to support refugees in accessing meaningful employment (Box 18).

Box 18. Breaking Barriers (343)

This programme provides one-to-one employment support and advice, education and skill building training to refugees. It works across London, Greater Manchester and Birmingham, with the most service users in London.

The programme has had limited but positive outcomes in helping refugees gain access to good employment. The reports from those that use the service are positive. However, it is limited in what it can achieve in tackling the wider problem of accessing work for refugees, due to the hostile policy environment.

According to its impact report for June 2021–May 2022, it supported 527 clients in London. (344) On average, clients received nine hours of support, six of which were one-to-one employment support sessions. Most of the clients had fairly good levels of English language. Their clients also had high levels of education, 50 percent with an undergraduate degree and 20 percent with a postgraduate degree, yet 82 percent were unemployed.

The impact report shows that during the year, 168 clients achieved some kind of positive outcome, with 111 entering employment. This was 51 percent of the 223 clients who completed their support, meaning 49 percent had no employment or training outcome on completion of the support. However, self-assessment of their progress showed that 93 percent of clients had improved their understanding of what is needed to do well in their sector, 92 percent felt more motivated to meet goals and 90 percent felt more confident. (344)

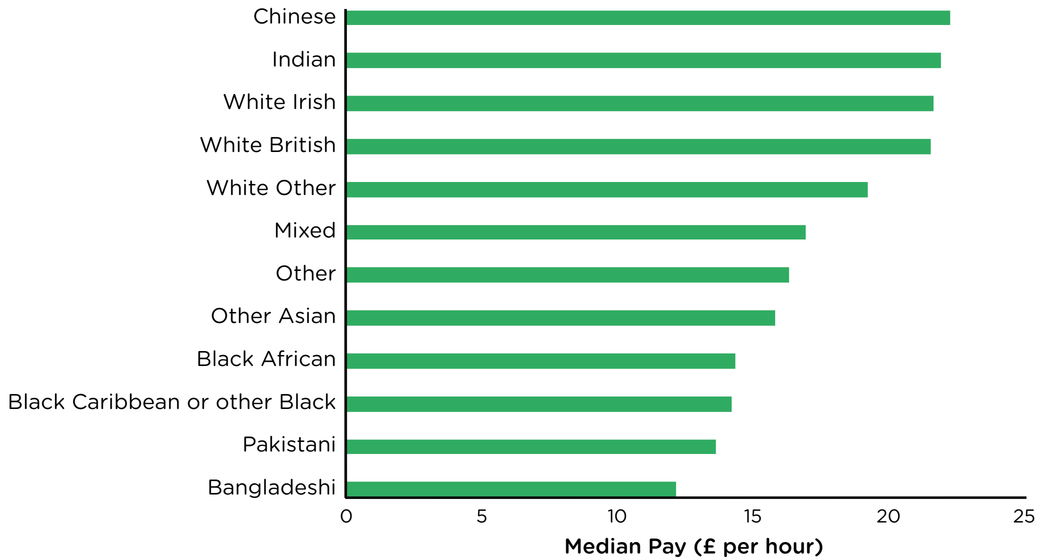
PAY AND INEQUALITIES IN PAY

There is no mandatory requirement to report ethnic differences in pay within organisations, however, across the UK it has been shown that ethnic minority groups frequently receive lower pay than White workers.

2017 Equality and Human Rights Commission (EHRC) analysis of ethnicity pay gaps suggests that some factors explaining these gaps can be seen in the data for certain groups. For example, pay gaps experienced by Bangladeshi and Pakistani people can be partly explained by the increased likelihood of people from these groups to be employed in low-paid occupations, itself partly related to employment practices, discrimination and racism. Black African immigrant men are also more likely to be in low-paid occupations and have low qualifications, and both British-born and immigrant Black Caribbean men are overrepresented in low-paid occupations and underrepresented among people with high qualifications. However, they found that these factors only account for a small portion of the pay gaps for these two groups, suggesting other factors including racism and discrimination within organisations. (345) In 2022 the ONS reported that in the UK after holding personal and work characteristics constant, to provide an adjusted pay gap based on a like-for-like comparison, UK-born White employees earnt more on average than most employees from ethnic groups (346)

Data from the ONS's Labour Force Survey show that in 2022 within London, Pakistani, Black African and Bangladeshi workers had the lowest rates of pay – approximately £10 per hour less than the highest earning groups Chinese, Indian, White Irish and White British ethnic groups, Figure 4.23.

Figure 4.23. Median pay per hour by ethnic group, London, 2022

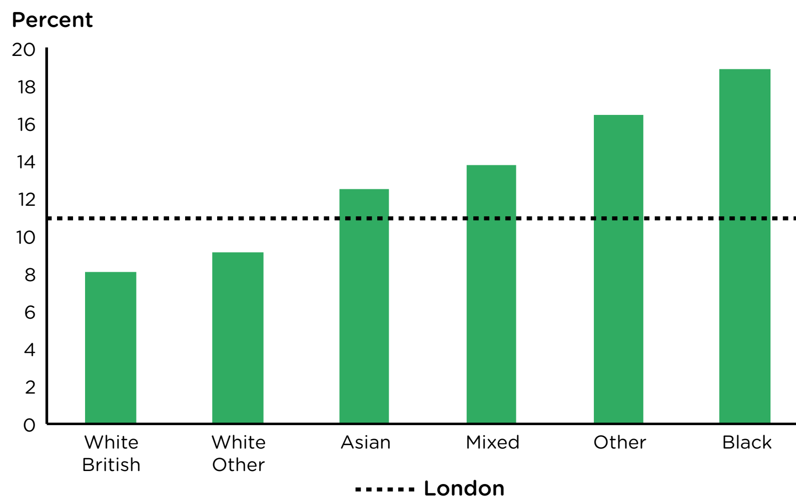


Source: *GLA (statistical analysis from ONS LFS) (347)*

The Living Wage Foundation and the Resolution Foundation calculate a 'Real Living Wage' annually, which is voluntary and based on the actual cost of living. They have one for the UK in general, and one for London, to reflect the higher living costs in the city. The amount is intended to be the minimum income necessary for a person to meet an acceptable, healthy living standard, and is higher than the Government's National Living Wage. (348) In October 2023, the Real London Living Wage rate was calculated at £13.15 per hour, while the UK Real Living Wage was £12 per hour. (349) The Trust for London reports that more than 500,000 jobs in London did not meet this minimum. (350)

Analysis from the Living Wage Foundation shows that Pakistani and Bangladeshi workers in London are almost three times as likely to earn below the Real London Living Wage as White workers, while over 18 percent of Black people in London are not earning the London Living Wage, over 10 percent more than White British people in London, Figure 4.24. (351) Overall in the UK, White household income was on average 63 percent higher compared with that of Black households in 2019. (352) (353)

Figure 4.24 Percent of Londoners aged 16 and over in work who do not earn at least the London Living Wage in their current job by ethnic group, London, November 2021 to February 2022



Source: *GLA (57)*

As ethnicity pay gap reporting is currently not legally required, although in 2024 the new Government indicated that it will be, the majority even of large enterprise employers fail to adequately collect data on ethnicity that would enable them to measure ethnic inequalities in pay and workforce diversity and to address any inequalities that are evidenced. Without mandatory reporting it is difficult to collect data on the extent of, or trends in, ethnic inequalities in pay. The Equality and Human Rights Commission found in 2018 that only 3 percent of employers measure their ethnicity and disability pay gaps. (354) More employers are voluntarily committing to recording the information. According to Business in the Community's Race at Work 2021 Scorecard, there was an increase from 11 percent of organisations in the UK capturing this information in 2018 to 19 percent in 2021. (355)

In many of the organisations who do publish their ethnicity pay gap, it is evident that the ethnicity pay gap is at least partly driven by a lack of progression among people from ethnic minority groups, who have low representation at senior levels.

The London Borough of Waltham Forest (LBWF) developed an Ethnicity Pay Gap Strategy in 2021.

Box 19. London Borough of Waltham Forest ethnicity pay gap strategy (356)

Based on analysis of self-reported data for 2019 Waltham Forest council found the median ethnicity pay gap among the council workforce was nearly 12 percent (£2.17 per hour) higher than the UK average gap (2.3 percent) although lower than the London gap (23.8 percent). The gap in Waltham Forest is primarily due to underrepresentation at senior levels of people of African or Caribbean, Asian or mixed heritage. They make up 49.6 percent of staff, but only 36.6 percent, 29.2 percent and 14.1 percent of the highest job levels, respectively. (356)

LBWF held workshops and focus groups with staff of African or Caribbean, Asian or mixed heritage to identify where progress has been made and where more needs to be done, to inform the strategy. Three key themes identified were:

- **Opportunities and progression:** a need for more diversity in senior management, inclusive recruitment and learning and development opportunities
- **Employee experience and wellbeing:** staff need better support in place for dealing with discrimination and preventative work is needed to tackle this
- **Policy and communications:** equality and diversity should be a priority and progress should be transparent, and internal communication, including on development opportunities should be accessible.

The strategy outlines actions that will be introduced in each of these areas to improve outcomes.

In 2021 it was set out that the borough would measure and report against its own data on workforce make-up, sickness, progression opportunities, equality, diversity and inclusion initiatives, appraisals, formal procedures, recruitment and leavers, and qualitative data (surveys). Then, based on the outcome of these measures, it would identify and collaborate with staff to set priority actions for year two.

Whilst there is no evaluation or publicly available data, the Council has been collecting and reflecting on this data internally and in 2023 a new Inclusion Action Plan was published. This includes a refreshed focus on tackling the ethnicity pay gap. The Council has continued to communicate with employees to ensure their strategy going forward reflects the needs of their workers.

In May 2022 the council became the first local authority to sign the Change Race Ratio pledge, which commits it to:

- Set and publish targets for racial and ethnic minority participation on boards
- Set and publish targets for racial and ethnic minority participation at an executive level and leadership pipeline
- Publish a race action plan and commit to publishing its ethnicity pay gap within two years of joining
- Create an inclusive culture that allows talent to thrive (357)

Many charitable organisations are actively campaigning for employers to pay a London Living Wage and a range of employers have actively pursued this strategy. Citizens UK, a people power alliance of diverse local communities, and Trust for London, an independent charitable foundation aiming to tackle poverty and its causes, launched the 'Making London a Living Wage City' campaign in 2021 (Box 20). (358)

Box 20. Making London a Living Wage City (358)

The ambition of this campaign is to identify low-pay sectors and employers and ask them to be accredited with the Living Wage Foundation, thus committing to paying the real Living Wage. In 2021, Trust for London invested £4.8 million over four years in Citizens UK to lift people out of in-work poverty. The campaign aims to win £635 million of increased pay to low-wage workers in London. (358) The project has an explicit focus on workers from groups who are more likely to experience low pay such as ethnic minority groups, women, young people, migrants and those with disabilities. Although the initiative is relatively recent and cannot be legally enforced, collective action and partnerships do have the capacity to spark positive change, especially when properly funded.

The Health and Social Care Action Strand was formed in May 2022 as part of the programme. As of August 2024, 77 percent of all NHS Trusts in London are Living Wage accredited, with a combined uplift of 9887 (uplifts signify the number of people paid at the LLW rate, who receive a pay rise when the new rate is calculated each year).

QUALITY OF EMPLOYMENT

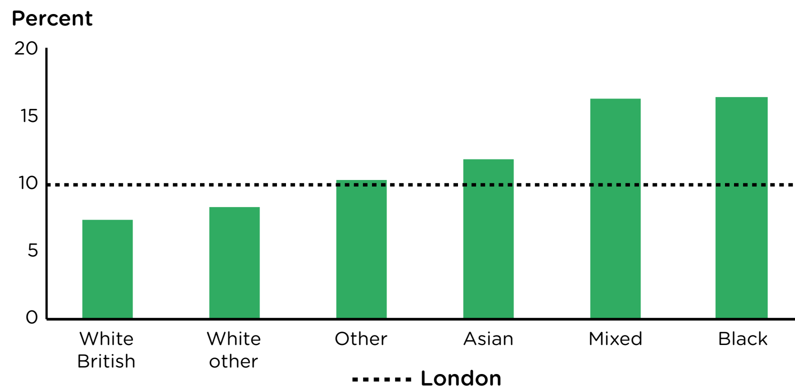
Poor quality work is harmful to physical and mental health. Those with a lower social position and from ethnic minority groups often find the work they can access is more likely to be low-paying, insecure, routine and repetitive, dangerous, stressful, and offer low satisfaction. (304) The risk of accumulating health problems increases the longer the time spent in insecure and poor-quality employment. (305)

There are clear ethnic inequalities in the quality of work in London. While data on experiences of racism are limited, many reports and surveys expose the day-to-day racism many ethnic minority groups are affected by from fellow workers, managers and systems and cultures in the workplace. This is further exacerbated by a lack of redress when complaints are made. In this section we overview ethnic inequalities in rates of insecure employment, job satisfaction, inequalities in career progression and seniority, and rates of business ownership.

Ethnic minority groups are more likely to be in insecure employment than their White counterparts in the UK. In 2022, the TUC commissioned polling of a weighted sample of 1,750 workers from ethnic minority groups in the UK intended to be representative of the ethnic minority workforce. It found that: almost one in five respondents worked at least two jobs; 15 percent had worked on a zero-hour contract at least once in the previous five years; and 13 percent had had their working hours changed at short notice. (359) Research from the Learning and Work Institute found that in the UK 41 percent of Bangladeshi workers, 33 percent of Pakistani workers and 28 percent of Black workers face work insecurity to a much greater extent than the UK average; lower levels of Chinese, Indian and White workers face similar employment insecurity. (360)

In London, as reported in the Survey of Londoners, 16 percent of Black and Mixed employees report being in insecure employment, more than double the rate of White British employees, Figure 4.25.

Figure 4.25. Percent of Londoners aged 16 to 64 who experienced insecure employment by ethnic group, London, November 2021 to February 2022



Source: *GLA (57)*

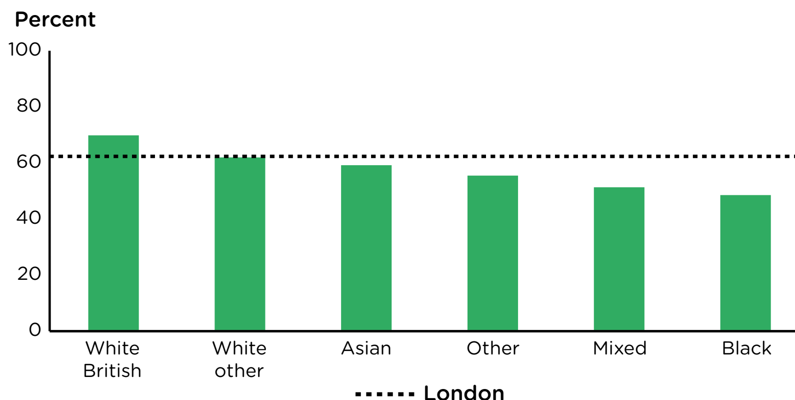
Building on the successful Living Wage accreditation, in 2019 the Living Wage Foundation developed a new standard of what 'good' looks like for those employers that can offer 'Living Hours' alongside a real Living Wage (Box 21).

Box 21. Living Hours (361)

The Living Wage Foundation developed a 'Living Hours' standard which calls on employers to: commit to the right to decent notice periods for shifts of at least four weeks' notice, with guaranteed payment if shifts are cancelled within this notice period; a contract that accurately reflects hours worked; and a guaranteed minimum of 16 hours a week, unless requested differently by the employee. Living Hours is reinforced by a new Living Hours accreditation programme with dedicated support for employers, which requires them also to be accredited as a Living Wage employer. (361)

Fewer people from ethnic minority groups in London report that they are fairly or very satisfied with their jobs compared with their White British counterparts: 70 percent of White British London residents say they are satisfied, compared with 48 percent of Black residents.

Figure 4.26. Percent of Londoners aged 16 and over in work reporting they are fairly or very satisfied with their current job, by ethnic group London, November 2021 to February 2022



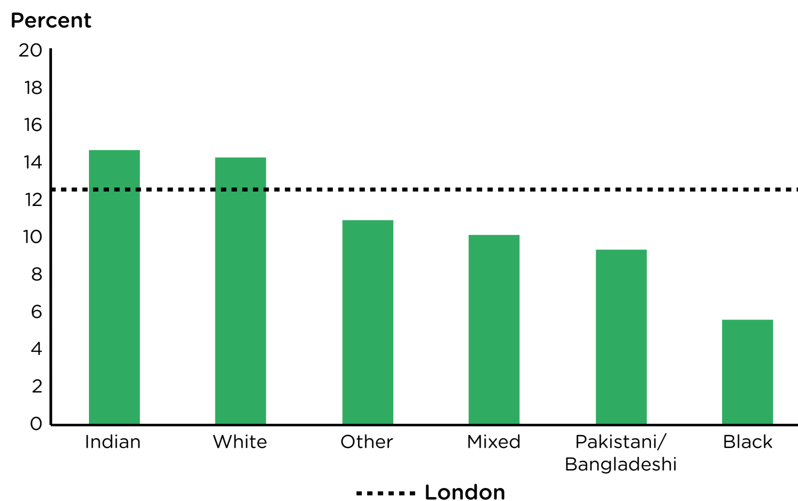
Source: *GLA (57)*

INEQUALITIES IN CAREER PROGRESSION AND SENIORITY

Barriers to progression in the workplace persist for ethnic minority groups. A survey conducted by SD Worx in February and March 2022 found that only 68 percent of UK employers had begun implementation of EDI strategies, meaning around one-third had not. (362) The McGregor-Smith Review in 2017 reported that people from ethnic minority groups made up 12 percent of the UK working age population but only 10 percent of the workforce and 6 percent of top management positions. (363) Surveys of workers show that racism and discrimination play a role in lack of progression, with people reporting difficulty in accessing training opportunities and being passed over for promotion. (364) In Section 2, we set out differences in occupational class by ethnicity and age in London.

There are clear ethnic inequalities in seniority in London, with White and Indian groups having higher rates of employment as managers and senior officials, nearly three times higher than Black groups (Figure 4.27).

Figure 4.27. Percent of those aged 16 and over in employment who are managers or senior officials by ethnic group, London, Oct 2022 to Sep 2023



Source: *ONS (311)*

There are interventions to support people from ethnic minority groups into senior roles, particularly in the public sector.

Box 22. NHS Leadership Academy programme 'Ready Now' (365)

Ready Now was a year-long positive action programme funded by the NHS Leadership Academy, designed to help aspiring senior leaders from ethnic minority groups within the NHS to progress. Elements of the programme include face-to-face, self-directed and workplace-based learning with taught elements. Participants are also expected to contribute to a more inclusive leadership culture.

An independent evaluation of Ready Now carried out in 2017 (366) found that the programme made a strong contribution to individual-, organisational- and systems-level change. On an individual level, participants strengthened their professional and leadership skills, supporting career progression, and obtained greater readiness to pursue further learning and development opportunities. Ready Now also enabled greater confidence in championing inclusion and diversity, increased connection with other professionals from ethnic minority groups and provided the knowledge and confidence to effect change and share insights with colleagues via mentoring, for example.

However, a quarter of the 26 interviewed people admitted that their colleagues were resistant to change and felt the problem of discrimination could not be addressed via the programme. (366) Further, only employees at senior-level positions are allowed to apply, which excludes a major portion of NHS employees. Ready Now has not run since 2020.

Box 23. Stepping into Leadership (367)

This programme, launched in September 2020, aims to equip teachers form ethnic minority groups with the leadership skills, personal confidence and professional networks to make a successful application for promotion. It is funded by the GLA and delivered by the London South Teaching School Alliance.

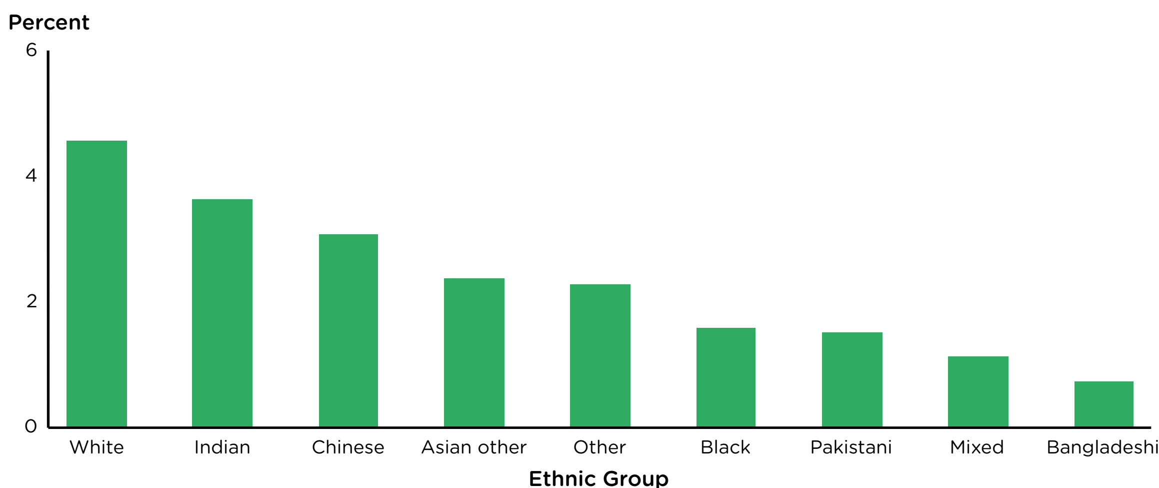
The programme consists of a two-day residential event, where participants hear from successful leaders of ethnic minority groups from education and other fields. They receive one-to-one coaching and structured feedback and can shadow ethnic minority groups. The residential event is followed by six sessions in which participants can set out their vision as educators and receive support in planning for their future.

An evaluation from 32 participants in the 2021/22 programme found that all would recommend the programme to potential future participants. They highlighted listening to inspiring stories of success, coaching and shadowing as the most useful elements. (368)

BUSINESS OWNERSHIP

There are clear inequalities in business ownership by ethnicity in London, with rates over six times higher for White Londoners than Bangladeshi Londoners (Figure 4.28) and higher rates among Indian and Chinese groups and below-average rates among Black, Pakistani, Mixed as well as Bangladeshi Londoners.

Figure 4.28. Percent of Census population estimated to be business owners from the Annual Population Survey, by ethnic group, London, 2021



Source: *ONS (369)*

Notes: *(1) The numerator in this calculation is based on an ONS approximation, using the following answers to a question on methods of payment in the Annual Population Survey (i) A sole director of your own limited business (ii) Running a business or a professional practice (iii) A partner in a business or a professional practice*

(2) The denominator is based on Census 2021 data.

REPORTS OF RACISM AT WORK

Race discrimination has been illegal in the UK since the Race Relations Act 1976, which was replaced by the Equality Act in 2010. Workplace discrimination in any form is illegal and individuals have the right to raise a complaint should they be affected by prejudicial treatment. (370) Despite this there are many substantial and persistent reports of racism from employers, colleagues and the public and many accounts of underreporting for fear of reprisal and inaction.

A 2022 TUC report that examined racism in the UK's labour market provides evidence of the scale of workplace discrimination facing ethnic minority groups. It found that, in the UK, 40 percent of workers from ethnic minority groups reported being affected by racism at work in the previous five years. (371) This took the form of racist jokes, stereotyping, bullying and harassment and other form of racist remarks. The report also highlights how issues of discrimination are often

not dealt with by employers and there is underreporting of incidents. Of those surveyed by the TUC, only 19 percent reported the incident to their employer, and of those who reported, 48 percent were dissatisfied with the way it was handled, with most cases not leading to any action to prevent recurrence. People stated that they believed that if the reported incidents of racism they would not be taken seriously, that it would have a negative impact on their working relationships, action would not be taken, and that they would experience worse treatment as a result.

A 2021 survey of 1,193 people by Pearn Kandola, a diversity and inclusion training company, looked into people's experiences of racism at work in the UK. When asked whether they believed racism exists in the workplace, nearly 90 percent of respondents of all ethnicities said yes. Both Black and Asian respondents were more likely to say yes, 4.5 times and 1.8 times respectively, than White respondents. Black respondents were the most likely to have witnessed a racist incident at work, followed by Asian respondents. Thirty-four percent of respondents said they had experienced racism at work, with Black people the most likely to say this. (372)

The Chartered Institute of Personnel and Development undertook a survey of UK employees in 2017. Black and ethnic minority respondents were more likely than White respondents to say that their career progression had failed to meet their expectations. Further to this, they were significantly more likely to say that identity or background can have an effect on your opportunities. This was particularly high among employees from Indian/ Pakistani/Bangladeshi backgrounds, who also cited a lack of role models and 'people like me' as a barrier to progression. Respondents from those backgrounds were also the most likely to say that in order to fit in, they needed to change aspects of their behaviour. (373)

Reports of racism within health and social care employment are overviewed in Section 5, here we note inequalities among other major employment sectors in London.

Higher education

In higher education, in 2020/21 only 1 percent of professors were Black, 7 percent were Asian and 89 percent were White. (374) A 2015 survey of Black and ethnic minority members of the University and College Union reported that nine out of 10 respondents had faced barriers to promotion often or sometimes. A majority of respondents also reported that they had been subject to bullying and harassment from managers and colleagues and 82 percent said they were subject to cultural insensitivity. Individual respondents said they believed their workplaces were institutionally racist and that incidents of racism go unchallenged by senior staff. (375)

Public services

There are many other reports about public services such as the Metropolitan Police and the London Fire Brigade, where surveyed employees have reported cultures of racism and discrimination, which predominantly White leadership has failed to address. (376)

Private sector businesses

A survey conducted by Be Inclusive Hospitality looked into the experiences of workers within the hospitality industry. They found that Black, mixed and Asian respondents were all more likely than White respondents to state they were concerned about the impact of racism within the workplace. A high number of respondents from these backgrounds reported having witnessed or experienced racism in their current workplace. In line with other reports, they said they were unlikely to feel comfortable reporting these incidents, though the report does not expand on why this may be. (377)

While many unions or bodies representing public institutions have surveyed experiences of staff from ethnic minority groups within their industries there is a lack of information on the extent and impacts of racism and inequity in the private sector. A report from Henley Business School into racism and equity in the workplace across various industries found that business leaders from ethnic minority groups, particularly those working in the public sector, were more likely to report that there is racial inequity in the workplace than those in the private sector. Whether this reflects a larger problem in the public than in the private sector, or more awareness of institutional racism is not clear. (378)

Business in the Community has developed a Race at Work Charter to reduce racism and discrimination among businesses, Box 24.

Box 24. Business in the Community's Race at Work Charter (379)

The charter includes seven key action areas for businesses to work on:

1. Appoint an executive sponsor for race equality
2. Capture and publish ethnicity data and progress
3. Commit at board level to zero tolerance of harassment and bullying
4. Make equity, diversity and inclusion the responsibility of all leaders and managers
5. Take action that supports ethnic minority employees' career progression
6. Support race inclusion allies in the workplace
7. Include ethnic minority-led enterprise owners in supply chains (379)

The Race at Work Charter, launched in 2018, has seen an increase of signatories from 85 employers at launch, to over 1,000 signatories in 2023. (380) 238 employers completed the Race at Work Charter Survey 2023 and examples of employer action include that 89 percent monitor their workforce by ethnic group at each management level in the organisation and 44 percent publish their ethnicity pay gaps. This has increased from 30 percent of employers in 2020 (380)

TAKING ACTION ON RACISM EXPERIENCED DURING EMPLOYMENT

Reliance on voluntary programmes like the Race at Work Charter (Box 24) are a positive step, but such measures on their own are not sufficient to tackle racism and inequalities in recruitment, pay and progression among London's employers as they rely on leadership in individual companies rather than legal obligations.

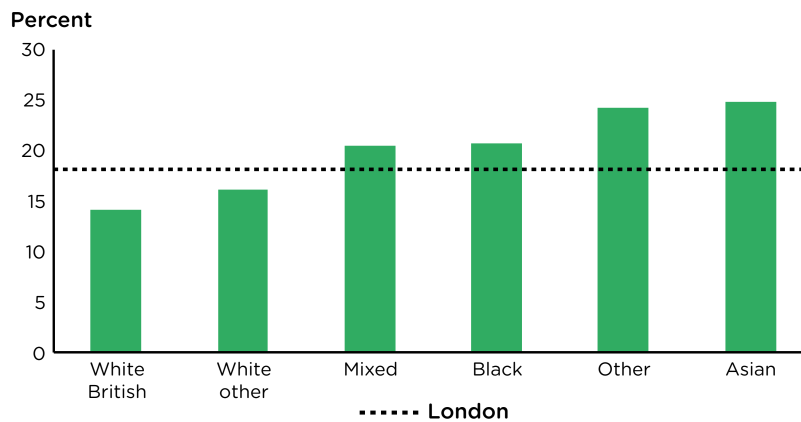
Failures to take adequate action on reported racism affecting workers from ethnic minority groups and to address systemic patterns of inequality as a result of discrimination and racism against workers from ethnic minority groups perpetuate racism and undermine trust in the reporting systems that are meant to hold organisations and individuals accountable. The uneven use by employers of EDI strategies and existing regulatory and legislative mechanisms to tackle racism are cause for concern and the legislation and its application need to be reviewed and strengthened, as set out in Section 6.

Many employers do have strategies in place to tackle racism and discrimination in their workforces but these vary widely in quality, level of accountability and measurable outcomes. It is good in practice for employers to recognise inequalities within their workplace and to set out strategies to improve these, but unless that is accompanied by clear reporting on outcomes, accountability and improvement, it is not effective.

Accountability must be strengthened, including as a requirement in the GLA Good Work Standard (GWS). The latter is a free accreditation programme providing employers with a set of best employment practices alongside information and resources to help achieve them. The initiative was developed in collaboration with London's employers, trade unions, professional bodies and experts and it aims to improve working lives across four pillars: fair pay and conditions, workplace wellbeing, skills and progression, diversity and recruitment. (381) Through the Good Work Standard, employers of all sectors and sizes are encouraged to publish their ethnicity pay gap and demonstrate their commitment to preventing discrimination. Employers are also encouraged to analyse workforce data by diversity and inclusion, and benchmarks itself against others. In addition, efforts to diversity interview panels and candidate shortlists by ethnicity are also promoted within the Good Work Standard accreditation scheme.

Despite the many reports about racism in work, many Londoners from ethnic minority groups report they are unsure about how to find information about employment rights (Figure 4.29).

Figure 4.29. Percent of Londoners aged 16 and over in work reporting that they did not know where to find information about employment rights, by ethnic group, November 2021 to February 2022



Source: *GLA (57)*

RECOMMENDATIONS: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

1. Ensure all employers pay the London Living Wage and eliminate inequalities in pay by ethnicity.
2. GLA to develop and lead an antiracism approach for all employers in London.
3. Ensure that programmes to support people into work and skills building programmes are appropriate for different ethnic groups and are developed with them including in-work training.
4. Reports on racism to be investigated by independent bodies not by employers.

ADDITIONAL RESEARCH AND EVIDENCE

- Implement mandatory collection of pay data by ethnicity.
- Carry out research to understand the reason for inequalities in employment rates by ethnicity for men and women.
- Institute annual surveys of experiences of racism in employment.

4D. ENSURE A HEALTHY STANDARD OF LIVING

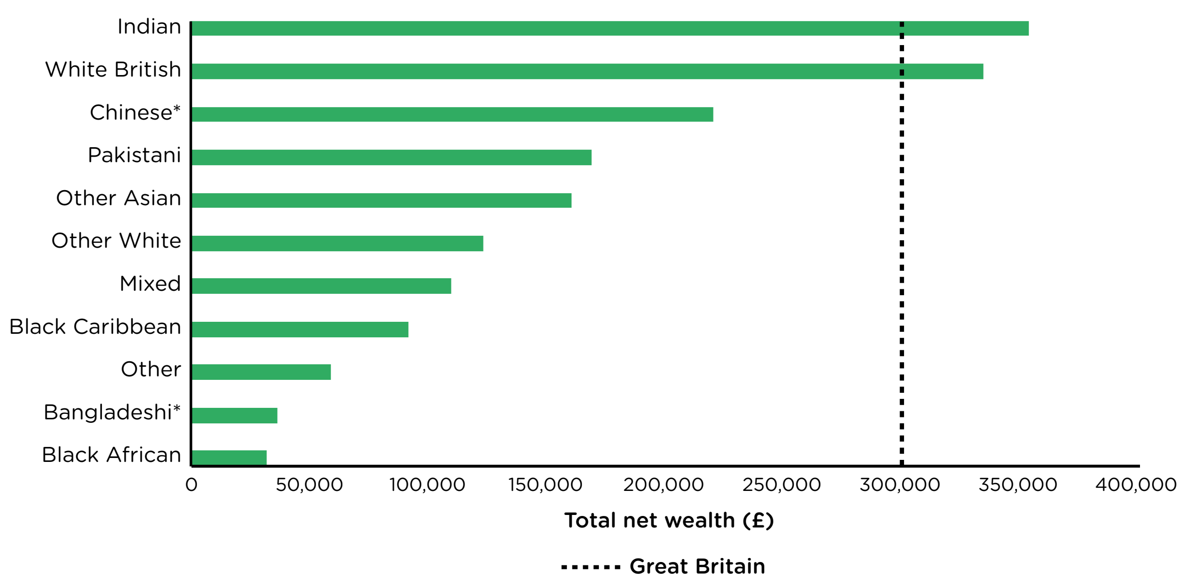
Many people in London are living in poverty, reliant on insufficient benefits or wages that are too low to enable a healthy standard of living. For an increasing number of households, this manifests in housing insecurity, fuel, food and digital poverty and debt. There are widespread and persistent ethnic inequalities in levels of poverty, debt and low income which harm the health and prospects of those affected. Programmes to reduce poverty and to support those experiencing its impacts are increasingly under strain, poorly resourced and unable to meet growing demand. Poverty reduction initiatives need to include an appropriate ethnicity framing and draw on the expertise of community and faith groups in working with affected communities.

WEALTH AND INCOME INEQUALITY

While the wealthy are wealthier in London than in the rest of the UK, the poor are poorer. In 2018–2020 those in the bottom half of London's wealth distribution held just 5.9 percent of the capital's total net wealth, while those in the top decile held 44.3 percent. (382)

There are clear ethnic differences in wealth in Great Britain (ethnic wealth data is unavailable for London). Figure 4.30 shows Indian and White British households have the greatest wealth, by some margin. Black African and Bangladeshi households have a level of wealth nearly one tenth that of White British and Indian households.

Figure 4.30. Median household total wealth, by ethnic group of household representative person, Great Britain, 2018-20



Source: *ONS (383)*

Notes: 1 The household representative person (HRP) is the person that is the sole or joint householder or is responsible for household affairs. Where there are joint householders, the HRP will be the person with the highest income. In cases where income is the same for a joint householder, the eldest person is assigned as the HRP.

**Data are of low reliability due to being based on small numbers in sample.*

London also has the widest inequalities in income compared with the rest of the UK: people in the top decile earned over 10 times more than people in the bottom decile in London in 2017/18–2019/20, while in the rest of the UK that difference is five times. (384) Incomes in the bottom decile in London are 30 percent below incomes in the bottom decile in the rest of the UK. (385) Data from April 2019 to March 2022 combined (data was not collected during the year April 2020 to March 2021) show that in the UK, Bangladeshi households had the highest proportion of households in the lowest two income quintiles compared with other ethnic groups. 79 percent of Bangladeshi households were in the two lowest income quintiles after housing costs, followed by 75 percent

of Pakistani households, 61 percent of Asian other and 59 percent of Black households. 48 percent of Chinese households were in the two highest income quintiles, after housing costs – the highest percentage of all ethnic groups, followed by 45 percent of Indian households, 42 percent of White and White British households. (386)

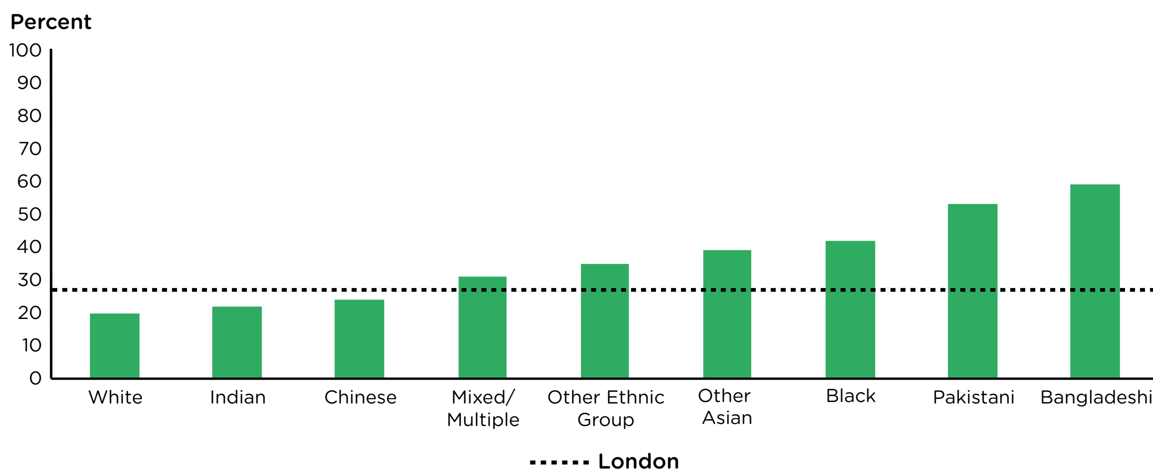
POVERTY

Poverty has a cumulative negative effect on health throughout life. It is associated with poor long-term physical and mental health and increased mortality at all ages, and lower-than-average life expectancy. Poverty negatively affects most of the social determinants of health: early child development, educational attainment, access to quality employment, quality of housing and living environment, the ability to have a healthy diet, and interactions with services. Poverty is stressful: it reduces the 'mental bandwidth' available to deal with day-to-day challenges as well as material deprivation. (387) Poverty has increased across the UK since 2020, a result of austerity policies and the pandemic including the two child benefit cap and inflationary pressures. (388)

In the UK inequalities in rates of poverty between White and ethnic minority groups have not reduced significantly since 1995. In 2019–21 there was a 30 percent difference across the UK. The Social Metrics Commission reported in 2023 that that the rate and level of poverty in the UK had increased significantly since the start of the pandemic with children and disabled people particularly badly affected, reporting that 40 percent of people living in families where the household head is Black/African/Caribbean/ Black British were in poverty, compared to just under 20 percent of those living in families where the head of household is White. (388)

Housing costs have a large impact on poverty rates in London. (175) (384) (389) There are persistent inequalities in rates of relative poverty by ethnicity in London, defined as households with income below 60 percent of the median. White households have the lowest rates of poverty after housing costs, 20 percent, followed by Chinese and Indian households (Figure 4.31), while 59 percent of Bangladeshi and 53 percent of Pakistani households in London were in poverty after housing costs in 2017–20. Indian and Chinese Londoners are more likely to have higher socioeconomic position, to have more resources and therefore to be more protected from the harmful impacts of racism and discrimination. (388)

Figure 4.31. Percent in poverty after housing costs, by ethnic group of head of household, London, financial years 2017/18, 2018/19, and 2019/20 combined



Source: *DWP (157)*

The Runnymede Trust defines 'deep poverty' as household income less than 50 percent below the relative poverty line, itself defined as 60 percent of the median UK income. A Runnymede Trust report showed that in the UK in 2022 Bangladeshi people were more than three times as likely to be in deep poverty (16 percent) compared with White people (5 percent). Further, 14 percent of people of 'Other ethnicity' were found to be in deep poverty, followed by 13 percent of Pakistani and Black people, 11 percent of Asian people and 8 percent of people with Mixed ethnicity. (390)

A 2023 report from the JRF shows that destitution has increased in all regions, with London having the highest destitution scores in 2022. People are considered destitute if they cannot meet two or more of their most basic physical needs including having shelter, heating, lighting, food, clothing and footwear and basic toiletries. (391) Overall, in the UK there were over 3.8 million people considered destitute in 2022, including over a million children. Of the total, nearly a quarter of destitute households were migrants. For the first time since the series on destitution began, ethnicity was

included. Although the data are not available separately for London, in England and Wales Black, Black British, Caribbean or African households were three times more likely to be destitute than their population share in England and Wales. (391)

As well as being stressful and leading to worse mental health and restricting people's ability to live healthily, people on low incomes are more likely to live in deprived areas, which has associated factors harmful to health such as poor air quality, lack of access to quality green spaces, unhealthy high streets, and higher rates of crime and fear of crime, as set out in more detail in Section 4E. Given the higher proportion of ethnic minority populations, particularly Black and Bangladeshi groups, living in more deprived areas, there is a need for interventions that tackle place-based deprivation to be designed with and for ethnic minority households.

FOOD POVERTY AND INSECURITY

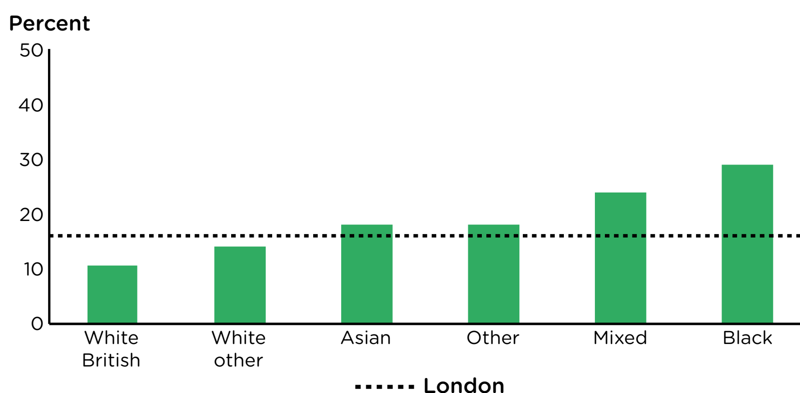
Food poverty, defined by the Food Standards Agency as the inability of individuals and households to secure an adequate and nutritious diet, is increasing across the UK. (392) (393)

According to the Food Foundation Food Insecurity Tracker from January 2024, 14.8 percent of UK residents had reported experiencing food insecurity in the previous month, up from 6.9 percent in August 2020, although down from the high of 18.4 percent in September 2022. For households with children, 20 percent of households had reported food insecurity, up from 10.8 percent in August 2020. (394) (395) The figures from the Food Foundation are based on its online survey of 6,000 adults in the UK. The Foundation defines food insecurity overall as people 'struggling to get the food they need'. This might include experiencing one or more of the following:

- Having smaller meals than usual or skipping meals because of being unable to afford or get access to food
- Being hungry but not eating because of being unable to afford or get access to food
- Not eating for a whole day because of being unable to afford or get access to food. (394)

The GLA Survey of Londoners in 2021/22 reports that nearly a third of Black residents were living with low or very low food security, compared with one in 10 White British people, Figure 4.32.

Figure 4.32. Percent of Londoners aged 16 and over living in low or very low food security, by ethnic group, London, November 2021 to February 2022



Source: *Survey of Londoners (57)*

Although there are several food charities across London boroughs, (396) most do not specifically include provisions for ethnic minority groups. Lambeth and Lewisham are examples of boroughs that have recognised this need, reflected in the Lambeth Food Poverty and Insecurity Action Plan 2021–2024 (Box 25) and the Lewisham Food Poverty Plan (Box 26). Food Poverty Action Plans have been developed across the capital by the London Food Programme in partnership with the advocacy group Sustain to support London boroughs to develop coordinated strategies that map the current situation, identify gaps in provision and offer potential solutions. (396)

Box 25. Lambeth Food Poverty and Insecurity Action Plan 2021–2024 (397)

Around two-thirds of Lambeth's population has an ethnic minority background. Lambeth Council launched the Food Poverty and Insecurity Action Plan in 2021. (397) In its plan, the Council strives to advance physical access to good food in the borough and address inequalities in access. It specifically names improving access and addressing inequalities among Black, Asian and ethnic minority groups as a key target. It aims to achieve this goal by facilitating access to more affordable, healthier foods, including fresh fruit and vegetables, for example via community hubs, markets, shops and social supermarkets, home-delivered and shared meals, and addressing any transport challenges. This is only a small recognition of the needs of ethnic minority groups, but it is further than many other local action plans go. (397)

In its *Good Food for All Londoners report* (2022), the advocacy group Sustain rates Lambeth as showing leadership among London councils in improving food access for Black, Asian and ethnic minority people. On Sustain's criteria, this means the council is taking more than five of its recommended actions. (398)

Lewisham's steps to tackle food poverty in the borough also recognise that ethnic minority groups in London are affected disproportionality by food insecurity. Lewisham has identified the need for specific support for ethnic minority groups (Box 26).

Box 26. Lewisham Food Justice Action Plan (399)

Lewisham Council has provided funding for the provision of culturally appropriate foods, including fresh fruit and vegetables, for food projects supporting Black, Asian and ethnic minority residents. In March 2022 culturally appropriate foods were provided to 11 groups supporting over 300 households per week. (399)

This support has continued through the Food Justice Community Grants programme launched in 2023 to support Lewisham's new Food Justice Action Plan. This programme funded 10 community food projects to provide cultural foods reflecting the diverse ethnic make-up of the borough to support community food banks, social pantries or other projects providing food or meals. While the programme is still running, the initial impact report outlines that the grants improved the variety of food available, particularly healthier, fresh food and cultural food that reflected residents' cultural preferences which many projects and families may otherwise struggle to afford. This enabled projects to cater better for dietary requirements for example halal meat, vegan options, fresh foods such as yams, plantains, and chillis.

The recognition of the need for a specific focus on the experience of ethnic minority groups in accessing fresh, affordable food is promising. As in Lambeth, more work can be done to identify and provide solutions to the wider barriers to accessing healthy food faced by these groups, as outlined in Lewisham's Food Justice Action Plan. (400)

Much of the action on food poverty in London comes from small community groups, often from particular religious groups that serve their local communities and emphasise provision of culturally suitable food. One example of this work is from the Rastafari Movement UK (Box 27).

Box 27. Rastafari Movement UK (401)

The Rastafari Movement UK offers African Caribbean cultural foods, fresh fruits and vegetables and ital (a natural food diet of some in the Rastafari movement) to vulnerable people in Southwark, Lewisham and Lambeth. It received a grant from Southwark Food Action Alliance to support its work in the community and supports 92 people with food, while also providing emergency response to those with no recourse to public funds, or those who are awaiting benefit payments. It also aims to improve quality of life and isolation by providing doorstep befriending services. (401)

While this is a small service it is providing culturally appropriate relief and support to those who have limited access to support from other sources.

Public health has frequently been involved in support for action on food poverty. There is scope to strengthen its focus on ethnic minority groups and their needs and to work with local community, voluntary sector and faith organisations to ensure that the offer is appropriate and developed with input from affected communities. More broadly, the public health system should strongly advocate for sufficient incomes and social protection measures to reduce poverty and remove the need for food banks altogether.

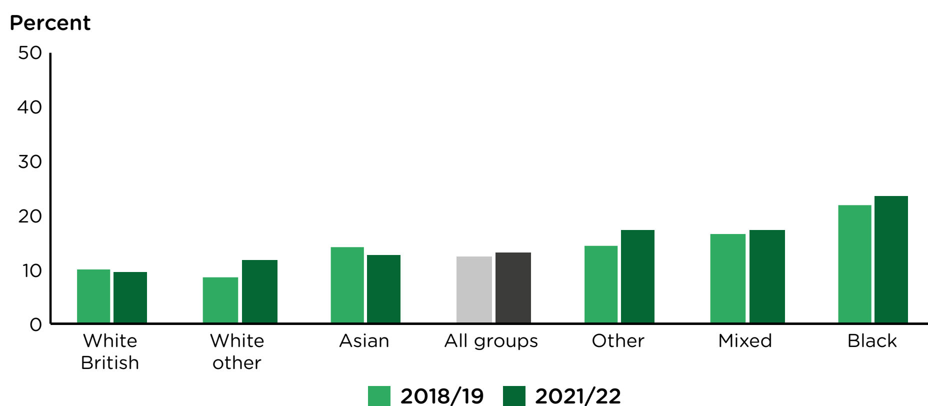
FUEL POVERTY

A household in England is considered 'fuel poor' if they are living in a property with an energy efficiency rating of Band D or below and if, when they spend the required amount to heat their home, they are left with a residual income below the official poverty line. (402) This definition and the method of measurement were changed in the Government's 2021 fuel poverty strategy. Before this, a household would have been considered fuel poor if its required fuel costs were above the national median level and were they to spend that amount they would be left with a residual income below the poverty line. (403)

Cold homes are associated with a range of health problems, including poor respiratory, mental and long-term health, and in winter may cause people to die. (118) Evidence suggests that around 10 percent of excess winter deaths in England are directly attributable to fuel poverty and around 21.5 percent of excess winter deaths are attributable to the coldest 25 percent of homes. (404) (405) Data on fuel poverty and ethnicity is only available until 2021. Subsequent years have seen an increase in fuel prices resulting in many more households living in cold and damp homes. (406)

In 2014 Public Health England recommended a temperature of at least 18 degrees in homes in winter. (407) The Survey of Londoners, which covers 2021/22, shows an increase in the proportion of London residents unable to keep their homes warm enough, except among White British and Asian groups. Black, Mixed and other ethnic groups have higher rates than the average for London and nearly one in four Black Londoners cannot keep their home warm enough, according to the survey (Figure 4.33).

Figure 4.33. Percent of Londoners aged 16 and over who cannot keep their home warm enough in winter, by ethnic group, London, October 2018 to March 2019 and November 2021 to February 2022



Source: *Survey of Londoners (57)*

In 2022 the Mayor of London launched the Warmer Homes Programme with the aim of supporting those London residents the most impacted by poor quality housing and fuel poverty (Box 28).

Box 28. Mayor of London: Warmer Homes Programme (408)

This programme provides low-income homeowners and renters grants of between £5,000 and £25,000, dependent on existing energy efficiency rating, tenure and fuel type, to undertake renovations such as heating, insulation and ventilation improvements. (408) Although the programme is not a targeted intervention for ethnic minority groups, it can contribute to addressing inequalities; low-income ethnic minority groups living in low energy-efficient homes who would not otherwise have the means to make renovations should benefit from the programme.

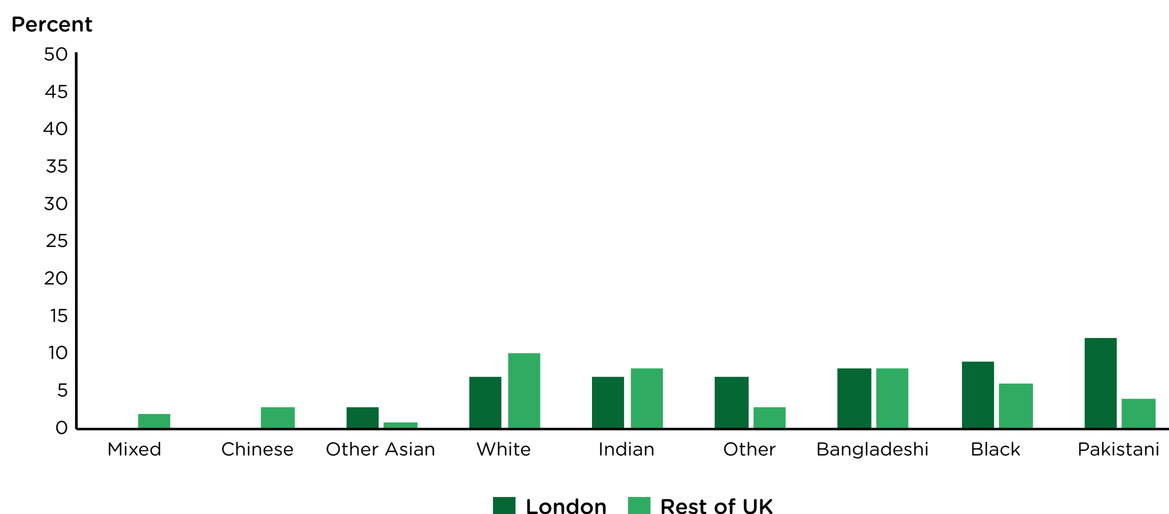
Fuel poverty among Gypsy and Travellers is a significant issue, particularly for those living in caravans or mobile homes. Households on local authority sites were excluded from the Energy Bills Support Scheme when it was

introduced in October 2022. Research in 2022 showed that 82 percent of residents on local authority sites in the South East of England were on pre-payment meters, which charge higher rates per unit of electricity compared with billed usage. (409) (410)

DIGITAL POVERTY

There are barriers in the use of digital technology that prevent people from accessing services and, as a result, widen inequalities in access to services including health. Digital exclusion also limits social integration and increases social isolation. Digital exclusion is linked to wider inequalities already present in society, such as low income and poverty, and it most affects vulnerable groups already facing disadvantage. While rates of internet use have increased across the UK, there are still inequalities in use and for some ethnic minority groups in London. Data on internet use show that digital exclusion is pronounced in older Asian adults, suggesting that there is a need for tailored programmes to support older people from certain ethnic minority groups to increase their digital inclusion. (411)

Figure 4.34. Percent of people aged 16 and over who have never used the internet, by ethnic group, London and the rest of the UK, 2018



Source: *ONS (412)*

A 2018 survey by Friends, Families and Travellers found that only 38 percent of Gypsy and Travellers interviewed had a household internet connection, compared with 86 percent of the general population. (413)

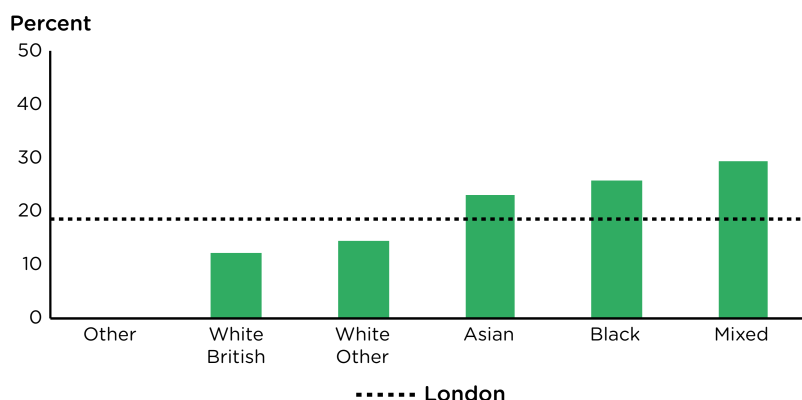
DEBT

Problem debt is associated with depression, anxiety, and other poor psychological health outcomes and levels of self-rated health. (414) (415) (416) (417) Between April 2018 and March 2020, before the cost of living crisis, 5 percent of households in Great Britain and London were identified as having 'problem debt'. (418) The ONS considers a household to be in 'problem debt' if it has liquidity problems, solvency problems or both and includes arrears on household bills or credit commitments. (419) In the UK problem debt is particularly high for many ethnic minority groups due to higher rates of poverty. (420)

As ethnic minority groups disproportionately experience debt, they are consequently particularly affected by associated poor health impacts. The initial findings report from the Survey of Londoners 2021–22 shows that 32 percent of adults in London owed money on unsecured debt, including personal loans, credit cards and household bills. (57) Further, 25 percent did not have at least £1,500 in savings. Both figures for debt and savings constitute an overall reduction from 2018–19, but inequalities between White and ethnic minority groups remain. In 2021–22, 45 percent of Black people in London owed money on debt and were, on average, twice as likely (47 percent) to not have savings of at least £1,500 compared with White people (25 percent). (57)

The Survey of Londoners provides a clear indication of differential impacts of debt by ethnicity, with nearly 30 percent of mixed multiple ethnic and 26 percent of Black groups feeling their debt is a heavy burden compared with 13 percent of White British people (Figure 4.35).

Figure 4.35. Percent of Londoners aged 16 and over with debts who feel their debt is a heavy burden, by ethnic group, London, November 2021 to February 2022



Source: *Survey of Londoners (57)*

WELFARE, BENEFITS AND FINANCIAL SUPPORT ORGANISATIONS

The Government's policies of austerity involved making significant changes to working-age welfare and benefits over the last decade. The health impacts of these changes, described in the 2020 report, *Health Equity in England: the Marmot Review 10 Years On*, include damage to physical and mental health. The changes have also damaged key social determinants of health in affected communities. (6)

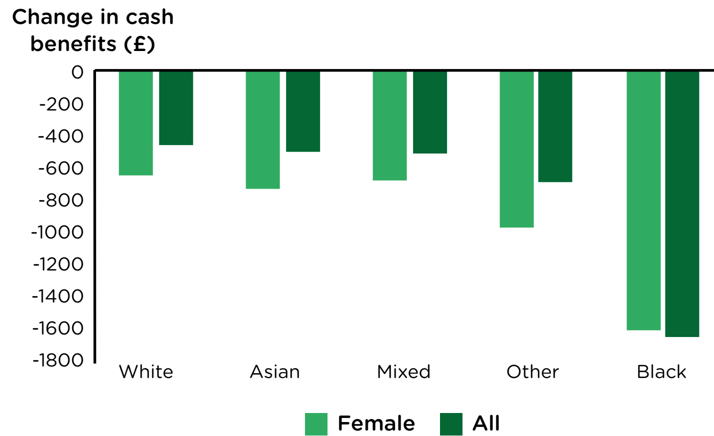
Research from the Joseph Rowntree Foundation and the Trussell Trust shows that 90 percent of low-income households on Universal Credit are going without essentials including food, utilities and vital household goods. (421) They calculated that in 2023 the minimum amount per week needed for a single adult to access essentials is £120 and for a couple £200. This is higher than the current standard Universal Credit allowance, which was set at £85 for a single adult and £134 for a couple in April 2023, showing that the current benefit system only provides approximately 70 percent of what is necessary to afford life's basic essentials. (421)

People from ethnic minority groups tend to have larger families than White British people and have been particularly affected by the two-child limit for receipt of Universal Credit. The limit means that people receiving Universal Credit do not receive an additional amount for a third child born after 6 April 2017, except in special circumstances. (422) The wider benefit cap limits how much working age people can receive from benefits, and the cap varies based on location and circumstance. (423)

A 2018 cumulative impact assessment by the EHRC looked into the changes to taxes, benefits, tax credit and Universal Credit made from 2010. It found that the greatest impacts were felt by those on lower incomes and protected groups, including disabled people, certain ethnic minority groups, and women. Increases in child poverty were predicted to be largest for Pakistani, Black and Bangladeshi households and found that the changes would reduce the income of Bangladeshi households on average by around £4,400 a year, and Pakistani households by £2,700 a year. It also highlighted that households with three or more children would have larger losses, which would disproportionately impact larger families from ethnic minority groups families. In an intersectional analysis, the EHRC found that the worst losses would be felt by disabled women of 'mixed ethnicity' and disabled women of 'other' ethnic groups not specified in the categorisation. (424)

Figure 4.36, based on analysis by the Runnymede Trust, shows that while changes in the benefit system have decreased income for families of all ethnicities in the UK, they have been especially damaging to the income security of people from ethnic minority groups. Black families in the UK now receive £1,635 less a year in cash benefits than they did a decade ago, compared with a decrease of £454 for White families, who have had the lowest decreases of all ethnic groups. (390)

Fig. 4.36. Real terms change in mean cash benefits received by families* between 2011 and 2020 by ethnic group, UK



Source: *Runnymede Trust (390)*
Note: *Breakdowns are at the benefit unit level in 2020/21 prices*

The EHRC has also found evidence of higher rates of sanctioning for claimants from ethnic minority groups by the Department for Work and Pensions. Sanctions are usually related to not meeting eligibility criteria. The EHRC draws attention to gaps in the evidence related to ethnicity and the reasons for lower rates of claiming among some ethnic minority groups. There are also gaps in evidence around the impact for Gypsy and Travellers and recent migrants. (425)

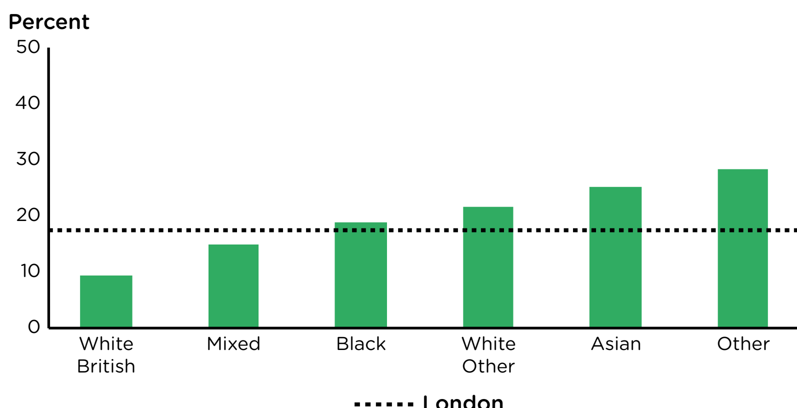
A report from the Women's Budget Group and Runnymede Trust looking into the impact of austerity on Black women and other ethnic minority groups since 2010 found that women from these backgrounds have been disproportionately impacted by the changes to taxes, benefits and public spending during the austerity years, particularly those women from the poorest households. Their calculations found among households in the lowest quintile of earnings, Black and Asian households experienced the biggest drop in

living standards between 2010 and 2020, over 11 percent compared with 9 percent for White households. They also discussed impacts with Black women from ethnic minority groups on what impact they had seen in their everyday lives. Two key themes that emerged were increasing financial precarity as benefits and earnings failed to keep up with costs, and the challenges in navigating the complex benefits system. The report also highlighted how the second of these can have particularly harsh impacts for people who have English as a second language. (426)

A 2010 study into the experience that Black, Asian and ethnic minority groups have with services provided by Her Majesty's Revenue and Customs (HMRC) highlighted several issues. Due to higher levels of employment in the informal economy in certain ethnic minority groups, some people found it harder to provide evidence of their financial status. They also cited complex and changing processes as a barrier, which was worse among those with poorer English language skills. Some groups cited lack of trust in government, but there was also a feeling that this was more to do with poor engagement from the government with specific groups, such as Travellers. (427)

The Survey of Londoners shows clear differences by ethnicity in awareness about financial hardship support, indicating that 'Other' ethnic groups and Asian people were least aware of this form of support and likely not to be accessing all the financial support they were entitled to (Figure 4.37).

Figure 4.37. Percent of Londoners aged 16 and over who were not aware of any of the listed financial hardship support organisations*, by ethnic group, London, November 2021 to February 2022



Source: *Survey of Londoners (57)*

Note: **Citizens Advice, Debt Free London, Law Centres Network /local Law Centre branches, borough's hardship/local welfare scheme, food bank, other local advice services/networks, or employment rights hub*

A 2023 briefing from Friends, Families and Travellers shows the economic and financial exclusion experienced by Gypsy and Travellers in England. In the 2021 Census, 53 percent of Gypsy and Travellers who responded were economically inactive. One of the key issues cited by the briefing is a decline in the traditional employment and self-employment opportunities for Gypsy and Travellers, along with the prejudice against them. The briefing highlights the difficulties faced by Gypsy and Travellers in accessing welfare benefits and services, which is worsened by increased digitisation, a barrier for those with low digital literacy and access to the internet. It also cites lower functional adult literacy and marginalisation leading to a lack of awareness about benefits they are entitled to and how to claim them. (428) In addition, having no fixed address can lead to difficulty in accessing financial institutions and services and missing correspondence regarding welfare benefits. (410)

REFUGEES AND PEOPLE SEEKING ASYLUM

The implications of having No Recourse to Public Funds (NRPF) are significant and contribute to a considerable number of people in the UK being unable to attain a healthy standard of living. (178) The Centre for Research in Public Health and Community Care conducted interviews with families with NRPF, as well as with support services and third-sector organisations across the UK and found that NRPF was limiting families' access to adequate and healthy food. (429) However, there is a lack of research on the specific health impacts of NRPF, highlighting the need for further investigation.

Project 17 (Box 29) is a UK charity that works to end destitution among migrant families across 52 local authorities, through advice, advocacy and support for individuals. This is provided mostly under Section 17 of the Children Act 1989, which states that local authorities have a duty to provide services ensuring the welfare of children in need and their families. (430) This duty exists even if the family has no right to work, no access to welfare benefits or social housing, and no leave to remain in the UK.

Box 29. Project 17 (431)

Project 17 is a charity that supports and facilitates a 'lived experience group' that works towards strategic change for people with No Recourse to Public Funds. In 2021/22, two-thirds of Project 17's clients were based in London.

Project 17 has undertaken annual reviews since 2013 to measure its impact. In the year 2021/22 it worked with 396 families, just over half of whom were undocumented migrants, with 20 percent having a pending immigration application and 31 percent limited leave to remain with a NRPF restriction. Many clients requested help under section 17 of the Children Act 1989. Project 17 supported 204 families to access accommodation and 208 families to access financial support. Eighty-seven percent of clients received some positive outcome including 52 percent accessing financial support and 51 percent accessing accommodation. Forty three percent received financial support from their destitution fund, 40 percent received foodbank vouchers and 30 percent received a grant. Feedback from a random sample of clients reported that 97 percent said Project 17 helped their situation and 100 percent understood their options better. (432)

The limited evaluation suggests Project 17 is effective in supporting the small numbers of people it helps directly in accessing services.

RECOMMENDATIONS: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

1. Tax and benefit system reoriented to reduce ethnic as well as socioeconomic inequalities.
2. Universal Credit should meet the cost of daily life essentials.
3. Develop advice and support services in collaboration with the ethnic groups who are most affected by poverty to ensure they access the financial support they are entitled to including uptake of benefits.
4. Increase the coverage of programmes to insulate cold, poor-quality homes working with ethnic minority groups who are particularly affected.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the tax and benefit system for impact on ethnic as well as socioeconomic inequalities.

4E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE COMMUNITIES AND NEIGHBOURHOODS

Places characterised by good-quality, affordable housing, access to green and other public spaces, clean air, affordable and active travel and community cohesion all support good health. Classifying people by where they live, according to these characteristics, shows there are inequalities in London related to ethnicity as well as socioeconomic position, disability and other dimensions of exclusion. Safety is a particular concern in London and there are marked inequalities by ethnicity in how people perceive their level of safety. The criminal justice system, which is meant to protect residents, is often seen as a source of violence and criminal behaviour by many ethnic minority groups following years of racism.

HOUSING AND ETHNICITY IN LONDON

A good-quality, secure and affordable home is foundational to a healthy life. There are clear ethnic inequalities in terms of housing affordability, tenure, quality and risk of homelessness. Racism and discrimination are present in the London housing sector, with reports of racism from housing providers, including social housing and private landlords. (433)

TENURE

Evidence shows that there are clear differences in tenure patterns between London residents of different ethnicities. (434) Different ethnic groups have different rates of home ownership. Between 2016 and 2018, 62 percent of White British people living in London were homeowners compared with 35 percent of ethnic minority groups. (435) Among London's Mixed, Indian, Pakistani and Black Caribbean households, there was nearly a 10 percent fall in home ownership rates between 2001–2021, compared with declines nationally of around 4–7 percent for these households from ethnic minority groups and around 3 percent for White British households. (436)

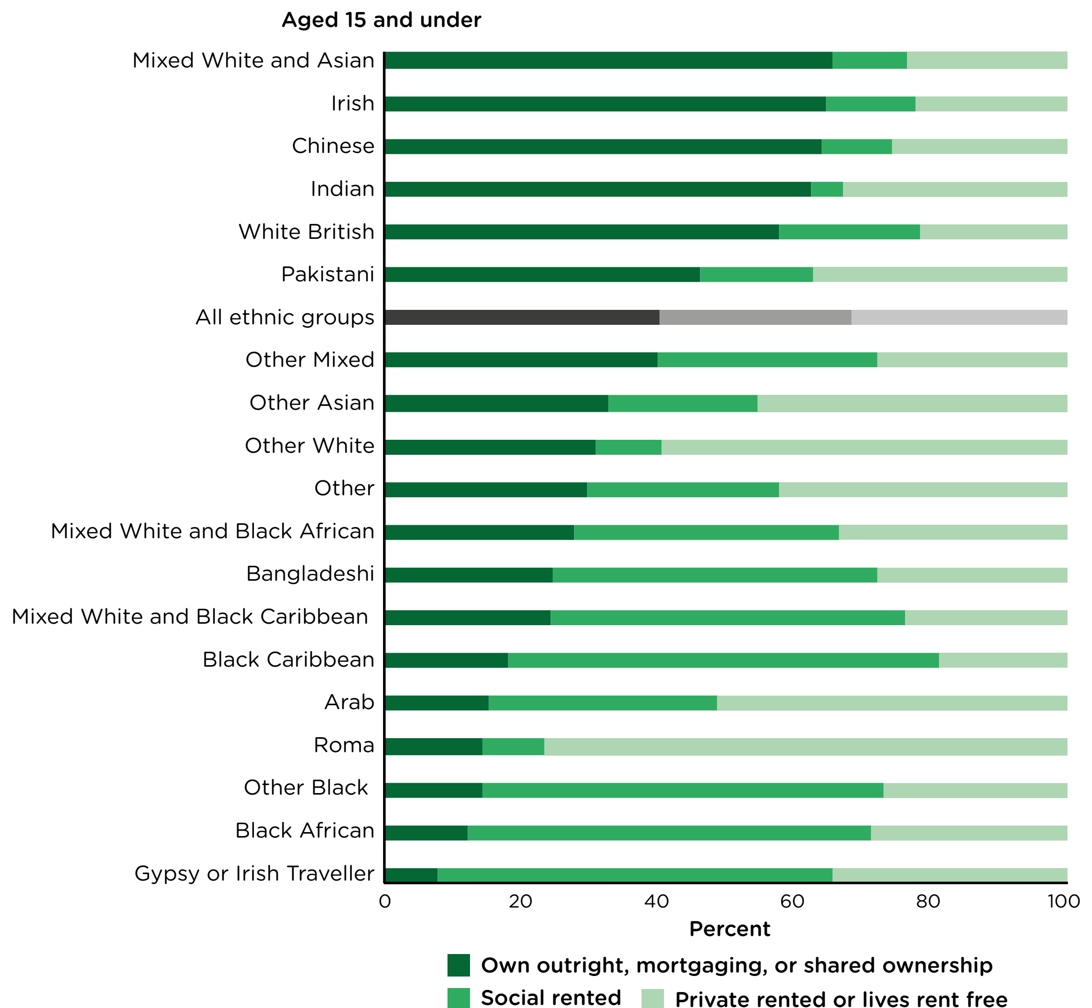
The private rented sector in London features highly variable rents and standards of accommodation, especially in inner London boroughs. While there is expensive rental accommodation available, much is poor quality and the private rented sector is larger in London than in other regions of England, meaning more people are affected by accompanying issues of poor quality and insecurity of tenure in the capital. (437)

Figure 4.38 shows differences in types of housing tenure by ethnicity and age. There are higher rates of poor quality housing in the private rental and in some cases social housing sectors than in owner occupied housing, therefore people living in these types of housing are more likely to be affected by health-damaging housing. There are much higher rates of children living in social and private rental housing among Gypsy and Irish Traveller, Black, Roma and Arab families. These inequalities persist among older age groups. Indian, Chinese and White British people are most likely to own their own homes.

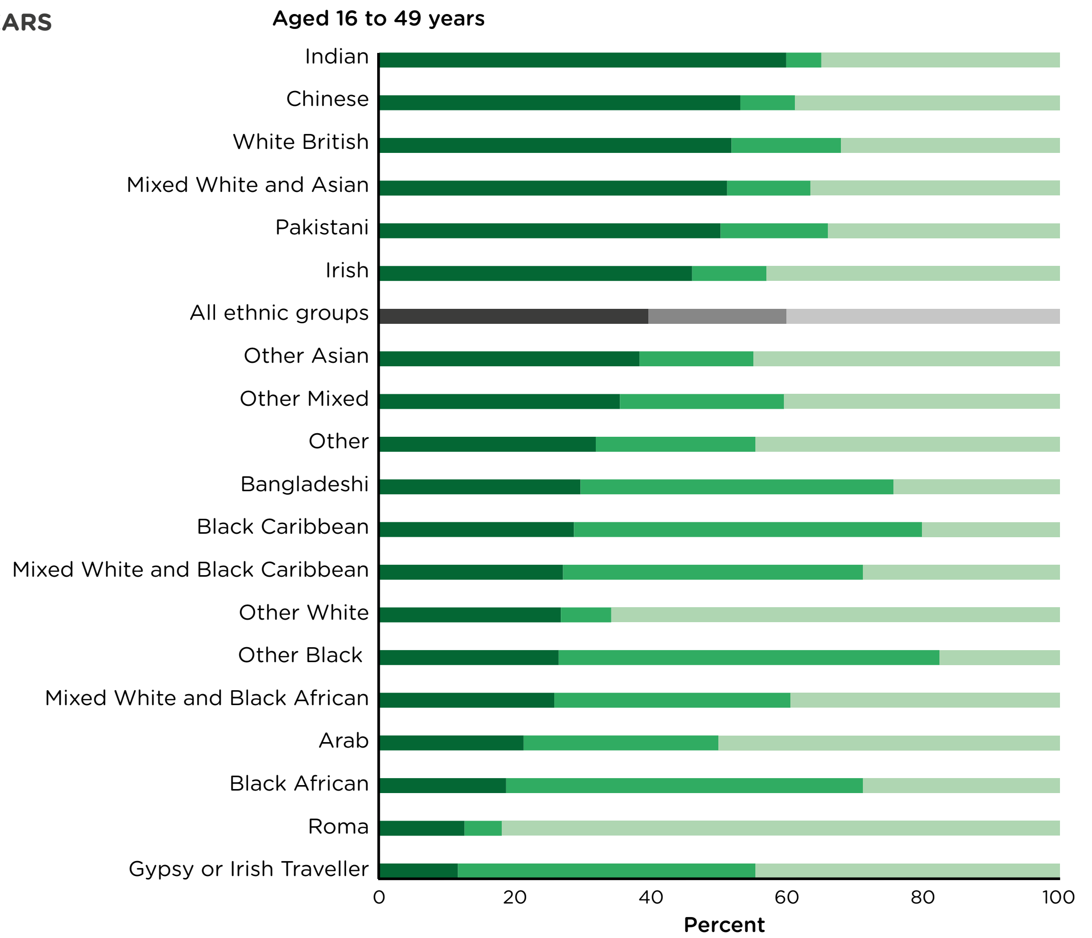
For all ethnic groups, the rise in the private rental sector is striking – shown as higher rates of private renting, and lower rates of home ownership, in people 16-49 compared to those 50 and over.

Figure 4.38. Percent distribution, within each ethnic group, of all usual residents in private households by housing tenure, London, 2021

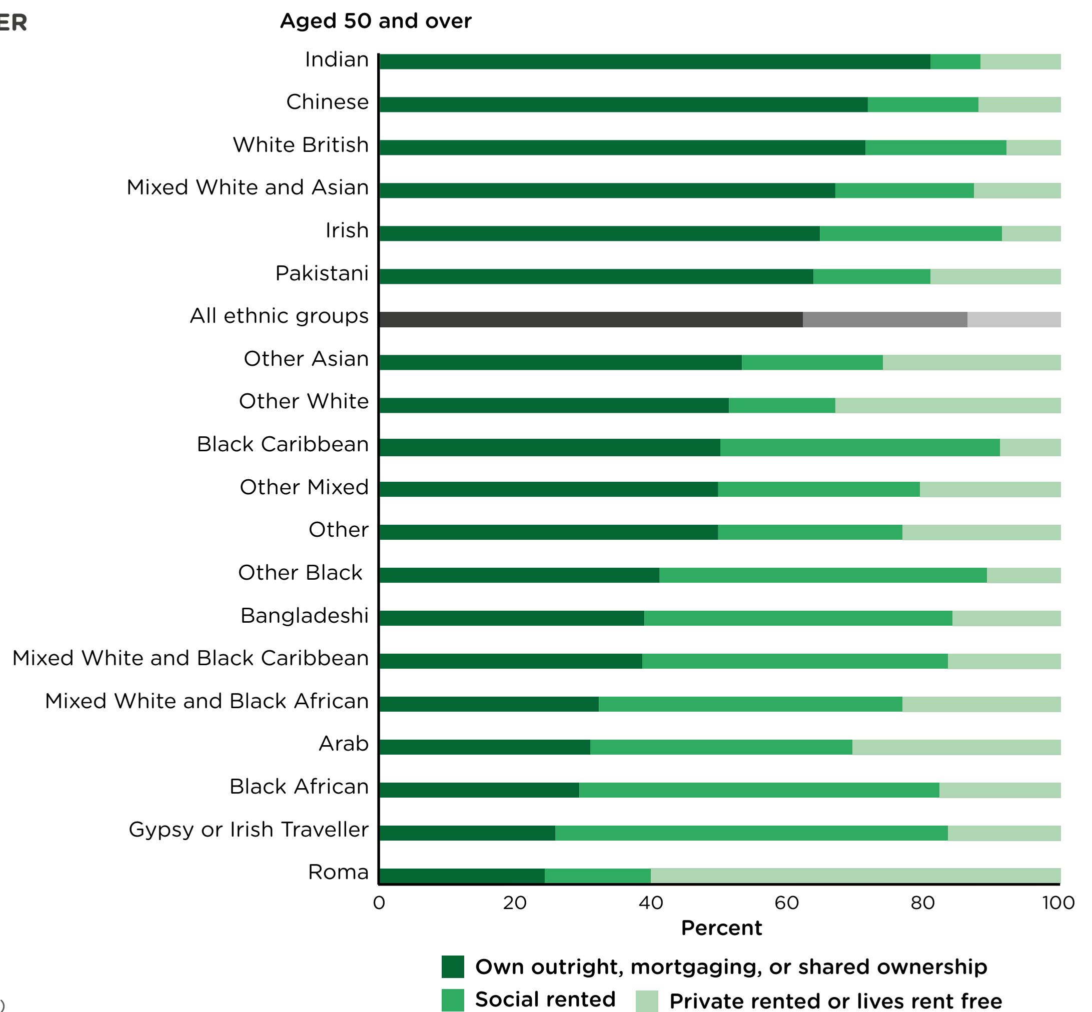
A) 15 AND UNDER



B) AGED 16 TO 49 YEARS



C) AGED 50 AND OVER

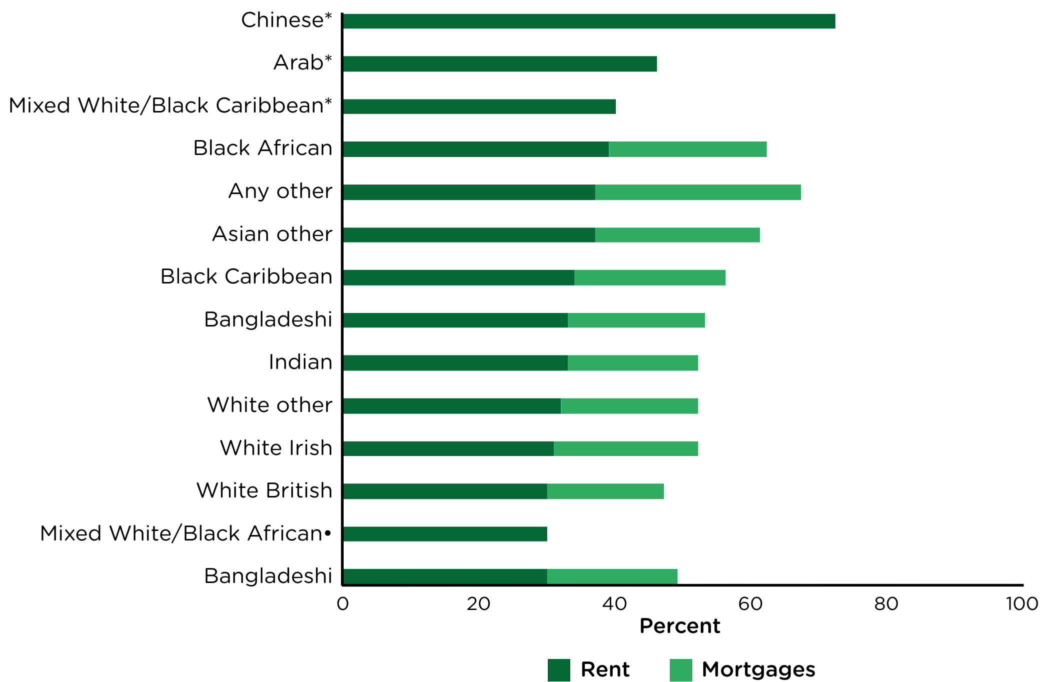


Source: *Census 2021 (238)*

AFFORDABILITY

The cost of housing in London is rising significantly and costs are much higher compared with the rest of England. This contributes significantly to the high rates of poverty in London. Ethnic minority groups spend a significantly higher average portion of their household income on rent compared with their White counterparts, due to lower incomes and pay and being more likely to rent. (438) As Figure 4.39 shows, White British renters in England spend on average 30 percent of their income on rent compared with 46 percent for Arab households. Among homeowners of all ethnicities, a lower proportion of household income is spent on mortgages than non-homeowners spend on rent, and there are not marked inequalities by ethnicity.

Figure 4.39. Average spending on homes as a percent of household income, by ethnic group, England, April 2015– March 17



Source: *Ministry of Housing, Communities and Local Government (439)*
Note: **Figures on mortgage spend not published due to small numbers in sample*

The GLA programme 'Homes for Londoners: Affordable Homes Programme 2021–2026' (the AHP) aims to increase the number of affordable homes in the region, which, given the ethnic differences in rates of housing affordability, should help reduce ethnic inequalities in housing costs and resulting poverty (Box 30). Analysis from Savills in 2021, found that London needs approximately 90,000-100,000 new homes a year with at least 42,500 of these being sub-market rent homes, meaning the rent is set at a level between social rent and market rent. (440) Further 2022 analysis commissioned by the GLA from Savills found that London required £4.9bn a year to deliver affordable housing at levels that would have met the city's housing need as identified in the London Plan, subject to sector capacity. (441)

Box 30. Homes for Londoners: Affordable Homes Programme 2021–2026

The Homes for Londoners: Affordable Homes Programme 2021-26 is London's allocation of Department for Levelling Up, Housing and Communities' £11.5bn Affordable Homes Programme 2021-2026 and is administered by the GLA. The rest of the national programme is administered by Homes England.

The Government's three main objectives for the national Affordable Homes Programme 2021-2026 are to provide additional rented housing for those who cannot afford it at market price; to increase access to home ownership; and to increase the supply of housing in general. (442) In London, the programme is expected to deliver between 23,900 and 27,100 new affordable homes by March 2030. The majority of these homes are expected to be Social Rent homes. Shared Ownership and London Living Rent tenures are also delivered through the programme.

Shared Ownership is a government backed scheme which offers eligible buyers the chance to buy a percentage share of a leasehold home, rather than the full market value of the property and means the amount of money required for a deposit is usually significantly lower than would be required when purchasing outright. (443) London Living Rent is a tenure funded by the Mayor to help people transition from renting to Shared Ownership. London Living Rent homes will be offered on tenancies of a minimum of three years. By offering a below-market rent, tenants are supported to save and given the option to buy their home on a shared ownership basis during their tenancy. To be eligible for a London Living Rent home, tenants must live or work in London, be renting or living in an informal arrangement with family or friends due to struggling with housing costs and have a maximum household income of £60,000.

One of the programme's four strategic objectives is to work with smaller housing associations. There are over 100 small and medium sized housing associations in London, including several ethnic minority housing associations, which are community-based housing associations primarily focused on serving community members. The GLA encourages bids that demonstrate partnership working with Black, Asian and ethnic minority housing associations in development of homes, service delivery or staff development. (444)

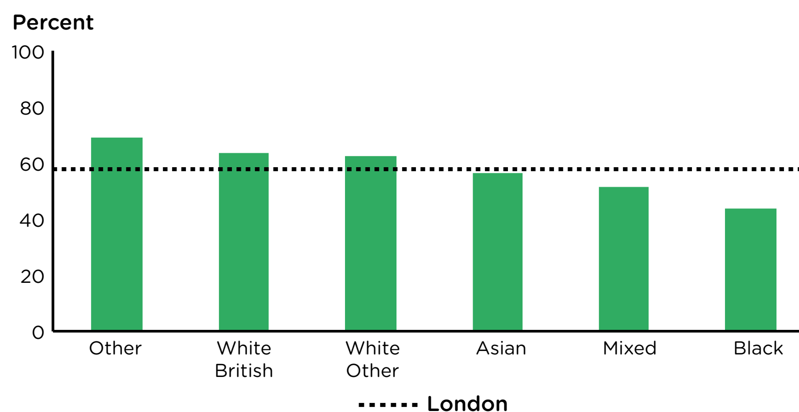
The funding conditions of the Affordable Homes Programme 2021-26 require all registered providers in receipt of grant funding to comply with five minimum standards and develop, publish, and implement an equality, diversity, and inclusion action plan. The action plans must address the following three themes: organisational equality, diversity, and fairness, sustainable and diverse supply chains, and working together with Londoners. The funding conditions have been developed to increase diversity in the sector and ensure that the homes delivered through the Affordable Homes Programme 2021-26 meet the needs of London's diverse communities.

In 2020 the GLA undertook an Equality Impact Assessment for the AHP to assess the potential impacts of its policies on individuals with protected characteristics. As the programme goes on, data monitoring may show that a relatively high percentage of households from ethnic minority groups individuals were able to benefit from the programme and this should be a consideration for success, or otherwise, of the policy. (434)

QUALITY OF HOUSING

Living in poor-quality and non-decent housing is linked to poor physical and mental health. Ethnic minority groups in London disproportionately experience poor-quality housing and living conditions, which is damaging to health. (445) (446) In the Survey of Londoners in 2021/22, Black people were least likely of all renters to rate their housing as good or very good, well below the average for London as a whole (Figure 4.40).

Figure 4.40. Percent of those Londoners aged 16 in rented accommodation who rated their housing very good or good, by ethnic group, London, November 2021 to February 2022



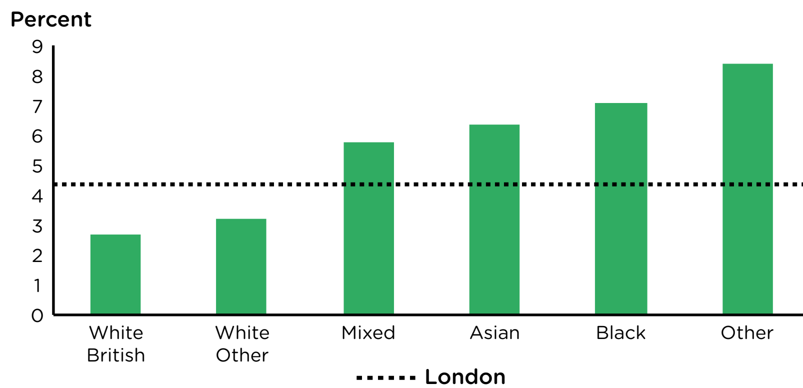
Source: *Survey of Londoners 2021–22 (57)*

OVERCROWDING AND INDOOR SPACE

Overcrowding is increasing in London due to rising housing costs relative to income and housing benefits, high inflation, rent increases and a very limited supply of affordable housing. (445) (433) Overcrowding is a health risk as it increases stress and increases exposure to communicable disease, including respiratory diseases, as shown during the pandemic. One qualitative study investigating the experiences of Filipino migrants during the pandemic demonstrated contexts of extreme overcrowding, with one respondent living with 14 people in five bedrooms, all of whom experienced COVID-19 symptoms simultaneously. (447) Stress and depression are also common consequences of living in an overcrowded space. Educational attainment of children living in these spaces is reported to be lower even after accounting for parental education. (448)

Figure 4.41 shows that in England, White British people are the least likely to live in overcrowded housing and therefore the least likely to experience the adverse health impacts.

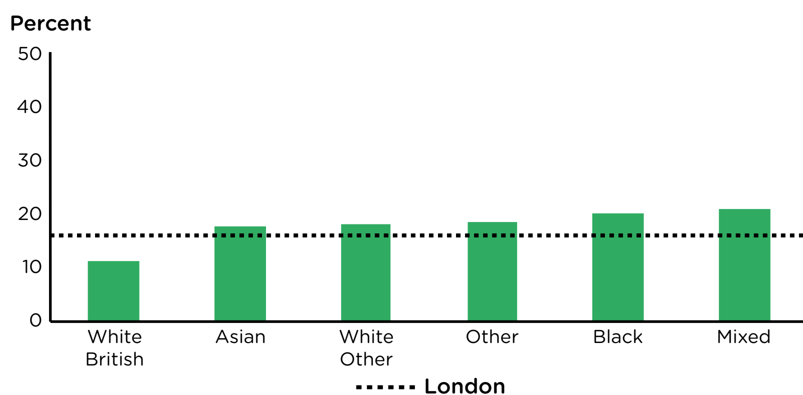
Figure 4.41. Percent of Londoners aged 16 and over living in overcrowded accommodation, by ethnic group, London, November 2021 to February 2022



Source: *Survey of Londoners 2021–22 (57)*

As well as having less indoor space, ethnic minority groups in London are less likely than White British people to have access to outdoor space. Figure 4.42 shows that in the Survey of Londoners, nearly 90 percent of White British Londoners reported access to either private or shared outdoor space, 10 percent more than Black and Mixed groups.

Figure 4.42. Percent of Londoners aged 16 and over with no access to outdoor space at home, by ethnic group, London, November 2021 to February 2022



Source: *Survey of Londoners 2021–22 (57)*

A 2019 briefing from the Race Equality Foundation and the Housing Learning and Improvement Network looked into the experience of housing for older people from ethnic minority backgrounds. (449) The briefing uses the ONS definition of housing deprivation: living in a household that is overcrowded, has no central heating or is a shared dwelling. It shows that ethnic minority groups over the age of 50 have higher rates of housing deprivation than the White British group of the same age in all types of property. The briefing found that housing deprivation is highest for Bangladeshi and Black African people over 50 who live in flats, with nearly half having experienced housing deprivation. For those aged 65 and over, levels of housing deprivation are greater in social

housing than in owned or privately rented housing for all ethnic groups other than White British and White Other, for whom it is highest in private rented accommodation. The briefing highlights the importance of investigating the factors through the life course that lead to higher levels of housing deprivation among the older ethnic minority population. It also calls attention to the lack of an evidence base regarding the access older older people from ethnic minority groups have to housing and care that is suitable for their needs. (449)

The Bangla Housing Association was founded in 1991 to support the Bangladeshi community that was experiencing housing problems in Hackney. They expanded over the years to support and house people from the wider community in Islington and Waltham Forest. (450) Their mission is to provide decent, affordable homes and support services for those in the local Bangladeshi community, and those from other ethnic minority groups, Box 31.

Box 31. Bangla Housing Association and the London Bangladeshi Health Partnership Project (451) (452)

Bangla provide community support programmes and are one of the main partners in the London Bangladeshi Health Partnership project. This group brings together health partners with Bangladeshi community organisations, to support the development of a plan responding to the health priorities of Bangladeshi communities in London.

Their aims are to use learnings from the pandemic and work directly with communities to mitigate health inequalities for Bangladeshi Londoners. This includes work supporting immunisation and screening, focus on specific health needs that are relevant to individual communities, collect data to inform on the main priorities and health needs of communities, and bring together good practice for health equity amongst Bangladeshi communities. There is not yet a review of the effectiveness of this work, but it is a clear example of community co-production to challenge health issues that impact a specific ethnic minority group.

The Enterprise Development Programme is a five-year programme funded by Access – The Foundation for Social Investment and managed by a coalition of partners. It has partners in seven sectors, including homelessness, mental health, equality, and environment. The programme supports organisations to develop financial resilience and impact by providing a mixture of grant and learning support. (453) The Ubele Initiative joined the Enterprise Development Programme in 2021 as the Black and Minoritised Communities sector partner and established the Black and Minorities Communities Enterprise Development Programme. It is developing the first National Strategic Alliance, which aims to support Community Wealth Building within Black and minoritised communities. This is still at early stages, but once established will consist of up to 12 Black and minoritised regional infrastructures with key local anchor organisations. (454) As part of the Ubele Initiative commitment to community wealth building the GIDA Housing Cooperative, Box 32, was set up in response to the experiences of ethnic minority groups' poor quality of private rented housing across London, including affordability and lack of influence over management and maintenance of their homes. (455)

Box 32. GIDA Housing Cooperative (456)

GIDA means 'home' when translated from Hausa, a language of Northern Nigeria. Established in 2021, GIDA is a partnership of three community groups: the Ubele Initiative, Rode Housing Cooperative and Bahay Kubo Housing Association (456)

The initiative is in its early stages. Over time, it aims to become an affordable housing provider that empowers underrepresented communities by giving them agency and control over their own home. Its first project involves St Anne's Hospital site in Tottenham which is owned by the GLA and provides the opportunity for at least 50 community-led homes to be established. (455) Community-led housing requires that there is meaningful community engagement and consent throughout the development process; that a local community group or organisation owns or manages the homes and that there are clearly defined and protected benefits to the local area or a specified community. (457)

The ambition is to influence the plans for construction and decision-making by ensuring there is sufficient provision for one-bedroom and two-to-three bedroom homes in order to create an intergenerational community. The wider objectives are to make sure underrepresented communities are accommodated on the development and that the homes and community spaces create a sense of community for the long term.

RACISM IN THE HOUSING SECTOR

Race Equality in Housing, a 2022 review into policy approaches across England, Scotland and Wales, highlights a significant lack of up-to-date research, evidence and data into ethnic inequalities in the UK housing system. Importantly, it highlights a reduction in research into people's experiences over the past 20 years. Most of the evidence that is available comes from third sector groups and charities and a few news articles that report individual experiences of racism within housing (458) but it is difficult to find recent in-depth analysis or surveys with people affected by racism in the housing sector.

A 2021 survey conducted by Shelter reported on the discrimination experienced by people from ethnic minority groups in the UK. Eleven percent of Black and Asian respondents, compared with 3 percent of White respondents, said they had found it hard to find a safe and secure home because of discrimination. The survey also highlighted inequalities in living conditions and reported private landlords refusing to let to anyone claiming benefits, disproportionately impacting women, Black and Bangladeshi families, and disabled people, as they are more likely than other people to be in receipt of housing benefits. (459) A Guardian newspaper survey from 2018 showed unequal responses to inquiries to flat share adverts between applicants with the name 'Muhammad' and applicants called 'David'. For every 10 positive replies 'David' received, 'Muhammad' received eight. (460)

Though not in London, the death of Awaab Ishak, a two-year-old boy from Rochdale who died in 2020 from exposure to persistent black mould, highlights the racist treatment many households from ethnic minority groups face from housing providers in England. The landlord had repeatedly failed to fix the mould issues in the flat, blaming the family's lifestyle. (461) An Ombudsman report prompted by this death found that Rochdale Boroughwide Housing had a culture of 'othering' residents and had discriminatory and prejudiced attitudes towards residents, particularly refugee residents, tending to dismiss residents' concerns and blame lifestyle choices. Comments from housing department staff included that refugee residents were just 'lucky they have roof over head'. (462)

In June 2017, 72 people died in the Grenfell Tower fire in West London. Grenfell was a preventable tragedy, which revealed the failures of the construction industry, housing sector, fire service and local and national government to ensure safety for residents. The fact that the tower provided mainly social housing in the richest borough of the UK, Kensington and Chelsea, highlights the stark contrast in quality of housing and living conditions between the wealthy residents of the borough and its poorer residents, many of whom were immigrants. There was a systematic failure to take regard for the safety of these groups. After the fire, residents reported that their fears and complaints about safety had been ignored. Of those who died, at least 34 were of African, Middle Eastern or Asian backgrounds. Members of the Grenfell Next of Kin group requested that the official inquiry investigate the role race and class played in the tragedy. The inquiry in 2024 into the causes and events that led up to the fire shows failure, incompetence and knowingly unsafe practice throughout the system, with parties still failing to take responsibility for their role. (463) (464) (465) (466)

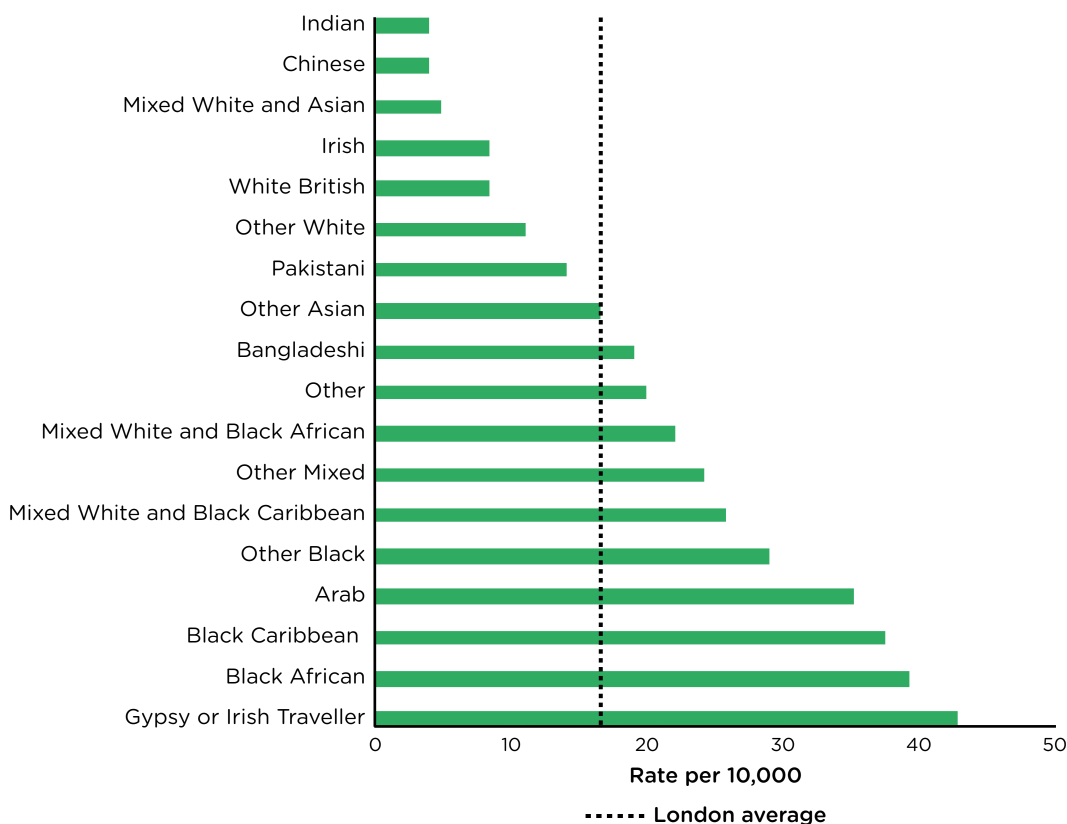
A Guardian article reports the failure of a Housing Association to take action following racist incidents. A young Black woman was forced to flee her London flat in 2016 after nine months of racist incidents from a neighbouring family, including death threats. The housing association, London and Quadrant, ignored the code of practice on protecting tenants from racial harassment by failing to evict the racist neighbours or relocate the young Black woman, and was ruled guilty of defensiveness and insensitivity by a county court judgment in 2020. The woman was awarded £31,000 in damages after the judge discovered she had been misled by assurances that there was no record of antisocial behaviour at the property, when in reality, a previous Black tenant had also been chased out of the flat by the same neighbours. (467)

Policies directed at finding and tackling ethnic inequalities in housing have not been a strategic priority in England. In a review of national housing policies, the UK Collaborative Centre for Housing Evidence found that from all three nations there was little attempt in housing policy statements to consider the factors driving ethnic inequalities in housing. This was particularly notable in England, where recent housing policy statements made little or no comment on discrimination or racism within the housing system. (468) There was also a significant lack of specific proposals promoting race equality in housing or illustrating good practice across all the policies reviewed. Stakeholders engaged in the review highlighted the importance of improving the evidence base. A number of stakeholders also suggested that action was long overdue, and inequalities in housing for ethnic minority groups around certain issues such as overcrowding and conditions have been known about for years with little progress being made. (468)

HOMELESSNESS

Figures for the period July to September 2022 in London, indicate that Gypsy or Irish Traveller, Black African, Black Caribbean and Arab households have over double the rate of homelessness than is the average for London. Gypsy and Irish Traveller households have over 10 times the homelessness rates of Indian and Chinese households, and more than five times the homelessness rate of White British households, shown in Figure 4.43. It is essential to include different risks and reasons for homelessness by ethnicity in policies to prevent homelessness and to support people who are homeless.

Figure 4.43. Rate per 10,000 households assessed as homeless and owed a prevention or relief duty, by ethnic group, London, July to September 2023



Source: *Department for Levelling Up, Housing and Communities (469)*

Analysis by Heriot-Watt University in 2022 found that the risk ratios for homeless application rates from Black and ethnic minority-led households were higher in London than in any other part of the country and that in London the risk ratio for the statutory homelessness of Black-led households was over five times the rate of White-led households. (470)

In London there are higher numbers of White people rough sleeping than people from ethnic minority groups. However, the numbers of people from ethnic minority groups sleeping rough have risen faster than White people in London. (471)

In 2022 the ONS completed qualitative research into the housing experiences of Gypsy and Traveller communities in England and Wales. There was a wide variation in the living situations of the participants, with some in permanent homes and some continuing to live nomadic lifestyles. These participants described nomadic living as increasingly difficult due to a lack of authorised stopping places, police moving people on, and a fear of prosecution. Respondents living on Gypsy and Traveller sites managed by a local authority named several issues concerning rubbish, infestations, location, insufficient facilities, damp and lack of heating. They said they wanted sites to be provided with the same facilities other communities have and highlighted the frustration of having to rely on wardens or managers to be able to access water and electricity. Participants on these sites named a number of ways traditional aspects of Gypsy and Traveller lives were not accommodated, such as not allowing fires or keeping horses or other animals. Participants who had moved onto private sites had mixed responses on relationships with settled communities, some saying they were good and increased their sense of belonging while others described strained relationships, discrimination and feeling the need to hide their background due to fear of prejudice. (472)

The Roma Rough Sleeping Team (Box 33) is run by St Mungo's and funded by the GLA and the Department for Levelling Up, Housing and Communities (DLUHC). It works with various partners with the ambition that noone from the Roma community has to sleep rough in London.

Box 33. Roma Rough Sleeping Team (473)

The initiative was run as a pilot in 2021–22 and made into a regular service in 2022. The team works to ensure that the needs of people from the Roma community are understood, and that they and other partners are providing a culturally competent service and share learning and best practice. There is an immigration adviser and a Roma employment coach attached to the rough sleeping service. (473)

A learning document from the initial pilot programme highlighted some of the key issues that Roma people face that homeless workers should be aware of, along with the training and support the Roma Rough Sleeping Team can offer other homelessness workers in providing this service. This includes emphasising the importance of mediators who are from the Roma community, having individuals who can speak Romany and understanding stigma around mental health. (474)

An April 2023 evaluation of the pilot's approaches, commissioned by the Westminster Homeless Partnership, included interviews with 18 Roma people experiencing rough sleeping. It found that the new approaches adopted under the pilot had been successful in increasing access to services in a non-discriminatory way. The principal recommendation was that the team are funded to continue and expand into other parts of London. (475)

The service worked with 279 people during the pilot, and another 80 between January and March of 2022. Over this 15-month period it assisted 103 people in applying for the EU Settlement Scheme. Of the 18 people interviewed in the evaluation, 14 had been supported by the Roma mediators to obtain pre-settled or settled status. Interviewees also reported having a good relationship with the Roma mediators.

The evaluation compared the services with findings from 2016. It reported huge improvements, with services far more engaged with Roma, better relationships and trust between the service users and services, and increased knowledge facilitated by the training provided. (475)

ASYLUM SEEKERS AND HOUSING IN LONDON

The Government's 'hostile environment' policies are restricting a significant part of society from accessing housing in the UK; this includes the intended targets of those with insecure immigration status. The policies also indirectly affect migrants who have permission to rent, and UK-born ethnic minority groups who are increasingly treated with suspicion by housing providers who are required to assess the immigration status of those looking for housing.

Private renting is the primary housing option for recent migrants, in part due to the widespread No Recourse to Public Funds condition attached to a variety of migration statuses. This condition means they cannot access state benefits and services, including social housing. Additionally, Right to Rent legislation enacted in 2016 made it a criminal offence for private landlords to rent to tenants who cannot prove they have Leave to Remain in the UK, (476) and can lead to five years in prison and fines of up to £5,000 per lodger and £10,000 per occupant for renting to those with insecure immigration status. (477) (478)

The rationale behind Right to Rent is to encourage those "residing illegally in the UK" to leave the country by "making it more difficult to establish a settled lifestyle through stable housing". (479) However, research suggests that this approach does not encourage people to leave but rather forces them into more dangerous living conditions. (480) Additionally this policy impacts on all migrants, including those with Leave to Remain status, who may end up renting from landlords at the margins of the housing market who do not carry out immigration checks,. (477) (481) The policy allows landlords to evict tenants without due legal process, nurturing a culture of precarity that results in tenants having to accept inadequate living conditions. (482) (483) (477)

People with insecure migration status are not the only ones impacted by Right to Rent and there is mounting evidence of the discriminatory consequences; the exploitation of fear extends to those who do have permission to rent. British immigration law and the housing entitlements associated with different visas are complex to decipher, even for experts. (484) Yet like many hostile environment policies, Right to Rent places the burden on those without expertise. A study by McKee et al. (2021) included interviewing 11 housing officials in the UK. One described instances of landlords telling documented migrants "if they talk to the council, they'll end up getting deported". (477) The officials highlighted that the complexity of Right to Rent guidelines, coupled with the severity of sanctions, encourages discrimination against ethnic minority groups more broadly. (477) The competitive nature of the private housing market enables most landlords to be selective, often choosing the cautious route of renting to someone they presume to be British, racially profiling prospective tenants and pre-screening them based on accents and names. (477) In a survey of over 100 landlords, the Joint Council for the Welfare of Immigrants (JCWI) found that 42 percent of landlords were less likely to rent to tenants without a British passport. (480) A High Court ruled in 2019 that Right to Rent was in breach of human rights and equality law but was later repealed. (485) While racism within the housing market in the UK is a deeply embedded historical issue, (486) Right to Rent is further disadvantaging people from ethnic minority groups.

The Home Office has poor temporary accommodation provision for asylum seekers. (487) (488) The Home Office does not publish data on deaths in its accommodation but deaths among those living in contingency accommodation have been reported in London and nationally. (489) The health risks associated with undermining the adequacy of housing as a tool of deterrence was exemplified by the Home Office housing asylum seekers in abandoned military barracks during the height of the COVID-19 crisis. (490) The extreme overcrowding of the dormitory-style barracks and the lack of adequate hygiene facilities led to a COVID-19 outbreak affecting nearly 400 asylum seekers, which was described by the High Court as "inevitable". The Home Office's justification for using the barracks was that more "generous" accommodation would "undermine public confidence in the asylum system". (491) (492) (493)

There are relatively high concentration of asylum seekers accommodation in London compared with other areas in the UK and the current issues with asylum policies lead to increases in rough sleeping. (494) (495)

For migrants with No Recourse to Public Funds, accessing homelessness assistance is limited or unclear. This is increasingly difficult due to huge cuts to legal aid and spikes in legal fees, which means many migrants have limited pathways out of homelessness. (433)

Box 34. Refugee Council – Private Rented Scheme in London (496)

The Refugee Council is a charity that supported 14,411 refugees in 2023/24. One of the services it offers in London is a Private Rented Scheme. This includes one-to-one sessions, help finding affordable accommodation, assistance with accessing housing benefits, support in applying for loans or grants to help with rent deposits, advice on training and employment, and ongoing support through tenancies. (496)

In 2024 the Refugee Council re-produced a report on how the London Mayor and the national government can support ending refugee homelessness and analysed data and outcomes of 115 refugees from its Private Rented Scheme from the two-year period between 1 January 2022 and 31 December 2023. Ninety-seven percent of the service users were homeless when they approached the scheme. Across the two years, the most common situation people were in when approaching the scheme was street homelessness. In 2022, one in five refugees were street homeless. This rose to two in five in 2023. Despite the specialised support, only 56 percent were able to access a private tenancy through the scheme. Only 3 percent of refugees that the Refugee Council supported who were able to access a private tenancy were able to do so with a tenancy deposit; others were limited to properties that did not require one. The report highlighted that one of the key issues for refugees seeking private rental housing was the cost of the deposit, and that refugees are unable to save sufficient funds due to an inability to work while they are waiting for an asylum claim to be assessed and because they are given just 28 days from the moment of decision to find secure housing before facing eviction from Home Office asylum support accommodation – a timeframe putting refugees at high risk of homelessness and destitution.

The report made two key recommendations to the Mayor of London: establish a City Hall fund to cover the costs of tenancy deposits, making this a consistent approach throughout the city, and look at how tenancy support can be provided to refugees through pre-tenancy training on their responsibilities as tenants, access to information and support on their rights, and closer work with local authorities. (497)

PLACES, HEALTH AND ETHNIC INEQUALITIES

Healthy and sustainable places need to be socially cohesive and feature safe and accessible urban and green spaces with access to affordable transport, clean air, opportunities for active travel and services and employment to support good mental and physical health. There are clear differences in access to these features by ethnicity as well as socioeconomic position. (11)

COMMUNITIES

In the English Housing Survey 2019–20, 'Wellbeing and Neighbourhoods', respondents from ethnic minority groups had less positive perceptions of their area than those from White backgrounds, with 81 percent of respondents from Black, Pakistani or Bangladeshi backgrounds satisfied with their area, compared with 87 percent of White people. Black respondents were the least likely to say that most people in their neighbourhood could be trusted, at 30 percent, compared with 42 percent of those from an Indian background, 45 percent from Pakistani/Bangladeshi backgrounds and 61 percent from White backgrounds . (498) The survey does not distinguish how much of these differences are down to experiences of racism and/or experience of poverty and deprivation, and

as in much of the inequalities in ethnicity which we show, these distinctions are difficult to establish.

In 2022 the Home Office commissioned Ipsos UK to conduct public polling on community safety. Ipsos surveyed a nationally representative sample of adults over 16 in England and Wales. When asked whether they felt safe in the area where they live, respondents from ethnic minority groups were less likely to agree that they did, 63 percent, compared with 80 percent of White respondents, as were those living in the most deprived areas, 62 percent, compared with 89 percent in the least deprived areas. Rates of those selecting 'crime and anti-social behaviour' in the area where they live as a concern were higher in respondents from ethnic minority groups (52 percent) than White (46 percent). These issues were also significantly more likely to be a concern for those in London (62 percent) and those from the most deprived areas (58 percent) than in other parts of the country and less deprived areas. However, the level of concern reported did not always correlate to actual local crime levels. (499)

In a 2015 survey of people from urban areas, two of which were in London, the importance of safety when choosing a place to live varied according to ethnicity. White British interviewees, Indian, Pakistani and other Black and ethnic minority groups rated safety as the most important quality out of eight choices. Bangladeshi, Black African and African-Caribbean respondents rated it second most important, first being the design and construction of housing. (500)

While it is impossible to infer from this data whether ethnic inequalities in feelings about an area and its safety and about the people that live in their neighbourhood relate to experiences of racism, a qualitative study in the UK from 1999 interviewed people who had experienced racist victimisation in and around the home and found that parents whose children had suffered racist attacks had less freedom to move about the neighbourhood on their own. Reports from participants in the study said that in some cases both adults and children used space outside the home less due to their own fear of further incidents, whilst others reported not letting their children go out to play due to fears for safety. Overall, respondents suggested racist victimisation resulted in denial of movement, loss of relationships and prevented children enjoying space outside their home. (201)

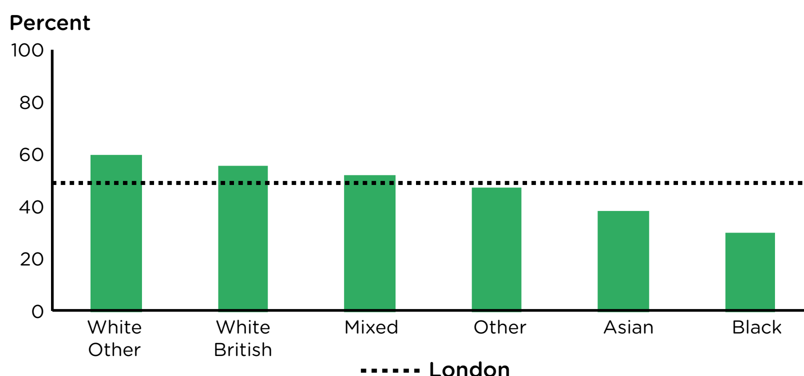
ACCESS TO GREEN SPACE AND NATURAL ENVIRONMENTS

Access to safe local green space and being in regular contact with nature has benefits to health and improves wellbeing, reducing stress, fatigue, anxiety and depression. Green spaces are also effective in mitigating the negative effects of noise and air pollution, excessive heat and flooding. Green urban spaces can also increase healthy life expectancy and life expectancy. (501) Analysis has found that if everyone in the UK had good access to quality green space, £2.1 billion could be saved in health costs every year. (502) There are inequalities in access to green space in London related to socioeconomic position and ethnicity, as well as to other dimensions including disability, and while London's population has grown rapidly in the last decade, spending on green space has decreased by over 30 percent. (503)

In England, people from ethnic minority groups are more than twice as likely as White people to live in areas deprived of green space. (504) Almost 40 percent of people from ethnic minority groups live in locations disconnected from green space. Although there are significant evidence gaps in the exploration of difference in use and perceptions of urban green space by ethnicity, research has found that people from ethnic minority groups access natural environments less frequently than others do. Reasons for this can be attributed to poor quality and low maintenance of available green space, as well as safety concerns such as racist attacks or feelings of exclusion due to use by a dominant and different cultural group. (505)

The Survey of Londoners for 2021/22 shows clear inequalities in the frequency of visiting a park by ethnicity (Figure 4.44). White Londoners were more than twice as likely as Black respondents to have visited a park at least once a week in the previous 12 months; only one-third of Black respondents said that they had.

Figure 4.44. Percent of Londoners aged 16 and over who had visited a park at least once a week in the 12 months prior to being surveyed, by ethnic group, London, July to September 2023



Source: *Survey of Londoners 2021–22 (57)*

Despite ethnic inequalities in visiting green spaces, the relative importance attributed to accessing green space as part of having a good living environment reported in a 2015 Commission for Architecture and the Built Environment (CABE) survey was similar across all ethnic groups. Public health and other organisations which aim to support greater use of green spaces must include considerations of different ethnic groups reason for not visiting parks and provide ways to overcome those barriers and support greater use. (500) The Mountford Growing Community, Box 35, is a small resident-led community organisation in Hackney that aims to strengthen community cohesion and health, encourage civic participation and reduce isolation through activities including the creation of an edible garden.

Box 35. Mountford Growing Community (506)

The organisation engages young people in the area, providing free after school activities and encouraging their participation in civic life. While it is not specifically targeted at ethnic minority groups, the local community it serves is diverse and the founder reports it serving a positive role in bringing residents from different ethnic backgrounds together.

The Mountford Growing Community was awarded £31,861 from the 2021 Grow Back Greener fund to create five new green spaces across the Mountford Estate in Dalston. The project is delivered by local horticultural professionals from ethnic minority backgrounds, bringing together older and younger residents. It supports people from ethnic minority groups in several ways which include: firstly, providing residents with free activities right on their doorsteps, removing barriers of time (in travel) and money that might otherwise prevent participation, and secondly improving access to green space in an area that was evidently lacking provision for participation with green space, providing residents with the possibility to grow food particular to their own culinary cultures and thirdly, fostering community cohesion and participation by enabling different ethnic minority groups to work on the project together. It is too soon to make conclusions regarding the effectiveness of the project as it is ongoing.

Flock Together is a community organisation set up in London 2020 to encourage birdwatching among people from ethnic minority backgrounds, Box 36.

Box 36. Flock Together (507)

Flock Together organises monthly birdwatching walks, originally within London green spaces, and now expanded into neighbouring counties. It is a movement to encourage community building, the benefits of nature, environmental protection, mental health support and creative mentorship.

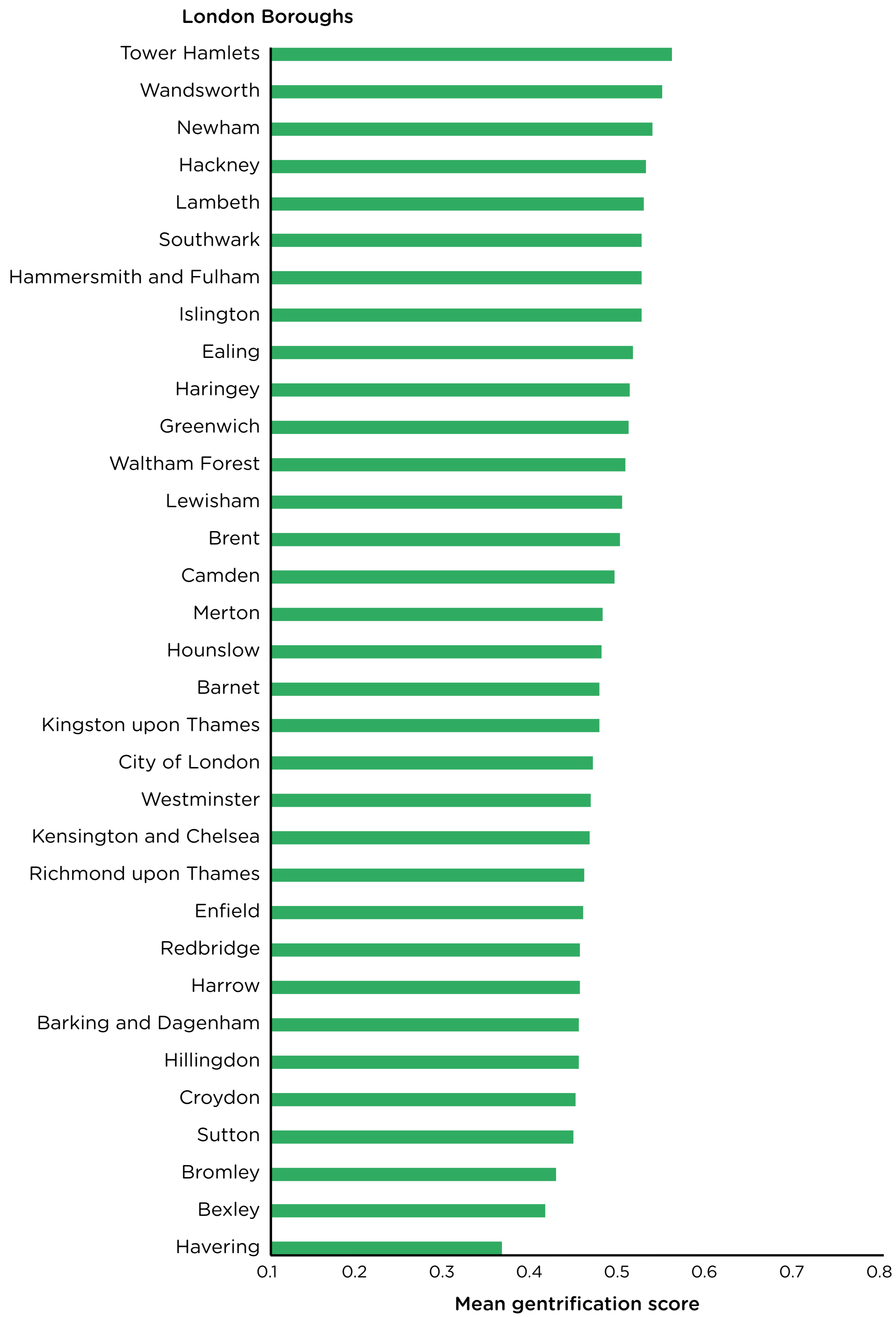
There is no evaluation of the effectiveness of this work. However, it has grown rapidly since its conception and its popularity online shows success in getting people from ethnic minority groups to engage with nature and build community.

EXCLUSION AND SEGREGATION IN PLANNING AND BUILT ENVIRONMENTS

Gentrification is the process in which a deprived area experiences an increase of wealthier people, new home building and the arrival of new businesses, increasing house prices and displacing the current residents of the area in the process. Gentrification of deprived areas is widespread in many London boroughs and many ethnic minority groups, particularly those with low incomes, are particularly affected by gentrification in London and associated changes in demographics, community cohesion, housing affordability and price of goods. Gentrification can lead to new inequalities emerging as gentrified areas attract new residents and increase prices, which can result in existing residents having to move out. (508)

In 2021, Runnymede and CLASS developed a quantitative analysis to measure gentrification across London boroughs from 2010–2016, considering population churn, relative change in the proportion of non-White residents, relative change in median house sale price and related change in Index of Multiple Deprivation (IMD) scores. They focused on three boroughs, Southwark, Waltham Forest and Brent, which all experienced different levels of gentrification. Southwark had the sixth highest level of gentrification across both inner and outer London boroughs. One neighbourhood with particularly high gentrification within Southwark experienced a net loss of 45 percent of all people from ethnic minority groups between 2010 and 2016, with residents from ethnic minority groups declining from 27.5 percent of the neighbourhood to 15 percent. In Waltham Forest, between 2010 and 2016, 60 percent of residents left gentrifying neighbourhoods; the proportion of residents from ethnic minority groups fell by 13 percent in those areas and the average house price increased from £165,000 to £445,000. Notably, neighbourhoods located within 'Opportunity Areas' – locations identified in the Mayor's London Plan as having potential for new jobs, homes, and infrastructure – were significantly more likely to be gentrified and had higher rates of displacement. (509)

Figure 4.45. Mean gentrification score, London boroughs, 2010–16



Source: *Runnymede Trust (509)*

Note: *The 'gentrification index' comprises a weighted measure, for each LSOA in London, of population churn and relative changes in the proportion of non-White residents, median house sale price and the index of multiple deprivation (IMD) score. While in theory the index is between zero and one, all LSOAs in London lie in the range 0.1 and 0.8.*

In focus groups in Waltham Forest, many participants discussed their concerns about the pace of housing and population growth in the borough. They spoke of Waltham Forest being 'noisier and busier', and that growth was undermining a sense of community and belonging, with longstanding residents often living in areas of high deprivation and new residents in more affluent areas. The differences left them feeling depressed and divided. Many residents from ethnic minority groups felt particularly excluded by the changes. (510)

Redevelopment of areas needs to take account of existing residents' needs and views and to adapt to suit these. It is essential to differentiate between the needs of different ethnic communities who may have specific requirements such as proximity to each other, faith organisations and certain businesses. Latin Elephant is an approach being used in Elephant and Castle to try to ensure that ethnic minority groups and businesses can benefit from gentrification (Box 37).

Box 37. Latin Elephant (511)

Latin Elephant is a charity that supports the Latin American community and business owners in the south London district of Elephant and Castle. Its work has primarily focused on supporting this community so it is not displaced by regeneration in the local area. This includes advocating for the community in local planning decisions for support in relocating displaced businesses. It has co-produced research on the business strength of local ethnic minority and migrant transactions, and offered individual businesses such as local traders support in the form of training and mentoring.

Following the demolition of the shopping centre and the charity's involvement in the process of regeneration, Latin Elephant released a report on how these processes exclude ethnic minority and economically disadvantaged groups and what can be done to achieve social and spatial justice around gentrification in London. It reports positive outcomes in the form of an increased relocation fund from developers and the local council for existing traders. It also identifies numerous challenges and barriers in community engagement, from working in partnership with different groups. (512)

Box 38. Southwark Stands Together and Peckham Library Square (513)

Southwark Stands Together started in June 2020 in response to the Black Lives Matter movement, led by the local authority. It identified eight key themes, the first of which is 'renewing and reinventing our open spaces', following backlash against the council's procurement framework for architecture and design not reflecting the diversity of the borough. (514) It focuses on reviewing its naming, public art and built environment policies to make them reflective of the community and to ensure they contribute to the vision for diverse and inclusive open spaces and buildings. It used Peckham Library Square as a pilot for this work, engaging in community consultation throughout all stages of the design process. A panel of residents chose Spheron Architects, an emerging ethnic minority-led practice. It has continued to work with the local community to understand their need from the public space and is attempting to meet this need.

AIR POLLUTION

Air pollution damages health and exposure to it is unequal. On average, air pollution levels (Nitrogen Dioxide and fine particulate matter or PM2.5) are worse in areas of high deprivation. (515) Health harm related to air pollution includes respiratory disease, cardiovascular disease and dementia. (516) The burden of disease attributable to air pollution is the fourth leading cause of preventable morbidity and mortality globally, as reported by the Institute for Health Metrics and Evaluation (IHME). (516) The IHME further suggests that 40 percent of chronic obstructive pulmonary disease is attributable to air pollution and that in 2019, 192 million years of life worldwide were lost due to it. London has the highest rate of deaths in the country attributable to particulate air pollution. (517) On average across London, air pollution is reported as contributing to 7 percent of overall mortality, compared with 5.5 percent in England as a whole, and air pollution is a significant contributor to inequality in health and life expectancy. (518)

The London Mayor introduced the Ultra Low Emission Zone in 2019 to Central London, it was expanded to include all areas within the North and South Circular Roads in 2021, and in August 2023 to cover all London boroughs. (519) A 2024 report from the GLA shows air pollution concentrations have reduced across the city since 2016, largely driven by the introduction and expansion of a range of policies to improve air quality. The research shows that roadside levels of NO2 fell between 2016 and 2023, despite an increase in London's population. (520) NO2 concentrations fell by 65 percent

in central London, 53 percent in inner London and 45 percent in outer London. (521) An assessment of air pollution in London in 2019 found that recent policies to improve air pollution have also reduced inequality in exposure between different socioeconomic groups and the gap in exposure to NO2 between the most and least deprived areas has narrowed by up to 43 percent. Despite the improvements NO2 levels in areas where the most deprived Londoners are more likely to live were 17 percent higher than the least deprived areas and PM2.5 concentrations were 7 percent higher. The areas in London with the highest NO2 and PM2.5 concentrations have a disproportionately large ethnic minority populations. (522)

PUBLIC TRANSPORT AND ACTIVE TRAVEL

London's public transport system plays a role in influencing health as it enables individuals to be connected with the employment opportunities, everyday activities, resources and services necessary to lead a healthy and satisfying life. Access to public transport is often not equal and increasing costs, fears around safety and negative experiences reduce use. A 2019 TfL report focusing on travel in London among equality groups assessing London residents' uses of and views about public transport, showed that Black, Asian and other residents from ethnic minority groups were more likely to say that cost, service disruptions and slow journey times were barriers to increased use than White residents. (523) They were also more likely to be worried about their personal safety on public transport in London than White residents. (523). Prices for travel on Transport for London were increased by 5 percent in 2022 and 5.9 percent in 2023. (524) From March 2024, TfL fares have been frozen until 2025. (525) All day off-peak pay-as-you-go fares on a Friday were trialled on tube and rail services across London between 8 March to 31 May 2024. (526)

Active travel, including walking and cycling, promotes healthy behaviours both directly and indirectly. As well as improved physical activity, which lowers the risk of obesity and certain diseases, the benefits extend to cleaner air, lower greenhouse gas emissions, reduced noise pollution, better mental health and fewer road traffic injuries. (527) Attitudes towards active travel have changed among ethnic minority groups since 2011. Active travel, especially cycling, used to be much higher among White Londoners, but data for 2020–2021 shows that people from ethnic minority groups were just as likely to cycle as their White counterparts. Nevertheless, safety concerns as a reason for not cycling are present irrespective of ethnic background, with 82 percent of non-cyclists apprehensive about road safety and collisions. (528)

Box 39. Older Person's Freedom Pass (529)

The Older Person's Freedom Pass is a concessionary travel scheme that permits free travel across London and free local bus journeys nationally for adults who are eligible for state pensions, coordinated by London Councils. (530) The age of eligibility has increased with the pension age and as of 2024 is aged 66 and over. (529) A 2018 study, (531) focusing on bus travel, found that uptake increased quickly following implementation, from around 60 percent in 2006 to 75 percent in 2009; uptake remained at 75 percent in the most recently available data, collected in 2015.

The Older Person's Freedom Pass is aimed at every older London resident, but the study found that 84 percent of Black participants held the pass, compared with 74 percent of South Asian and 75 percent of White participants. Having the pass increases the odds of taking the bus as part of active travel in all ethnic groups, although this is greater among ethnic minority groups. (531)

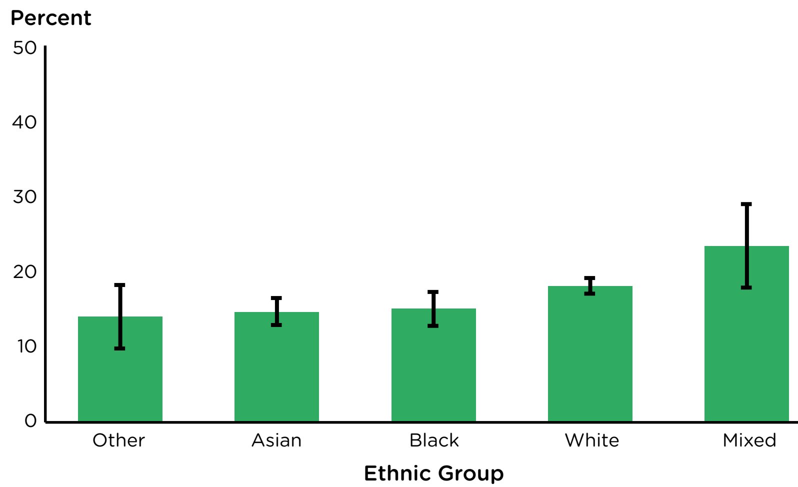
CRIME AND EXPERIENCE OF THE CRIMINAL JUSTICE SYSTEM

Crime rates are higher in more disadvantaged areas of London and people from ethnic minority groups are more likely than others to be victims of crime. Living in an unsafe, or perceived to be unsafe, neighbourhood or community can also cause chronic stress that leads to poor mental health, and again fear of crime is more prevalent among ethnic minority and more disadvantaged groups. (532) Institutions involved in criminal justice have enabled, and not tackled, widespread racism which leads to unfair arrest, violence, incarceration and treatment all of which directly damage physical and mental health and also harm education, employment, income and family and community relationships – all key determinants of health. The effects of racism from criminal justice institutions undermines trust in systems and authority including and extending beyond the criminal justice system, and this also damages health. (533)

VICTIMS OF CRIME

Figure 4.46 shows that among all age groups, those from Mixed/multiple ethnic groups are the most likely to be victims of crime.

Figure 4.46. Percent of people aged 16 and over who said they were victims of crime*, by ethnic group, City of London and Metropolitan police, April 2017 to March 2020

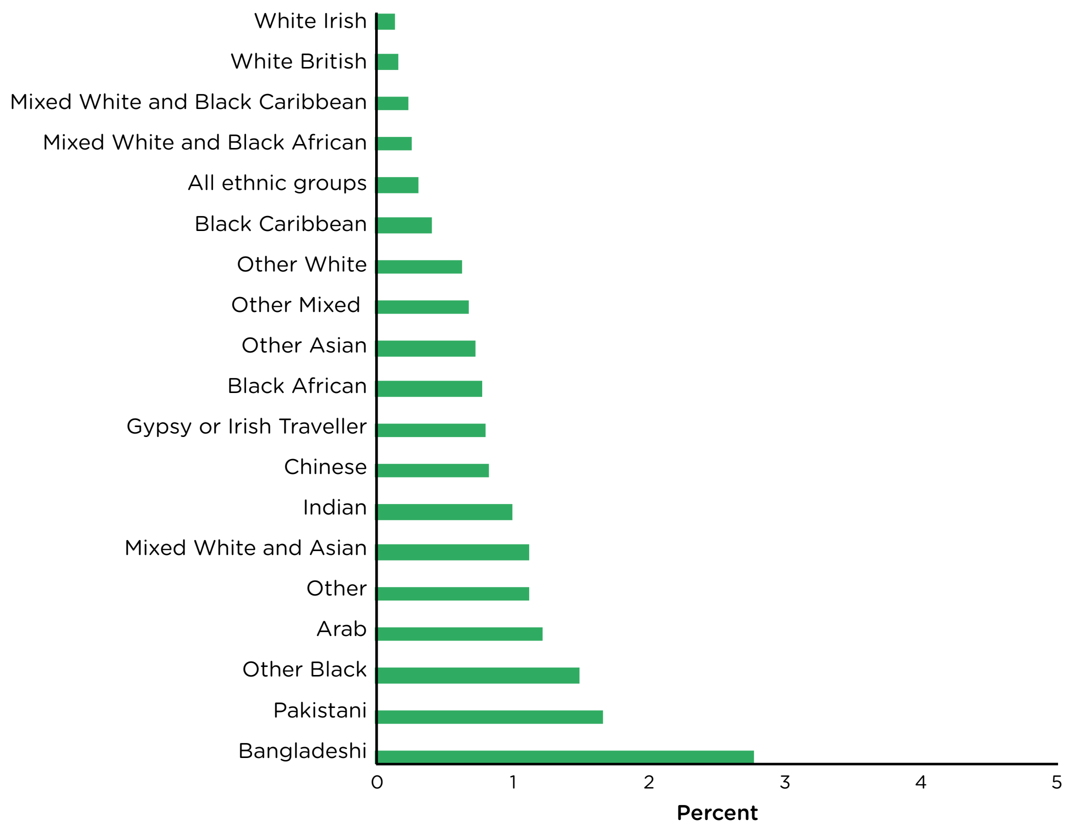


Source: *ONS (534)*
Note: **All Crime Survey for England and Wales (CSEW) crime (excluding fraud and computer misuse)*

Since January 2020, a Black person in London has been 70 percent more likely than a White person to be recorded as a victim of violence against the person; twice as likely to have been recorded as a victim of rape and 66 percent more likely to have been recorded as a victim of domestic abuse. In March 2023, the data shows that Black people in London are nearly six times more likely to be murdered. (535) Clearly there is a case for Black people to have significantly more protection from police.

There are clear ethnic inequalities in the likelihood of becoming a victim of a hate crime in England and Wales. Over the period April 2015 to March 2018, Bangladeshi and Pakistani people were the most affected by hate crime in England and Wales, and White people were 10 times less likely to be a victim of a hate crime. (536)

Figure 4.47. Percent of people aged 16 and over who were victims of a hate crime, by ethnic group, England and Wales, April 2015 to March 2018



Source: *ONS (536)*

POLICING

Black and Mixed ethnicity London residents have lower levels of trust and confidence in the Metropolitan Police than White residents, with rates falling for both groups. The experience of many Black people in London is of racism, underprotection and overpolicing. Studies have found that an increase in daily prejudiced interactions, together with proactive and often aggressive policing, negatively affect self-rated health, depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, hypertension, asthma and obesity. (537) (538) These negative health outcomes particularly impact young people from ethnic minority groups, via heightened stress, trauma and anxiety. Indirect experiences of violence or police encounters and witnessing police violence can also severely affect mental health outcomes, leading to increased risk for cardiovascular conditions and emotional distress. (539) (540)

In 2017, the Lammy Review set out the unequal treatment of and outcomes for people from ethnic minority groups at each stage of the criminal justice system. Although the data from the review is now outdated, its findings are still highly relevant. (541) (542) In 2022, the Police Race Action Plan was published, developed by the College of Policing and the National Police Chiefs' Council. (543) The Plan sets out the changes needed for the police to become an antiracist service, addressing the low levels of trust and confidence among Black people. Still, racial bias and discrimination persist in the criminal justice system. (543)

The 2023 Casey Review of policing in London showed that policing exacerbates ethnic inequality and is systemically, institutionally and individually racist. (535) The report shows a continued failure to properly recognise and address institutional racism within the Metropolitan Police, despite this problem having been acknowledged following the Macpherson Report in 1999 and the Lammy Review in 2017. Immediate action to address these ongoing failings is crucial. (535)

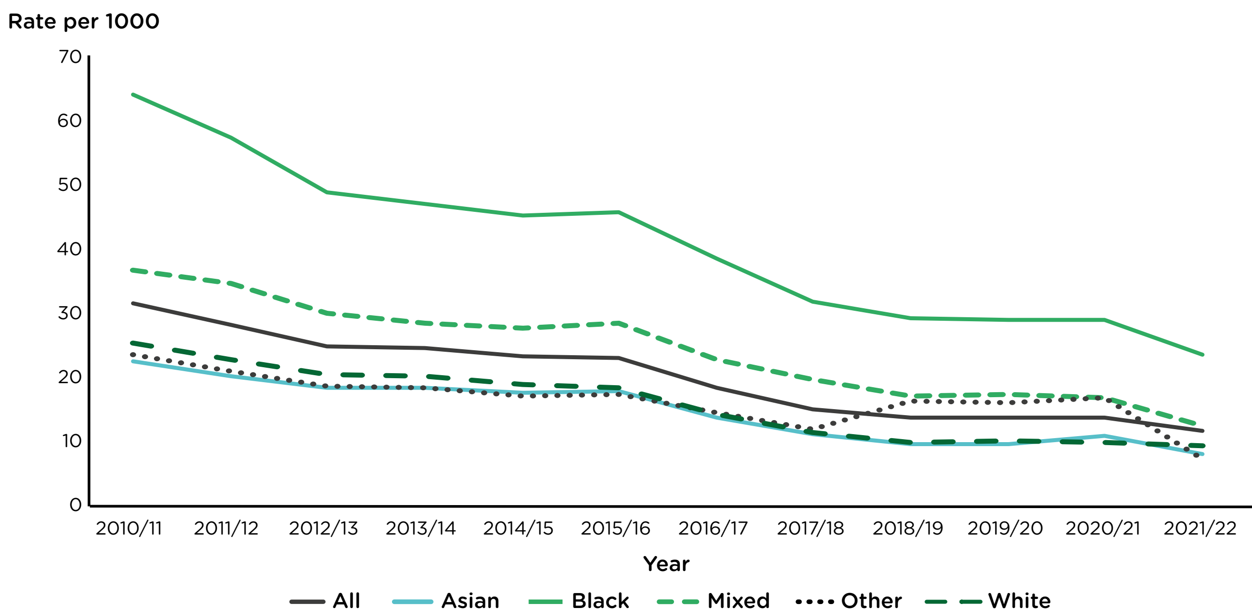
The Casey Review also highlights racism against police officers from ethnic minority groups. Representation of Black, Asian, and police officers from ethnic minority groups is disproportionately low compared with the diversity of London. These proportions are even lower at higher ranks, showing significant issues with progression for police officers from ethnic minority groups. This is reflective of racism and systemic bias within the police force, with 46 percent of Black officers and 33 percent of Asian officers saying they have faced racism at work. They are also disproportionately more likely to face misconduct proceedings.

A 2022 report from the Independent Office for Police Conduct has found that stop-and-search is disproportionately used against Black, Asian and other Londoners from other ethnic minority groups, in particular young Black men. (544) There is also a disproportionate use of force against people who are Black and of Mixed ethnicity in interactions with the police. Victims from Black and other ethnic minority groups are also more likely to complain about their treatment by the police. (535)

The Race Disparities Unit commissioned a systematic rapid evidence review of a limited range of published government and academic studies of crime and ethnic disparities. One of the conclusions of the review was that the relative overrepresentation of people from ethnic minority groups in arrest, prosecution and conviction statistics, particularly drug offences, cannot be separated from police targeting areas with high proportions of ethnic minority groups. The review states that it is reasonable to conclude that the interrelationship between policing and recorded offending exaggerates the extent to which the ethnic categories are then disproportionately understood to be involved in crime more generally. (545)

Arrests by the Metropolitan Police decreased between 2010/11 and 2021/22, although this is not necessarily related to actual crime rates. Rates of arrest of Black people remain higher than for other ethnicities and over two times higher than the rate for White people (Figure 4.48). It is currently difficult to understand how much the overrepresentation of Black people in arrest figures is down to targetting areas with higher numbers of people from ethnic minority groups. (546)

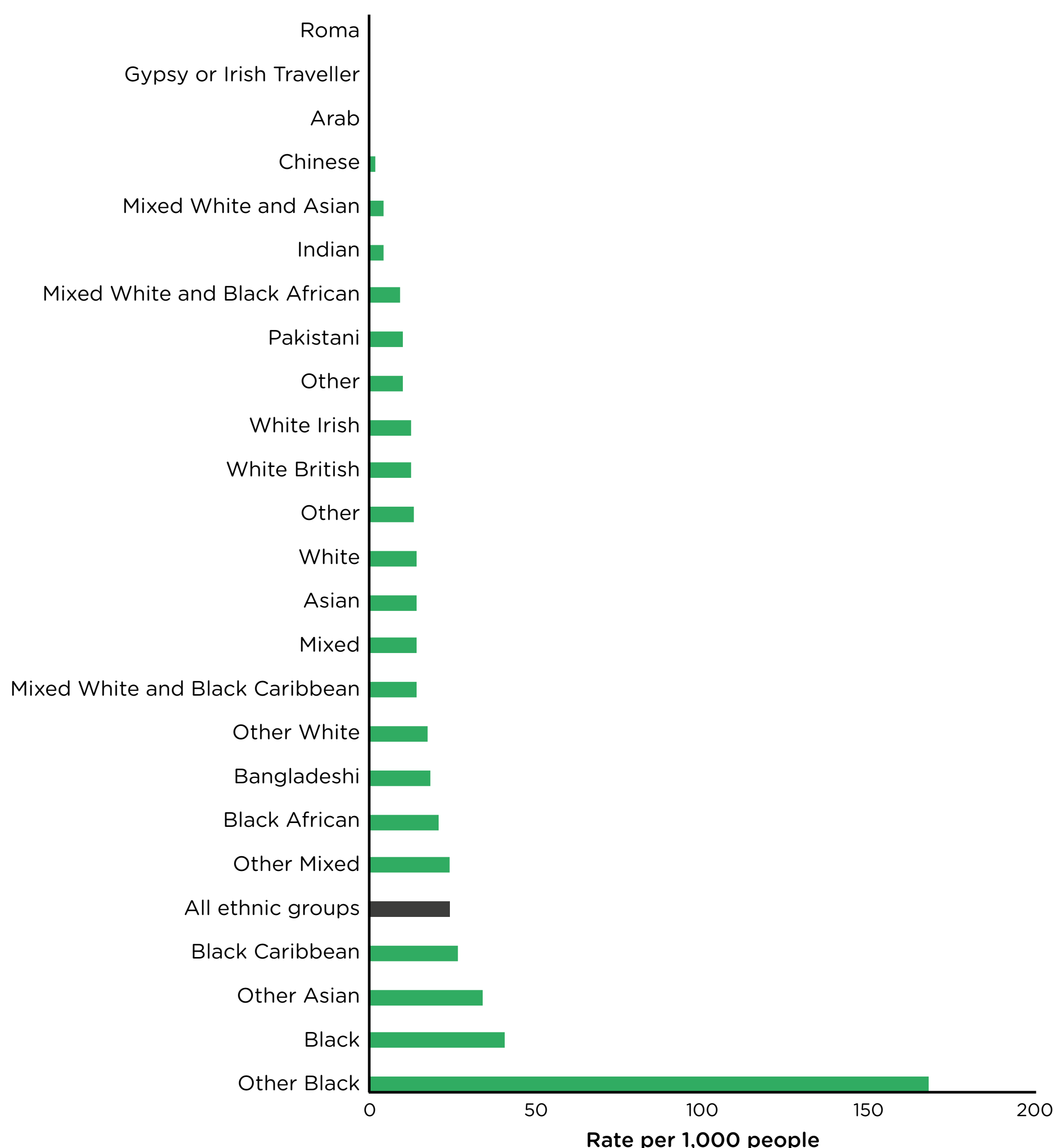
Figure 4.48. Arrest rate per 1,000 people by ethnic group and financial year, Metropolitan Police force area, 2010/11 to 2021/22



Source: *Home Office (547)*

Of the almost 700,000 incidences of stop-and-search carried out by police in England and Wales in 2020/21, almost half (45 percent) of these took place in the Metropolitan Police Service area. Figure 4.49 shows the stop and search rates by the Metropolitan police by ethnicity. In 2021, there were 168 incidents for every 1,000 Other Black people compared with 13 for White British and even lower rates among some other ethnicities. (548)

Figure 4.49. Rate of stop-and-search per 1,000 people by ethnic group, Metropolitan Police force area, April 2021 to March 2022



Source: *Home Office (548)*

Note: *Figures for stop and search are based on police recording of ethnicity and this differs from 2021 Census self-identification in several respects. In particular, 27 percent of stop and search had no ethnicity recorded. Furthermore, the' Other Black' group includes people who did not identify as Black African or Black Caribbean or were not recorded as such by the police – this differs considerably from 2021 Census recording of this category. Similar issues relate to 'Other Asian' and 'Other mixed' categories.*

In the three years from April 2017 to March 2020, a lower percentage of Black Caribbean people in England and Wales had confidence in their local police force than White British people. Further, Asian (77 percent) and White people (74 percent), as well as 'Other' ethnic groups (75 percent) were more likely to trust their local police in 2020 compared with Black individuals (64 percent). (549)

Decisions on whether to charge someone with an offence, following an arrest, often fall to the police. A 2023 inspection from His Majesty's Inspectorate of Constabulary and Fire & Rescue Services found that there while there are differences by ethnicity in the outcomes of police decisions it is difficult to get a full picture of charging decisions, due to a significant lack of data or analysis. Whilst caution data is published, there is no published data on community resolution, police charging decisions and decisions to bail or not after charge available for all police forces. It also highlighted that where data is available it is not easily accessible, unlike similar data on stop and search statistics by ethnicity. The report recommended that there should be more information gathered and published for these measures, and that the data gathered should include ethnicity information and be analysed for race disparity. (550)

In 2020, in response to concerns about the disproportionate and unfair use of police powers towards ethnic minority groups, the Action Plan for Transparency, Trust and Accountability was produced by City Hall (Box 40). A cross-

City Hall initiative launched by the Mayor and involving the Mayor's Office for Policing and Crime (MOPAC), the Greater London Authority (GLA) and London's Violence Reduction Unit (VRU), working together with the Metropolitan Police Service (MPS) and organisations representing London's Black communities. More than 400 individuals and organisations participated in the development of the Action Plan. This includes representatives of more than 100 civil society organisations – 45 of which are Black-led - working with and within Black communities on a variety of areas, including youth work, work with older people, criminal justice and human rights and education. The Action Plan was superseded in 2023 by the New Met for London Plan, which has been developed based on priorities identified by partners and the police. (551) It is a broader plan for change than the Action Plan and while not focused on ethnic minority groups, has principles of anti-discrimination embedded, Box 40.

Box 40. Mayor of London: Action Plan for Transparency, Trust and Accountability in Policing 2020 and the New Met for London Plan (552) (551)

The Action Plan responds to concerns set out by Black Londoners, Black-led community organisations and those representing the views of Black Londoners about the lower level of Black representation in the police service, disproportionality in police powers affecting Black Londoners and a perceived lack of transparency and accountability around the way these powers are used. The action plan is focused on four themes: (552) These are: better use of police powers, working together to make Black communities safer, a police service that better represents and understands Black communities, and holding police accountable for their actions. The strategic outcomes are to improve ethnic minority groups' perceptions of the police, challenging inequalities in the use of police tactics, having a more representative workforce, and improving accountability of the police. The plan is extensive and includes 43 commitments that the MPS and MOPAC agreed to deliver to ensure the policing of Black communities is fair and proportionate.

Overall, the action plan is intended to respond to the concerns set out by both Black Londoners and equity-led organisations advocating for the views of Black Londoners. It also focuses on ensuring the needs of Black women victims of crime are met. Additionally, as a result of the findings of the Action Plan consultation, London's Independent Victims' Commissioner launched a new consultation with Black women and the End Violence Against Women (EVAW) coalition to understand their specific needs and experiences. Out of this, any recommendations directed at the wider criminal justice organisations in London were pursued.

The New Met for London (NMFL) plan responds to the Casey Review and sets out the Met's plan to deal with the recommendations in that review including commitment to becoming an anti-discrimination police service, using the definition from the Macpherson report: 'elimination of racist prejudice and disadvantage and the demonstration of fairness in all aspects of policing'. (553)

The first priority is community crime-fighting and outlines how the Met plan to put communities first including by putting more resources into local policing, working with the public and communities to understand Londoners' crime concerns and working more closely with community partners such as local authorities and community leaders. This priority includes:

- Tackling crime which disproportionately affects some communities
- Reducing disproportionality in levels of trust
- Working with communities who have experienced discrimination from the Met in the past
- Using data and evidence to ensure interventions are more precise and less disproportionate
- Reforming the way the Met delivers for women and children

Their second priority is a culture change. This outlines how the Met will embed the values of policing by consent across the Met. The plan highlights the need for the Met to tackle racism, misogyny and homophobia, as identified by the Casey Review. Some of the commitments focused on anti-discrimination include:

- Targeted action and reform to ensure individuals who discriminate are rooted out
- Reviewing stop and search and force, and creating race action plans
- Reforming the Met culture to be an inclusive, diverse and supportive workplace
- Reforming armed policing

Their third priority is fixing the foundations. This focuses on ensuring the Met is a well-run organisation that properly equips staff to succeed and police effectively and includes redesigning the corporate governance structure to drive greater accountability and better decision-making, with more external scrutiny. Within this priority commitments to become anti-discriminatory include:

- Encouraging leadership to drive culture change
- Giving officers what they need to take a precise and proportionate approach to policing and use of force

As well as larger and systems-level changes such as the New Met for London Plan, London boroughs have attempted to address distrust around policing and ethnic minority groups through local actions; Box 41 provides an example.

Box 41. City of Westminster: Metropolitan Police Service (MPS) Mentoring Scheme (554)

Following conversations between Westminster's minoritised staff network, the council and the MPS, the City of Westminster developed a six-month pilot mentoring scheme in September 2020. The partnership paired senior Westminster Metropolitan Police officers with minoritised staff from the council to share their experiences of community policing. The programme is a small-scale intervention that initiates discussions on discrimination, biases and policing attitudes towards individuals from minoritised ethnic groups.

The mentoring scheme aimed to tackle structural racism within policing in the city, and address racial trauma for minoritised staff. Further, open dialogue between the Metropolitan Police and the sharing of experiences from the staff enabled the development of greater understanding of specific cultural distinctions.

Impact assessments are not available, but the programme has created a sense of urgency and agency in both organisations, and the programme helped create a culture change and a shift of perspective. The City of Westminster have also adapted the programme based on feedback. Police officers are now paired with members of the community, as community members highlighted that there was a lack of trust in both the Council and the Metropolitan Police. The programme uses a restorative lens, based on developing understanding between the pairs on how harm was caused and how relationships can be restored.

Lewisham Youth Justice Service is aiming to strengthen its approach to youth justice by ensuring cultural competency and including trauma-informed services (Box 42).

Box 42. Lewisham Youth Justice Service (555)

The Lewisham Youth Justice Service (LYJS) has implemented a trauma informed, antiracist and restorative (TI-AR-RA) approach. The LYJS has worked with partners to devise an antiracist action plan that aims to challenge and change systemically racist practices. The service has developed and adopted an evidence-based model, applying theories of childhood trauma, restorative approaches and unconscious bias. This model has contributed to significant reductions in children and young people entering the youth justice system, lower reoffending rates and reduced numbers of incidents of serious violence.

This approach includes working with partners across the system including police, social care, education and mental health. For example:

- advocating for children who have been subject to discrimination, including adultification
- working with schools to ensure all children's voices are heard
- promoting an immersive schools programme to help apply restorative practice and policy, to reduce school exclusions

The service's approach for 2019–2020 was evaluated through surveys of young people and their families, 81 percent of whom were from global majority backgrounds. The survey showed that the service provided was 'safe and trusting'. The report also said the approach to bias awareness and the trauma-informed service had a positive impact on the experience of the service. (555)

There are plans to roll out the training offer to support and develop a trauma-informed approach across the whole of the Lewisham Safeguarding Children's Partnership. The Lewisham Safeguarding Children's Partnership is a partnership between all agencies, organisations and services in the borough that are responsible for safeguarding and promoting the welfare of children.

THE CROWN PROSECUTION SERVICE

In 2001, following intervention from the Commission for Racial Equality and the release of the Denman Inquiry report into race discrimination in the Crown Prosecution Service (CPS), the CPS accepted that it was 'institutionally racist', within the Lawrence Inquiry definition. (556) The CPS committed to addressing the recommendations set out in the report and to improve racial equality within the CPS workforce. (556) In 2021 the CPS commissioned research on 'demographic disparities' in the outcomes of CPS charging decisions. Research from the University of Leeds found there was evidence of disproportionality in relation to ethnicity. By controlling for the effect of a range of variables on charging decisions, the researchers' statistical analysis suggested that White British suspects had the lowest charge rate out of all ethnicities, at 69.6 percent. Suspects with Mixed ethnicities of all types had the highest charge rate, with 81.3 percent for mixed White and Black Caribbean, 79.5 percent for mixed White and Black African, 78.4 percent for Mixed White and Asian. As this only showed a correlation, it does not show what was causing the differences in charging decisions, however, it is likely, from the findings of the Denman Inquiry this relates to racism within the Crown Prosecution Service and is evidence of the effect of institutional and systemic racism within the criminal justice system. The CPS has committed to undertake a programme of research into what is driving these disparities and has set up an independent Disproportionality Advisory Group. The next stage of research was scheduled to be completed in September 2023, but is now expected at the end of 2024. (557)

PROBATION SERVICES

An inspection into race equality within the probation service in 2021 looked into experiences of service users from ethnic minority groups and staff of the National Probation Service (NPS) and Community Rehabilitation Company (CRC). Service users from Black, Asian and ethnic minority groups reported experiences of racism throughout their lives and in previous encounters with the criminal justice system. A predominant theme was a lack of cultural understanding within probation services, and a reluctance to talk about experiences related to race and ethnicity. Staff members from ethnic minority groups highlighted concerns that current engagement with matters of racial equality would not be sustained. A majority of these staff said they did not feel safe raising issues of racial discrimination, as they lacked confidence it would be appropriately dealt with. This is reflected in the fact that while more grievances are raised by staff from ethnic minority groups than White staff, their grievances are far less likely to be upheld. The Review drew attention to the lack of cohesive strategy to support and service users from ethnic minority groups and highlighted the failure to show sufficient progress on previous actions set out by the probation service response to the Lammy Review. (558)

LEGAL PROFESSIONALS

A report responding to the Judicial Diversity and Inclusion Strategy (2020–25), which surveyed legal professionals and examined existing research, found evidence of institutional racism within the justice system. (559) Ninety-five percent of professional respondents said that racial bias plays some role in processes/outcomes, with 63 percent saying it plays a significant role, and 29 percent saying it plays a fundamental role. Comments from the survey include examples of discriminatory practices by judges, with 56 percent of respondents saying they had witnessed at least one judge acting in a racially biased way towards a defendant. The group that respondents most frequently named as targets of discrimination by judges were Black defendants, in particular young Black men. The report highlights that there is a dearth of research into the topic of racism in the judiciary in England and Wales. While a small survey, the responses and research suggest institutional racism exists within the judicial system and is systematically left unrecognised or denied by the judiciary. (559)

Box 43. 4 Front Project (560)

The 4 Front Project is a grassroots campaign to empower and encourage change for young people harmed by violence and the criminal justice system. (560) It works to challenge the structures in place in the system and provides support to and uplifts the voices of those who have experienced these problems. The work is additionally focused on racial justice and provides services tailored to support Black people who have experienced violence and the criminal justice system. The project has received funding from the Mayor of London, the Lottery Community Fund and the London Community Foundation, among other sources.

It provides one-to-one support, group training, mentoring and advocacy for individuals. It also campaigns on systemic issues and provides community support. There is no evaluation of its work or the outcomes it has achieved.

Shewise is a voluntary sector organisation based in working at the community level to support primarily Asian and Middle Eastern women and girls.

Box 44. Shewise (561)

SHEWISE is a women-only, community-led charity based in the London borough of Hounslow, working across various boroughs to support the educational, economic, and social development of minority ethnic women and girls. Through casework support, counselling, advice, signposting, workshops, and training, they empower women to recognise their potential and develop the skills necessary to be the primary agent of their lives.

They offer support through a holistic empowered living model, providing multilingual intervention and prevention across key areas of domestic abuse, wellbeing, skills development, enterprise support, and support for women involved with prison and the criminal justice system.

Key programs like **Domestic Abuse** support and **Reconnect and Rebuild** have uncovered significant structural inequalities and their profound effects on mental health, wellbeing, and health disparities, particularly within ethnic minority communities.

Reconnect and Rebuild goes beyond addressing a singular need and tackles the broader dimensions of resettlement for South Asian women leaving prison. The project addresses interconnected issues such as faith, ethnicity, gender, dishonour, shame, and stereotyping, which these women often face. South Asian women experience a range of cultural, practical, and structural inequalities during their time in prison and after release.

Over 80% of their clients access domestic abuse services. They work closely with Hounslow Violence Against Women and Girls (VAWG) services, running campaigns and delivering LA commissioned work conducting domestic abuse awareness workshops in schools and faith settings.

While the experience of domestic abuse in these communities' mirrors that of other women, it is often compounded by additional layers of complexity. These include dowry-related crimes, marriage abandonment, human trafficking, forced marriage, isolation, Female Genital Mutilation (FGM), and marriage under false pretences, among others.

They implement trauma-informed programs and promote gender equality, diversity, and inclusion by addressing cultural norms, social expectations, and stigmas that often hinder women's wellbeing and independence.

Their services are specifically designed to recognise the unique barriers faced by South Asian women, in recognition of a need for culturally sensitive, tailored, and adequate model of support that reflects the diverse needs of these communities.

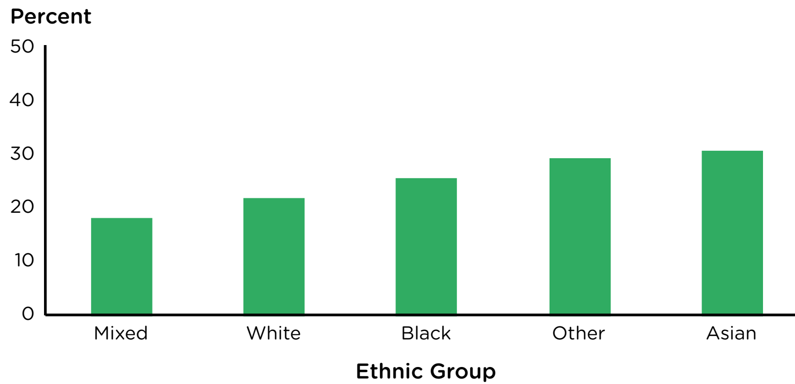
GYPSY AND TRAVELLERS AND THE CRIMINAL JUSTICE SYSTEM

Qualitative research by the ONS into the experiences of Gypsy and Travellers in England and Wales in 2022 found that participants reported negative experiences of the criminal justice system. They described a fear of the police and justice system, due to a sense of bias and perceived pre-judgement of them as criminals due to their ethnicity. They also cited experiences of police taking heavy-handed approaches in the past, including sending vans, helicopters and armed police to Traveller sites. When it came to seeking help as a victim of a crime, they said they were treated as suspects and that they would avoid engaging with the police due to fear. They viewed parts of the justice system as unfair, such as being denied bail because of living on a Gypsy and Traveller site or having no fixed address. When discussing solutions to the negative experiences with the police and justice system, the importance of having their voice heard and being involved in government, and the need for better understanding of Gypsy and Traveller culture were highlighted. (562)

FEAR OF CRIME

Fear of crime has significant effects on health – directly, through stress and anxiety, and indirectly, by preventing people from undertaking everyday activities that are beneficial to health. In London there are clear inequalities in fear of crime according to ONS data for 2013/14 to 2015/16. Nearly one-third of Asian Londoners experienced fear of crime (the highest rate), and White and Mixed-ethnicity groups had the lowest rate of fear of crime, Figure 4.50.

Figure 4.50. Percent of people aged 16 and over reporting fear of crime, by ethnic group, London, April 2013 to March 2016



Source: *ONS (563)*

The GLA State of London 2022 report shows that only 55 percent of London residents from an ethnic minority group feel that their local area is a safe place for their children to grow up in, compared with 76 percent of White British residents. (564)

RECOMMENDATIONS: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

1. While increasing supply of affordable housing enforce the Decent Homes Standards across all housing sectors and inform tenants about their housing rights by offering culturally appropriate free advice, support and advocacy services.
2. Assess housing providers, including the private rental sector, for racism and regulate the sector appropriately, enforcing sanctions.
3. Ensure that the views and concerns of ethnic minority residents are incorporated into planning including regeneration, access to green spaces and safety.
4. Implement the recommendations of the Casey and Lammy Reviews to end systemic racism in the criminal justice system.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the differing housing needs of ethnic groups through the life course.
- Conduct further research into racism within the housing sector in London.
- Expand research and evidence about racism in the criminal justice system including Gypsy and Travellers.

4F. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

In this section we build on the analysis in Section 3 that outlined ethnic inequalities in rates of smoking, and we include ethnic inequalities in overweight and obesity and use of alcohol and drugs. We see how often services that are developed to reduce unhealthy behaviours do not take ethnic differences into account and are not appropriately designed for particular ethnic groups. We then review ethnic inequalities in healthcare access, use, experience and outcomes, followed by experiences of racism towards NHS employees from other staff and the public.

SMOKING

Smoking is more prevalent among low- than high-income groups, and the differences in smoking prevalence can translate into differences in disease burdens and death rates between social groups. (565) (566) As previously indicated (Figure 3.3), smoking rates also vary by ethnic group, with White groups being the most likely to smoke currently or to have ever smoked in England. Women in each ethnic group are more likely to have never smoked but the differences vary; there are very low rates of Bangladeshi women who have ever smoked, while Bangladeshi men are among the most likely of males of all ethnicities to have ever smoked. Smoking prevention services need to consider socioeconomic position, gender and ethnicity and other drivers of smoking such as poor mental health.

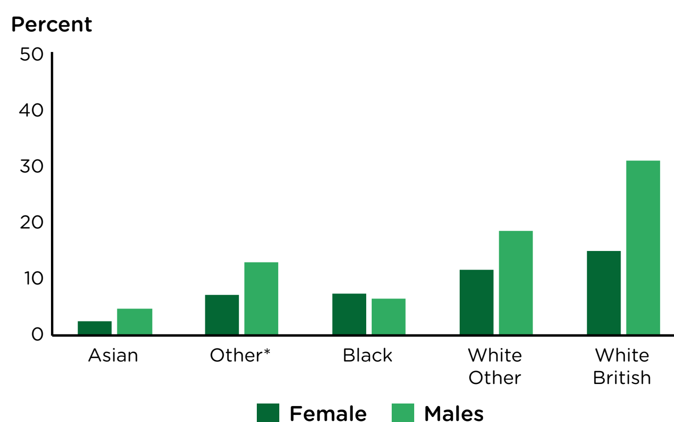
Stress and anxiety have consistently been found to be risk factors associated with smoking. (567) (568) (569) A longitudinal study with participants drawn from London schools, published in 2018, assessed whether racism had any influence on cigarette smoking. (570) The study found that smoking initiation in late adolescence was associated with cumulative exposure to racism and had a strong impact on likelihood of smoking after accounting for socioeconomic disadvantage or parental smoking. Ethnic- or gender-specific effects of racism on smoking were not evident in these analyses. Positive parent-child relationships and religious involvement buffered the impact of racism on smoking behaviour, reducing smoking initiation rates. (570) Qualitative findings suggested that protective factors from religious involvement and parenting included social support, ethnic/cultural socialisation, a shared sense of culture, educational and career aspirations, and positive coping styles. (570)

ALCOHOL

Alcohol misuse has been associated with a range of adverse health and social consequences. Some of the long-term health risks associated with alcohol misuse include high blood pressure, depression, liver disease, certain types of cancer and pancreatitis. (571) (572) As outlined in the Marmot Review (2010), there is an inverse social gradient for alcohol consumption, with consumption generally increasing with increasing level of household income; however, health harm runs the opposite way, with greater harm increasing with decreasing level of household income. (11)

Individuals from ethnic minority groups are regularly reported to have higher rates of abstention from alcohol compared with their White British counterparts. (573) (574) However, data on the rates of alcohol use or misuse are not collected by ethnicity, which makes alcohol misuse by ethnicity difficult to assess. (574) Nationally, a 2019 report found a prevalence of problematic alcohol use among Sikh men, refugees and asylum seekers, but accurate estimates of rates are unavailable. (446) Across England, NHS Digital reports large variations in hazardous, harmful or dependent drinking by ethnicity and sex, which shows that rates are highest among White British men and women. (575)

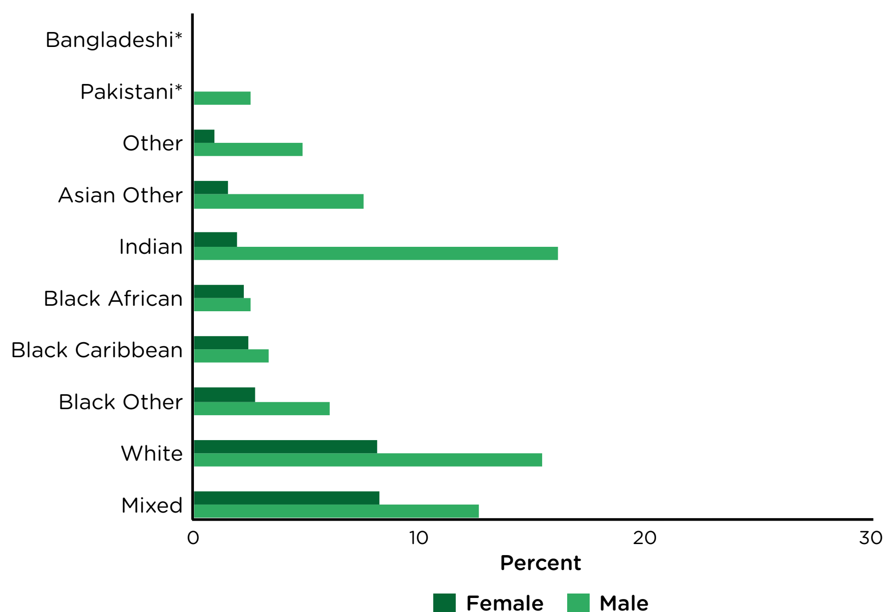
Figure 4.51. Percent of people aged 16 years and over drinking at hazardous, harmful or dependent levels, by ethnic group and sex, England, 2014



Source: *NHS Digital (576)*
Note: **Other includes mixed ethnic groups in this figure*

While data shows White British have highest rates of hazardous drinking, Figure 4.52 shows the wide gender and ethnic inequalities in mortality from alcohol by ethnic group in England and Wales in 2017–19. There were particularly high levels of alcohol-related mortality among Indian, White and Mixed ethnicity men and relatively high rates among White and Mixed ethnicity women. This indicates that while Indian males don't flag up in NHS data as having harmful drinking they have high mortality from alcohol.

Figure 4.52. Alcohol-specific age-standardised mortality rates (ASMR) per 100,000 population, by ethnic group and sex, England and Wales, 2017–19



Source: *ONS (577)*
Note: **Rates not calculated due to small numbers of deaths*

Other evidence points to high alcohol-related morbidity in South Asian men in the UK. A 2009 study provided possible explanations for this, including religious taboos around substance use combined with cultural differences and acculturation (578). The study also suggested that biological factors play a role in organ damage. For example, a 1995 study found that alcohol-dependent South Asians had considerably higher rates of acetaldehyde mediated haemoglobin modification compared with alcohol-dependent White British people even if they had a shorter history of heavy drinking. (579) In fact, a 2002 observational study in the West Midlands found the standardised mortality ratio of deaths from alcoholic liver disease in South Asian men, 80 percent of whom were Sikh, to be almost four times that of White British men. (580) More research is needed to understand the specific factors leading to the significantly higher levels of South Asian men's mortality linked to alcohol consumption.

Barriers faced by people from ethnic minority groups in accessing support for problematic alcohol use may include taboos around alcohol dependence. Shame and stigma among communities where there is a religious restriction on drinking alcohol prevents help-seeking behaviour. (581) Cultural norms encourage members of some ethnic minority groups to hide alcohol problems. (446) Other barriers to accessing support for problematic alcohol use among ethnic minority communities include: difficulties in understanding how to navigate the often multi-layered services; (582) (583) not knowing where to go initially to ask for help; having problems that are not recognised by services or professionals; (584) not being aware of the types of support that are available; (585) and low awareness of the health implications of excessive drinking. (584) (446)

Research has found a lack of programmes specifically targeting ethnic minority groups and a lack of national, regional or local best practice guidance on how to develop and provide alcohol services for minority communities which makes developing culturally appropriate interventions challenging. (446)

Birmingham-based social enterprise KIKIT offers help, advice, peer support and mentoring to ethnic minority groups dealing with alcohol dependency and is an example of culturally sensitive practice that London could seek to replicate (Box 45).

Box 45. KIKIT, Birmingham (586)

KIKIT is a drug and alcohol support service designed to meet the needs of marginalised communities, predominantly people from ethnic minority groups. It works in collaboration with local grassroots organisations, faith-based communities and neighbourhood forums to reflect the values and lived experience of local people and harness local knowledge to increase the chances of successful change. This is especially important due to the strong culture of denial in ethnic minority groups about drug and alcohol problems and a reluctance to admit to problems because of the shame attributed to it.

KIKIT provides community-based activities and structured treatment programmes that guide, mentor and support people to address issues including substance misuse, health and social wellbeing and community safety. It motivates people to find effective pathways to recovery that enable them to contribute positively to their communities and wider society and lead independent, healthy and productive lives.

KIKIT offers a non-judgemental and culturally sensitive approach. Its Muslim Recovery Network Programme, for example, is a 12-step Islamic addiction recovery programme. The steps, traditions and five pillars are based on Islamic principles and follow the Islamic prophetic example as a route to productive, healthier and drug-free lives. This is a first-of-its-kind programme, running over a six-week period of religious and spiritual healing as a path to recovery. (587)

DRUG MISUSE

Drug misuse deaths in England and Wales rose between 2012 and 2021 to 3,060 in 2021 – the highest figure since comparable records began. (588) Age-standardised mortality rates per million people shows that in 2021 there were 65 deaths related to drug misuse in London (588). London, along with the South East and South West, has higher rates of recreational drug use than other regions. but has low rates of related deaths compared with national figures. (589)

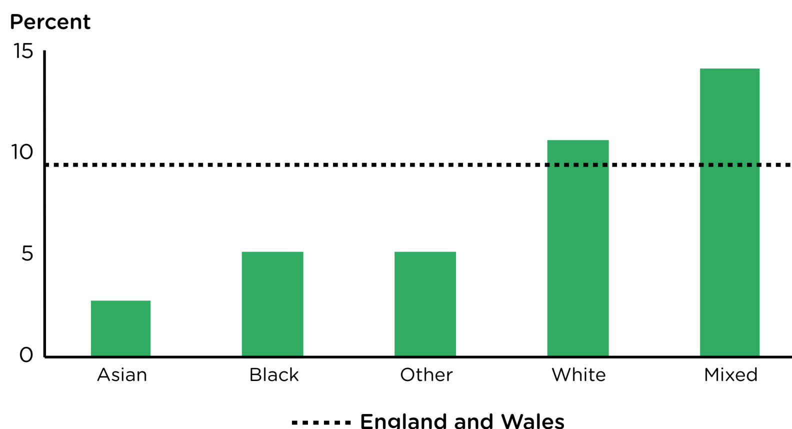
The Misuse of Drugs Act 1971 classifies controlled drugs into three categories (Classes A, B and C), according to the harm that they cause, with Class A drugs considered to be the most harmful. Class A drugs include powder cocaine, crack cocaine, ecstasy, heroin, LSD, magic mushrooms, methadone and methamphetamine. (590) Although drug use is closely linked to poverty and social deprivation, (591) it also spans social classes and is prevalent among wealthy sections of the population as well as poor. (592) ONS data shows that the prevalence of drug use in England and Wales varies by household characteristics and that in 2022, those earning less than £10,400 per year were more likely to have used any drug in the last year (15.2 percent) than those with higher incomes. Those earning less than £10,400 were most likely to have used cannabis (13.2 percent), while those in the highest income groups were most likely to have used a Class A drug, with 3.2 percent of households earning £52,000 or more per year having used a Class A drug in the last year, compared with 2.4 percent of households earning less than £10,400 per year. (590)

There is strong and longstanding evidence of racism in the process of drug law enforcement. In 2021, Stopwatch found that Black people were nine times more likely to be stopped and searched under section 1 of the Police and Criminal Evidence Act (PACE) for suspected drug possession, despite using drugs at a lower rate than White people. (593) Further, Black people were given suspended sentences at 5.6 times the rate of White

people. Black people are particularly overrepresented from the initial point of contact through to sentencing and, as highlighted in Section 4E, there is a police bias in the disproportionate use of stop-and-search on Black individuals. (542) (544) (594)

Drug use is self-reported in the Crime Survey for England and Wales and in that survey is most prevalent among Mixed/multiple ethnic groups and least prevalent among Asian people. (590) Black people have the highest rate of arrests for drug possession and drug supply but have relatively low self-reported rates of drug use according to the Crime Survey. (590)

Figure 4.53. Percent of people aged 16 to 59 reporting use of illicit drugs in the last year by ethnic group, England and Wales, April 2021 to March 2022



Source: *ONS (590)*

As with all services it is important that drug support and treatment services are culturally appropriate and attuned to the needs and prevalence of different ethnicities as well as gender, socioeconomic position and other dimensions of exclusion and disadvantage.

Box 46. Ethnic Minority Centre Drug Awareness Project (EMDAP) (595)

The Ethnic Minority Centre was a Voluntary Organisation in the London Borough of Merton that provides advice and information for ethnic minority groups on health and mental health and well-being welfare. It built and served a diverse community to promote understanding, tolerance and acceptance of all cultures.

EMDAP was a project commissioned by London Borough of Merton to the Ethnic Minority Centre, which was to raise awareness about drugs and alcohol misuse among ethnic minority young people, parents and carers. It offered a culturally sensitive support and advice service, organises awareness days for parents and young people and a confidential service. (595)

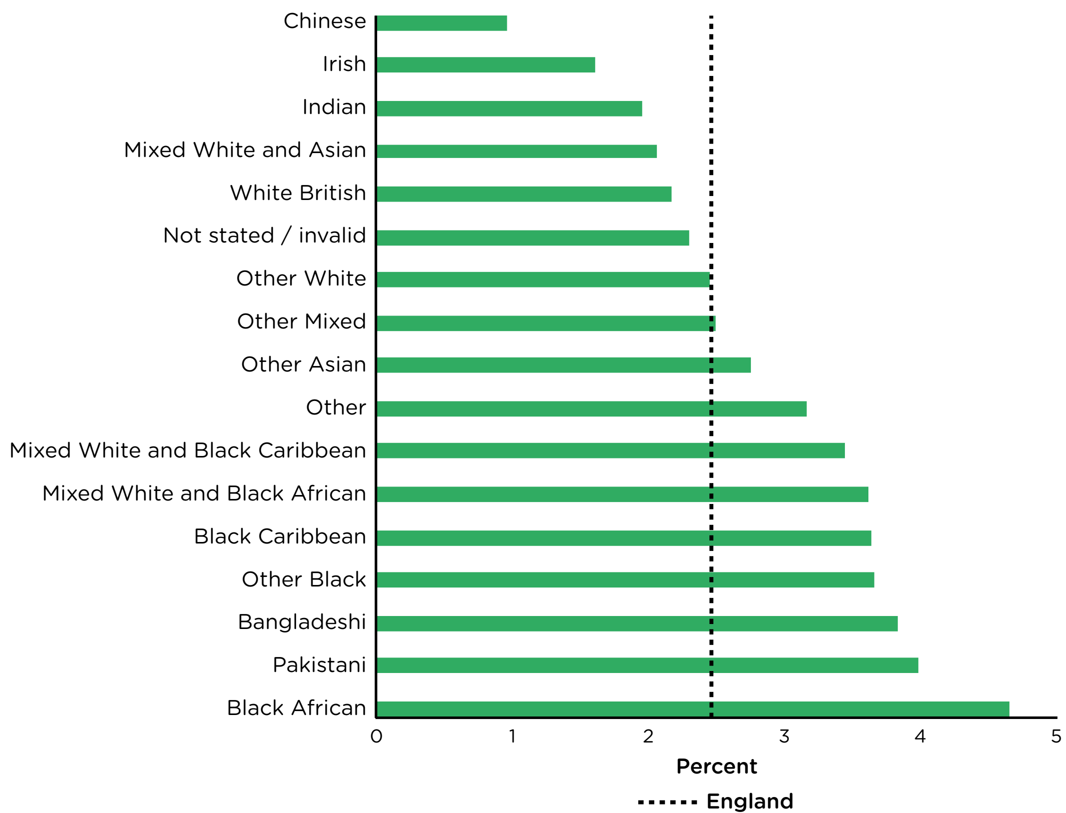
This project has now ceased due to lack of funding from London Brough of Merton.

OBESITY

Obesity is a significant health risk and is associated with lower life expectancy, lower healthy life expectancy and increased risk of diseases including diabetes, heart disease, and some cancers and musculoskeletal conditions. (596) As reported in Section 3, diabetes death rates in England and Wales are significantly higher in every non-White ethnic group than in the White group. Obesity also has an impact on people's physical health, quality of life and mental wellbeing and is associated with anxiety and depression. (597) There are clear and widespread socioeconomic inequalities in rates of obesity, with more deprived people being more at risk. In 2019, the obesity gap between the most and least deprived areas in the UK stood at 8 percentage points for men and 17 percentage points for women. (598) Differences in obesity rates translate into poorer health outcomes for people in more deprived areas and contribute to health inequalities. (599) (600)

Obesity is usually defined as having a body mass index (BMI) of 30 or above. When BMI exceeds 40, this is classified as severe or morbid obesity. As Figure 4.54 shows, among reception-age school pupils in England in 2022/23, severe obesity was most prevalent among Black African, Pakistani and Bangladeshi pupils.

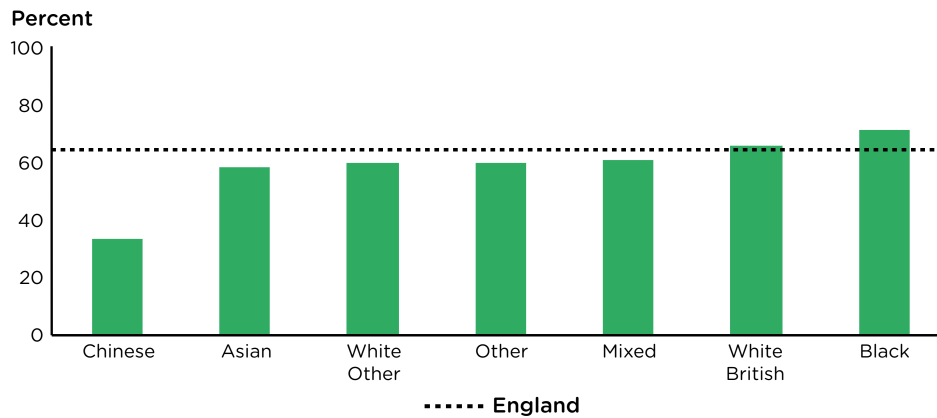
Figure 4.54. Percent prevalence of severe obesity in reception pupils aged four to five, by ethnic group, England, academic year 2022/23



Source: *OHID analysis of NHS England (601)*
Note: *According to the NHS, severe obesity constitutes a body mass index (BMI) of 40 or above.*

Ethnic inequalities in obesity persist from childhood into adulthood, with the highest rates of overweight and obesity being among Black adults, as shown in Figure 4.55. Being overweight is defined as having a BMI between 25 and 30. (602)

Figure 4.55. Percent of adults aged 18 and over who are overweight or obese, by ethnic group, England, mid-November 2021 to mid-November 2022



Source: *OHID (603)*

Local or regional data on obesity by ethnicity is not available for adults.

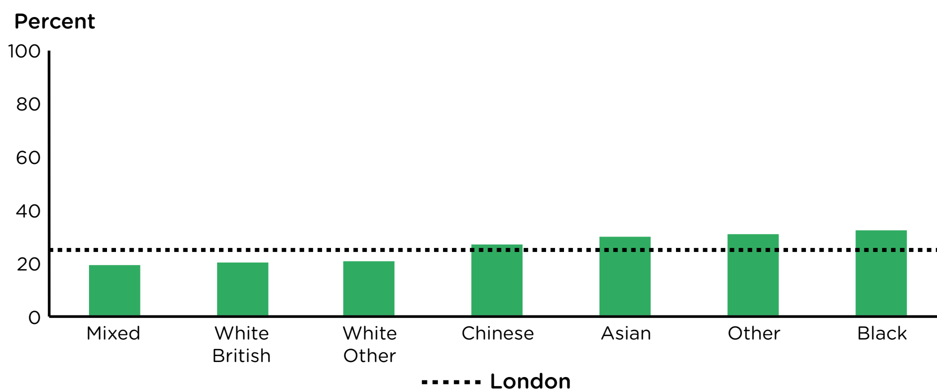
PHYSICAL ACTIVITY

Physical inactivity is a major risk factor for non-communicable diseases and is ranked as the fourth leading risk factor for mortality globally by the World Health Organization. (604) (605) In England between 2021/22, 65.6 percent of men and 60.8 percent of women aged 16 and over were physically active. (606)

Sport England's Active Lives Adult Survey 2021–22 reported that in London, 62.4 percent of the population were active, meaning they were meeting the Chief Medical Officer's recommended 150-plus minutes of physical activity every week. This means 37.6 percent of residents were not doing the recommended amount of physical activity, while over a quarter (26.4 percent) were listed as 'inactive' for doing less than 30 minutes of moderate intensity exercise each week. (607)

In London there are widespread inequalities in physical activity by socioeconomic position and sex and, as shown in Figure 4.56, by ethnicity, with White and Mixed-ethnicity residents being the most physically active. (607) There are also clear gender inequalities and in every ethnicity recorded, men are more likely to be physically active than women. (606) Many ethnic minority groups in London live in economically disadvantaged areas with inadequate physical activity facilities, unsafe walking paths and limited access to open green space. (608) There are additional issues for many ethnic minority groups who often do not feel safe visiting some green spaces and being outside (see also Section 4E).

Figure 4.56. Percent of adults aged 16 and over classed as being physically inactive, by ethnic group, London, mid-November 2021 to mid-November 2022



Source: *Department for Digital, Culture, Media and Sport (609)*

A 2019 systematic review of qualitative studies conducted between 2007 and 2017 explored the barriers to and opportunities for physical activity among adults from ethnic minority groups in areas across the UK. (608) Six themes emerged, including: awareness of the links between physical activity and health; interaction and engagement with health professionals; cultural expectations and social responsibilities; suitable environment for physical activity; religious fatalism and practical challenges. It found a substantial gap in research into barriers and opportunities for Black African groups. Work–life balance can act as a barrier to physical activity, too. Most of the South Asian men in the studies reported working long hours to meet family and household demands. Sociocultural norms might also make South Asian women less prone to take up some types of physical activity. (608) The 2019 review also identified the importance of providing access to a culturally appropriate environment for physical activity. Further, only two of seven studies included in the review reported that participants understood the benefits of physical activity. Public health and health care have an important role in deepening awareness about the health benefits of physical activity in a culturally sensitive and appropriate way. Public health also has an important role in reducing the identified barriers to more physical activity, for instance addressing safety concerns and having culturally appropriate exercise groups. (608)

In 2020 Sport England's Active Lives Survey revealed that 95 percent of Black adults and 80 percent of Black children in England do not engage in water-based activities, and 93 percent of Asian adults and 78 percent of Asian children do not. This means that these groups are less likely to experience the health benefits of swimming and are at increased risk of drowning. In light of this, the Black Swimming Association (BSA) was founded in a bid to increase swimming rates among people from ethnic minority groups (Box 47). (610)

Box 47. The Black Swimming Association (BSA) (610)

The Black Swimming Association (BSA), founded in 2020, aims to ensure African, Caribbean and Asian communities have equitable access to water safety education, drowning prevention and the benefits of aquatics. They produced a survey and subsequent report identifying key attitudes and barriers to swimming and participation in aquatic activity for ethnic minority groups. This found that 48 percent of Black survey respondents were not aware of how to stay safe in water, 44 percent said they had a fear of water, and 33 percent of Black respondents said that hair was a barrier to engaging in aquatic activity. (610)

Based on this the BSA developed recommendations for the aquatic sector addressing barriers to participation, increasing water safety awareness and suggesting ways culturally relevant support could be provided to underrepresented ethnic minority groups.

RECOMMENDATIONS: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

1. Ensure that the focus of the public health system incorporates the fundamental role of social determinants, ethnicity and experiences of discrimination and racism in shaping health.
2. Redesign public health approaches to smoking, alcohol, drugs and obesity to ensure they are culturally appropriate for ethnic minority groups in London.
3. The health system to take a longer-term, prevention focussed approach to tackling health inequalities.

ADDITIONAL RESEARCH AND EVIDENCE

- Ensure that data on health behaviours are disaggregated by ethnicity as well as socioeconomic position, gender, disability and age.
- Further research on ethnic dimensions of alcohol misuse, obesity and physical activity and ethnicity.

CHAPTER 5

RACISM AND ETHNIC INEQUALITIES IN HEALTH AND SOCIAL CARE

There are widespread ethnic inequalities in access to health and care services and many incidents and reports of systemic racism within services and a lack of cultural sensitivity. There are also many reports of the NHS workforce experiencing racism from their employers, from the public and from other employees. This section overviews these concerns, while referring to the more substantive reports and organisations which are working to identify racism in health and care, support those who have experienced it and to eliminate racism in health and social care.

5A. NHS SERVICES

In 2022, the NHS Race and Health Observatory (RHO) published *Ethnic Inequalities in Healthcare: A Rapid Evidence Review*, analysing evidence of ethnic inequalities in healthcare and reasons for them. (19) Barriers to accessing NHS services for minority ethnic patients include a lack of appropriate treatment for particular health issues; poor quality or discriminatory treatment from healthcare staff; a lack of appropriate interpreting services for people who do not speak English confidently; and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.

Ensuring equitable access to healthcare must include dissemination of culturally appropriate information; the provision of timely, relevant and culturally sensitive services; and receiving a respectful and dignified experience in quality of care. (611) The RHO sets out the importance of people working at all levels in the NHS being provided with support to understand ethnic health inequalities, their causes, and the actions needed to address them. Diversity of leadership that allows for ethnic minority representation is fundamental and equitable accountability mechanisms must be enforced. (612)

As well as language barriers, there is often a lack of cultural competence within services, including a lack of awareness of others' cultural beliefs and practices, and a subsequent lack of ability to communicate and work appropriately with service users according to their cultural background. Care is compromised if patients and practitioners do not understand each other and can lead to a higher risk of inappropriate medical testing, increased hospitalisation rates and adverse medical reactions, as well as decreased patient satisfaction and increased mistrust of services. (613) It is also recognised that translation efforts alone are insufficient and there should be more focus on creating outreach services tailored to ethnic minority groups. (614) Even when interpreting services are available, they are often inadequate, placing an unfair and heavy reliance on family and friends to communicate, which can lead to harmful misinterpretations. (615) Individuals without linguistic and cultural competence are placed at an unfair disadvantage and face poorer health outcomes.

Box 48. The NHS Race and Health Observatory (616)

The NHS Race and Health Observatory is an independent expert body established in 2021 to examine ethnic health inequalities and support national bodies in implementing change for ethnic minority groups, both for patients and members of the workforce.

It works as an investigator of racism in health care services, commissioning research and synthesising existing evidence. Using this it makes recommendations for policy leaders and support practical implementation of recommendation through antiracism methodologies.

Its key goals are:

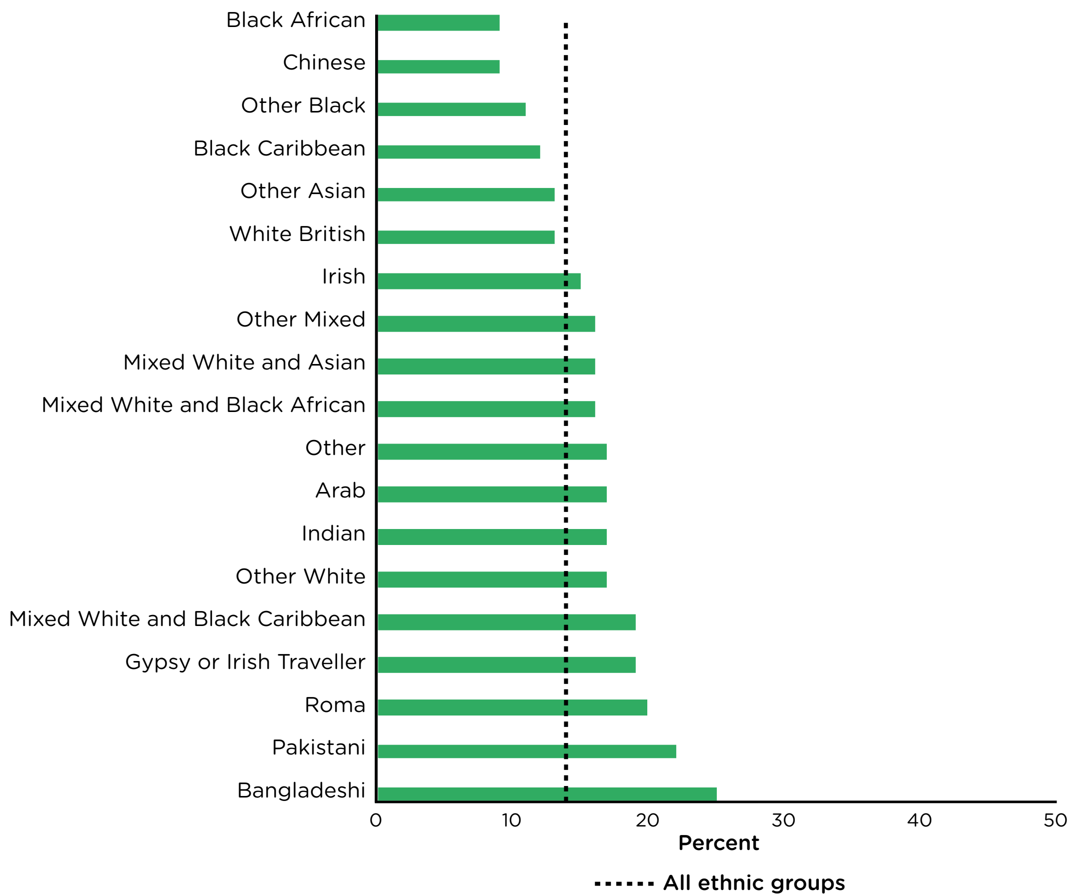
- Improving health and care in areas that have ethnic inequalities in access, experience or outcomes
- Empowering vulnerable communities
- Innovating by ensuring new digital technology and data collection structures are developed to help reduce ethnic health inequalities and tackle structural racism
- Creating equitable environments by supporting systems to tackle inequalities and promote quality of care, safety, compassion and a fairer experience for all
- Collaborating globally and sharing practice and learning.

Its 2023 progress report highlighted the 12 reports it published over the year and its partnership with the National Institute for Health and Care Research to enhance efforts to drive race equity in healthcare research. It has worked in partnership with NHS England, the Government, the Care Quality Commission, the Professional Standards Agency and the Healthcare Safety Investigation Branch. (617)

In January 2024 it launched, in partnership with the Institute for Healthcare Improvement and supported by the Health Foundation, a 15-month, peer-to-peer Learning and Action Network to address inequalities among women from different ethnic groups related to maternal morbidity, perinatal mortality and neonatal morbidity. The programme will run across nine NHS Trusts and ICSs until June 2025. The network will combine quality improvement methods with antiracism principles to drive clinical transformation. (618)

There are clear inequalities by ethnicity in patients who report poor or very poor experiences of primary care (Figure 5.1), with nearly a quarter of Bangladeshi and Pakistani patients in England rating their experiences as poor in 2022. The intersection between poverty and ethnicity leads to particularly poor experiences for ethnic minority groups in deprived areas where there are particular issues with low access to primary care. (619) (620) (621)

Figure 5.1. Percent of patients aged 16 and over who describe their overall GP experience as 'poor' or 'very poor', by ethnic group, England, January to April 2023

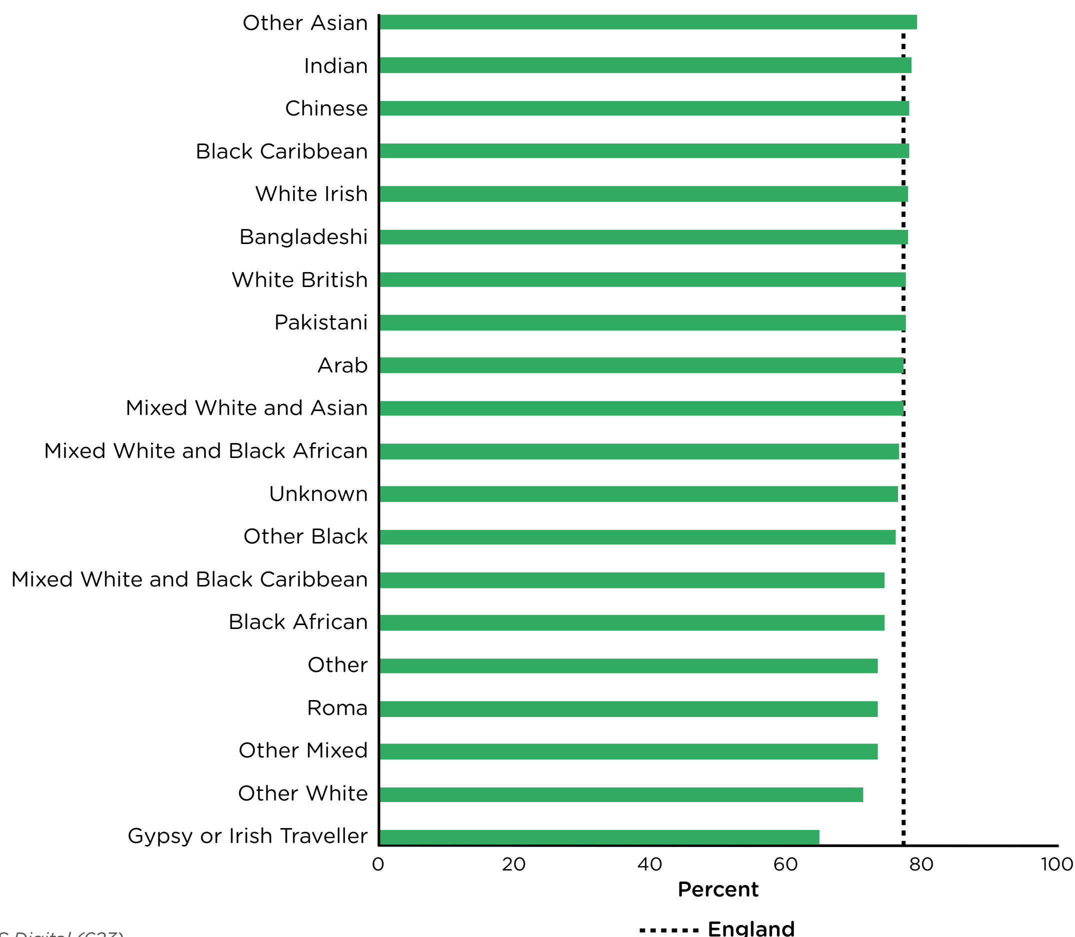


Source: *: NHS England (622)*

The 2022 RHO rapid evidence review also reports experiences of ethnic inequalities in digital access to healthcare, including via NHS telephone services. (611) There is some limited evidence that participants from ethnic minority groups use digital health apps less frequently than White people, with less use of NHS Direct services by most ethnic minority groups compared with the White British group. Further, there is evidence of Bangladeshi people, particularly those living in deprived areas, being referred to urgent and emergency care services less often by NHS Direct compared with other ethnic groups. (611)

There are also clear inequalities in access to NHS dental appointments by ethnicity (Figure 5.2). Over the period January to March 2021 in England, people with an Indian or 'other Asian' background reported the greatest success in booking appointments (78 and 79 percent, respectively) while Gypsy/Irish Travellers and those from 'any other' White backgrounds the least success (64.7 and 71.2 percent, respectively).

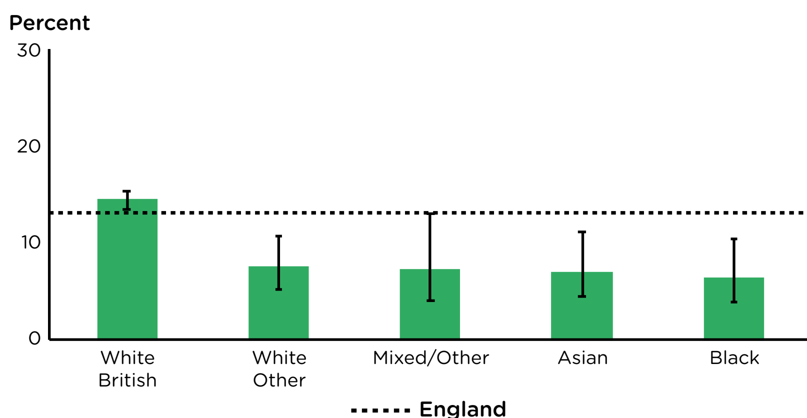
Figure 5.2 Percent of patients aged 16 and over who were successful in getting an NHS dental appointment if they tried in the last two years, by ethnic group, England, January to March 2021



Source: *NHS Digital (623)*

Unequal experiences of accessing and receiving health and social care are particularly pronounced for people from ethnic minority groups who have a learning disability. A five-part review commissioned by the NHS RHO in 2023 explores the barriers to and experiences of accessing healthcare for people from ethnic minority groups with a learning disability examining the lived experiences of self-advocates and carers. (624) The review highlights systemic discrimination based on the intersectional grounds of a person's disability, their ethnicity and other characteristics such as gender and socioeconomic position. Participants reported experiences that included substandard and unresponsive care, isolation and stigma, barriers to community engagement, barriers to vaccination and reluctance to be recognised as having a learning disability, and some fear of being added to the learning disability register, often due to a concern about being treated differently or unfairly if registered. (624)

Figure 5.3. Percent of adults aged 16 and over in private households reporting receiving treatment for mental or emotional problems, by ethnic group, England, 2014



Source: *NHS Digital (2016) (625)*

Reports suggest that access to mental health services is heavily impacted by racism, fears of being discriminated against, consequential distrust of care providers, and a lack of appropriate interpreting services, all of which deter help-seeking behaviour for mental health conditions. (19) The 2022 NHS RHO report identified clear inequalities by ethnicity in rates of accessing the Improving Access to Psychological Therapies (IAPT) service and in receiving cognitive behavioural therapy (CBT); compared with White people, people from ethnic minority groups were less likely to refer themselves for IAPT, less likely to be referred by their GPs for IAPT or CBT, and less likely to attend as many CBT sessions. Further, evidence shows significant and persistent inequalities in compulsory admission to psychiatric wards, which particularly affects Black people, and harsher treatment for Black patients when in inpatient wards, such as forced seclusion or increased likelihood of being restrained. (19) (626)

Service users from ethnic minority backgrounds report that their negative perceptions and experiences of the mental health care system are primarily due to a belief that the model of care is not suitable to deliver culturally appropriate and useful care. They highlight the lack of understanding of the lived experience of people during assessment and treatment (627) and report a lack of cultural awareness, including a lack of understanding of religion, culture and individuals as a part of systems and families. Service users from ethnic minority groups also suggested that signposting and accessing services through community and religious organisations, and other services, in addition to through GPs, would increase awareness. (628)

A report interviewing young Black men in South London suggested that they would not access mental health services through a GP due to a lack of people from their background in these spaces and a scepticism over whether their GP would understand their experiences and identity, alongside increased community stigma around mental health. (629)

Box 49. Bayo (630)

Bayo is a digital platform launched in 2021, developed by the Ubele Initiative, Mind, Young Minds and Best Beginnings, and funded by the National Emergencies Trust.

Bayo provides tailored support and care for young Black people, offering culturally appropriate and accessible services from Black-led organisations and collectives catering specifically to the Black community. It doesn't offer its own mental health support, but functions as a digital directory that hosts Black-led initiatives, community groups and mental health services. These services cover a wide range of mental health and wellbeing needs and locations across the UK.

Bayo is a first-of-its-kind programme to empower Black communities in finding effective and accessible mental health support. (630)

The Ethnicity and Mental Health Improvement Project (EMHIP) is an intervention from 2019 developed by health care organisations and local communities in South West London to respond to community experiences (Box 50). EMHIP has recognised the need for change in the mental health system and the community. The project sets out a clear approach for system-wide change and addresses discriminatory patterns of mental healthcare by creating a programme that was developed and adapted through co-production with ethnic minority community groups.

Box 50. Ethnicity and Mental Health Improvement Project (EMHIP) (631)

EMHIP is a collaborative project involving the South West London and St George's Mental Health NHS Trust , South West London Clinical Commissioning Group, Merton and Wandsworth Locality, and networks of ethnic minority voluntary, faith and community groups, convened by the Wandsworth Community Empowerment Network. The project, commissioned for development in 2019, was intended to be a practical, locality-based service improvement programme to bring about change for ethnic minority groups in mental health. (631) EMHIP was commissioned as an 18-month project with multiple phases to be implemented in Wandsworth and, more recently, Croydon.

In Wandsworth, phase 1 involved a knowledge synthesis process to assemble the available knowledge and evidence on ethnic inequalities in mental health care in the UK and strategies to reduce them; engagement and consultation with stakeholders to understand and prioritise key areas of change and improvement; the development of tailored interventions to reduce ethnic inequalities in service access, experience and outcomes; and devising a process for evaluation. (631) Phase 1 was completed in October 2020 and led to five interventions and seven 'hubs' to address ethnic minority groups' experiences with mental health care.

(632) The Mental Health and Wellbeing Hubs were developed to be specific to the needs of ethnic minority communities with 'community-embedded' workers.

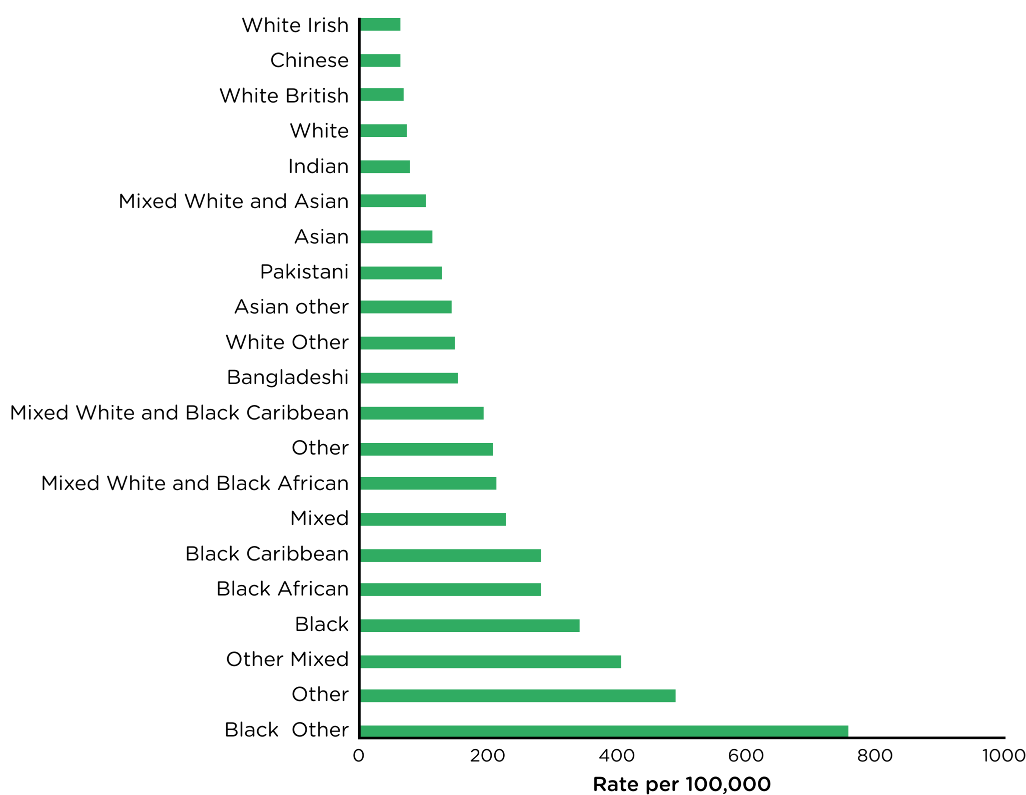
The second of the five interventions in phase 1 involves increasing service options by providing alternative residential crisis provisions, including crisis houses and crisis family placements, enhanced support for people with longer term mental health needs, and specialist support for those subject to multiple Mental Health Act admissions. Thirdly, EMHIP tackles coercion by having inclusive and shared decision-making and eliminating the use of restraint and control in order to reduce the disproportionate numbers of individuals from ethnic minority groups subject to detention under the MHA. The fourth intervention addresses inpatient care experience by calling for community involvement in inpatient care and cultural mediation. Lastly, capability training is being implemented, to create a culturally capable mental health workforce that is able to work across various culturally diverse communities.

An EMHIP delivery group was set up to drive forward the key interventions. Three working groups were also setup to go into the detail of the phasing and delivery of the interventions. No progress updates on implementation nor impact evaluations are yet available.

DETENTIONS UNDER THE MENTAL HEALTH ACT

In 2021–22 Black and Black British people were detained under the Mental Health Act (MHA) at over four times the rate of people from a White British background. (633) Figure 5.4 shows the more detailed breakdown by ethnic group (based on 2001 Census categories). Black 'Other' groups experienced the highest rate of detentions under the MHA, a rate more than 10 times higher than for White British, Indian, White Irish and Chinese groups, while Black African and Black Caribbean groups each had rates four times as a high.

Figure 5.4. Detention rates under the Mental Health Act per 100,000 population, by ethnic group, England, April 2021 to March 2022



Source: *NHS Digital (634)*

Note: *Detention rates for the 5 'other' ethnic groups (for example 'Black other' and 'other') may be overestimated because groups labelled 'other' may have been used for people whose ethnicity was not known.*

Research into why Black groups are disproportionately detained suggests several possible explanations, including higher rates of psychosis, resistance to seeking help, mistrust of services, misdiagnosis, poor diagnosis at primary care level and institutional racism. (635)

The *Independent Review of the Mental Health Act* highlighted the need to tackle the structure of mental health services that leads to racial inequalities. (636) The final report in 2018 made a series of recommendations, including culturally appropriate treatment, more opportunity for people to have a say about the care they receive, more analysis of the use of restraint and recommendations to local authorities and the police force. In the King's Speech in July 2024 the Government introduced a Mental Health Bill, which will include many of the recommendations of the Independent Review, by introducing reform across the system to give service users more autonomy, power and dignity. (637)

Following the Independent Review the NHS developed its first antiracism framework - the Patient and Carer Race Equality Framework (PCREF) for all NHS mental health trusts and mental health service providers to embed across England. The framework can also be used by other organisations including local authorities and the police. (636) The PCREF was coproduced, piloted by mental health providers and is being rolled out nationally, Box 51. (638) It sets out the legislative and regulatory context for tackling mental health inequalities and provides steps to deliver culturally responsive care. All NHS mental health trusts and mental health providers are now required to have a PCREF in place by the end of the financial year 2024/25. (638) The pilots and early adopters reported progress on developing antiracist approaches through reflection on needs of the local communities, elevating the voices of service users, carers and communities. The PCREF is meant to be adaptable to local community needs. (638)

Box 51. The Patient and Carer Race Equality Framework (638)

The framework sets out practical steps to deliver culturally responsive care. It was codeveloped with PCREF pilot trusts and early adopter sites, ethnic minority groups, voluntary sector partners, patients, carers and communities, and regulators.

There are three core components:

Part 1 – Leadership and governance: Leaders of the trusts and mental health providers need to ensure core pieces of legislation identified are complied with. NHS England has identified 12 key legislative and regulatory requirements which include duties for trusts and providers which impact ethnic minority groups.

Trusts will be expected to embed the PCREF in their governance structures and should have a nominated executive lead at board level who is accountable for the delivery of the PCREF.

NHS England has worked with regulators including the Care Quality Commission and the Equalities and Human Rights Commission in the development of the PCREF. The CQC has developed a new assessment framework which was rolled out in late 2023. Implementation of the PCREF will be one of the pieces of evidence considered by CQC when scoring quality statements.

Part 2 – National organisational competencies: These align with the Independent Review of the Mental Health Act which identified six essential organisational competencies. Trusts and mental health providers should work with their communities and patients and carers to assess how they fare against the six organisational competencies (and any more identified as local priorities) and codevelop a plan of action to improve them. These were developed alongside pilot and early adopter sites to identify what a 'culturally competent' trust is. Feedback varied depending on the local context and existing practices, but the six most consistent areas of focus were:

1. Cultural awareness
2. Staff knowledge and awareness
3. Partnership working
4. Co-production
5. Workforce
6. Co-learning

Once the PCREF is rolled out nationally, it will be expected that trusts and mental health providers will coproduce a clear set of actions that are monitored by their governance structures.

Part 3 – The patient and carers feedback mechanism: which embeds patient and carer voices at the heart of planning, implementation and learning. The following mechanisms are needed:

1. Agreeing the most suitable and impactful tool to measure the experience of ethnically and culturally diverse patients and carers at a local level. Further, evidencing how these experiences vary, and how feedback is being taken on board in a transparent way.
2. Routinely provide access and outcomes measures to national mental health datasets to enable better understanding of the impacts of mental health services on racialised and ethnically and culturally diverse communities who are accessing/receiving care from trusts and mental health providers.
3. Agreeing/coproducing with racialised and ethnically and culturally diverse experts by experience which of these measures to monitor routinely at a trust and mental health provider board level alongside the existing nationally recommended outcome and experience tools. (638)

The South London and Maudsley (SLAM) Foundation Trust is one of the pilot trusts for the PCREF, Box 52 and has been developing its antiracism approach since 2020.

Box 52. South London and Maudsley antiracism pilot (639)

SLAM is focusing on people of Black African, Black Caribbean, Black Mixed and Black Other ethnicities as they have the worst access, experience and outcomes according to the Trust's data. It has been developing its work on all three components of the PCREF and will help inform the national roll-out. It has developed this work in partnership with Black Thrive Lambeth and Croydon BME Forum. (639)

Its six chosen national organisational competencies (NOCs) based on local priorities are:

- Cultural awareness
- Staff knowledge and awareness
- Partnership working
- Co-production
- Workforce
- Co-learning.

The six agreed PCREF Metrics for the Trust are:

- Equity in service user by ethnicity
- Equity in diagnosis of psychotic spectrum disorders by ethnicity
- Equity in use of medication for Black people with a diagnosis of psychotic spectrum disorders by ethnicity
- Equity in the use of detention by ethnicity
- Equity in the use of seclusion and restraint by ethnicity
- Culturally appropriate and accessible measures of recovery. (639)

The Trust, as a mental health service provider, aims to apply antiracism approaches to remove the conditions that hold systemic racism in place. It made a commitment in its 2021 strategy to be leading antiracism in mental health care by 2026. It has a joint PCREF Partnership/Trust strategy group to develop this plan and the steps.

In this plan it has committed to:

- Ensure organisational leadership and culture will embody antiracism
- Be an antiracism employer and workplace
- Collaborate with the mental health sector and partners to promote, and evaluate its antiracism approach
- Incorporate an antiracism agenda into organisational development; training, education and research work and innovations
- Integrate antiracism into brand, media campaigns and communications
- Nurture an environment of listening, learning and unlearning racism
- Embed antiracism in all that they do to ensure better access, outcomes and experience for service users, carers and the communities. (640)

SLAM has also committed to a quarterly review of the patient and service outcomes and adoption and engagement of PCREF through a racialised lens.

MENTAL HEALTH SERVICES FOR YOUNG PEOPLE

The Annual GP satisfaction Survey 2021 finds that young people from ethnic minority groups feel less recognised and understood when talking to their GP about their mental health needs compared to their White counterparts. (641) Further, children from ethnic minority groups are less likely than White children to access traditional mental health services (642) as they are found to be more likely to expect bad experiences from mental health services, perceiving the system to be unhelpful, racist and untrustworthy, which delays help-seeking behaviour. (643) (611) There is some evidence that children and young people from certain ethnic minority groups, in particular Asian and mixed-race young people, are less likely to show measurable improvement from mental health treatment. (644)

An analysis of national, routinely collected data from 14,588 young people accessing mental health services in the UK, found young people from ethnic minority groups are less likely to be referred through routes that are voluntary. Compared to White British young people, Black young people and Mixed-race young people were more than twice as likely to be referred through social care or youth justice than through primary care. Asian young people were almost twice as likely to be referred through social care or youth justice than through primary care agencies compared to White British young people. (645) This difference is significant as primary care referral implies voluntary and help-seeking behaviour, while social care or youth justice represents more compulsory admission driven by concerns about the person's safety or risk of harm.

Despite some evidence from service providers on ethnic inequalities in service use, there is a lack of substantive evidence about the prevalence of poor mental health among young people by ethnicity in London and this should be a focus for new research and evidence.

More programmes directly tackling the mental health needs of young minority ethnic groups are needed, such as that developed by the East London Foundation Trust (Box 53). In addition, inequalities in many of the outcomes and experiences for children and young people related to ethnicity, indicate that racism and discrimination harm the mental health of young people and in the drivers of mental health.

Box 53. The East London Foundation Trust Transformation Programme (646)

The Transformation Programme within the East London NHS Foundation Trust provided an opportunity to identify and address the unmet mental health needs of minority ethnic people within local communities in Tower Hamlets, Newham and City and Hackney. The programme did not specifically target minority ethnic groups, however, it has hosted a series of focus groups 'Let's Talk' between February and March 2021. The aim of these groups was to understand the experiences of people from ethnic minority groups with lived experience of accessing mental health services, or caring for someone accessing services. (646)

EXPERIENCES OF RACISM IN MATERNITY SERVICES

In Section 3 we reviewed ethnic inequalities in maternal and infant health. Here we review the strong evidence that shows racism plays a significant role in these stark inequalities. There is a great deal of evidence about the lack of culturally appropriate maternal and postnatal care for many ethnic minority groups in England and the racism experienced in these services. Racism leads to lower access to appropriate services and differential treatment within maternal and postnatal services as well as having contributed to the lower socioeconomic position and poor living conditions of many women from ethnic minority groups which affect their maternity outcomes. Many studies over a long period have explored racism the experiences of women from with maternity services in the UK but inequalities persist and recommendations for change have not been implemented. (647) (648) (649) (650)

An NHS RHO rapid evidence review of ethnic inequalities across a variety of healthcare settings published in 2022 found experiences of negative interactions, stereotyping, disrespect, discrimination and cultural insensitivity in maternal and neonatal healthcare services. (19) System-level factors, such as the lack of accessible and high-quality interpreting services, together with the attitudes, knowledge and behaviours of healthcare staff, contribute to women from ethnic minority groups feeling disregarded and poorly cared-for. The review found these factors appear to increase mistrust and feed fear, which in turn are described as resulting in poorer access to, and engagement with maternal and neonatal services. The RHO also carried out a review which mapped existing policy interventions to tackle ethnic inequalities in maternal and neonatal health across England in 2022. (651) The review identified several areas where people from ethnic minority groups faced barriers that inhibited their access to maternity services. The report found that

the majority of the services and approaches reviewed did not have a specific focus on race or ethnicity which is urgently needed to tackle the inequalities in maternal and infant health.

In 2022, UK charity Birthrights published *Systemic Racism, not Broken Bodies*, a report on its year-long inquiry into racial injustice in UK maternity services. (652) Collating the experiences of women from ethnic minority groups, common themes in the report include a lack of physical and psychological safety, feelings of being ignored and disbelieved, racism by caregivers, dehumanisation, lack of choice and consent, coercion, stereotyping and discriminatory behaviour. (653) A report on Black maternal health released in March 2023 by the Women and Equalities Committee found that implicit or explicit racism played a role in Black women's access to treatment and the maternity care they received. Over 42 percent of Black women surveyed reported feeling discriminated against during their maternity care, with one of the most common reasons being their ethnicity. (654) A 2010 survey of 24,300 women found that Black and South Asian women faced more barriers to access and choice and were less likely to be treated with dignity and respect, compared with White women. They were less likely to report being sufficiently involved in decisions to give birth at home or in a birth centre or to receive pain relief in labour and were more likely to deliver by emergency caesarean. (650) (648)

Research into why Black and Asian women were at higher risk of maternal mortality, reported in 2024, explored whether living in more deprived areas and having less access to and use of antenatal services explained the much higher mortality among pregnant Black and Asian women in the UK. (655) The research showed that among women of White ethnicity, deprivation was associated with higher risk of mortality. By contrast, among women from ethnic minority groups deprivation did not account for the greater risk of mortality. After accounting for age, levels of deprivation, smoking, BMI, multiparity and comorbidities women of Black ethnicity still had over three times the risk of mortality than White women . The authors suggest that their results show that efforts to dismantle structural bias and deliver culturally competent maternity care are urgently required together with research about and how to implement the change. (655)

Migrant women face additional barriers in accessing care and experience poorer maternal and perinatal outcomes compared with residents in their host countries. A 2019 systematic review of asylum-seeking women's experiences of maternity care in the UK reported seven key themes: communication challenges, isolation, mental health challenges, professional attitudes, access to health care, effects of dispersal and housing challenges. (656) A Doctors of the World report based on UK data collected on a cohort of 257 pregnant women with insecure immigration status who accessed their health support service between 2017 and 2021 found that 38 percent had been charged for healthcare, often inappropriately. (657) NHS maternity care in the UK is free at the point of use for those deemed 'ordinarily resident'. As this does not apply to women without regular migration status, it widens existing inequalities in maternal health.

A service at King's College Hospital that was developed to improve maternal outcomes for migrant women shows that culturally appropriate services improved experiences and outcomes (Box 54).

Box 54. Specialist migrant service provided by King's College Hospital (658)

A 2020 study reported on experiences of an NHS specialist migrant maternity service at an initial accommodation (IA) centre for migrants and refugees provided by King's College Hospital, London. The service cares for approximately 90 women per year and is unique in providing antenatal care provision for migrant women within an IA centre. Other services provided include bookable subsidised transport for hospital appointments and intrapartum transfer, working alongside multidisciplinary health teams of GPs, health visitors, the Refugee Council therapeutic listening service, safeguarding teams and community groups.

A semi-structured, multilingual, in-depth interview was conducted with 10 service users, including Vietnamese, Chinese, Albanian, Nigerian, Afghan and Yemeni women, with an age range of 23–37 years. Interviews comprised 17 questions based on the NICE 2010 guidelines for 'service provision for pregnant women with complex social factors'. (658)

The women conveyed a high level of satisfaction with the service, in particular in terms of satisfactory access to midwives, with the majority having continuity of care with access to the same midwife; referrals for obstetric and medical care and mental health support in their native language; access to interpreters both at the IA centre and the hospital; provision of essentials and transport; and respect and kindness of caregivers. The negative aspects such as poor maternal nutrition, lack of access to hygienic infant-feeding equipment, lack of social support building and lack of service signposting were outside the immediate remit of the maternity team. Notwithstanding, the health impact of these issues on the women in the study raises the need for holistic care. The study did not find evidence of a reduction in ethnic health inequalities but the small number of interviews on which the evaluation was based should be noted. (658)

MATERNAL MENTAL HEALTH

The NHS RHO review described above includes a study indicating that access to mental health services during the perinatal period varies between women from different ethnic groups and that women from ethnic minority groups were more likely than White women to not receive treatment for a mental disorder in both the antenatal period and in the first year postpartum and were also less likely to be receiving treatment postnatally compared with White women. (659) (19)

There is some evidence of ethnic differences in the percentages of involuntary admissions to psychiatric inpatient care during maternity. Women from White other backgrounds, Asian and Black African women had higher percentages of involuntary admissions than White British women, though the small numbers in the study in question mean that standardised rates cannot be compared. (660) (611)

A 2023 study using cross-sectional data from the 2014–2020 national maternity surveys in England found differences in who is asked about their perinatal mental health. Overall, women from ethnic minority groups were less likely to report being asked about their mental health antenatally and postnatally across all surveys compared to White women. (661)

A 2019 study exploring the experiences of 51 women from ethnic minority groups with perinatal mental health problems living in the UK found that over half of the women reported difficulties in accessing support for services during pregnancy or right after birth. (662) Further, 67 percent were not able to identify sources of support for perinatal mental health problems. Three themes were identified: suffering in silence, the need for a safe space to talk and be listened to, and representation. Some women from ethnic minority groups stated that cultural expectations and stigma associated with mental health problems led to their silence. Moreover, language barriers and health professionals' prejudice impacted the women's ability to access support. In some cases, the support provided was culturally inappropriate or inaccessible, dominated by White women and failing to account for culturally specific needs. (662)

REDUCING ETHNIC INEQUALITIES IN MATERNAL AND INFANT HEALTH SERVICES

A range of reports has set out ways to reduce inequalities in prenatal and postnatal services, including provision of culturally appropriate and sensitive services; ensuring that staff are trained to listen and to act on, the concerns and wishes of mothers and families; and to treat patients with dignity and respect. (85) (611) The 2019 NHS long-term plan set a target to achieve a 50 percent reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. (663) Improving outcomes in maternal and neonatal health is clearly a priority, but the plan did not mention a commitment to reduce ethnic differences. The NHS needs to go much further in its efforts to end racism in maternal and neonatal services and to eliminate the ethnic and socioeconomic inequalities in maternal and neonatal mortality and health.

The UK Parliament's Women and Equalities Committee reports that the solutions to ensure equitable continuity of care and a reduction of inequalities in maternal and infant health put forward by the Government and NHS at present are necessary yet insufficient as they do not tackle the problem of ethnic inequalities in maternal death and potentially underestimate the extent of racism's role in perpetuating inequalities. (664) While there is a continuing insufficiency of implementation of action on racism in maternity and neonatal services, there is evidence that culturally appropriate and sensitive midwifery services can reduce preterm births and improve birth outcomes among ethnic minority groups.

An evaluation of caseload midwifery, an approach developed in London, shows it significantly reduces preterm birth and birth by caesarean section when compared with traditional care, and that when applied to targeted groups (more deprived women and women of diverse ethnicities) the impact of the intervention is greater (Box 55). Further research is needed to determine whether the significant improvement seen would translate to other inner-city populations with similar demographics.

Box 55. Caseload midwifery (665)

The Lambeth Early Action Partnership (LEAP) caseload midwifery approach was implemented at Guys and St Thomas' NHS Foundation Trust, London. In LEAP, teams of six midwives care for 18 pregnant women per month. Individualised care pathways enable frequent and longer visits as required. Two midwives are involved from booking to postnatal care for each patient. Teams are on call for labour and provide extended postnatal care (up to 28 days).

An evaluation of the approach and its outcomes for women booked for antenatal care after July 2018 explored whether it would improve important measurable outcomes including preterm birth, mode of birth and newborn outcomes when compared with standard care in an area of social deprivation in inner London. The evaluation showed that following the intervention, preterm births in non-White women were significantly reduced in those allocated to caseload midwifery compared with those allocated to traditional care, 7.3 percent compared with

14.4 percent, but the preterm birth rate remained higher overall in non-White women . For women who needed interpreters, there was a statistically significant reduction in the preterm (before 37 weeks) birth rate among those receiving caseload midwifery compared with the standard care.

Long-term follow-up of these women would determine whether there are long-term clinical and economic benefits of caseload midwifery in this cohort.

North East London maternity and neonatal services have developed a vision of more equitable and appropriate maternity services. The approach works with women at risk of exclusion and discrimination and resulting poor outcomes and although there is no evaluation at present, it indicates a willingness to co-produce appropriate services and tackle racism and discrimination and reduce ethnic inequalities in outcomes.

Box 56. North East London maternity and neonatal system equity and equality strategy and action plan (666)

North East London has the highest birth rate in the UK. In December 2022, NHS North East London (NEL) published its vision to improve equity for mothers and babies from ethnic minority groups and those living in the most deprived areas, and to improve equality in experience for staff from ethnic minority groups, within the NEL local maternity and neonatal system.

The published vision is designed to support NEL to achieve the NHS's four pledges to improve equity for mothers and babies and race equality for NHS staff in England:

Pledge 1: The NHS will take action to improve equity for mothers and babies and race equality for NHS staff

Pledge 2: Local maternity systems will set out plans to improve equity and equality

Pledge 3: Local maternity systems will receive support to improve equity and equality

Pledge 4: The NHS will measure progress towards the equity aims.

As part of its engagement and coproduction in developing a strategy and action plan to help deliver improvements in this space, NEL worked with Healthwatch and Maternity Mates to better understand the experiences and expectations of the women in their care. By meeting women in a variety of community-based settings, it was able to gain insight into their experience of maternity services and identify themes and areas for improvements.

The key themes focused on engagement, communication, information sharing and consent. It was evident that some difficult experiences and poor outcomes could have been different with more accessible information, stronger communication, greater cultural awareness and a trauma-informed approach. With these themes identified, an action plan has been developed, worked on collaboratively with maternity staff, public health colleagues, and Maternity Voice partnership chairs. The action plan will provide direction for the five maternity units in North East London to have an equity lens in all these areas over the five years 2022–2027. At present they have established several practices and projects to support health inequalities across NEL's communities.

There are well-evidenced approaches that show improvements in maternal and child health outcomes for women and babies from ethnic minority groups. These approaches show the need to include communities in the design and delivery of maternity services, to ensure effective and culturally sensitive engagement and communication, and to provide targeted support where it is needed most. To ensure that such approaches are developed at scale across maternity and postnatal services in London, there needs to be a strengthened focus on reducing ethnic inequalities, tackling racism and the necessary capacity and investment for implementation. Additionally, as women from ethnic minority groups are regularly underrepresented in research and data and, consequently, in the design and delivery of services (due to inaccurate or incomplete ethnicity data held by trusts), there must be routine collection of outcomes and experiences of maternity and postnatal services by ethnicity, based on consultation with ethnic minority groups. (664)

The NHS Core20PLUS5 covers key aspects and different lenses on health inequalities but does not explicitly focus on the social determinants of health or on the impacts of racism and discrimination. It does have a focus on ethnic minority groups related to outcomes in

five clinical areas. In order to make informed decisions regarding ensuring equitable access, experiences and outcomes, ICSs are expected to firstly recognise their Core20PLUS population locally and subsequently identify their specific healthcare needs which should include a focus on ethnic minority groups with poor health and care outcomes. (667) (668)

Box 57. Core20PLUS5 – An approach to reducing health inequalities

Launched in 2021, Core20PLUS5 is a national NHS England and NHS Improvement approach supporting the health care system to reduce health inequalities at national and system level. The approach has three components that define a target population, focus on local inequalities and identify five focus clinical areas. The 'Core20' are the 20 percent of the most deprived population, identified by the national Index of Multiple Deprivation (IMD), that take on the disproportionate and overarching impact of deprivation on access, experience and outcomes.

The 'PLUS' group constitutes an additional focus on local health inequalities in intersecting population groups, such as ethnic minority groups; inclusion health groups; people with learning disabilities and/or autism; coastal communities with pockets of deprivation hidden among relative affluence; people with multi-morbidities; and protected characteristic groups; among others. Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

Lastly, the '5' identifies five key clinical areas priorities in the NHS Long Term Plan, that require accelerated improvement. These include: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding and optimal management and lipid optimal management. (668)

Given the experiences of racism in healthcare, it is clear that NHS organisations and senior leadership need to take a more proactive antiracism position and apply a racial equity lens in the design and development of policies and interventions. The NHS has made some important improvements in this area recently which can be strengthened, and the establishment of the NHS Race and Health Observatory is making important contributions in that endeavour.

5B. RACISM AND MEDICAL PRACTICE, TECHNOLOGIES AND RESEARCH

There is increasing evidence showing that clinical standards and practice developed for White patients may not be appropriate for some patients from some ethnic minority groups. There are also gaps in medical knowledge about differing risks of disease by ethnicity. Some of those were described in Section 3 and we suggested there that health care services and public health must be much more attuned to these ethnic differences. Here we overview how medical practice including diagnoses and treatment, research and new technologies are based on research, education and training and medicines centred on White people can be inappropriate and harmful for other ethnic groups.

MEDICAL PRACTICE

In 2021 the RHO published a report highlighting that pulse oximeters, devices used to estimate the level of oxygen in the blood, are not as accurate for patients with darker skin tones. (669) The report found that pulse oximeters overestimate the amount of oxygen in the blood of people with dark skin. Evidence from the US showed these biases leading to delayed diagnosis and treatment and death in Black patients. It recommended that the inaccuracy should be recognised and adjustments in practice made to counteract when using existing devices, but that new devices should be developed with higher standards for approval, including clinical data to show accuracy overall and in groups with darker skin tones. (669)

An independent review into equity in medical devices in 2024 found that other medical devices are biased, and recommended modifications, equity assessments and improved regulation. (670)

A 2023 RHO report into neonatal assessments for cyanosis and jaundice, and the Agpar score looked at how these tests have the potential to disadvantage babies with darker skin tones as they have been developed with White European babies as the standard. (671) These tests are routine health checks for newborn babies and all three of the assessments involve assessing skin colour in babies. The review points to assessment methods that are more reliable and consistent for babies with darker skin which should be implemented instead. The review identified a lack of appropriate training for healthcare workers and parents in identifying these conditions among diverse populations. While the report team did talk to healthcare professionals who knew these tests could be problematic, they recommended the need for more consistent training, including establishing a national image database on the presentation of symptoms in babies of different ethnicities. (671)

There are also biases in dermatology services where assessments are taught on the basis of White skin. This is partly the result of training and education reflected in a the lack of representation of diverse ethnicity in many medical school resources. (672) The organisation 'Mind the Gap' highlights the lack of diversity in medical literature and is providing education resources about what signs and symptoms look like in Black and Brown skin. They have created a clinical handbook of various conditions on darker skin tones.

Box 58. Mind the Gap (673)

Mind the Gap is a freely available handbook of clinical signs in Black and Brown skin. It was created between November 2019 and May 2020 by Malone Mukwende, a medical student, in partnership with senior lecturers at his university, after he noticed the lack of teaching about symptoms and conditions in darker skin when at medical school. The aim is to improve the education of medical professionals and subsequently improve diagnosis and patient confidence and trust in professionals.

NHS Digital is trying to make improvements in representation of people in the photos it has on its website. (674) People use these images to identify their own symptoms, and without a range of skin tones they may not know what to look for. In 2021 they did a rough assessment of the images available on the NHS A-Z of health topics and found:

- Out of 75 pages about skin problems, only 7 described various skin tones
- Out of 61 pages with images, only 3 included an image of non-White skin
- Many other pages about health conditions described how to identify symptoms on White skin only, and 10 of these topics are in the 100 most visited pages on the website.

NHS Digital have started work to improve the diversity of the images on their webpages, in consultation with people from ethnic minority groups who have experienced skin conditions and utilising resources from organisations such as Mind the Gap. (674)

Diseases which only or mostly affect specific minority groups are often poorly funded and there is a lack of research about them and there are complaints of racism which have been overlooked or ignored. Box 59 overviews some of the poor diagnoses and treatment for people with Sickle Cell Disease.

Box 59. Sickle Cell Disease

Sickle cell disease (SCD) is a hereditary blood condition that primarily affects people from Black backgrounds although it can affect any ethnicity. There is a history of racism associated with the diagnosis and treatment of SCD in the UK, associated with views that it only occurs in Black people.

There has been community activism for recognition of the severity of SCD by the medical establishment. An inquiry into avoidable deaths and failures of care for sickle cell patients published in 2021 highlighted serious care failings in acute services and evidence of attitudes underpinned by racism. (675) It found that patients often receive sub-standard care, which varied significantly based on staff and location within the UK. Reports of poor care in general wards and emergency departments were found to have led to patients fearing accessing secondary care or avoiding hospital and causing 'near misses' and patient deaths. The inquiry also found that sickle cell was not widely understood among healthcare professionals, with patients having to educate staff on their condition. Partially due to this lack of awareness, there were also extensive reports of people not being treated with respect and not being believed or listened to. The role of racism in underpinning these negative attitudes was highlighted. In addition to poor care, the inquiry reported that research and services have been chronically underinvested in for decades and continue to be so.

There are many reports over a long period of time of people not being given adequate pain treatment due to doctors and nurses not believing their reports of pain and assuming they were seeking drugs. (676)

One of the recommendations in the report was for the NHS RHO to undertake a study into sickle cell care in relation to race and ethnicity. This research is being done in collaboration with the National Haemoglobinopathy Panel, the UK Forum on Haemoglobin Disorders, and the Sickle Cell Society. It is aiming to provide a strong evidence base for comparing SCD care and research with other rare inherited diseases. It is scheduled to be published in September 2024. (677)

RESEARCH

Health research has the potential to highlight some of the ethnic inequalities in health in the UK and recommend solutions. However, lack of diversity in medical research exacerbates existing ethnic health inequalities. A 2022 analysis of racism in health research found systemic barriers across all areas of UK health research, including commissioning, implementation, assessment and publication. Ethnic minority groups are also often under-represented in communities involved in research leading to inadequate research on critical issues. (678)

The National Institute for Health and Care Research (NIHR) is the largest funder of health and care research in the UK. Its diversity data report for 2022 shows that applicants from ethnic minority groups are less likely to be successful than White applicants and are underrepresented on funding committees.

NIHR established a Race Equality Public Action Group (REPAG) in 2020 which aims to give ethnic minority groups a stronger voice in shaping priorities for research.

The group is co-chaired and led by public contributors of Black African, Asian and Caribbean heritage working alongside NIHR staff and members of the academic, health and care communities. (679)

Following community consultation with representatives from ethnic minority groups REPAG identified four main barriers to engagement with health research:

1. Harm, betrayal, recognition and repair – enduring issues of harm, betrayal, trauma and loss of confidence caused by racial injustices and cultural incompetencies.
2. Inequity, loss of value, partnership, shared value – community participants in research have neither been treated equitably, nor have derived value from the benefits of their involvement.
3. Stereotyping, lack of diversity, misdiagnosis, respecting difference – diversity among and between communities is routinely ignored, misrepresented, or stereotyped leading to misdiagnosis.
4. Tickboxing, consultation fatigue, eurocentrism – community members experience collective 'consultation fatigue' and are sceptical of research consultations and 'tick box' exercises, with little meaningful action or outcomes that benefit the community consulted. (680)

The Ethnicity and Health Unit, Box 58 was established in 2021 at Imperial College London in partnership with the North West London Applied Research Collaboration. Its aims are to advance health equality for ethnically diverse communities through research.

Box 60: The Ethnicity and Health Unit (681)

The work of the Ethnicity and Health Unit involves:

- Establishing a community of researchers focused on understanding health issues relevant to ethnic minority groups.
- Creating opportunities for ethnically diverse individuals to progress in academia and education through scholarships and mentoring.
- Producing data and intelligence to enhance the evidence base on health inequalities in ethnic minority groups.
- Supporting policy, practice and strategy which would enable equity in health and healthcare across ethnic minority groups.

The unit delivered the Northwest London multi-partnered NHS England Integrated Care System Research Network Development Programme. This program aims to facilitate more creative ways to engage people from marginalised communities in health research. They are developing a research network reflective of local communities' challenges and needs; generating evidence of the impact of multi-organisational partnerships to improve diversity in research; building local capacity in research and health; and engaging with local stakeholders. (682)

TREATMENTS AND NEW TECHNOLOGIES

Ethnic differences in responses to some drugs may be the result of genetic differences but they may also relate to interactions with the health care system of the type that we have documented above. There is evidence of differences related to ethnicity in chemotherapeutic drug response or toxicity. But there are also issues related to racial stereotyping that may lead to inappropriate guidelines. (683) (684) (685)

Improved precision medicine could help in tailoring treatment to specific patients' needs in these cases. However, as highlighted by the RHO there are new dimensions of ethnic health inequalities emerging in the development of new technologies.

In 2024 the RHO showed ethnic inequalities in genomics precision medicine. Precision medicine uses greater understanding of genetic variation in groups and individuals to develop efficient tailored treatment. The report found that there was a significant underrepresentation of ethnic minority groups in genomics and precision medicine research, with resulting inequities in access to genomic medicine services. It also reported that there was a lack of trust from ethnic minority groups about the research, and recommended improvement in the diversity of the workforce and training in cultural awareness. (686)

An Independent Review into equity in medical devices looked at devices enabled by AI and showed how existing societal biases and discrimination can be incorporated into devices and magnified in algorithm development and machine learning, with AI devices largely trained on images of lighter skin tones. (670) The Independent Review's report made several recommendations, including that developers should engage with diverse groups of patients and the public, increased transparency about the diversity and completeness of data through development and improved training for those who may use devices on the risk of biases in AI devices and how to mitigate these. (670)

5C. SOCIAL CARE SERVICES

There are limited reports and data on social care and the experience of social care service users by ethnicity in England.

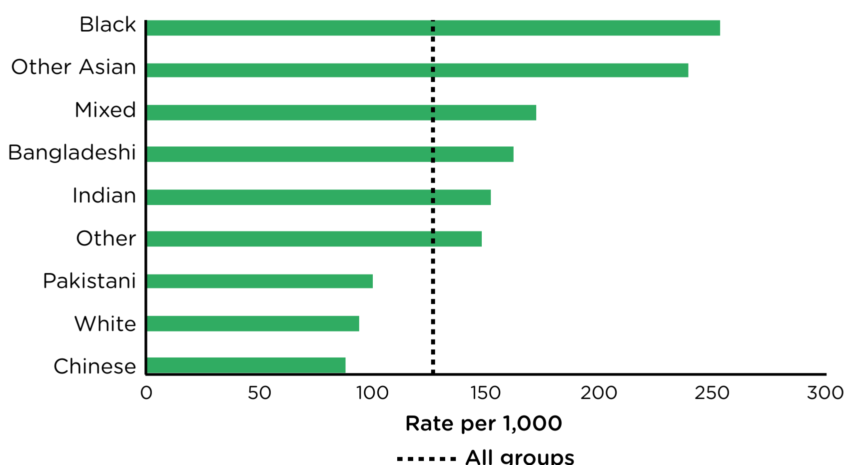
According to the 2022-23 NHS Personal Social Services Social Care Survey the proportion of social care service users was highest amongst Black groups and lowest for other and Asian groups. (687) Mixed and White service users were the most likely to report that they were extremely satisfied with the care and support services they received (28.3 percent), and Asian service users were the least likely (22.7 percent). Black service users were most likely to report that they were extremely dissatisfied. Asian and Black service users were less likely to report that they were extremely or very satisfied with the way staff helped them (57.9 percent and 59.3 percent) compared to White service users (65.4 percent). A higher proportion of White service users (56.6 percent) said that they feel their home meets their needs very well. Service users from the Asian group had the lowest proportion (37 percent) of respondents who felt their home met their needs very well, followed by Black service users (44.1 percent). (687)

5D. EMPLOYMENT IN HEALTH AND SOCIAL CARE AND EXPERIENCES OF RACISM

HEALTH CARE

There are numerous reports of racism within employment and recruitment within the NHS as well as reports of members of the public being racist towards staff from ethnic minority groups. In the NHS, the London region has the highest percentage in England of staff from ethnic minority groups, at 48.1 percent of the workforce (108,503 individuals). Over one-third of all NHS staff from ethnic minority groups work in the London region, with just under one-sixth of the overall NHS workforce in England situated there. (688) Figure 5.5 shows the proportion of workers in each ethnic group employed in health and social care in London in 2022/23.

Figure 5.5. Rate of employment in health and social care, per 1,000 in employment at ages 16 and over, by ethnic group, London, October 2022 to September 2023



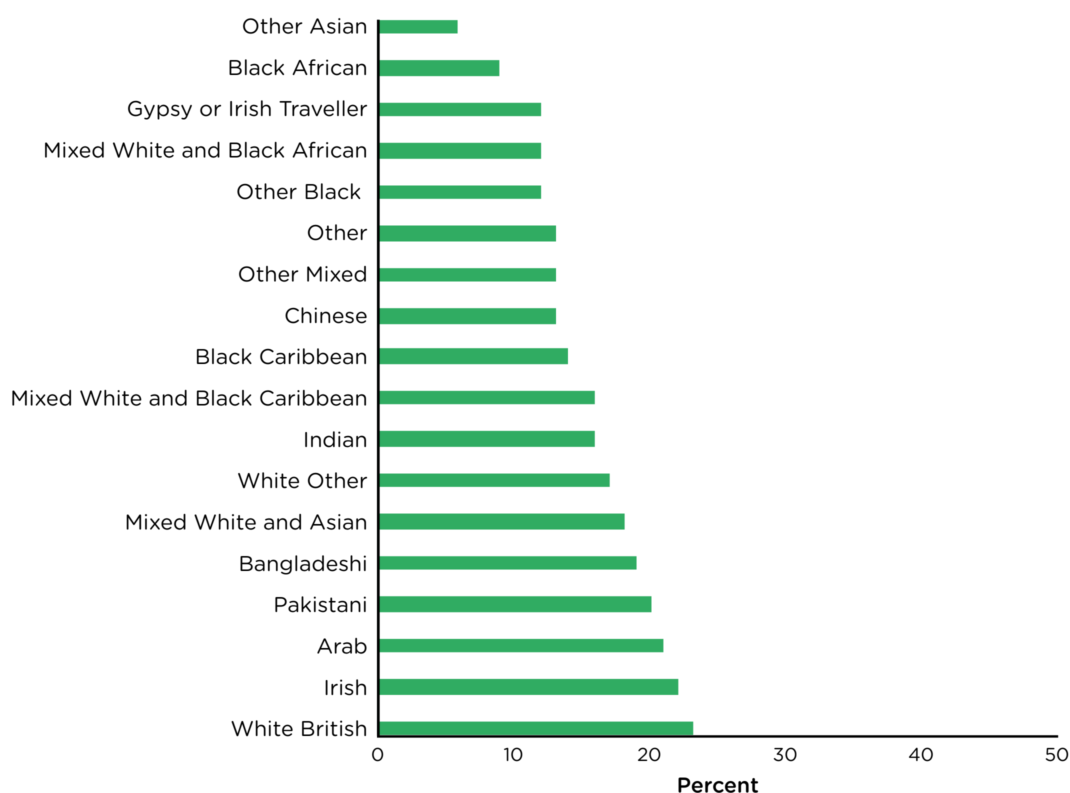
Source: *ONS (689)*

The NHS Workforce Race Equality Standard (WRES) developed in 2015 to ensure employees from ethnic minority groups had equal access to career opportunities and receive fair treatment in the workplace.

The 2021 WRES data report shows no improvement in the persisting inequality that exists in staff appointments made at interview between applicants from ethnic minority groups and White applicants. (688) In 71.5 percent of NHS trusts in England, White applicants were significantly more likely than applicants from ethnic minority groups to be appointed from shortlisting and according to WRES data, in 2021 White applicants in London were 1.62 times more likely to be appointed from shortlisting than applicants from ethnic minority groups. (688) WRES data also shows that the percentage of staff experiencing harassment, bullying or abuse from other staff in 2021 at the UK level was higher for staff from ethnic minority groups at 27.6 percent than for White staff at 22.5 percent. Data show this pattern to have been evident since 2015.

In London, NHS survey data from 2023 show that staff of all ethnicities had reported experiencing harassment, bullying or abuse from patients, service users, their relatives or the public over the previous year. White staff reported these experiences the least, at just over 6 percent, while at the other end of the spectrum, 'other' Asian staff were most likely to report experiencing harassment, bullying or abuse, at 23 percent (Figure 5.6).

Figure 5.6. Percent of NHS staff who in the last 12 months have experienced discrimination from patients/service users, their relatives or other members of the public in work, London, December 2023



Source: *NHS Staff Survey (690)*

In November/December 2021 Health Education England and NHS England and Improvement undertook the first London-wide survey of experiences of discrimination and harassment in the primary care workforce. (691) The number of participants was 1,025, approximately 3 percent of London's total primary care workforce, and respondents were largely representative of age, gender, ethnicity and roles across the wider workforce. Ethnicity was found to be the most common characteristic associated with harassment and discrimination in primary care, more than gender, age, religion or disability. Of those surveyed, 30 percent reported racial discrimination or harassment from patients in the previous 12 months and 18 percent reported that staff they worked with demonstrated these behaviours towards them. People from Black ethnic backgrounds were most likely to say they had experienced racial discrimination or harassment from patients and colleagues. (691) Sixty-six percent of incidents involved subtle or underhand comments or actions, rather than overt or confrontational behaviour, which makes it more difficult for people to question, address or complain. Some of the reported impacts included people losing confidence, feeling upset or anxious, taking sick leave, changing roles and in a small number of cases, having significant effects on their mental health. The survey found that 12 percent of survey respondents had left or considered leaving their role due to racial discrimination or harassment, 27 percent of whom were Black individuals and 15 percent were from Asian backgrounds. (691)

A 2022 British Medical Survey, among doctors and medical students working in the NHS found 76 percent of respondents saying they had been affected by racism at work at least once in the last two years, including 43 percent of those from White British background, 91 percent of Black respondents, 85 percent of Asian and 82 percent of Mixed respondents. Seventeen percent of respondents said they experienced racism regularly. These experiences were greater for doctors who had qualified overseas, who also were more likely to think that racism was a barrier to their career progression than those from ethnic minority groups who had qualified in the UK. The survey also showed that most respondents who were affected by racism chose not to report it due to a lack of confidence in it being addressed or worries about how they would be perceived. Respondents who had reported racism stated that no action being taken was the most common outcome, and over 50 percent

said reporting an incident had a negative impact on them. As well as racism, respondents reported religious and gender discrimination. The report also includes examples of good practice and institutional policies aimed at tackling racism. (692)

A recent survey with stakeholders from the health and social care system in London indicated that reporting racism within organisations needs considerable strengthening and interviewees pointed ways forward. The report provided a summary of approaches aiming to dismantle structural barriers to ethnic minority groups' representation, recruitment, progression and retention. (693) Stakeholders identified that more attention should be paid to how complaints are made and dealt with and exploring the work of the regulators. Stakeholders talked about changing the approach to complaints by shifting the focus from the individual to the system as complaints might reflect the work culture. While stakeholders did not suggest any concrete interventions to address this, they suggested exploring why people get into these situations or why people fail, and to develop interventions based on these findings. Where organisations had created roles and systems to support staff to voice their concerns and creating safe spaces to do so e.g., cultural ambassadors, staff networks, freedom to speak up guardians, safe space clinics and carer forums, the response to concerns was seen as crucial as staff would feel discouraged to speak up if their voiced concerns did not result in any changes. Stakeholders also talked about psychological safety, creating safe spaces where staff feel comfortable speaking up. Stakeholders said that what was small for one person could be significant for another, and so all complaints should be taken seriously. (693)

A report from the Royal College of Nursing revealed experiences of physical abuse by patients, service users or relatives were highest among Black respondents. There were also disparities in terms of career progression, with Black and Asian respondents less likely to say they had received a promotion since the start of their nursing career than White or Mixed ethnicity respondents. (694)

Organisations in London's health and care system have made public commitments to being antiracist. They are working individually and collaboratively to turn their commitments into action. Collaboratively, their work is being supported by cross-sector tools and leadership, which have developed through the above Boards and Groups. This includes ways in which antiracism approaches could be developed in the health care and public health system in London, set out in Box 63, Section 6.

EMPLOYMENT IN SOCIAL CARE

A 2022 report surveying registered social workers in England found that racism within social work is widespread and has a serious impact on Black and ethnic minority social workers' wellbeing and progression. (695)

The Social Care Workforce Race Equality Standard (SC-WRES) is a voluntary programme that supports organisations to address evidence and make progress towards race equality. (696) It requires local authorities to report data on nine indicators, to track and address differences in experiences of Black, Asian and ethnic minority staff. It was established in 2022 with 18 trial local authorities. Funding from government was withdrawn and Skills for Care agreed to fund another year to test sustainability. It is an important programme as it increases the data collection by local authorities and provides a much-needed picture of ethnic inequalities in experience of working in social care. Whether the programme will continue is not clear. Their 2022/23 report shows that London has a far higher proportion of workers from ethnic minority groups, in particular Black workers, in adult social care than the rest of England. An estimated 47 percent of the adult social care workforce in London are Black, compared to 14 percent for England; 14 percent are Asian in London compared to 9 percent for England; and 29 percent are White compared to 73 percent for England. (698)

A lack of career progression and representation in senior positions were among the top-three challenges facing workers from ethnic minority group in social care. Data produced for the EHRC by Skills for Care found that care workers from ethnic minority groups in the independent care sector were more likely to be on zero-hours contracts than their White British colleagues. Staff from ethnic minority groups tend to be over-represented in lower-paid, commissioned-out and outsourced roles. Evidence also suggests that workers were often unaware of their rights. This is a particular issue for migrant workers and those working in outsourced roles. Given these inequalities amongst those working in social care and the higher rates of social care workers from ethnic minority groups in London, this is an issue that needs more attention. (697)

The 2023 SC-WRES report compares data from 23 local authorities. They found that, in the past 12 months, workers from ethnic minority groups were half as likely to be appointed from shortlisting compared to White staff; were 40 percent more likely to enter the formal disciplinary process than White staff; 20 percent more likely to have experienced harassment, bulling or abuse from service users, relatives or the public than White staff, and 30 perfect more likely as a colleague and 90 percent more likely as a manager to have experienced harassment, bullying or abuse from colleagues and managers compared to White staff. There was also a smaller proportion of staff from a Black, Asian or ethnic minority group in the higher pay band of '£70,000 and over' (15 percent), compared to the proportion of total staff from all responding local authorities from Black, Asian and ethnic minority groups (19 percent).

RECOMMENDATIONS: END RACISM IN HEALTH AND SOCIAL CARE

1. Eliminate racism and ethnic inequalities in access to NHS services and in quality of experiences and outcomes through coproduction, increased investment, education and training, provision of appropriate support and culturally informed practices.
2. Address racism and systemic bias in diagnoses, treatments, medical devices, AI and resource allocation.
3. Eliminate racism in NHS and social care employment with greater equity in recruitment, pay, progression and seniority.
4. Ensure awareness of racism in the NHS and social care among both providers and users and apply appropriate sanctions.

ADDITIONAL RESEARCH AND EVIDENCE

- Further research on the extent of racism in all NHS and social care services.
- Through collaboration with ethnic minority groups improve the collection of data on outcomes and experiences in health and social care services by ethnicity.

CHAPTER 6

TAKING ACTION ON RACISM – THE ROLE OF ORGANISATIONS AND SYSTEMS

This report has set out a number of significant ethnic inequalities in health and its social determinants in London which relate to structural and institutional racism and their impacts and has overviewed some of the many reports of racism within organisations that employ and provide services to Londoners. In Sections 4 and 5 recommendations were made for health care and in each major social determinant of health to support action to reduce racism and tackle unfair and avoidable ethnic inequalities. Racism is a form of structural injustice. We proceed from the assumption that by removing racism from the way institutions function, it makes it more likely that individuals will act in ways that make racism unacceptable in the wider functioning of society.

This section sets out principles for all organisations and sectors to strengthen actions on racism and lead the way in reducing the unfair ethnic inequalities which result. This requires leadership and strengthened accountability, capacity building, community coproduction and sufficient funding and resources. Action on all these areas is essential for all organisations in London, particularly as current legislative and regulatory mechanisms are too weak to be effective in holding many organisations to account. There is considerable scope for legislation and regulatory mechanisms to be strengthened.

Dominant cultures and histories and unfair legal and economic and political systems bear much of the responsibility for ongoing racism and discrimination, but even within this broad structural context there are approaches to tackling racism and mitigating its impacts which are beneficial and which, along with advocacy and education can challenge these structural drivers. The recommendations in this report are aimed at policy makers, the legal system and leaders and organisations in many sectors which shape our health.

6A. LEGISLATION, REGULATION AND ENFORCEMENT

THE EQUALITY ACT

In the UK individuals are protected against racial discrimination under the 2010 Equality Act. The other protected characteristics included in the Equality Act are age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, religion or belief, sex and sexual orientation. (698) The Act is intended to protect individuals against the four types of discrimination identified in the Act: direct discrimination, indirect discrimination, harassment and victimisation. (699)

Under the Equality Act, individuals are protected from discrimination in the workplace, in education, when using public services, when buying or renting property, when using business or organisations that provide services and goods, when using transport, when joining a club or association and when in contact with public bodies. Individuals can take action against any of these bodies or organisations if they feel they have experienced discrimination against a protected characteristic. However, as outlined in this report racism persists in many of these arenas in London and it is often very challenging for individuals to report.

The Equality Act also sets out the Public Sector Equality Duty (PSED). This general equality duty applies to public authorities. In summary, those subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not. (700)

There are specific equality duties that require public authorities to publish information on how they are complying with the duty and set and publish equality objectives. (701)

The Equality and Human Rights Commission (EHRC) is an independent, statutory regulatory body responsible for enforcing all parts of the Equality Act. The EHRC was established in 2007, when three separate commissions responsible for race, sex and disability were combined into one regulatory body. The EHRC is responsible for encouraging equality and diversity, eliminating unlawful discrimination, and protecting and promoting the human rights of everyone in Britain. (702) While the Equality Act and EHRC are important for protecting and promoting equality there are limitations to their powers and capacity to take action.

The EHRC does not investigate structural or institutional racism, as these are not legal terms. They can investigate failures to comply with the Equality Act that have an impact on ethnic minority groups. The limitations of the scope of the EHRC means that there are no bodies investigating structural or institutional racism, only breaches in compliance with the Equality Act and responses to individuals who make complaints.

Since 2017, the EHRC has had a fund for legal support for race discrimination cases for individuals. It has helped fund cases of workplace racial discrimination using this fund, with some positive outcomes. However, these are individual cases and do not necessarily lead to widespread change and the onus is on the individual to initiate and see through actions – a significant challenge and responsibility. (703)

A 2019 report from the Women and Equalities Committee, a cross-party committee appointed by the House of Commons, on 'Enforcing the Equality Act: the law and the role of the Equality and Human Rights Commission' looked into how effective the EHRC is in enforcing the Equality Act. (704) It found that current legislation and action from the EHRC place an undue burden on the individual facing discrimination, too often requiring individuals to fight discrimination in the courts. This may lead to some resolution for individuals, if they do take on the burden, but does not lead to the necessary and wider systemic change. (704) The Committee also found that there had been a reduction in the use of EHRC's investigative powers between 2009/10 and 2019 and that it is mainly reactive rather than proactive. It recommended that the EHRC significantly increases its enforcement work and publicises that work, reducing the reliance on individual complainants. It also recommended that the EHRC publish data on its enforcement activity, including both formal and informal compliance work. (704)

The report also made recommendations regarding the more than 90 other regulatory bodies, in the UK, which are all covered by the PSED. (705) As public bodies, all regulatory bodies should be using their powers to secure compliance with the Equality Act 2010 in the areas for which they are responsible, such as education, housing,

healthcare and the criminal justice system. The Women and Equalities Commission stated that these regulatory bodies are better placed than the EHRC to combat routine, systemic discrimination, where the legal requirements are clear and employers, often service providers and public authorities, ignore them because there is no realistic expectation of sanction. (704) Strengthening the powers of regulatory bodies would supplement the work of the EHRC, enhance the enforcement of the Equality Act and enable the EHRC to focus on its strategic enforcement role and act where its expertise and unique powers are most needed. The report recommended that regulatory bodies must be a priority target for investigation over their failings to implement their PSEDs (704)

The EHRC's response to the Women and Equalities Committee's report agreed that burden for compliance with the Equality Act needs to be shifted away from individuals and stated that its strategic plan included increasing the role of enforcement in its work. It also agreed that more onus should be placed on public sector organisations and regulatory bodies to root out discrimination. It stated that it would like to see a clear duty for oversight bodies to inspect for progress on the delivery of equality outcomes within their sector. However, it does not think these bodies should have powers to enforce the Equality Act. (706)

An example of EHRC's application of enforcement powers is its assessment of the 2018 policies from the Home Office which led to the Windrush scandal, Box 61. It is important to note that the enforcement followed the enaction of Windrush policies and following public outcry about the impact of these policies on ethnic minority groups; the assessment and enforcement was not proactively initiated by the EHRC - highlighting its reactive approach in tackling racism.

Box 61. The Windrush Scandal: EHRC investigation of public body PSED duty

Following the public attention on the Windrush Scandal and the Government's "hostile environment" policies in 2018, the EHRC used its enforcement powers to investigate whether the Home Office had complied with its PSED obligations in developing, implementing, and monitoring hostile environment policies. Its findings were that the Home Office had failed to develop and implement immigration policies that were fit for purpose for the Black people affected by them. (707)

There are some exceptions to the Equality Duty in relation to the exercise of immigration and nationality functions. The Home Office is exempt from the obligation to show due regard to race in advancing equality of opportunity when carrying out immigration and nationality functions. However, the PSED still applies in the case of racial groups defined by reference to colour. The investigation found that the Home Office showed an inconsistent and sometimes incorrect understanding of how parts of the PSED intersected with immigration law, policy and practice. (707)

The investigation found insufficient evidence of the Home Office showing due regard to the need to advance equality of opportunity in relation to colour (the language used in the PSED) and that the Home Office did not comply with section 149 of the Equality Act 2010 (the PSED) in understanding the impact on the Windrush generation and its descendants when developing, implementing and monitoring the hostile environment policy agenda. The investigation also concluded that outcomes to the members of the Windrush generation affected were 'foreseeable and avoidable'. (707)

In November 2020 the EHRC published its assessment and set out recommendations for the Home Office to help them comply with the PSED. In 2021, it entered into a legal agreement with the Home Office under section 23 of the Equality Act 2006. This commits the Home Office to a two-year plan of improvements it will make to show that it:

- Looks for and properly considers evidence and feedback from stakeholders representing affected groups to understand the equality impacts of policies and practices
- Has a clear understanding of equality data and evidence that it uses to inform decisions and policymaking at all levels, including of the potential and actual impact of the department's work on different protected characteristic groups and
- Has taken meaningful action to improve internal knowledge and expertise on how to comply with the PSED. (708)

This legal agreement was extended by a year, until 31 March 2024. If the Home Office does not adhere and implement the plan, the EHRC can take further enforcement action. (709) In April 2024 the EHRC recognised improvements from the Home Office in relation to some of these recommendations. Despite not completing all the actions, the legal agreement with the EHRC has been ended, with commitment from the Home Office to continue working on the remaining requirements. (709)

A report in 2020 from the Joint Committee on Human Rights, appointed by the House of Commons and House of Lords, on *Black People, Racism and Human Rights*, noted that there is a perception among the Black community that the replacement of the Commission for Racial Equality with the EHRC has resulted in weaker focus on race equality issues. (711) It recommended that, for the EHRC to be a more effective enforcer for Black people's human rights:

1. Black people must be represented at the top level of the organisation including as commissioners.
2. The EHRC must have adequate resources, urging the Government to restore its budget to previous levels.
3. The Government must harmonise the EHRC's human rights enforcement powers (as set out by EHRC) in line with its powers in relation to equality (set out by the Equality Act), so it can undertake investigations where it is suspected an organisation has breached the Human Rights Act, and provide legal assistance to individuals in Human Rights Act cases.

The Joint Committee on Human Rights recommended that an individual national body be established, focused on race equality, and supported the Women and Equalities Committee's recommendations for more focused and strategic specific duties under the PSED. (711) Given some of the limitations of the EHRC and other regulatory bodies in protecting communities from discrimination on the grounds of race and the extent of persistent discrimination and racism in many organisations, a specific national body focused on race and equality should be established.

In 2020, the Labour Party announced plans for the inclusion of a Race Equality Act if it was to form a government and that this would focus on disproportionately low rates of pay, tackling workplace discrimination, tackling disparities in healthcare, in particular the maternal mortality rate, and following through on the remaining recommendations of the Lammy review (541). It appointed Lady Doreen Lawrence to lead a race equality taskforce to draw up policies to tackle structural racism. (712) In February 2024 the Guardian published an update detailing that the Labour Party, if in government, would extend the full right to equal pay that exists for women, to ethnic minority groups, and mandate ethnicity pay gap reporting. Other proposals included are introducing new targets for maternal health discrimination and inequalities experienced by many women from ethnic minority groups, and enacting protections against dual discrimination. This means that a person bringing a discrimination claim for multiple protected characteristics, such as gender and race, can bring one claim, rather than bringing two separate claims as currently, and that the Act would include the appointment of a Windrush commissioner to monitor the compensation scheme. (713) These approaches are conducive to strengthening accountability for discrimination and racism, for improving conditions in the social determinants and reducing discrimination and racism in healthcare services. All these have been highlighted as beneficial in this report. In the King's Speech following the 2024 General Election the Government introduced the Draft Equality (Race and Disability) Bill, outlining the Government's intention to publish draft legislation which would enshrine in law the full right to equal pay for ethnic minority groups and disabled people and to introduce mandatory pay gap reporting for these groups. (714)

A report from the ESRC Centre on Dynamics of Ethnicity at the University of Manchester, analysing the 2015 Business in the community (BITC) Race at Work Survey, highlighted the persistence of racism within the British labour market, despite the legislation. Its recommendations to Government included that the EHRC should be given an adequate level of 'ring-fenced' funding that will enable the Commission to ensure that employers comply with existing legislation and equality duties. It also said the EHRC should be given further power to apply sanctions in cases of non-compliance, particularly in cases of systemic non-compliance. (715)

HATE CRIME LEGISLATION

Incitement to racial hatred has been a criminal offence since 1965, with later laws introduced around religious belief and sexual orientation. This offence is infrequently prosecuted. (716)

Hate crime is a legal designation which can support holding individuals to account for some forms of racism. It is covered by legislation which allows prosecutors to apply for an uplift in sentence for those convicted of a hate crime. (717) Following the Stephen Lawrence Inquiry Report in 1999 the police and the CPS agreed the following definition for identifying and flagging hate crimes:

"Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability or perceived disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation or transgender identity or perceived transgender identity." (718)

There is no legal definition of hostility so the everyday understanding of the word is used which includes ill-will, spite, contempt, prejudice, unfriendliness, antagonism, resentment and dislike. (717) There is inconsistency in the application of the legislation and hate crime law is difficult to prosecute. Victims withdraw from proceedings at a higher rate than other types of crime. In 2020, hate crimes had an abandonment rate of 32 percent compared to 25.3 percent for other types of crime. (719) One suggestion of the cause is an issue of trust where victims from minority groups have low trust in the police. (719)

Between 2012-2023 there have been 709,599 racially motivated hate crimes recorded by police in England and Wales. Race is the most common motivating factor for hate crime, and recorded race-motivated hate crimes increased 189 percent between 2012 and 2023, although 2022-23 was the first year since 2012 there had been a decrease in recorded crimes. (720) This overall increase is thought to be due to improved recording of these crimes from the police and better identification of what constitutes a hate crime. (721) Data from 2022/23 showed that only 7 percent of hate crime offences ended with a charge or summons, 7 percent were either settled out of court or action was deemed not in the public interest or taken by another body, 11 percent were waiting to be assigned an outcome, and 74 percent did not result in any further action, either due to lack of evidence, the victim not wanting to pursue further action or no identified suspect. Racially or religiously aggravated offences related to causing public fear, alarm or distress are more likely to result in a charge or summons than non-aggravated offences of the same kind. (720)

Hate crime laws are different from hate speech laws, which are specific offences to counter the dissemination of inflammatory material that is designed to incite violence, inflame community tensions, or instil fear among or of particular groups. Prosecution numbers for hate speech offences are very low.

Given the lack of a legal definition and the low prosecution and charge rate under hate crime and hate speech legislation it is clear that the legislation needs legal definition, better enforcement and more successful prosecution.

HEALTHCARE INEQUALITY DUTIES

As this, and many other reports, have set out, there are clear ethnic inequalities in access, experience and outcomes from services particularly for maternal and child health and in mental health. There are many reports of racism within services. The NHS has to meet its PSED obligations, but in some services it is clearly failing to do this for some ethnic minority groups.

The Care Quality Commission (CQC), the independent regulator for all health and social care services in England, has an equality statement outlining tackling inequalities as a core ambition of its strategy. It states that it will use its monitoring and regulatory activity to ensure health and social care services are taking steps to tackle inequalities in care. It names ethnic minority groups as one of the initial focus of its equality objectives. In 2023 it had a 'listening, learning, responding to concerns' review of its own practices. The review found clear evidence of widespread lack of competence and confidence within CQC around understanding and identifying race and racism. (722) The review showed there is a lack of understanding about the requirements placed on the CQC by the PSED, and its regulatory responsibilities. Since the review findings, the CQC has been working with the EHRC to address these shortfalls. (722)

Since 2012, in addition to the PSED, the NHS is required to meet duties related to health inequalities. A Health Inequalities Duty was introduced to the Health and Care Act 2012 and updated in 2022 with new duties relating to health inequalities for Integrated Care Boards (ICBs). This includes a requirement to reduce inequalities in respect of access to health services, and to reduce inequalities in outcomes achieved by the provision of health services. There is also a requirement to publish data in relation to these duties. While the duties have led to a stronger focus on health inequalities within organisations in the NHS, there is a very limited amount of testing of these duties. NHS England has statutory responsibility for assessing how ICBs have worked to meet their obligations regarding health inequalities.

The NHS Outcomes Framework (NOF) is a set of indicators that monitor the health outcomes of adults and children in England and provides an overview of how the NHS is performing. These indicators are, where possible, broken down by ethnicity, deprivation, religion and gender. The indicators should be able to monitor how the NHS is meetings its equality duties. A response to the consultation on the NOF in 2024 is ongoing, with proposals that only a limited number of indicators be published on an annual basis. (723)

6B. ORGANISATIONAL ACTION ON ANTIRACISM

Above we summarised the legal and regulatory obligations under the Equality Act and other racial discrimination laws which must be complied with, although often are not. In this section we overview the role of organisations in pushing further and beyond legislative requirements in tackling racism. While there is no requirement for them to do so, many public sector and private sector organisations are going beyond the legislation and developing as antiracism organisations which can, if well developed, further strengthen action and accountability on racism.

There are several important elements to developing as antiracism organisations which have been implemented, and they often follow a similar set of principles. (724) (725) (726) They require strong leadership and organisational accountability for racism and discrimination, they require capacity building at all levels, they must be developed in close collaboration with affected communities, have sufficient funding and resources and be backed up by research and monitoring.

LEADERSHIP ON ANTIRACISM WITHIN ORGANISATIONS

Structural racism requires leaders to effect comprehensive and consistent change for the long term. Leaders must challenge racism within organisations and society more broadly, establishing clear reporting lines and accountability systems for the organisation, developing approaches and policies with communities, building understanding among the workforce, using the position for broader advocacy within and outside the organisations and ensuring sufficient resources to achieve these aims. Leaders can also encourage other people within the organisations to be part of social movements for changes.

There have been some steps taken through the establishment of Equality, Diversity and Inclusion (EDI) leads and policies in many organisations. Organisational antiracism approaches build on these and strengthen the focus on racism, while EDI policies cover all forms of discrimination.

As well as identifying that racism is an issue societally and within an organisation, leadership on antiracism requires actions that can be operationalised, including through delivery plans and capacity building, so that the whole workforce, including leaders, can understand the drivers of ethnic inequalities, how racism operates and how to speak about it and call it out. The principles below have been developed from the principles of Camara Jones, a leader in the USA for antiracism in the field of public health.

Box 62. Camara Jones launched a National Campaign Against Racism with three tasks (726):

1. **Naming racism** – Start by naming racism as a system that structures opportunity and assigns value based on social interpretation of race and unfairly disadvantages some individuals and groups, unfairly advantages other individuals and groups, and saps the strength of the whole society.

2. **Asking "how is racism operating here?" –** Racism is pervasive throughout structures, policies, practices, norms and values. Evaluate the mechanisms of racism, paying particular attention to absence (of people involved in the conversation, of what is on the agenda) in order to take action to fill in the gaps.

3. **Organising and strategising to act –** building an antiracism collaborative. Further detail is available. (727)

Camara Jones' principles for developing antiracism organisations could be used to develop action across the London system. Box 63 sets out how these principles could be adopted.

Box 63. Say it, see it, act on it

Naming it (verbally declare the word racism) (726) (728)

In addition to examining data for local populations, leaders have a role in encouraging and taking part in reflexive practice within their organisations. Understanding their own organisation through active listening and learning from their teams about how racism has had an impact on them will facilitate a deeper understanding of structural racism, and the health inequalities that are evident among the staff. Similarly, a reflection of their own biases can help leaders to be better allies for minority ethnic groups.

See it (ask "how is racism operating here")

Teams and organisations need to have self-knowledge and understanding surrounding race and racism. This review has provided a strong narrative on the state of ethnic health inequalities, with identification of drivers and more risk factors that mediate the impact of racism on health and care experience and outcomes. Data can help organisations to prioritise, target and monitor action. However, describing the problem is not a solution, and although we have an incomplete understanding of the pathways, there are actions that we can start immediately to enable change.

Act on it (organise and strategise to act)

Structural racism and health inequalities require a systematic approach to change, to tackle racism at all levels, that is linked to funding, sustained action and a willingness to change.

- Coproduction of antiracism strategy alongside community organisations
- Monitor and support board representation so that the leadership team better reflect the ethnic composition of the communities that they serve
- Gain support
- Develop senior leadership alignment – setting out the case for EDI and tackling racism
- Support from staff, promote staff development
- Align words with resources – allow time for training, funding the work, dedicated teams to develop plans
- The London population and health and care and other workforce have high proportions of diverse ethnic groups, with differing values, beliefs and behaviours. In order to provide appropriate and accessible care, interventions should be culturally tailored. Training to promote cultural competence and awareness is essential for effective care. This requires additional resources.

There are other, well-aligned frameworks for developing antiracism organisations, including an approach for business, many originating in the US. (729) Due to their relative recency it is difficult to establish impact, but given the evidence we have presented and the reports of what needs to happen we understand that the approaches are supportive when combined with accountability and resources and community involvement.

Wales has developed principles for becoming an antiracist country by 2030. There are approaches which are relevant to London.

Box 64. Antiracist Wales (730)

The Welsh Government published an antiracist Wales plan in 2022 – with the aims of making Wales an antiracist nation by 2030. It made this explicitly antiracist after public consultation. This codesign meant the Welsh Government adapted its initial plans according to the feedback from the consultation.

It describes its antiracist approach as:

"Adopting an antiracist approach requires us to look at the ways that racism is built into our policies, formal and informal rules and regulations and generally the ways in which we work."

It has introduced three key aspects of measuring delivery of this plan:

- Clear measures of successes
- An external independent accountability group
- Resources – race disparity evidence unit, equality data unit to improve quantitative and qualitative data.

It is focused on six ways racism impacts ethnic minority groups as the focus of its action plan:

- Experience of racism in everyday life
- Experience of racism when experiencing service delivery
- Experience of racism in being part of the workforce
- Experience of racism in gaining jobs and opportunities
- Experience when they lack visible role models in position of power
- Experience of racism as a refugee or asylum seeker.

It has also focused on the leadership within the Welsh Government and the Welsh public sector (730)

APPROACHES TO ANTIRACISM AT A LONDON LEVEL AND IN BOROUGHS

As noted in Section 1 of this report, the GLA has provided leadership and action on antiracism and is working to strengthen antiracism in its own organisation and in organisations the GLA can influence. However, it is mostly too soon to be able to assess the impacts of these changes. Based on evidence from the US, where the approach is more established, there can be important impacts. Here we set out some of the programmes which have been developed on the understanding that they are likely to have positive impacts for highlighting ethnic inequalities and racism and for developing accountability mechanisms and approaches in collaboration with communities.

In 2020 the Mayor of London, Sadiq Khan, declared his commitment to the Greater London Authority (GLA) being an actively antiracist organisation. (731) The health and care system in London has developed a series of strategic and delivery approaches and public commitments to being antiracist, some set out in Section 5. They are working to turn their commitments into action.

Box 65: Antiracism approaches and the GLA and health system in London

A Strategic Framework to Tackling Ethnic Health Inequalities through an Antiracist approach published in 2023. (732) This calls for health and care organisations to make progress on five strategic commitments - leadership, workforce, health equity programmes, anchor programmes and a commitment to communities. All regional partners and ICBs are in support of tackling ethnic health inequalities through an antiracism approach.

The London Antiracism Collaborative for Health (LARCH), launched in 2023 with delivery starting in 2024, is a peer collaboration – including London's ICBs, boroughs, public health and the GLA - that seeks to address ethnicity-related health inequalities in London, by supporting and enabling better practice across London's health and care partners, including antiracist approaches. (732) It aims to achieve this through providing leadership and creating space and opportunity to bring people together to share practice and ideas, learn from one another, explore challenges and unblock barriers to implementing antiracist practices. The idea was scoped and the proposal designed through a community and sector co-production approach, and delivery started in 2024 – led by the Race Equality Foundation and the Health Innovation Network. A monitoring and evaluation plan is being developed and further information on the LARCH will available online as the project develops.

The **London Partnership Board** is a GLA-led cross-sector group comprising leaders from health, local government, the voluntary and community sectors, education, police and trade unions. In 2021 a sub-group of the Board tackling structural inequalities published an action plan, the *Building a Fairer City Action Plan*, to support organisations and institutions in tackling the deep-seated, structural inequalities affecting the lives of Londoners and which underlay the disproportionate impact of the pandemic in London. (733) The plan set out four priorities - labour market inequality, financial hardship and living standards, equity in public services and civil society strength and 14 actions. In addition to tackling the wider determinants of health and structural racism across wider policy areas and sectors – such as ensuring Londoners from ethnic minority groups know their rights and entitlements and have access to good work and are able to progress in work, the action plan also makes it a specific priority to make London a Living Wage City. In Year 1 of the programme, a series of three Action Learning Sets were delivered over four months with outer South London Boroughs. The learning was designed to drive positive change to address financial wellbeing by encouraging local organisations to become living wage employers, providing a safe space to explore challenges, share learning, as well as encourage further action.

The **London Health Board** (LHB) is a non-statutory partnership board, chaired by the Mayor of London, bringing together leaders from across London's heath and care system to drive improvements in London's health, care and health inequalities, where political engagement at this level can uniquely make a difference. (734) Having nominated a Board champion for tacking structural racism (in response to a recommendation from the Building a Fairer City work) , the LHB receives an update on antiracism work at every meeting (as part of the health inequalities programme) and is picked up as part of agenda items.

The **London Health Equity Group** (HEG), a sub-group of the LHB, comprises health equity leaders and champions from across London's health and care system and the voluntary, community and faith sectors. The HEG was originally established in response to the inequalities exacerbated by the pandemic, and in particular ethnic health inequalities relating to COVID-19. The LHB and HEG have a leadership role in many of the London antiracism and health programmes, particularly pan-London, cross-sectoral work which supports collaboration and shared leadership.

In 2020 the **Mayor of London** declared his commitment to the GLA being an actively antiracist organisation. (731) The Mayor has provided leadership on these agendas, as well as committed staff time and resources to antiracism projects. In 2022, the Mayor made the development of the LARCH a key commitment of the London Health Inequalities Strategy. Other GLA projects which support his ambition include providing mentors to young Londoners from disadvantaged backgrounds, funding youth social action projects in schools, the Workforce Integration Network (WIN) which improves pathways to sustainable careers for Black Londoners and publishing the WIN inclusive employers toolkit (Box 66 below), part of the Building a Fairer City Action Plan's commitment to tackling labour market inequality. (735) (733)

As well developing GLA and associated organisations as antiracism organisations the GLA oversees key parts of the London infrastructure and has influence over businesses and other organisations which have an impact on racial equity and on health. In order to support those organisation to develop their antiracism approach the GLA has developed a series of inclusive employers toolkits. (731) (316) The toolkits offer guidance to organisations to help diversify their workforce and foster an inclusive workplace culture. (316)

Box 66. Mayor of London's Inclusive Employer Toolkits (316)

There are Inclusive Employer toolkits for four sectors with toolkits relevant to different-sized organisations, from micro-enterprises to large organisations, within each sector:

1. Creative and cultural industries
2. Green economy
3. Hospitality
4. Healthcare
5. Digital.

The toolkits are organised around five key themes, to support businesses to address underrepresentation in the workplace:

- Commitment and collaboration – establishing a strategy and accountability
- Engagement and recruitment
- Retention and progression
- Building an inclusive culture
- Suppliers - fostering and sustaining diverse, and inclusive, supply chains.

The toolkit for healthcare organisations differs from the others with specific toolkits for:

- Health GPs and PCNs
- Health Integrated Care Boards
- NHS Trusts.

Many London boroughs have been active in challenging racism and developing strong antiracism approaches. Approaches from Hackney and Southwark are summarised in Boxes 67 and 68. But there are many other approaches, although it is too early to establish impact. In 2022 London Councils – the membership body of London's local authority leaders –and the Chief Executives of London Councils (CELC) published the London Local Government Antiracism Statement (736) setting out their shared commitment and expectations of London's local authorities. This focused on data, lived experience voices and community engagement, and leadership. London Councils' *Tackling Racial Inequality* programme provides resources, good practice and leadership on this area for councils. (736) In 2021 London Councils developed a Corporate Race Equality Strategy (2022– 2025) with the aim of embedding race equality across the organisation. The next steps for London Councils will be to ensure that the commitments and expectations are being met and to work with London boroughs to strengthen their individual and collective impact.

Throughout the report we have highlighted antiracism actions among London boroughs. Below we highlight Hackney Council and Southwark and in Section 6C we report on Waltham Forest's approach. They are just a selection and do not include all the varied activities undertaken by London boroughs to tackle racism.

Box 67. Antiracism – Hackney Council (737)

Hackney is working to embed anti-racist practices into their structures, systems, and processes and has pledged to change behaviour across the council to build an anti-racist borough. There have been a range of approaches to support this endeavour, and in 2024 Hackney Borough Council formally adopted an Anti-Racist Framework. (738) The Framework has built on previous work within Hackney.

Hackney's first Anti-Racism Action Plan in 2021, scrutinised their practices, cultures and behaviours in 5 areas:

- Institutional change
- Community engagement
- Culture and leadership
- Accountability
- Influence. (737)

In March 2022, the Council adopted definitions of racism and anti-racism. It also hosted its first four-day Anti-Racist Praxis Conference for its Children and Education Directorate, to raise awareness and understanding of racial trauma and examine strategies for unmasking, healing, prevention, and transformation with their workforce, schools, and partners.

Also in 2022 the Council announced a new Child Q Action Plan following the police strip-search of a child in a Hackney school. The plan includes:

- Support for Child Q and her family.
- Work in schools, the education system and children's social care to ensure they have a framework for conducting searches, are informed and listening to children and staff affected by racism, adultification, children's rights and poverty, and are focusing on safeguarding, inclusion and antiracism.
- Activity initiated by the council to develop and implement a shared plan to improve trust and confidence in the police.
- Community engagement: activity to capture the voices of children, young people, parents/carers and community members to coproduce solutions and to inform new ways of working (policies) within the council and other organisations.
- Support for staff. (737)

In 2023 Hackney held an council-wide Anti-Racism Summit, with over 60 educational events across the Council within six weeks. The Summit resulted in 15 internal commitments for change being pledged to the organisation in February 2024. The work continues with the newly appointed central role of Head of Equalities, Diversity, Inclusion & Belonging, who will lead and support engagement across Hackney Council.

From November 2023 City and Hackney Public Health team have focussed on addressing ethnic health inequalities and dismantling racism in public health in line with local and regional strategic objectives.

There are three actionable areas for change:
- Anti-racist commissioning
- Training and competence
- Internally focused work to support a work environment which is actively anti-racist.

Box 68. Southwark Stands Together: The Council's antiracism strategy (739)

Southwark's 2020 strategy has five pledges to:

- Promote an open and transparent culture where people can raise experiences of racism or discrimination and expect the issue to be dealt with swiftly
- Listen to and amplify diverse voices within Southwark
- Work to address and prevent structural racial inequalities and structural racism within Southwark, partner organisations and services
- Champion organisations that address racial injustice and organisations that promote equality and diversity
- Ensure that people of all backgrounds can rise to the top of organisation.

A year on, in 2021, the Council set out the progress and reported on residents' input. (739)

It highlighted two new values introduced into the Borough plan:

- Always work to make Southwark more equal and just
- Stand against all forms of discrimination and racism.

By 2021 progress included the work of the Southwark Youth Independent Advisory group, which has a partnership with and provides advice to the police and the Council on issues affecting young people and crime, policing and community safety and the work on Peckham Library Square.

The Council continues to work on; renewing and reinventing open spaces and buildings, education, health, culture, communities, policing, employment and business and council staff engagement. (740) As part of the communities theme the Council commissioned an independent review from Equinox Consulting to identify structural barriers felt by ethnic minority organisations trying to access funding from the council. (741)

ORGANISATIONAL ACCOUNTABILITY FOR RACISM

Developing effective, meaningful and clear lines of accountability for racism is essential. Many antiracism strategies within organisations are relatively recent - many since 2020 – and there has been little evaluation of the outcomes. What reporting there has been does not show a great deal of change and it is important that organisations learn from this, take accountability. and further strengthen their approach, and not be disheartened.

An example of an organisation publicly reporting on its progress and taking accountability is the Wellcome Trust. In 2020 the Wellcome Trust publicly acknowledged that as a funder, employer, museum and library it has perpetuated racism. Following this it developed an antiracist framework and committed publicly to taking an antiracist approach. The Wellcome Trust subsequently evaluated the impact of the strategy and, holding itself accountable for its lack of impact, has committed to strengthening impacts. This provides a good example of an organisation holding itself publicly accountable by reviewing and evaluating its progress and making changes to improve this, Box 69.

Box 69. Wellcome Trust antiracism strategy (725)

In 2021 Wellcome, a UK- based independent charitable foundation supporting science globally, published its diversity and inclusion strategy. This outlined its commitment to being an inclusive organisation, after committing to anti-racism action, following publicly recognising that Wellcome had perpetuated racism.

An independent evaluation, facilitated by Wellcome, however, found limited progress on those commitments. While progress through targeted interventions was identified, the overall assessment showed Wellcome had failed to meet its commitments. (742)

Following this assessment in August 2022, Wellcome acknowledged it had not done enough and committed to three actions to drive greater progress against anti-racism:

1. **Positive action principles** to be applied to Wellcome's funding decision-making process. To ensure that when applications are similar in merit, Wellcome will favour those which add to the diversity of the pool of people it supports.
2. **Dedicated funding stream** for researchers who are Black and people of colour, targeted at the career stages where this will have the greatest benefits for diversity.
3. **New equity, diversity and inclusion role at executive level** to lead on Wellcome's internal and external work on equity, diversity and inclusion, including a specific focus on anti-racism. The role to implement and extend Wellcome's existing diversity and inclusion strategy (launched in 2021) ensuring that it is embedded across the organisation and its work. (743)

Two years on, Wellcome reports that an internal review of on these actions against anti-racism shows progress including:

- **Leadership** – Wellcome's first Chief EDI Officer was appointed in October 2023, following appointment of a permanent Anti-Racism Programme Lead in May 2023.
- **Research funding** – In March 2024 Wellcome opened a new dedicated funding scheme of £20 million to assist researchers from Black, Bangladeshi, or Pakistani heritage backgrounds to advance their careers and improve representation in science. Demand has been high and funding awards are due to be announced in Autumn 2024. (744)
- **Action plans** – The executive leadership's second annual anti-racism action plan is nearing completion, with progress tracking shared with all staff.
- **Training** – Three-quarters of Wellcome staff have completed initial racial fluency training including the Executive Leadership Team and the Board of Governors. An anti-racism and anti-ableism learning programme designed for Wellcome Collection staff has also been introduced.
- **Data and evidence** – Implementation of systems for collecting, analysing, and reporting on data on organisational diversity is supporting targeted interventions. For example, a quarterly workforce survey enables measurement of staff engagement by ethnicity, leading to action when concerns are raised.
- **Staff networks** – Staff networks have played an important role in building an inclusive culture at Wellcome. A series of recommendations to develop support has included establishing protected time for networks within working hours, increased budgets, and training for Network committees, including Wellcome's Race Equity Network (WREN).

As well as organisational accountability for impacts from their strategic approaches to antiracism, senior leaders must be directly accountable for racism and discrimination within the organisation. This includes ensuring that reporting racism is a clear, transparent process and is taken seriously, with effective sanctions in place. As set out in other sections of this report, there are many accounts from people who experience racism within a workplace who do not report it because they believe that their reports won't be taken seriously or will be ignored, or worse, that they may suffer repercussions within the workplace including from other staff members, and barriers to career progression.

While there have been some positive moves within the NHS to reduce racism in the design, delivery of services, in interactions with and between employees and the public, reported in Section 5, there are many continuing reports of racism and unequal outcomes in services. In February 2023, EHRC wrote to ICBs reminding them of their responsibilities under the PSED and the specific equality duties (SEDs), noting that it will be monitoring ICBs' compliance with the duty. (638)

Successful implementation in a health system requires governance and accountability to define the roles and agreed delivery between and within organisations. While there are many, relatively new antiracism commitments from NHS organisations and systems, there is so far little reporting on impacts and outcomes. The South East London Integrated Care Board (ICB) has developed an antiracism strategy to try and tackle racism within the workforce.

Box 70. South East London ICB – Antiracism strategy (745)

In 2023, 41.5 percent of the SEL ICB workforce was from an ethnic minority group, however, White staff are significantly overrepresented at senior and executive levels, and Black and Mixed/Other groups significantly underrepresented. (745)

To try and redress this and tackle discrimination and racism within the workforce the ICB has already committed to an ICB antiracism strategy as one pillar of their wider anti-discrimination strategy (covering the nine protected characteristics). They highlight that the antiracism strategy is a workforce-facing strategy and that it will initially cover two years and be reviewed annually. They commit to:

- Take a proactive approach to ensuring that everyone sees antiracism as their responsibility and is enabled to actively minimise and challenge racism – being actively antiracist rather than simply 'non-racist'.
- Build antiracism into the culture, policies and processes of the ICB by embedding antiracism enablers and actions across the employee lifecycle.
- Ensure ongoing engagement with their people and networks to ensure that our strategy is socialised, codeveloped, implemented and measured.
- Ensure the actions set out are evidence based and outcomes-focused.
- Devise a set of success measures that are specific, measurable, achievable, relevant, and time-bound

The strategy will be updated to reflect new evidence and solutions.

The antiracism strategy builds on existing commitments and mechanisms for measuring success. (746) It operates alongside their commitment to wider NHS strategies including:

- Workforce Race Equality Standard (WRES) –there are some areas requiring improvement and there is a need to accelerate progress.
- The People Plan and People Promise – they have committed to being a compassionate and inclusive employer.
- The NHS London Workforce Race Strategy and Workforce Race Strategy in Primary Care.
- A Strategic Approach to Antiracism in London Health and Care Systems – Antiracism statement from the ICB CEOs and chairs.
- The NHS Workforce EDI Improvement Plan – addressing six high impact actions.

As noted throughout this report public health has a vital role to play in challenging and reducing structural racism in health and the social determinants of health.

In 2023 the FPH produced an antiracism framework, Box 71.

Box 71. The Faculty of Public Health – Antiracism approach

The Faculty of Public Health has prioritised antiracism and addressing racial and ethnic health disparities as one of its 11 board-led focus areas for action between 2022-2025. It has also declared racism a public health crisis, emphasising the need for a comprehensive public health approach.

The FPH has made efforts to make this support for antiracism vocal to others within the sector through publications, events, and advocacy efforts. (748)

In December 2023 the Faculty of Public Health launched an antiracism framework. This has been designed following the Chartered Institute of Personnel and Development principles to help organisations develop strong antiracist strategies. (724)

The Framework contains four key commitments:

1. To recognise that structural racism exists and is harmful, and to support ethnic minority staff.
2. To act to redress racism and call out discrimination.
3. To be transparent and accountable, and to measure our progress.
4. To use its unique position to influence the public health workforce and wider community. (749)

ANTIRACISM TRAINING AND EDUCATION

Workforce training and education is an important component of antiracism organisations. At a minimum the whole workforce must understand the antiracism approach within the organisation and to understand what racism is, how it operates and the effects it has. An organisations' workforce, including White employees, must be able to identify and call out racism and be able to report and ensure accountability for racism experienced at the place of work.

Workforce training and education extends to ensuring that there is equitable recruitment and representation within the workforce and equitable pay and progression. As section 4C highlighted, there are significant ethnic inequalities in employment rates and progression and pay, which are the result of inequitable recruitment and workforce practices and racism among employers.

6C. COMMUNITY CO-PRODUCTION

As set out in this report, one of the drivers of ethnic inequalities a result of systemic racism is that the needs and experiences of different ethnic groups are overlooked and that services are culturally inappropriate and do not address needs. Cultural inappropriateness and misalignment with needs are barriers to accessing services, drive poor experiences with services and lead to worse outcomes.

Co-production between organisations and community groups in order to develop antiracism strategies and interventions as well as in the design and delivery of services is essential in efforts to tackle racism and mitigate its impacts. Those with lived experience must be centrally involved in plans and strategies and services and interventions to tackle it. Given the paucity of data relating to ethnic inequalities and particularly to experiences of racism, the involvement of affected communities is particularly important. The evidence for the most effective ways to undertake co-production with ethnic minority communities is still emerging, but there are some basic principles which have been identified for co-production more generally (750)

- Building mutually beneficial relationships based on honesty and trust.
- Sharing power and decision-making.
- Make sure all voices are included and valued.
- Recognising people's strengths and supporting their development.
- Continuous reflection, learning and improvement.

Waltham Forest is working with local residents to develop its Equality, Diversity and Inclusion (EDI) Strategy to tackle structural inequalities, Box 72.

Box 72. Waltham Forest: Putting communities at the centre of tackling racism and structural inequalities (751)

The work is focused on improving quality of life and how people are able to make a living after the COVID-19 pandemic. While supporting many who face structural inequalities, the project will target additional interventions at six groups: Black men, disabled people, migrants, including refugees and asylum seekers, older residents, South Asian women and young people.

The process involved a review of over 100 documents; engaging with 550 residents through workshops, face-to-face sessions and an online survey, to understand the experience of residents from groups who experience the structural inequalities the most; and an EDI Making a Living summit with 32 participants from key target groups to identify solutions and create 15 recommendations for the council to deliver. (751)

The report 'Making a Living Strategy' and full action plan was launched in July 2022. Based on the evidence of the State of the Borough report it outlines four priorities and 15 recommended areas of action. All of these were based on community conversations and agreed by a representative group of residents and VCS representatives. (752) The key themes are:

- Building inclusive workplaces
- Developing good quality jobs for all
- Learning, advice, and skills support for those who need it most
- Create a caring and fair system.

The Council has also published an action plan with short-term and long-term goals to meet and intends to review the progress of the project against these goals.

The Council remains committed to putting the voices of residents impacted by inequalities at the heart of their response. This is reflected in Mission Waltham Forest – the Council's mission-driven plan for a more equal borough by 2030.

In 2021 the Association for the Directors of Public Health (ADPH) released a position statement supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic. This statement highlights racism as a public health issue. As part of ADPH London's commitment to mitigate any further widening of inequalities between Black, Asian and minority ethnic communities and White British people, the position statement highlights the following five themes for action development: Trust and cohesion; Improving ethnicity data collection and research; Diversifying the workforce and encouraging systems leadership; Co-production with communities; Embedding public health work in social and economic policy. This commits to ensuring good principles and practice of coproduction are embedded in public health and the wider system. (747) The ADPH has set out four actions as part of their 'Supporting Black, Asian and Minority Ethnic Communities' strategy:

1. Definition and practice of coproduction: A unified definition of what it is and what good practice looks like, recognising local charters and good practice that is already taking happening in the system.
2. Toolkit and training for boroughs: Informed by coproduction practitioners/specialists for public health teams and wider partners.
3. Support in embedding evaluative methods in coproduction: Work with an academic to support public health and the wider system to measure outcome and impact of initiatives.
4. Public health's voice on access to resources: challenging the status quo on access to resourcing and funds for public health professionals and support from system partners.

This programme of work is delivered by the ADPH London, Public Health; Tackling Racism and Inequality Programme and continues to lead, support and challenge the London public health system and wider stakeholders. There continues to be a compelling need to take action to address the persisting ethnic health inequalities present in the UK, and ADPH London continues to have a voice in the London equity.

Other sources of guidance on community-coproduction are available from NHS and these have been summarised in Box 73.

Box 73: NHS England Working in partnership with people and communities: Statutory guidance (753)

- Codesign: Designing with people and incorporating their ideas into the final approach.
- Coproduction: An equal partnership where people with lived and learnt experience work together from start to finish.

The guidance identifies three main pitfalls to avoid:

- Tick box exercises: community involvement should not be approached as an obstacle to overcome. Any strategy or service change resulting from this will be seen as tokenistic and uninformed by public insights, which will not only undermine trust, it is also unlikely to be supported at local, regional or national level.
- Unrealistic timescales: planning for service design and service changes should include achievable timescales that allow for early, ongoing and effective public involvement. This should include careful consideration and discussion of the views expressed by people and communities.
- Limiting public dialogue to service change proposals: involvement should not only take place when a system wants to make changes, it should be part of every decision driving policy. This is enabled by regular dialogue with people and their communities; enabling them to also influence the agenda.

One approach to reducing pervasive racial and ethnic inequalities in health is through community coalitions. Community coalitions are a strategy for involving community members in improving population health alongside approaches including community-based participatory research, lay community health workers, and advisory boards that include community members.

Box 74: Community coalition approach (754)

Specifically, community coalitions bring together citizen groups, public and private organisations, and professions from multiple sectors in bottom-up planning and decision making. They operate through partnerships and emphasise using local assets and resources to build community capacity.

Characteristics of the partnering organisations affect how a coalition functions. The broad cross-sector composition and the voluntary nature of community coalitions make them unique from other public health models.

An analysis of 58 community coalition-driven intervention studies (from the US, Canada, Australia, England and Netherlands), with at least one racial or ethnic minority group representing the target population, found that these interventions benefit a range of health outcomes and behaviours, as well as systems. They found that community coalition led interventions may connect service providers with ethnic and racial minority communities in a mutually beneficial way. (754)

Lewisham and Birmingham City councils formed a partnership to undertake a ground-breaking review of health inequalities within Black African and Caribbean communities. (755)

Box 75. Birmingham and Lewisham African and Caribbean Health Inequalities Review (755)

The review took place from July 2021 to January 2022 and the review report was finalised in March 2022 and launched thereafter. (756) The review captured the lived experiences of Black African and Black Caribbean communities alongside data and evidence for action that can be taken to address health inequalities in Black African and Black Caribbean communities. The review concluded that the system does not take enough notice of the needs of Black African and Black Caribbean people in the UK. They published a data pack and outlined seven key areas to address:

- Fairness, inclusion and respect
- Trust and transparency
- Better data
- Early interventions
- Health checks and campaigns
- Healthier behaviours
- Health literacy. (756)

Specific recommendations include ensuring that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should involve direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include:

- Community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support.
- Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health.
- Support and investment in grassroots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services. (756)

The Newham Community Champions programme was developed during the COVID-19 pandemic to have open conversations with communities about the latest COVID-19 advice, the situation in Newham and to hear what people were experiencing and what they needed, box 76.

Box 76: Newham Community Champions: (757)

The aim was to make sure policy decisions were made in direct response to community intelligence. The programme continues to gather and share information quickly, responsively, and on channels that are simple to use. Professionals aim to do this with a conscious commitment to a shared approach with their residents rather than top down. Recommendations from this programme include:

- Listen to and act on issues when the community wants things to happen, not just when the system wants things to happen.
- Manage expectations, create clear boundaries, and grow capacity and resource within your team in order to make programmes sustainable.
- Engage the Champions effectively in the learning from programmes; consider ways of making findings accessible and acknowledge and act on people's input. This will help foster ongoing trust and engagement.
- Invite the most engaged Champions to help explore what other issues of concern exist and how the Community Champions model can continue to work together with the local authority to build back better, without taking advantage of their good will.

WORKING WITH VOLUNTARY, COMMUNITY, FAITH AND SOCIAL ENTERPRISE ORGANISATIONS

There is growing recognition of the importance and value of VCFSEs across London in supporting their own members and the wider community and delivering a range of services and developing community cohesion and wellbeing. (758) There was an increase in the cooperation between local authorities and VCFSEs in London during the pandemic. Faith groups were often on the frontline of supporting and advising their communities and their role in helping reduce health and other inequalities was apparent. (759)

Faith groups in London represent some of the most excluded communities and their leaders play an invaluable role in addressing health inequalities and communicating health messages. (760) (761) Over 70.9 percent of Londoners who answered the question in the ONS 2018 National Population Survey identify with a faith or belief and there are over 2,200 faith buildings across the city. Strategic engagement between local authorities, public services and faith groups can support culturally competent provision of services and information reaching highly excluded communities. These partnerships need to take account of other equality and diversity principles, but can build a culturally-sensitive understanding of the diverse needs of some of London's ethnically and religiously diverse communities and shape work to tackle inequalities accordingly. (762)

Although they are a powerful voice for representation and support for Londoners facing discrimination and inequality, the voluntary and community sector has historically faced and continues to experience a lack of sustainable funding. (763) The cost-of-living crisis, and continuing impacts from the pandemic, have made the situation even more precarious as contributions to minority-led organisations are declining in the wake of the pressure on incomes. The heavy reliance on volunteers, part-time staff and limited or no cash reserves meant that 89 percent of minority ethnic-led VCFSEs were predicted to close within three months of the first national lockdown in 2020. (764)

The Ubele Initiative highlights that access to funding relates to broader issues of structural racism within the VCFSE sector. (765) Its Booksa paper exposes the issues that minority-led organisations experience with inequitable funding structures. The funding made available to these organisations during the pandemic was short-term in nature and given in the context of the pandemic. Further, there are inequalities in the distribution of funding that excludes many minority-led groups due their inability to meet the strict eligibility requirements. The paper also finds that in London, the majority of funds allocated go to organisations 'serving' minority communities instead of those led by and for them.

Inequalities in funding decisions are another reason for concern. In 2015, over one third of ethnic minority VCFSEs' funding applications were unsuccessful. (766) Evidence showed that organisations would benefit from support across five emergent priorities if they are to survive over the medium to longer term; capacity support needs, access to financial resources; adaptation of services to meet online digital opportunities; continuity and strategic planning; policy and influencing.

6D. RESOURCING AND INVESTMENT TO TACKLE RACISM

Funding is required to develop antiracism approaches and for the organisation to have sufficient capacity to be able to act on the recommendations and for the approaches to last. Without investment in antiracism approaches they will be well-intentioned documents which do not have impact. The lack of impact will be damaging to the endeavour to tackle racism as it will undermine trust in the intentions and process and as impacts will be limited or non-existent it will be seen that the approaches have failed and should be abandoned. Resources are essential for effective implementation.

Few organisations detail how they will adequately fund and resource their programme of change in their antiracism statements and strategies. Having an effective antiracism strategy and delivering on it requires resources. Additionally enforcement of the measures, including ensuring pay equity, workforce training and capacity building and ensuring there is sufficient organisational and leadership accountability take resources.

In previous sections we have made recommendations for funding of interventions to be proportionate to the scale of the issues related to ethnic inequalities as well as to socioeconomic position and other dimensions of discrimination. This is one of the principles for our recommendations.

6E. DATA, RESEARCH AND EVALUATION TO IDENTIFY AND TACKLE RACISM

This report has pointed to many of the gaps in research, evaluation evidence and data in key areas of health, health systems and social determinants of health. We highlight that there are wide inequalities in ethnicity where data are available and also an inability to measure and monitor structural racism. There is a need for more data in these areas and we have highlighted particular gaps in data and evidence in the recommendations in each part of Section 4.

Related to the lack of available data which is disaggregated by ethnicity which we highlight throughout this review, the EHRC 2023 Equality and Human Rights Monitor recommended on what data and evidence is needed to better understand and address structural racism and other inequalities (767):

- Data and evidence – this is insufficient for many protected characteristics, but in particular there is a lack of complete data about ethnic minority groups, especially in relation to mental and physical health, maternity, educational outcomes and bullying. Improvement in the quality and amount of data collected is crucial for the design of policy to address the issues.
- Understanding and addressing needs of diverse populations – e.g. groups like older people in prisons, or pregnant Black women. Government and service providers need to understand the needs of these diverse populations and design targeted policies to address their needs. These policies should also be regularly monitored, reviewed and evaluated with attention paid to their impact on different population segments.
- Outcomes by race - Some ethnic groups in England are experiencing improving outcomes and narrowing gaps in education and employment. But Black adults have seen earnings stagnate and unemployment remain relatively high.

As we have highlighted throughout this report, there is a lack of data by ethnicity in many important policy areas and organisations and, what there is is often not presented at a sufficient level of disaggregation to allow meaningful understanding of which groups are most affected by ethnic inequalities. There is also a lack of analysis about the interrelationship between ethnicity and other forms of disadvantage and discrimination including socioeconomic position, gender, age and disability within ethnic groups.

As a prerequisite for more information on ethnicity and racism, there is a need for improved guidance and implementation of harmonised collection of data by ethnicity and religion. (768) (769) This guidance needs to allow for the presentation of evidence at different levels of aggregations, but always guided by the principle that sufficient disaggregation by different ethnicities is provided, where population or sample sizes allow, to enable understanding of the needs and specific inequality issues of discrete ethnic groups. At the same time, where numbers do not allow, harmonised aggregate groups should be defined that enable meaningful comparisons between small studies and large data sources. For this purpose, the detailed data collected by the 2021 Census should be taken as the starting point and classification built, bottom-up, to the broad classifications published by the Census. (769)

Based on this multi-level, harmonised classification and associated guidance on data collection, ethnic and religious inequalities, their intersections with other dimensions of discrimination and poor outcomes can then be used to support the development of appropriate interventions and services to reduce ethnic inequalities.

Tackling structural racism requires both a nuanced understanding of the way that racist structures affect health and a way of measuring the impact of this type of systemic injustice. Direct measurement of structural racism is uniquely challenging and complex and the usual reliance on measurement of inequalities between ethnic groups is often used as a proxy, but this does not enable understanding of the extent or impacts of racism nor illuminate the role that societal structures and institutions facilitate racism and its impacts. Similarly, measurement of interpersonal racism, while important, is not sufficient as a method of identifying the patterns of structural racism that are built into the societies in which we live (770). If we are to collect evidence on the impact of structural racism, we need to ensure that the national and regional bodies who are collecting and analysing data are having active discussions about antiracism, the role that it plays within their research and intelligence functions and the way that they can understand and address structural racism through their work.

In 2021 the Wellcome Trust established the research, data and evaluation methods that address structural racism, as part of its wider exercise exploring its approach to antiracism (725). Principles based on this are set out in Box 75.

Box 77: Wellcome trust and data on racism

Principle 1: Prioritise antiracism work

It is important for organisations to prioritise antiracism work . In order to do this there must be adequate allocation of resources and time to do the work. Public health organisations must consider this a priority in their work and establish programmes that have dedicated resources and time to design actions, put them in place, and continue monitoring outcomes.

Principle 2: Investigate racial inequity

While many UK organisations collect data that could be used in the investigation of structural racism and health, much of this data is not collected in a way that reflects the complexity of race and ethnicity. The first priority is to ensure that race and ethnicity are routinely recorded during the collection of population level data. This, however, is an endeavour that has the potential to perpetuate structural racism. Without a full understanding of the nature of race – in particular, the fact that race is a sociopolitical construct that does not have any biological underpinnings – public health organisations run the risk of presenting data in a way that unwittingly supports racist narratives. (771) Decisions about the racial divisions used when collecting and publishing data should take into account the historical context behind many racial classifications, and efforts should be made to avoid collectively treating all racially minoritised people as a single group (772).

Principle 3: Meaningfully involve ethnic minority groups in decision making, data collection and data analysis

Any effort to address structural racism through the use of data, research and monitoring requires the organisations who use and collect data to confront any systemic racism that exists internally. In particular, it is important for public health organisations to ensure that racially minoritised people are involved in the analysis and presentation of data surrounding race and ethnicity – not only a research subjects and people from whom data is collected, but at every part of the research process. This may require a move away from the perceived primacy of quantitative data, and a better understanding of the role of community groups and people with lived experience within the research environment. In particular, many organisations would benefit from the development of training around the importance of race-based data and the way to use and collect it using antiracist approaches.

Principle 4: Take positive action or other targeted approaches to redress racial inequity

It is important for all public health organisations to recognise their key role in creating a more holistic understanding of race, ethnicity and the impact of racism on health. For many organisations, this will go beyond their perceived population health functions – that is, the collection and presentation of data. As previously discussed, decisions surrounding the way that race-based data are presented can have a direct impact on the way that these data are interpreted, and it is therefore the responsibility of public health organisations to advocate for antiracist principles across the research and evaluation landscape. (773) With that in mind, public health organisations who collect and analyse data would benefit from the development of a purpose statement that specifically outlines their approach to race-based data and research to understand and mitigate the impact of structural racism. (774)

Principle 5: Use your power to make measurable process towards racial equity

The ultimate goal of research surrounding race, ethnicity and health should be a full understanding of the impact of structural racism on health that allows the systems to address the resultant inequities. Public health and other organisations therefore need to ensure that they are not just collecting and presenting data on ethnic disparities within health outcomes, but that they are playing an active role in the use of research to mitigate the impact of structural racism. Monitoring and evaluation of data collection processes should be embedded into public health organisations, particularly focusing on the completeness of race and ethnicity-based data, the breadth of data collection methods (i.e. utilisation of methods that move beyond the collection of quantitative population-level data), and the discourse and analysis surrounding the data that are collected. In particular, public health organisations would benefit from policies that lay out a pathway for the transformation of data into action, ensuring that the data they collect can be used to promote and facilitate antiracism.

6F. NATIONAL ADVOCACY AND SOCIAL MOVEMENTS TO SUPPORT ANTIRACISM

Part of organisational approaches to antiracism include an obligation to speak out and highlight societal injustices - including to national and local governing bodies and to other organisations. While an antiracism strategy may focus only on the immediate levers which can be directly affected by an organisation these must be accompanied by a public commitment to tackling structural racism and ethnic health inequalities and using all opportunities to hold other organisations to account. While many issues may be beyond the remit of individual organisations there are national and local advocacy routes.

Another component of change, beyond the actions of organisations, are the developments of antiracism social movements. There have been some recent examples of how social movements have made significant progress in highlighting injustice and pushing for change. While the influence of organisations or systems on the development of social movements is sometimes unclear, there are important ways for organisations and sectors to support them, including through encouraging workforce and the public to join and promoting the social movements through advocacy. (775)

RECOMMENDATIONS TOWARDS A MORE RACIALLY EQUITABLE SYSTEM: THE ROLE AND IMPACT OF INSTITUTIONS AND ORGANISATIONS

1. **Strengthen legislation, regulation and enforcement**
   - Establish a separate national body to focus on race equality covering both private and public sectors.
   - The Equality and Human Rights Commission to prioritise enforcement of the Public Sector Equality Duty.
   - Restore EHRC budget to its previous level and strengthen powers to ensure regulatory bodies uphold the Equality Act and the PSED in the organisations for which they have responsibility.
   - Implementation of the Equality Act to be more proactive and require private and public sector organisations and regulatory bodies to root out and be accountable for racism.
2. **Aim for all London organisations to develop and apply antiracism approaches**
   - Strong antiracism leadership to ensure equitable employment opportunities, appropriate representation, pay and progression.
   - Develop training and support for all employees to ensure they understand racism and and are empowered to report it.
3. **Ensure communities are central to the development of approaches to tackle racism.**
4. **Ensure there are sufficient resources for all organisations to tackle racism and evaluate and monitor antiracism approaches.**
5. **Develop data, research and evaluation to better identify and tackle racism.**
6. **Strengthen national advocacy and development of social movements to support antiracism.**

CHAPTER 7

REPORT CONCLUSIONS

We began this report by recognising that racism in the capital is widespread and persistent, despite impressive antiracism leadership and programmes developed by some organisations in London. This report has set out the many ways in which racism, often unacknowledged, damages individuals, groups and society. Our focus has been on the effects of racism on health and the social determinants of health and how racism contributes to avoidable inequalities in health between ethnic groups – a pattern that is quite unacceptable. It is urgent that society tackle the damage to health and wellbeing as a result of racism.

In London higher proportions of men and women from many ethnic minority groups report having high levels of ill health or disability. Gypsy and Irish Travellers, Bangladeshi, Arab and Pakistani and Mixed White and Black groups, are more likely to report higher levels of ill health or disability than other groups at ages 50 and over. Maternal, infant health and mental health services show particularly concerning ethnic inequalities which go well beyond what would be expected given relative levels of deprivation There are also clear patterns in risks of particular disease by ethnicity and there is a need for NHS and public health professionals to be attuned to the differing health needs of different ethnicities and for services to be developed accordingly.

There are stark ethnic inequalities in key social determinants of health, providing testament to the extent of damage caused by racism including high rates of poverty, lower pay and employment prospects and experiences of racism in many essential services. Racism is experienced by people and groups who may also experience other discrimination and exclusions related to socioeconomic position, disability, age, faith and gender which amplify the impacts of racism and lead to even greater disadvantage and exclusion.

While we divide the report into thematic, social determinants of health areas it is important to take account of the cumulative impacts of racism throughout life: from inequalities in maternal and child health, in access to nurseries and family services, to experiences of racism in schools and the criminal justice system, the very stark ethnic inequalities in employment rates, pay, progression and seniority and the much higher levels of poverty, poor quality housing and environments. Many people from ethnic minority groups have been particularly impacted by government policies of austerity and cuts to essential services and social protection. At every stage of life and in the key determinants of health we looked at there were reports of racism.

We highlight three interrelated ways in which racism negatively impacts physical and mental health that are often experienced simultaneously: Firstly, experiencing racism directly damages physical and mental health. Secondly, racism may be a cause of socioeconomic disadvantage and adverse exposure to the social determinants of health which undermine health. Thirdly, racism damages health through the operation of the health care system and other services. All are manifestations of structural racism which lead to institutional and interpersonal racism.

Several conclusions can be made from this review.

- First, racism in London is widespread and affects many ethnic minority groups in ways likely to damage health.
- Second, health and the social determinants of health show substantial variation among ethnic groups. To address the effects of racism on health, it is necessary to address all the key sectors that contribute to the 'social determinants of health' and health and social care.
- Third, the review shows the importance of intersectionality: poverty, disability, age, faith, gender and duration of living in the UK may all add to the effects of racism on health of certain ethnic groups.
- Fourth, we found that despite recent efforts there is potential for more systematic action to tackle racism within organisations and services, in recruitment, employment practices and in service design and delivery. The development of antiracism approaches by some organisations is promising.

Further, due to the significant differences in experiences and outcomes between ethnic groups there is strong empirical support for being specific about ethnicity and for the avoidance of the blanket term ethnic minority although at times we use the term when the sources we cite report the data that way. There is also support for using the term 'minoritised groups' to represent the ways in which ethnic groups are actively minoritised through systems and structures, rather than simply being part of a numerically smaller ethnic group. We use the term when used in reports and by organisations that we refer to.

In our research for this report we found many examples of organisations developing practices and interventions to end racism and reduce ethnic inequalities, some of these are included as case studies through the report. These include actions from businesses, the healthcare system, public health, education and other public services, the community and voluntary sector and London boroughs. The Greater London Authority has developed new approaches in collaboration with affected communities and many NHS organisations have strengthened their approaches as well. It is too early yet to see the enduring impacts of these efforts, but leadership, visibility and drawing critical attention to racism matter.

RECOMMENDATIONS:

The recommendations are designed for the many sectors and stakeholders in London that have the potential to do more to combat racism and its impacts. These include the GLA, London councils, the healthcare system, public health, the criminal justice system, education and other public services, employers, legislators and regulators.

While the recommendations are mainly aimed at institutions to help them tackle institutional racism, it is essential to tackle the structural drivers of these: the inequitable political, economic, legal and cultural systems that facilitate and encourage institutional and interpersonal racism. The report does not specifically focus on interpersonal racism except where it manifests in institutions: for instance, emanating from service providers or employers. Interpersonal racism is closely related to structural and institutional racism, so changes in these realms should impact on the attitudes and racism of individuals. Strengthened accountability and sanctions for individuals who exhibit racist or discriminatory behaviour, as well as for organisations that are at fault, are certainly needed.

We make recommendations covering the six areas of social determinants of health. Our general approach rests on proportionate universalism: universalist policies with effort proportionate to need. Ethnic inequalities and the health effects of racism make a simple appeal to universalism insufficient. We also make recommendations to develop a more racially equitable system across London, based on organisational antiracism approaches and leadership and strengthening legal and regulatory mechanisms.

There is insufficient data and evidence about ethnicity in many important areas. This limits our ability to report on ethnic inequalities in health and the social determinants of health. We therefore make many recommendations for further research and information. There are also gaps in the evidence about experiences and impacts of racism and discrimination, which means racism can be overlooked.

The following five principles apply:

1. Public health to take a leading role in highlighting the impacts of racism in health and the social determinants and in putting racial equity at the heart of policy and interventions.
2. Spending and resource allocation must be proportionate to the scale of inequities in health and its social determinants and address racism and its intersection with socioeconomic disadvantage and other dimensions of exclusion.
3. Services must be culturally appropriate and designed with ethnic communities that are most affected.
4. There must be effective action to combat racism with sufficient accountability and appropriate sanctions.
5. There must be appropriate data and evidence to strengthen accountability to enable the effects of racism to be monitored and anti-racism policies and interventions evaluated.

The recommendations in this report are high level. By their nature, the high-level recommendations will not be sensitive to the many and varied forms of racism experienced by individuals and between different ethnic groups. The GLA has commissioned the Race Equality Foundation to consult with community groups and experts to co-produce more detailed actions relevant to their experiences and specific institutions and sectors. The community engagement and co-production of more detailed recommendations should enable further adaptation to these differing impacts and experiences. The intention is that all the sectors in London, and indeed in other places across the UK, contribute positively to antiracism and take up both the high-level and the more detailed, co-produced recommendations.

RECOMMENDATIONS: GIVE EVERY CHILD THE BEST START IN LIFE

1. Increase the spending on early years provision at a minimum meeting the OECD average and ensure allocation of funding is proportionately higher for more deprived areas and excluded ethnic groups.

2. Reduce levels of relative child poverty in all ethnic groups to 10 percent – level with the lowest rates in Europe.

3. Ensure programmes that tackle child poverty and mitigate its impacts are designed appropriately to meet the needs of different ethnic groups.

ADDITIONAL RESEARCH AND EVIDENCE

- Carry out routine collection of data by ethnicity to establish the extent of ethnic inequalities in the early years.
- Analyse whether early years services and assessments of levels of development are culturally appropriate for the diverse populations and wide range of socioeconomic backgrounds in London.
- Undertake further studies on the experiences of racism and their effects among parents and children in the early years and ensure these are incorporated into actions to tackle racism and improve outcomes.

RECOMMENDATIONS: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THE LIVES

1. Reverse the cuts that have happened since 2010 in per pupil funding in schools and youth services.

2. Schools to strengthen antiracism approaches through capacity building and enforcement of legal obligations and additional duty to report and to act on racism in school settings.

3. Strengthen enforcement of legal requirements for non-discriminatory recruitment.

4. Increase the number of programmes to support young people's mental health and fund youth services and safe spaces that are culturally appropriate.

ADDITIONAL RESEARCH AND EVIDENCE

- Conduct further research into why many Black pupils do not benefit from being at secondary school in London as much as other ethnic groups.
- Assess why some young people from ethnic minority groups do not continue the good levels of attainment in primary school into secondary school and into good quality employment.
- Assess SEN diagnoses and referrals and support by ethnicity in London.
- Carry out further research into racism and discrimination by employers in London and their impact.
- Strengthen data on young people's mental health and wellbeing by ethnicity in London.

RECOMMENDATIONS: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

1. Ensure all employers pay the London Living Wage and eliminate inequalities in pay by ethnicity.
2. GLA to develop and lead an antiracism approach for all employers in London.
3. Ensure that programmes to support people into work and skills building programmes are appropriate for different ethnic groups and are developed with them including in-work training.
4. Reports on racism to be investigated by independent bodies not by employers.

ADDITIONAL RESEARCH AND EVIDENCE

- Implement mandatory collection of pay data by ethnicity.
- Carry out research to understand the reason for inequalities in employment rates by ethnicity for men and women.
- Institute annual surveys of experiences of racism in employment.

RECOMMENDATIONS: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

1. Tax and benefit system reoriented to reduce ethnic as well as socioeconomic inequalities.
2. Universal Credit should meet the cost of daily life essentials.
3. Develop advice and support services in collaboration with the ethnic groups who are most affected by poverty to ensure they access the financial support they are entitled to including uptake of benefits.
4. Increase the coverage of programmes to insulate cold, poor-quality homes working with ethnic minority groups who are particularly affected.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the tax and benefit system for impact on ethnic as well as socioeconomic inequalities.

RECOMMENDATIONS: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

1. While increasing supply of affordable housing enforce the Decent Homes Standards across all housing sectors and inform tenants about their housing rights by offering culturally appropriate free advice, support and advocacy services.
2. Assess housing providers, including the private rental sector, for racism and regulate the sector appropriately, enforcing sanctions.
3. Ensure that the views and concerns of ethnic minority residents are incorporated into planning including regeneration, access to green spaces and safety.
4. Implement the recommendations of the Casey and Lammy Reviews to end systemic racism in the criminal justice system.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the differing housing needs of ethnic groups through the life course.
- Conduct further research into racism within the housing sector in London.
- Expand research and evidence about racism in the criminal justice system including Gypsy and Travellers.

RECOMMENDATIONS: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

1. Ensure that the focus of the public health system incorporates the fundamental role of social determinants, ethnicity and experiences of discrimination and racism in shaping health.
2. Redesign public health approaches to smoking, alcohol, drugs and obesity to ensure they are culturally appropriate for ethnic minority groups in London.
3. The health system to take a longer-term, prevention focussed approach to tackling health inequalities

ADDITIONAL RESEARCH AND EVIDENCE

- Ensure that data on health behaviours are disaggregated by ethnicity as well as socioeconomic position, gender, disability and age.
- Further research on ethnic dimensions of alcohol misuse, obesity and physical activity and ethnicity.

RECOMMENDATIONS: END RACISM IN HEALTH AND SOCIAL CARE

1. Eliminate racism and ethnic inequalities in access to NHS services and in quality of experiences and outcomes through coproduction, increased investment, education and training, provision of appropriate support and culturally informed practices.
2. Address racism and systemic bias in diagnoses, treatments, medical devices, AI and resource allocation.
3. Eliminate racism in NHS and social care employment with greater equity in recruitment, pay, progression and seniority
4. Ensure awareness of racism in the NHS and social care among both providers and users and apply appropriate sanctions.

ADDITIONAL RESEARCH AND EVIDENCE

- Further research on the extent of racism in all NHS and social care services.
- Through collaboration with ethnic minority groups improve the collection of data on outcomes and experiences in health and social care services by ethnicity

RECOMMENDATIONS TOWARDS A MORE RACIALLY EQUITABLE SYSTEM: THE ROLE AND IMPACT OF INSTITUTIONS AND ORGANISATIONS

1. **Strengthen legislation, regulation and enforcement**
   - Establish a separate national body to focus on race equality covering both private and public sectors.
   - The Equality and Human Rights Commission to prioritise enforcement of the Public Sector Equality Duty.
   - Restore EHRC budget to its previous level and strengthen powers to ensure regulatory bodies uphold the Equality Act and the PSED in the organisations for which they have responsibility.
   - Implementation of the Equality Act to be more proactive and require private and public sector organisations and regulatory bodies to root out and be accountable for racism.
2. **Aim for all London organisations to develop and apply antiracism approaches**
   - Strong antiracism leadership to ensure equitable employment opportunities, appropriate representation, pay and progression.
   - Develop training and support for all employees to ensure they understand racism and and are empowered to report it.
3. **Ensure communities are central to the development of approaches to tackle racism.**
4. **Ensure there are sufficient resources for all organisations to tackle racism and evaluate and monitor antiracism approaches.**
5. **Develop data, research and evaluation to better identify and tackle racism.**
6. **Strengthen national advocacy and development of social movements to support antiracism.**

APPENDICES

APPENDIX 1: ETHNIC CATEGORIES IN THE CENSUS

The categories highlighted in Box 1, Section 1 are those provided on the Census website for tabulation purposes, with the intention that most categories are sufficiently large to allow cross-tabulation with other variables (such as region of residence) without the need to supress tables that have the potential to disclose the identity of individuals. (776) Such disclosure would be illegal under both data protection and census legislation as well the more general right to privacy in England.

However, these classifications are a very blunt instrument in this regard and lead to the suppression of information about some large groups who self-identified in answering the census question on ethnicity. (777) The extent of this suppression can best be appreciated from an understanding of the hierarchical structure of the 2021 Census question on ethnicity, illustrated, with numbers involved, in Table 1.

Respondents were first asked to identify with one of five broad categories, similar to those shown in Box 1. They were then asked to tick one of several boxes within each of the five categories, the last of which invited them to write in their ethnicity if they did not self-identify with any other tick box. The 19 categories in Box 1 are largely aligned with the 18 tick boxes in Table 1. However, as is evident from Table 1, ONS reclassified some write-in answers to the pre-defined ethnic categories (for example, there are more Africans and Whites in tables based on the 19-fold classification than ticked those boxes e.g. there are fewer "Other Black/African/Caribbean" than wrote in their country of origin and more in the "African" category than ticked this box because, for example, Black Nigerians were tabulated as "African").

In addition to the 13 ethnic groups that corresponded to tick box answer, ONS identified 274 distinct ethnic groups based on the write-in answers. In Table 1 only those cases where the number of write-ins exceeded 100,000 are shown, for brevity. However, this itself is misleading as, for example while 'Somali' was written-in 150,650 times in the 'Black other' box, a further 25,445 wrote in 'Somalilander' as an answer to this tick box – making a total of 176,095 responses to the 'Black other' tick box and these were all included in the tabulation group 'Black African'. However, the terms 'Somali' and 'Somalilander' were also used a further 13,140 times in response to the write-in tick box 'Other ethnic group'. Conversely, in their report on the Somali population at Census, ONS indicated that 176,645 people identified themselves as Somali – more than ticked the 'Black other' box but less than combining this with those in the 'Other ethnic group' box, suggesting that rather more judgement calls were made in producing their report than is evident from other published figures. (778)

Table 1. Numbers and percent in each ethnic category by (a) response to Census question and (b) 19-fold Census tabulation groups, England and Wales, Census 2021

Census question hierarchy						
Broad category	**Tick box**	**Write-in response**	**Detailed responses**		**19-fold classification tabulation**	
			Number	**Percent**	**Number**	**Percent**
A White						
	English, Welsh, Scottish, Northern Irish or British		44,311,395	74.4	44,355,038	74.4
	Irish		507,465	0.9	507,465	0.9
	Gypsy or Irish Traveller		63,445	0.1	67,768	0.1
	Other White (write in)				3,667,997	6.2
		European Mixed	646,120	1.1		
		Polish	614,345	1.0		
		Romanian	342,650	0.6		
		Other Eastern European	166,180	0.3		
		White unspecified	211,290	0.4		
		Italian	148,660	0.2		
		Roma	100,980	0.2	100,981	0.2
B Mixed/multiple ethnic groups						
	White and Black Caribbean		513,040	0.9	513,042	0.9
	White and Black African		249,600	0.4	249,596	0.4
	White and Asian		488,225	0.8	488,225	0.8
	Other mixed/multiple ethnic groups (write- in)				467,113	0.8
C Asian/Asian British						
	Indian		1,864,320	3.1	1,864,318	3.1
	Pakistani		1,587,820	2.7	1,587,819	2.7
	Bangladeshi		644,880	1.1	644,881	1.1
	Chinese		445,615	0.7	445,619	0.7
	Other Asian/Asian British (write-in)				972,783	1.6
		Filipino	162,140	0.3		
		Sri Lankan	149,245	0.3		
D Black/African/Caribbean/Black British						
	African		613,550	1.0	1,488,381	2.5
	Caribbean		622,395	1.0	623,119	1.0
	Other Black/African/ Caribbean (write-in)				297,778	
		Nigerian	271,390	0.5		
		Somali	150,650	0.3		
		Ghanaian	112,865	0.2		
		Black British	196,375	0.3		
E Other ethnic group						
	Arab		331,845	0.6	331,844	0.6
	Any other ethnic group (write-in)				923,775	1.6
All responses			**59,597,600**	**100.0**	**59,597,542**	**100.0**

Source: *ONS(2022)(31)*

Notes *(1) Ethnic groups in bold are those listed in the 19-fold classification*

(2) Only write-in responses with more than 100,000 responses are shown in this table

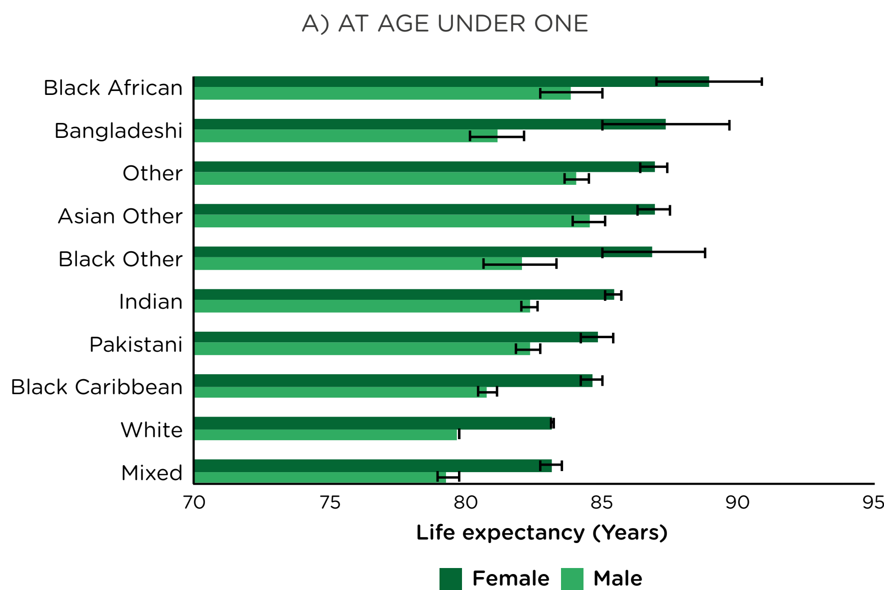
APPENDIX 2: LIFE EXPECTANCY BY ETHNIC GROUP

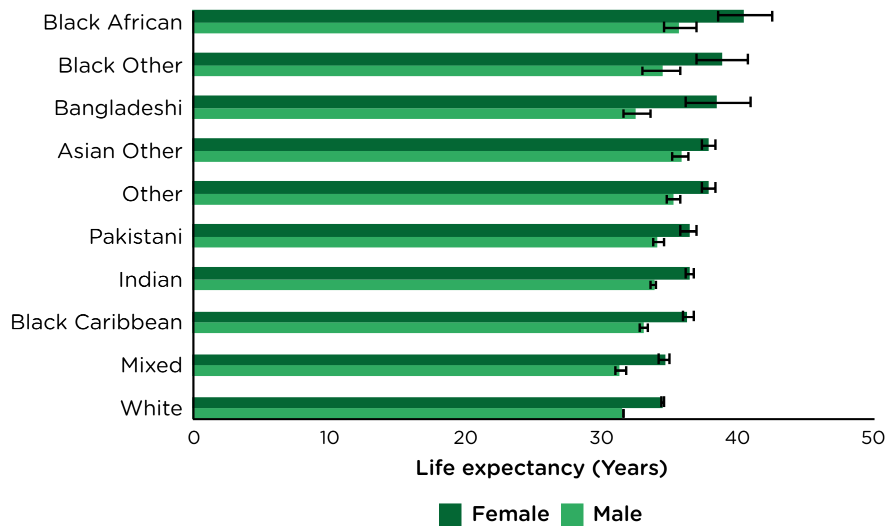
Many reports on health inequalities, including our own, focus on life expectancy. In many ways, morbidity and quality of life are more meaningful measures. But we use life expectancy because it is readily available. When comparing ethnic groups, however, life expectancy data may tell a misleading story. As will be seen in the figures below, Black Africans have life expectancy at age under one of 88 in women and 83 in men. Two comparisons suggest that this is improbably high. In Nigeria, for example, life expectancy in women is 53.1 and in men is 52.3. In Somalia and Kenya, it is a little higher.

The figures we cite below suggest that migrants are a highly selected group, in that their life expectancy is decades longer than the average for people in the countries whence they came. The second comparison is with the healthiest countries. Life expectancy in Hong Kong is 88.3 in women and 82.7 in men. Taken at face value it would suggest that Black Africans and Bangladeshis in the UK have life expectancy equal to that of the healthiest countries in the world. It is possible but strains credibility. We give the reasons why migrants are a select group and why these figures should be treated as a distorted picture of health of ethnic minority groups.

Data on life expectancy by ethnic group has been published by ONS for England and Wales as a whole by following up individuals in the 2011 Census, whose records could be matched to their deaths, over the period 2011 to 2014.(74) Overall, Figure 1 suggests that life expectancy is higher and mortality rates are lower for all ethnic minority groups than White groups, with the exception of those with mixed ethnicity, despite many groups having poorer self-reported health. The possible reasons for this are discussed below. The greatest difference in female life expectancy in 2011-14 was between Black African groups, who had the highest life expectancy and White groups (5.8 years at ages under one and 6.1 years at ages 50 to 54). Among men the greatest differences were seen in the Asian other group (i.e. other than Indian, Pakistani and Bangladeshi origin), with differences compared with White groups, of 5.2 and 4.3 years, respectively. Among women, the smallest differences were seen in the Mixed, Black Caribbean, Pakistani and Indian groups. Among men the smallest differences were seen in the Mixed, Bangladeshi and Black Caribbean groups.

Figure 1. Life expectancy at ages under one and 50 to 54 years by ethnicity and sex, England and Wales, 2011-14





Source: *ONS (74)*

In publishing these findings, the ONS argued that one of the potential reasons for the higher life expectancy in the Black African and Asian other ethnic groups was that they contain a higher proportion of more recent migrants than other ethnic groups. Previous research had suggested that those who migrate long distances tend to be healthier i.e. have lower mortality and higher life expectancy than others. (779) (780) (781) It has also been suggested, based on a theory originally proposed by Bradford Hill, that some migrants who become ill return home to die, thus depressing the mortality rates of the population who remain. (782) (783) However, Bradford Hill's own evidence predated the founding of the NHS and the modern welfare state. Subsequent research has shown that in more recent times, it is only moves within a county (e.g. into sheltered accommodation and care homes) that represent ill-health migration while moves of greater distances within England and Wales were selectively healthy. (784) In terms of international migration, Nazroo has argued that, where ethnicity is based on 2011 Census recording and mortality in 2020-22 (i.e. during the COVID-19 pandemic), there is considerable scope for selective ill-health return emigration to have taken place. To address this, based on awareness of the extent of intercensal migration among minority ethnic groups, in the analysis shown in Figure 1, ONS restricted the follow-up from Census day to less than three years, to reduce the impact of selective emigration, and also made specific adjustments for emigration. (785) While this will not have eliminated the possibility of ill health emigration, it is unlikely that this phenomenon would explain the differences seen in Figure 1., making one or more of the hypotheses discussed above likely to be a more important factor.

APPENDIX 3. ETHNIC INEQUALITIES AND COVID

Mortality rates from COVID-19 were much higher among many ethnic minority groups than the White British group in England in the early waves of the COVID-19 pandemic, with a changing pattern as the pandemic progressed according to ONS 2011 Census-based analyses, as described in the main report, see Figure 2.

In their early attempts to understand the factors contributing to the patterns of COVID-19 mortality by ethnicity, wave and geography, ONS-derived statistical models that summarised the intitial waves into three time periods between March 2020 and December 2021. Briefly, the first model, which relates to deaths occurring between 2 March and 28 July 2020 showed that accounting for population density and local authority of residence comprised a substantial part of the excess risk experienced by most ethnic minority groups. (134). In In this analysis, they also calculated risk ratios before and after lockdown in wave one, based on their fully adjusted model. In the pre-lockdown period, ratios for females in the Bangladeshi/Pakistani and Black groups were 1.22 [1.01–1.47] and 1.72 [1.53–1.93] respectively. (134) After the lockdown, these decreased to 0.87 [0.71–1.07] for the Bangladeshi/Pakistani population and 0.83 [0.70–0.97] for the Black population. For males, the Black, Indian and Other ethnic-minority groups continued to experience a greater rate of COVID-19 mortality than the white population, but with reduced ratios. It seems reasonable to conclude from this that had lockdown occurred earlier, a greater proportion of lives of ethnic minority groups would have been saved.

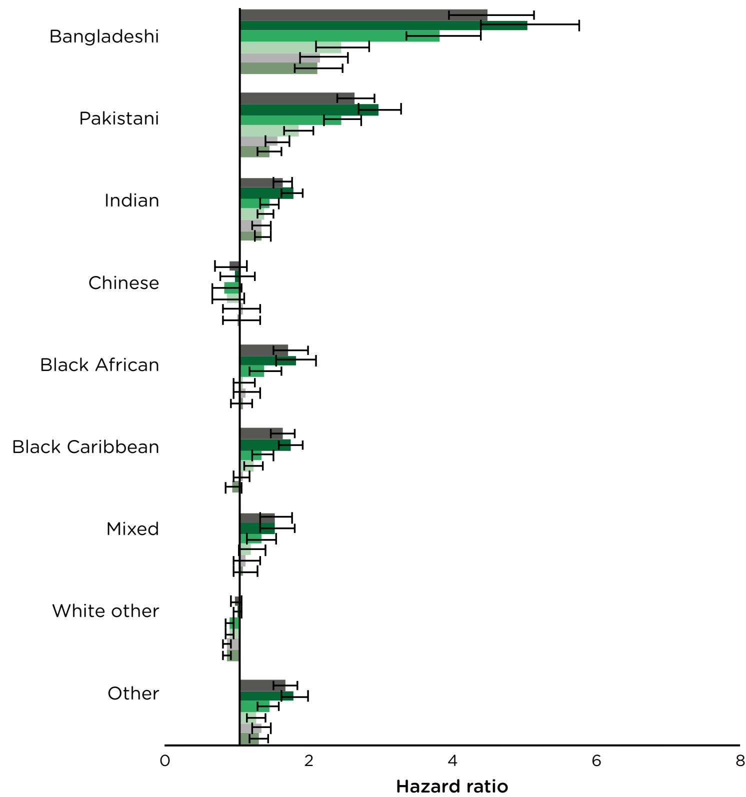
In modelling the factors that contribute to the excess COVID-19-related mortality rates in waves two and three, the ONS made several improvements and additions to the variables in their models. The principle one was to include a final model that incorporated vaccination data obtained from NHS Digital. The second key improvement related to access to GP and hospital episode data. They included pre-existing health conditions, BMI and hospital admissions over three previous years in the penultimate model. (786) The resulting analysis is shown in Figure 2.

This shows that in wave two, substantial amount of excess risk was explained in most ethnic groups by including geographic factors (model 3) and then sociodemographic factors (model 4). However, among males, neither these factors or the addition of all the additional factors, including vaccination, entirely accounted for the excess in most ethnic groups – except Chinese and 'Other white' groups. Among females, the inclusion of all factors accounted for all excesses except in Pakistani, Indian and 'Other' ethnic groups.

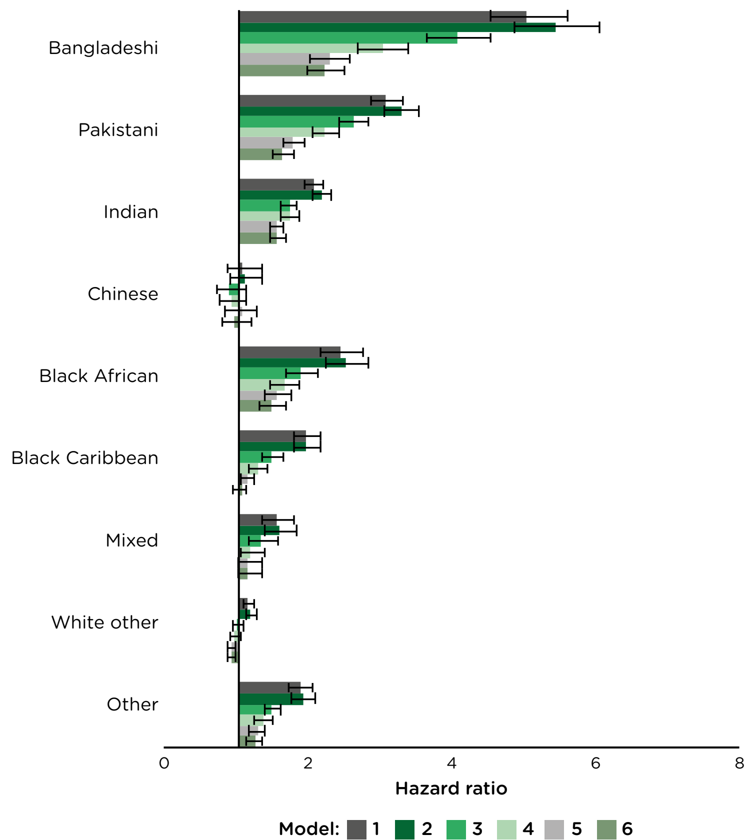
Figure 2. Hazard ratios for death involving COVID-19 by ethnic group compared to the White British group by sex during the second and third waves of the Covid-19 pandemic

SECOND WAVE (8 DECEMBER 2020 TO 12 JUNE 2021

FEMALES

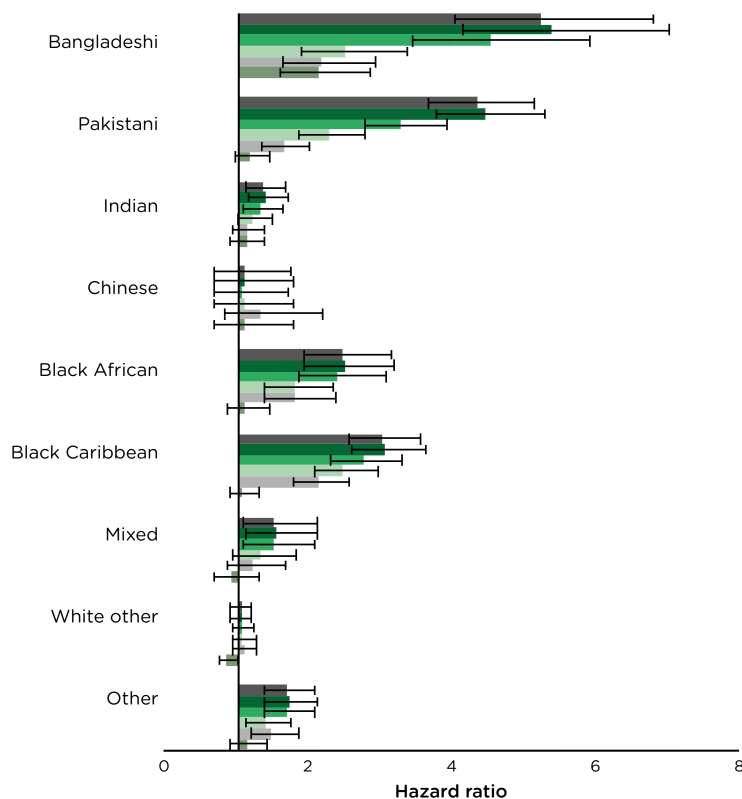


MALES

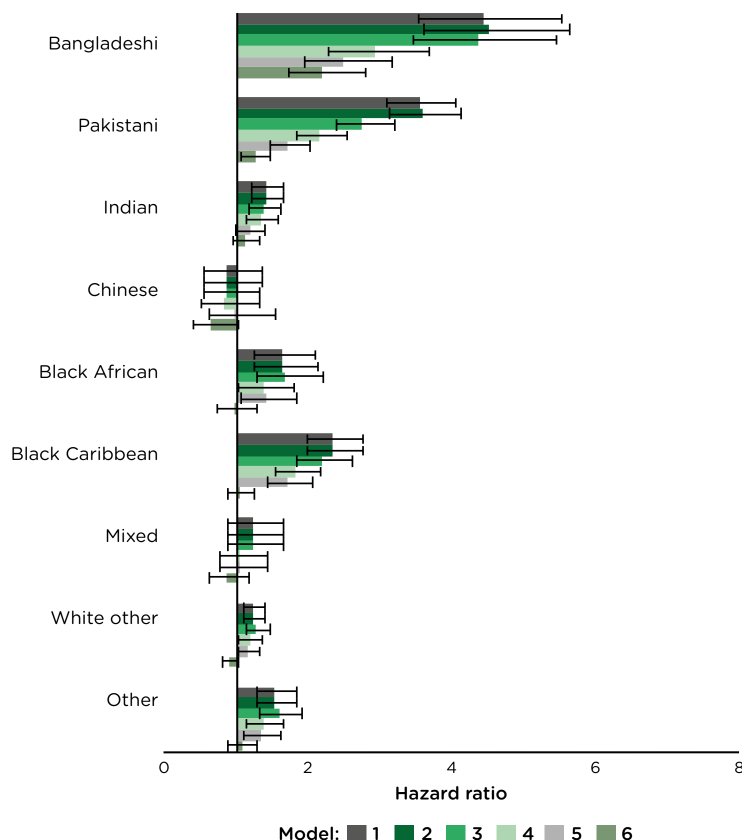


THIRD WAVE (13 JUNE 2021 TO 1 DECEMBER 2021)

FEMALES



MALES



Source: *Bosworth at al. (2023) (786)*

Notes. *Model 1 Age*

Model 2 + residence type (private household, care home or other communal establishment)

Model 3 + geographical factors (region, Rural Urban classification and population density)

Model 4 + sociodemographic factors (highest qualification, IMD decile, NS-SEC, household characteristics [tenure of the household, household deprivation, household size, family status, household composition and key worker in household], key worker type, individual and household exposure to disease, and individual and household proximity to others)

Model 5 + health status (pre-existing health conditions, BMI and hospital admissions over the previous three years)

Model 6 + vaccination status (unvaccinated, one dose or two doses or, in wave 3, third/booster dose).

Bars represent 95 percent confidence intervals.

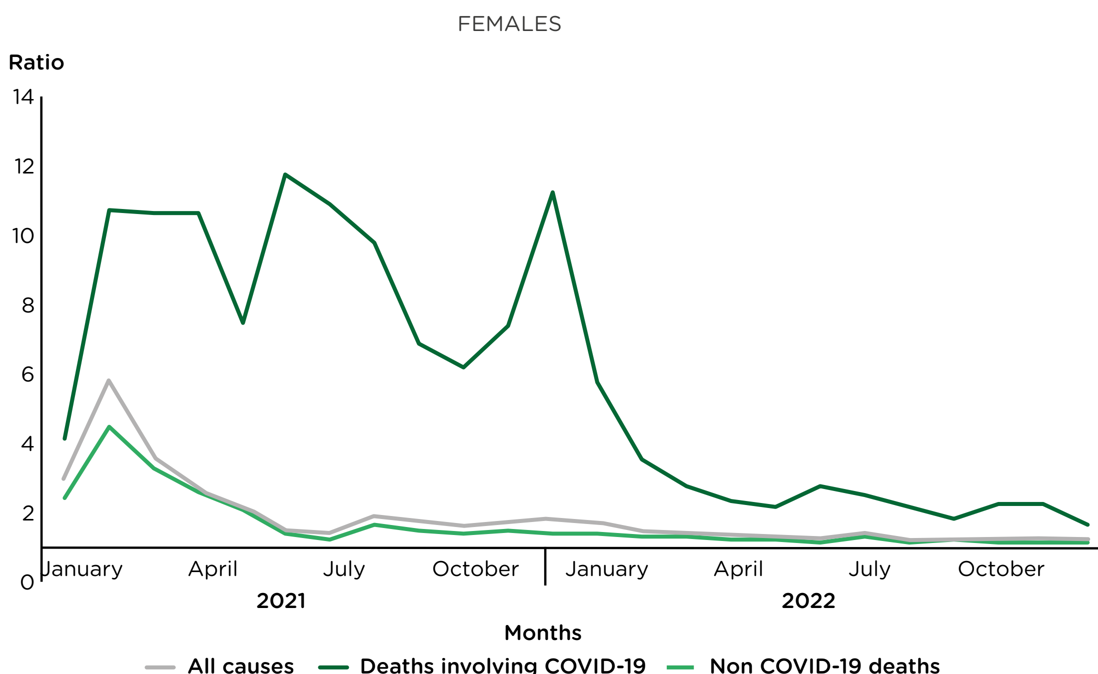
It was only after including sociodemographic factors in Model 4 that a substantial reduction in excess risk was identified for most ethnic groups. The major exceptions were Pakistani ethnic groups, for whom introducing geographical factors in Model 3 had already reduced risk ratios, and Indian, Chinese and White Other groups, for whom this model made no substantive change in risk. Once vaccination had been introduced, at the final stage of modelling, the only statistically significant excess risks remained for Bangladeshi males and females. For Pakistani males and females, the excess risks were of borderline statistical significance. This highlights the importance of public health working with all ethnic minority groups to improve trust.

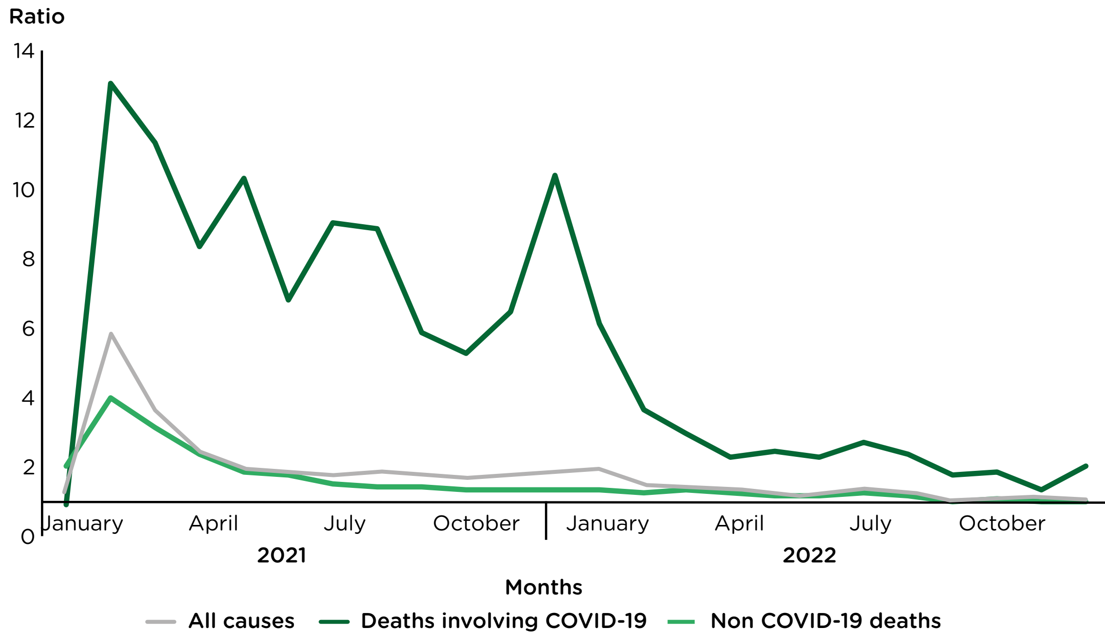
It should also be noted that all the exposure variables in the ONS analysis relied on individual information supplied in the 2011 Census and may not have accurately described people's situation in 2020. In particular, the only health status information available to the ONS in 2020 was self-reported general health and limiting long-term illness in 2011. It became evident, from research over the course of the pandemic, that specific health conditions increased the risk of severe outcomes from COVID-19 infection and, as discussed earlier in this section, some of these were particularly prevalent in some ethnic minority groups e.g. chronic kidney disease, diabetes and sickle cell disease. (145)

The analysis of COVID-19 mortality by ethnicity in London in Figure 3.18 in the main report was produced by the Office for Health Improvement and Disparities (OHID) on a substantially different basis to that used by the ONS. (132) First, ethnicity was derived from hospital episode records linked over time. Second, excess mortality in each time period, sex and ethnic group within London is calculated based on what would have been expected from the trend in death rates in 2015 to 2019 within the relevant sub-group. Third, the publicly available data cover very slightly different weeks to that used in the above ONS analysis.

The importance of vaccination in reducing fatality and other serious outcomes of COVID-19 infection was an important factor in the ONS and OHID analyses. Figure 3 shows the ratio of mortality in the unvaccinated to that in the ever vaccinated. While this summary clearly underplays the importance of number of doses, other health-rated differences between these populations and the time-limited protection provided by each dose, it does illustrate the role played by vaccination, particularly between February 2021 and February 2022. (787) (788)

Figure 3 . Ratio of age-standardised mortality rates of unvaccinated compared to vaccinated people by sex for all cause of death, deaths involving COVID-19 and deaths not involving COVID-19, England, deaths occurring between 1 January 2021 and 31 December 2022





Source: *ONS (2022) ONS (2023) (787) (788)*

Notes: *Figures for January to March 2021 are based on 2011 Census while those from April 2021 are based on the 2021 Census.*

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