City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

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1. Executive Summary

1.1 This report provides an update on local disparities, recovery planning and next steps to promote and protect the health and wellbeing of residents living in the Royal Borough of Kensington and Chelsea and the City of Westminster.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is invited to consider the local actions to reduce the disproportionate impacts of Covid-19 on particular groups and to engage in developing system-wide recommendations to reduce health inequalities.

3. Background

3.1 In June 2020, PHE published the report 'Disparities in the risk and outcomes of COVID-19'. It confirmed that the impact of COVID-19 has replicated existing health inequalities and had disproportionately affected some groups. Attention was given to disproportionate impacts associated with age and sex, geography, deprivation, ethnicity, occupation, inclusion health groups, deaths in care homes and comorbidities. A summary of the key findings from this report was discussed at the Health and Wellbeing Board on 9 July 2020.

3.2 National research and understanding about the disparities into coronavirus is growing, with a recognition that, as well as the direct impacts of coronavirus, the social distancing and

lockdown measures have had a disproportionate impact on individuals and communities where restrictions on social and economic activities have been more keenly felt.

3.3 To some extent, Covid-19 has displayed patterns of inequality shown across other health outcomes; many of our residents live long lives, with some of the longest life expectancy in the country however, variation exists and the gap in life expectancy has increased. In Westminster for men there is 13.5 year difference in life expectancy between the most and least deprived parts of the borough. This is the fourth highest gap in England. For women it is 7.4 years. In Kensington and Chelsea life expectancy varies for men by 14.5 years between the most and least deprived parts of the borough (second highest in England). For women it is 10.1 years.

3.4 On 25 February 2020, *Health Equity in England: The Marmot Review 10 years on,* was published. The report was commissioned by the Health Foundation and undertaken by Professor Sir Michael Marmot and the Institute of Health Equity, as a follow up to the 2010 report.

3.5 Health inequalities are avoidable by tackling the social determinants of health and harnessing the power of our communities to respond to need. Policies to tackle health inequalities should be based on the proportionate universalist principle, with the greatest investment being directed at regions and communities which have suffered most during the years of austerity.

4. Local data and response

4.1 The Public Health Intelligence team continually monitor local case details and testing activity to support a local needs-led response, mobile testing capabilities and outreach strategies.

4.2 In addition, to complement and localise the PHE and other national research, the Public Health department have conducted a rapid Health Impact Assessment (HIA) which assesses the national and local evidence of current direct and indirect impacts of COVID 19 on the health and wellbeing of our residents. The findings of this tool are feeding into the recovery and renewal programmes in each borough.

4.3 The HIA is intended to provide a snapshot of health impacts in the short to medium term and serves as a repository of useful national and local data that can be drawn upon to inform action. It covers the 9 protected characteristics included in the Equalities Act 2010 but also wider health considerations including how COVID-19 might have impacted on:

- health conditions and behaviours such as cancer, mental health, long term conditions, drug and alcohol use
- groups of residents – such as carers or people with dementia and those sleeping rough or living in overcrowded circumstances, refugees and other vulnerable groups
- wider determinants such as the security of housing, employment, air quality those who are at risk of homelessness or sleeping rough.

4.4 This data will need to be interpreted in the context of what we already know about health and wellbeing in both boroughs. Many of our residents live long lives, with some of the

longest life expectancy in the country. However, depending on where you live in Westminster, life expectancy varies for men by 13.5 years between the most and least deprived parts of the borough. This is the fourth highest gap in England. For women it is 7.4 years. In Kensington and Chelsea, life expectancy varies for men by 14.5 years between the most and least deprived parts of the borough (second highest in England). For women it is 10.1 years.

4.5 The gap in life expectancy has increased since 2010. In Westminster, the gap has increased by 1.5 years for men over the last decade (12 to 13.5 years) while it has increased slightly for women (6.7 to 7.4 years). In Kensington and Chelsea, it has increased by 2.9 years for men (11.4 to 14.5 years) and 3.9 years for women (6.2 to 10.1 years)

4.6 In the more deprived areas, people are living a greater proportion of their lives in poor health. In Westminster, this gap in healthy life expectancy between the most and least deprived areas is 20 years for men and 19 years for women. In Kensington and Chelsea it is 25 years for men and 21 for women.

4.7 The local data reflects the national findings that COVID-19 has disproportionately affected a range of groups including older people, Black, Asian and Minority Ethnic groups (BAME) groups and those with co-existing conditions.

4.8 In relation to co-existing conditions, of those residents who have died from Covid-19 and had their death registered in Westminster, 89% had an underlying health condition. In RBKC, 88% had an underlying health condition. Our One You and Change4Life services are addressing these risk factors but we are reviewing if there is more these services can do to reach BAME groups and others that have been disproportionately affected by COVID-19.

4.9 National research to date, including that published by Public Health England, has confirmed that Covid-19 has disproportionately impacted certain people and communities, and has exacerbated existing inequalities. Local data and intelligence suggests that this pattern is being reflected in both Kensington and Chelsea and Westminster. Specifically:

- A higher proportion of deaths from Covid-19 are among people from a BAME background compared to non Covid-19 deaths.
- Deaths are higher in more deprived areas with the pattern mirrored, not exacerbated, by Covid-19
- Those from a BAME background are more likely to be at risk due to higher prevalence of diabetes, hypertension and obesity.

4.10 Moving forward a population health surveying and monitoring approach will be adopted to support longer term recovery and enable prevention to be embedded in our local planning so early changes in local health and wellbeing are identified and addressed at the earliest opportunity.

5. Developing an Action Plan

5.1 With both local and national data showing clear disparities in the impact of Covid19 on our local populations, early interpretation of the Health Impact Assessments indicate there are four key focus areas where we will be looking to prioritise our response. Some of the

associated desired outcomes are listed below although we hope to shape this further following stakeholder engagement along with the actions to deliver change.

- **Improved health outcomes of BAME groups** to address the increased risk of Covid-19 infection, mortality and disparities in other health conditions
- **Enhanced action to support mental health and wellbeing** and address the drivers related to the pandemic such as social isolation, job and financial loss, housing insecurity and quality, working in front line services, reduced access to services and loss of coping mechanisms.
- **Specific health promotion efforts with targeted groups** particularly where there is evidence of reduced access to health services during the pandemic or where health outcomes were already of concern
- **Action on the social determinants of health –** the circumstances in which we live, work and play command the greatest control over our health and wellbeing. Policies to tackle health inequalities should be based on the proportionate universalist principle, with the greatest investment being directed at communities whose health we would want to improve the fastest.

Table 1

Areas of focus	Desired Outcomes
1. Improve health outcomes of BAME groups	• Improve the cardiovascular health of BAME residents specifically, reducing the risk of diabetes and obesity. • Greater understanding of health issues faced by BAME population, to focus on, engage and understand health from a resident perspective.
2. Improve targeted mental health support	• Support people at increased risk through having suffered a Covid19 bereavement • Increase in support for children and young adults 18-25 • Enhanced support for people at risk of or experiencing social isolation. • Increased community awareness and support for mental health issues and use of interventions that are available.
3. Specific health promotion efforts with targeted groups	• Enhanced support for rough sleepers that use drugs and alcohol. • Reduce the gap in child development and immunisation outcomes exacerbated by lockdown.

	• Increase the number of residents accessing health promotion services and health protection initiatives in targeted areas.
4. Action on the social determinants of health	• Improve understanding and action on risk factors for homelessness post Covid19. • Integrated health/employment support offers to sustain people in employment. • Enhance the numbers of people using active methods to travel to school and work and support action to create healthier food neighbourhoods in targeted areas where related health outcomes are the poorest.

6 Immediate Actions

6.1 In order to mitigate the risk and impact of COVID-19 amongst those groups known to be disproportionately affected, there are a number of communications and community engagement strategies that have already been implemented. These include:

- Targeted paid social media advertising in postcodes with high levels of cases, and among groups where we are seeing most cases occur.
- Delivering a community outreach offer on NHS Test and Trace and outbreak control to upskill our community groups, residents' associations, religious leaders, institutions and others on the importance of Test and Trace and their support roles.
- Working with our local groups and networks to ensure our residents, businesses, and stakeholders are aware of how we can all prevent the spread of the virus.
- Commissioned Support When It Matters (SWIM) to provide culturally sensitive information and support to residents to reduce their chance of COVID infection.
- Produced a short film with members of our Church Street community on the importance of using Test and Trace to protect themselves and our communities.
- Ensured resources are available in multiple, commonly spoken languages.

6.2 Additionally, every resident is invited to be a Health Champion. By recruiting Champions from all sections of the community, we will be able to mitigate as far as possible, the negative impacts of disparities and inequalities in disease prevalence and spread. Champions will reach our older and younger, more vulnerable residents and the range of diverse communities to ensure messages are communicated effectively and received well.

7 Next steps

7.1 As a system it is recommended that we recognise and act to address the disproportionate impacts of Covid-19. Through the recovery programmes being established in each local authority, plans are being developed to provide a collaborative and holistic approach to

addressing the wider determinants of health. Focus on active travel, employment, housing and education will seek to overcome the root cause of the health inequalities.

7.2 The Public Health team will publish an Annual Public Health Report which summarises the Health Impact Assessments conducted in each borough and set out more detailed recommendations for action following engagement with all stakeholders. It is proposed that progress against system wide key performance indicators are reviewed every year for the next three years.

7.3 A governance process will be established for oversight of this recovery investment programme to ensure investment is prioritised and outcomes independently monitored.

7.4 Bi-Borough will appoint an academic partner to review Bi-Borough approach to data and analysis in order provide an independent assessment and peer review. This partner will also support evaluation of the investment programme to ensure action delivers greater equality of health outcomes across Bi-Borough.

7.5 In the development of an action pan to address the disparities it will be crucial to engage widely with the community and groups we are looking to support to enhance both the quality and accessibility of the responses and interventions that are developed.

8. Legal Implications

There are no direct legal implications at present connected to these broad policy recommendations.

9. Financial Implications

There are no direct financial implications at present connected to these broad policy recommendations. The Public Health grant (and any reserve carried over) is ring-fenced and must only be used for eligible expenditure to be incurred by local authorities for the purposes of their public health functions or will have a significant effect on public health.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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