Ealing Annual Public Health Report 2020-2021

COVID Inequalities

Integrated Impact Assessment

March 2022

This Annual Public Health Report includes findings from a COVID Inequalities Integrated Impact Assessment that was conducted over a 14 month period. It describes the direct and indirect impacts of the COVID-19 pandemic upon the population of Ealing.
Data within this report spans the period March 2020 – March 2021.

This report illustrates ways that some groups in our local population have been disproportionately affected by the pandemic, and where existing structural inequalities have also been exacerbated.

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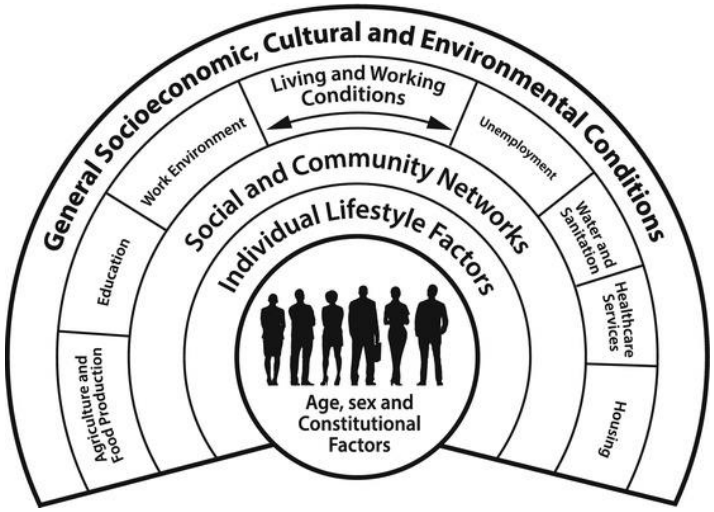
Context and Aims of Integrated Impact Assessment (IIA)

Context

- COVID-19 pandemic has impacted everyone
- But it has also exposed and exacerbated existing health, social and economic inequalities, the roots of which are complex and interdependent
- Recovery from the pandemic provides an opportunity to consider systemic changes to help address the root causes of inequalities

Aims

- To assess a wide range of direct and indirect impacts of the pandemic upon Ealing's population across the life-course, to understand how people have been impacted, including for those most affected
- To raise profile of theses impacts and how they connect to the wider determinants of health
- To identify assets and opportunities for whole system solutions
- Make recommendations for short-, medium- and long-term actions, strategy and policy
- Engage with the population of Ealing and to help build trust for collaborative recovery



Source: Dahlgren and Whitehead 1991 and 2007

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Ealing Resident and Community Feedback – COVID pandemic

Health services need to move from 'transactional to relational' ways of working together in the future

'Pre-pandemic health gains for the borough (e.g. on diabetes) have been lost, or are at risk of needing to be 'repeated' to get back to where they were.'

'Institutional racism has been felt as an acute problem during the pandemic… pressures of the pandemic made it harder for people to face this with their usual help and coping mechanisms constrained.'

'Ealing Together' helped form new collaborations and partnerships

'Poverty is the underlying cause of inequalities'

The COVID pandemic affected life for everyone. But for some Ealing residents, their lives were affected on many levels from a combination of multiple direct and indirect impacts

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Ealing: Impact of COVID and Inequalities (2020-21)

31,482
COVID-19 cases
March 20 - March 21

Frontline Occupations

11%
Ealing residents work in elementary roles, compared to **8% in London**

25%
people over 70 years live with working age adults. Ealing in top 5 for London

WEST
Higher Infection rates in West of borough (particularly Southall and Greenford)

91.4%
residents hospitalised with COVID had 1 or more long term conditions

35%
of Ealing residents with a COVID diagnosis who died in hospital had diabetes

Wards with a higher proportion of residents identifying as **Black Asian or minority ethnicity** had higher cumulative rate of infections, and the **highest COVID-related hospital admissions**

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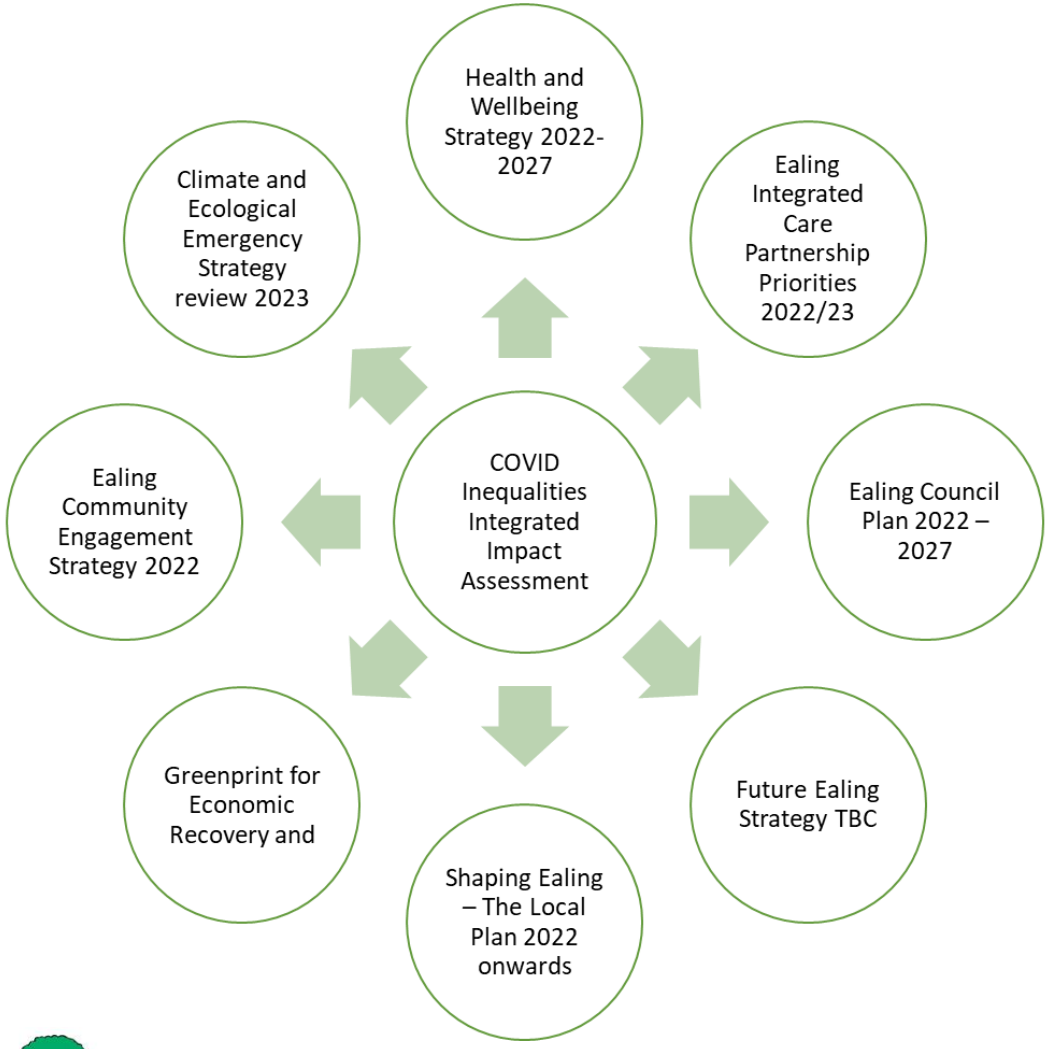
Strategic Links



IIA Development process

IIA Area	Input and Activity
Community Engagement and consultation	Conversations with community groups, community leaders, voluntary sector organisations and forums 4 area task group meetings in March 2021 Acton, Southall, Northolt and Greenford and Perivale Joint reflection on lived experience of inequalities and collective ideas for next steps to tackle these.
Quantitative analysis of COVID data Direct impact	• Infection • Severe Illness • Death By age, sex, ethnicity, long term health conditions, deprivation, urban living, occupation. For the full year from March 2020 to 2021. For CYP the current JSNA refresh will also inform
Indirect impact	Involved gathering information on homelessness, employment and job insecurity, digital exclusion and other key areas
Evidence review – national, regional, local (including Race Equality Commission)	
Cross council steering group	

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Summary of direct impact of COVID and inequalities: March 2020 - March 2021

Age and sex	Overall 20-59 year olds have been over-represented in those testing positive in Ealing. However, nearly 50% Ealing residents admitted to hospital were 65 years or over (32.6% over 75) Men accounted for 63.9% of all deaths in hospitals compared to 36.1% Women (1st wave data only) 78.6% of Ealing residents who died in hospital were over 65 years (1st wave data only)
Long term health conditions	91.4% of Ealing residents admitted to hospital with COVID also had one or more long term conditions. 35% of Ealing residents who died in hospital had diabetes and 62% had more than one long term condition.
Deprivation	In Ealing, higher infection rates appear concentrated in West of the borough (particularly Southall and Greenford). Wards with the highest COVID related hospital admission rates are statistically significantly higher when compared to a group of wards with the lowest COVID related hospital admission rates. A clear gradient exists between the Middle Super Output Areas (MSOAs) with the highest and lowest COVID death rates (x 5 approx.). MSOAs with the highest COVID related death rates are statistically significantly higher when compared to a group of wards with the lowest COVID related death rates.
Ethnicity	Wards with higher proportion of residents identifying as Black Asian or minority ethnicity had higher cumulate infection rates. Asian and Asian British groups appear to be disproportionately affected by hospital admissions for COVID, with a large proportion of those admitted for COVID identifying as 'other ethnic groups'. We would need to review hospital admission rates by ethnicity to draw solid conclusions from this.
Urban Living	In Ealing, 14% households overcrowded - 8th highest in London (11%), England (4.5%). In Ealing, 8,100 (25%) people over 70 live in a household with working age adults. Ealing in top 5 Boroughs in London
Front line occupations	Ealing has a higher proportion of people employed in low skilled, elementary occupations 11.7% compared to London (8%) and England (10%)

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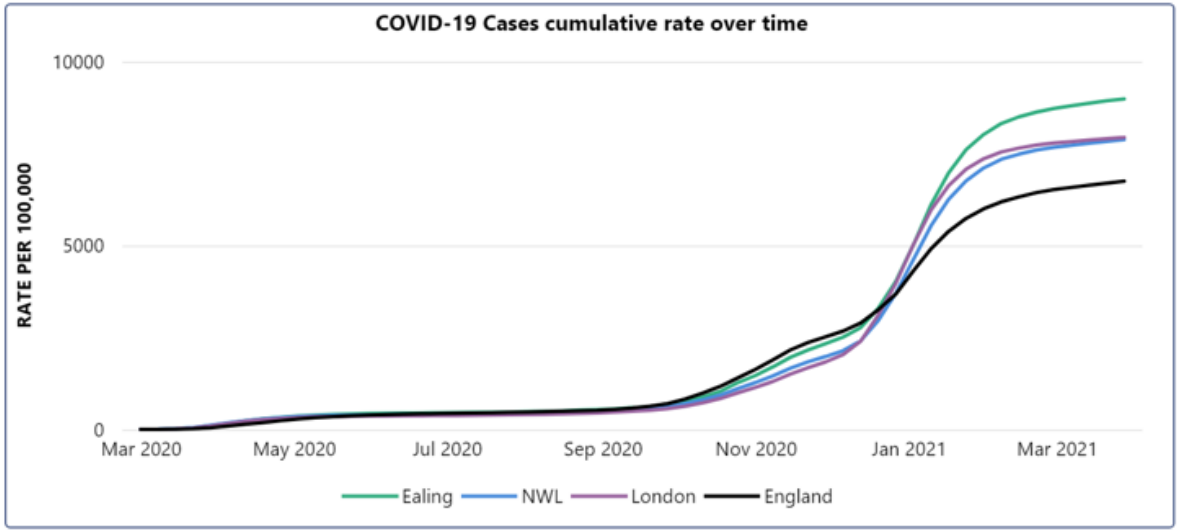
Ealing data: borough level COVID infection

Graph 1. COVID-19 cases cumulative rate per 100,000 over time for Ealing, NWL, London and England



Ealing's population has been significantly impacted by the COVID-19 pandemic. Between March 2020 and March 2021, Ealing had a total of 31,482 cases of COVID-19 that were confirmed through testing. Since these figures capture only those who were tested (testing was available only in healthcare settings at the start of the pandemic), this will be an underestimation of the overall number of infections experienced by the borough population.

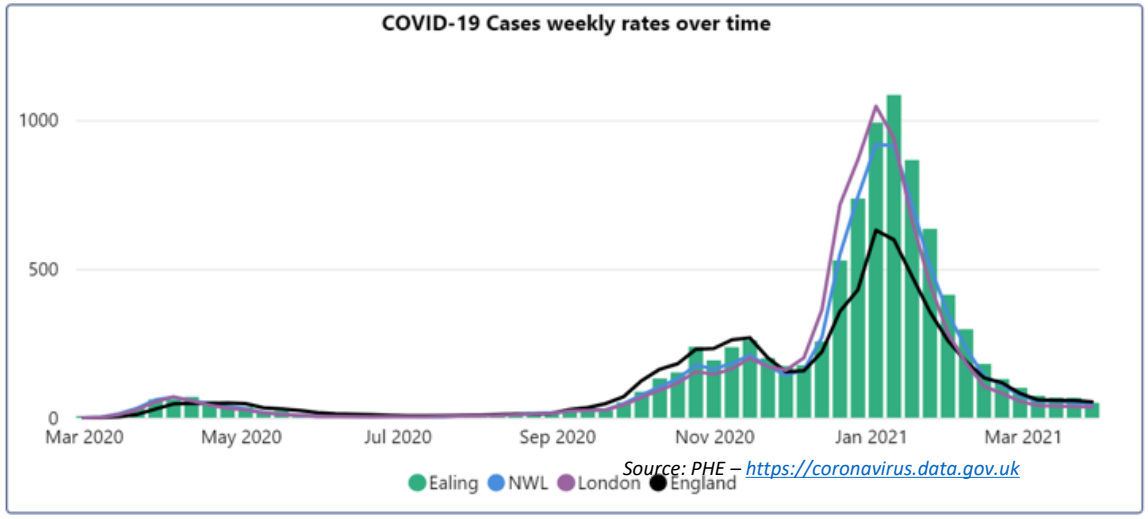
This total number of cases equates to a cumulative infection rate in March 2021 (for the period March 2020 – March 2021) of 9,251.3 per 100,000, which is statistically lower than England, but higher than North West London and London. (graph 1). Both graphs 1 and 2 demonstrate that London's peak occurred earlier than the rest of the country.

Graph 2: COVID-19 cases weekly rate per 100,000 population over time for Ealing, NWL, London and England

Ealing's weekly infection rates were as high and comparable to those of North West London region, London as a whole and as England.

During January and March 2021, Ealing's rates were often higher, and for several weeks were one of the highest in London (graph 2.)

There are many reasons for Ealing's significant impact from the pandemic and comparably worse situation for London overall. These include differences in demography, the burden of long-term health conditions in Ealing, socioeconomics and living conditions, different provisions of care services, testing uptake, and regional differences in transmission.



Source: PHE – https://coronavirus.data.gov.uk

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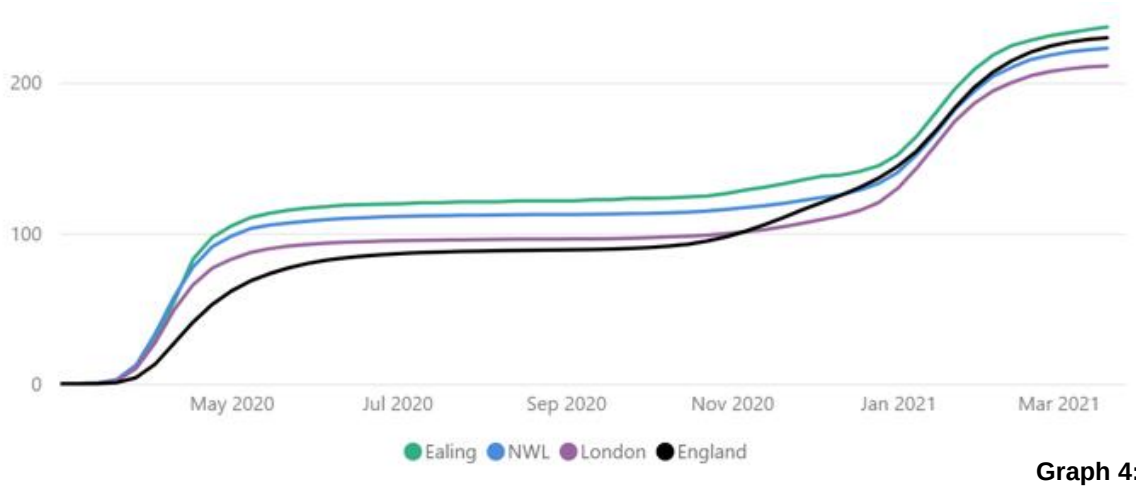
Ealing data: borough level COVID death

Graph 3: COVID-19 cumulative death rates per 100,000 population over time for Ealing, NWL, London, and England

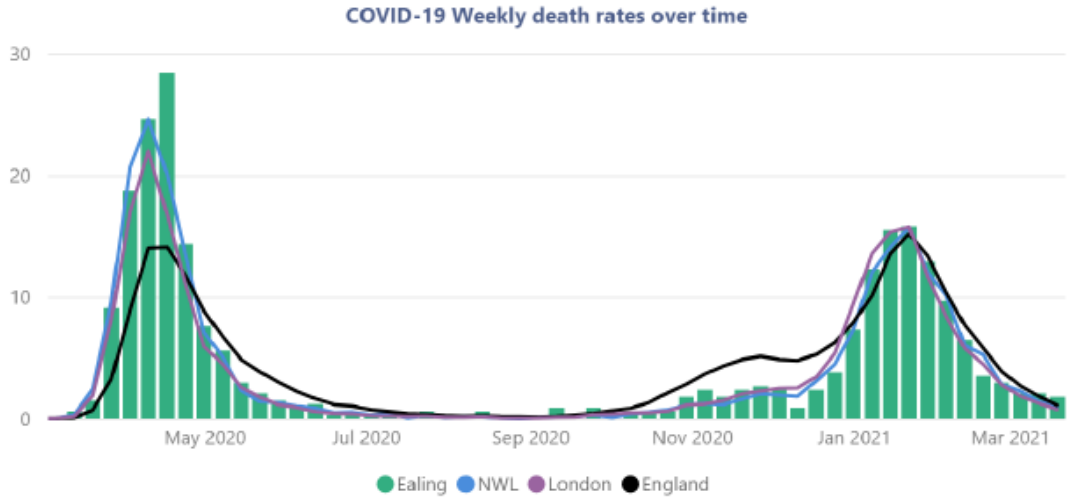


Ealing's population also experienced a high number of COVID-related deaths between March 2020 and March 2021, following the pattern of the two 'waves' of infection.

In the first COVID-19 wave, the peak for mortality in Ealing was statistically higher than NWL, than London and for England. In the second wave, COVID mortality rates for Ealing was statistically similar to that in NWL, London and England.

There will be many reasons for these differences in death rate from COVID-19. Just as for infection risk, it is important to investigate and understand the association between inequalities in Ealing and COVID-19 deaths.

Graph 4: COVID-19 weekly death rates per 100,000 over time for Ealing, NWL, London and England



Source: ONS, Mortality Data

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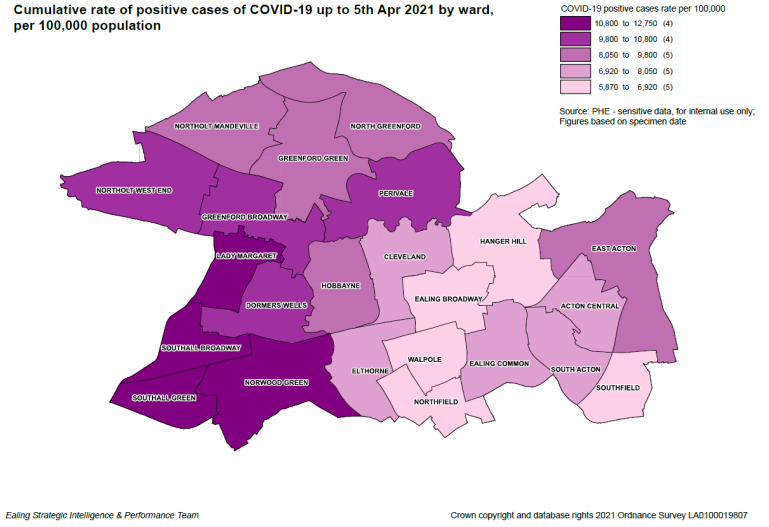
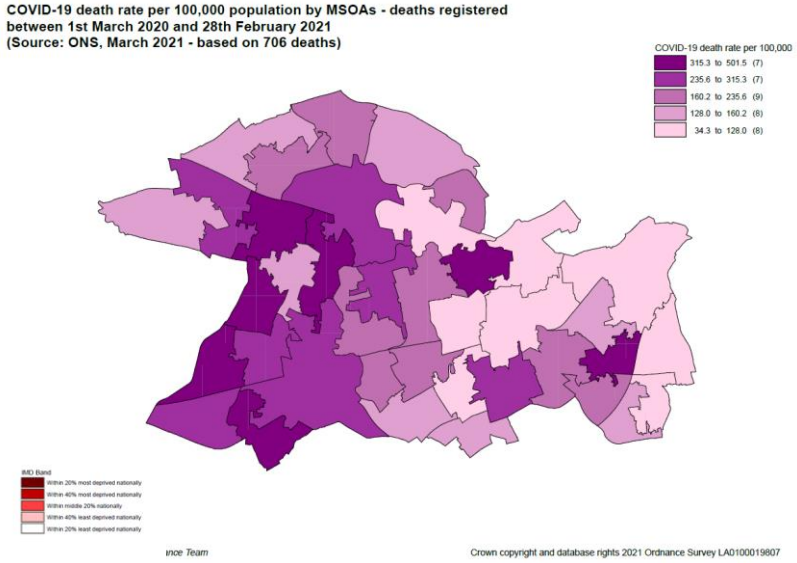
Deprivation impact on COVID infection and death in Ealing

On map 1. the wards with higher cumulative infection rates appear concentrated in the West of the borough (Southall and Greenford) and to a lesser degree Northolt and East Acton.
A similar concentrated pattern is seen with COVID death rates by ward in map 2.
Map 3. offers a visual reference for the areas (LSOAs) with the higher levels of deprivation as per IMD data for 2019. These areas of greatest deprivation appear to correlate with the wards with the highest COVID infection and death rates in maps 1 and 2, indicating that there was great inequality in direct COVID impact in the areas of greatest deprivation in the borough.

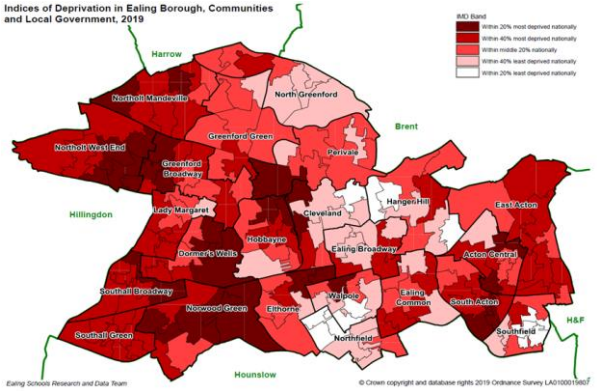
Map 1: Cumulative rate of COVID cases per ward per 100,000, up to 5th April 2021



Map 2: COVID-19 cumulative death rate by MSOAs



Map 3: Indices of Multiple Deprivat
Lower Super Output Areas 2019



These maps help to illustrate the associations between deprivation, COVID infection rates and risk of COVID-related death. This highlights the need to **focus on inequality and the wider determinants of health**, in factors such as economy, income and deprivation during **recovery from the pandemic**

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National Evidence

The same pandemic, unequal impacts: How people are experiencing the pandemic differently

It's been clear from the early stages of the COVID-19 pandemic that some groups are more affected than others.

People living in the poorest areas are at higher risk from COVID-19

People in the most affluent areas are **50% less likely** to die of COVID-19 than those in the poorest areas.

Black and minority ethnic communities are more affected by COVID-19

People of black ethnicity are **4 times as likely** to die from COVID-19 compared to people of white ethnicity.

Disabled people have been hit particularly hard

Disabled people have experienced death rates **2 to 3 times higher** than non-disabled people.

Young people are most likely to lose employment

One in three of 18–24-year-olds have been furloughed or lost their job – **twice the rate** of working-age adults.

Health and social care workers have an increased risk of adverse mental health outcomes

4 in 5 social care workers in Scotland reported their work during COVID-19 negatively impacted their mental health.

The COVID-19 impact inquiry is exploring the different ways the pandemic, and the national response to it, are affecting health and health inequalities in the UK.

Find out more at **health.org.uk/covid-19-impact-inquiry**

The Health Foundation

References are available at health.org.uk/same-pandemic-unequal-impacts

Sources:
The same pandemic, unequal impacts
The Health Foundation 2020

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Informing action

Actions adopted during the COVID pandemic response

Examples: immediate actions implemented during COVID response
Engage with Ealing's Black, Asian and Minority Ethnic and disadvantaged populations to ensure their experiences inform the ongoing pandemic response and recovery – through area task group meetings and EACH consortium
Care homes - Maintain effective multi-agency response at varying degrees of intensity (IPC, outbreak management, market & staffing, testing, PPE, vaccinations, enhanced GP support)
Tackle issue of digital exclusion ensuring people are able to access key advice, services and support.
Maintain strong operational response with health partners particularly for the COVID vaccination delivery
Continue to communicate clear and consistent messaging from national guidance especially to older people and people with health conditions in Ealing.
Target asymptomatic testing in groups to achieve most impact (e.g. occupation/geography)
Vaccination delivery - work with partners to ensure access and engagement is targeted to the most vulnerable.

Informing future ways of working

Principles for future cross-system working have been developed with partners

Informed by learning and experiences from the COVID-19 pandemic

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System wide Principles of Working on Health Inequalities – Summary (full detail, pg. 49-50)

Community Participation and ownership - Prioritise a truly participatory model of community engagement that is open, transparent and inclusive

Whole systems approach for health, wellbeing and community support – with common goals to reduce inequalities and to improve outcomes

Tackle structural racism - Identify structural racism and unconscious bias and deliver 2022 Race Equality Commission report recommendations

Use learning from the COVID pandemic - to improve addressing health inequalities, improve community engagement and targeted provision

Tackle and prevent digital exclusion - Promote and help build local digital skills and accessibility. Ensure non-digital options are there for those who need them

Tackle the causes of the causes - Identify and address root causes of inequalities to strengthen local capacity to thrive.

Prioritise prevention – Work to tackle the immediate issues, and also focus on independent living, prevention and early intervention of ill-health.

Embed equity and fairness and Improve local data collection – to support monitoring and evaluation of services for addressing health inequalities

Prioritise hyperlocal - Prioritise hyperlocal place-based needs assessment, community engagement, and strategy development

Work across the life course – from birth through to older age, to help ensure a commitment to longer-term prevention and early intervention.

Prioritise accessibility for all - to ensure age-friendly, disability-inclusive urban spaces, services, and opportunities in the borough

Incorporate action to address the unequal impact from climate change

Set an intention to tackle poverty locally, and also lobby to tackle poverty and inequality nationally

Take full responsibility as anchor institutions – Prioritise the building of community wealth; support and influence employers and workplaces

Promote and support volunteering – harness and build upon the local community networks and ties that grew during the pandemic response

Ealing Annual Public Health Report 2020-2021
Introduction

Whilst the COVID-19 pandemic has impacted everyone in Ealing, it has exposed and exacerbated existing health, social and economic inequalities, with many groups of people more negatively affected than others. Causal factors for inequality are complex and inter-related, as represented in the *overlapping dimensions of health inequalities* diagram in figure 1. Many root causes can be traced to the wider determinants of health as depicted by the HEAT diagram (figure 1). Impacts from the pandemic will be long-lasting and risk even further widening of inequalities.

In addition to the moral and ethical reasons to tackle inequalities for those most affected, such health, economic and societal inequalities have a universally negative impact on society. Amongst other impacts, they require the commitment of public resources, create societal tension and have profound psychological consequences upon us all.

Recovery from the pandemic provides an opportunity to consider systemic changes to address such root causes of inequalities, enabling future policy to avoid further exacerbating these divides. For equitable recovery from the pandemic, it demands a commitment to bold and sustainable action across the whole system in Ealing.

This annual public health report summarises the work of the Ealing COVID Inequalities Integrated Impact Assessment which began in Summer 2020.

The aim of the integrated impacted assessment has been to:

- Assess a wide range of complex and inter-related direct and indirect impacts of the pandemic upon Ealing's population across the life-course, to understand who is most affected.
- Raise profile of theses injustices and the wider determinants of health across the system
- To identify assets and opportunities for whole system solutions
- Make recommendations for short-term actions as part of the COVID response and develop approaches to tackle inequalities in longer term strategy and policy
- Engage with population in Ealing and build trust for collaborative recovery

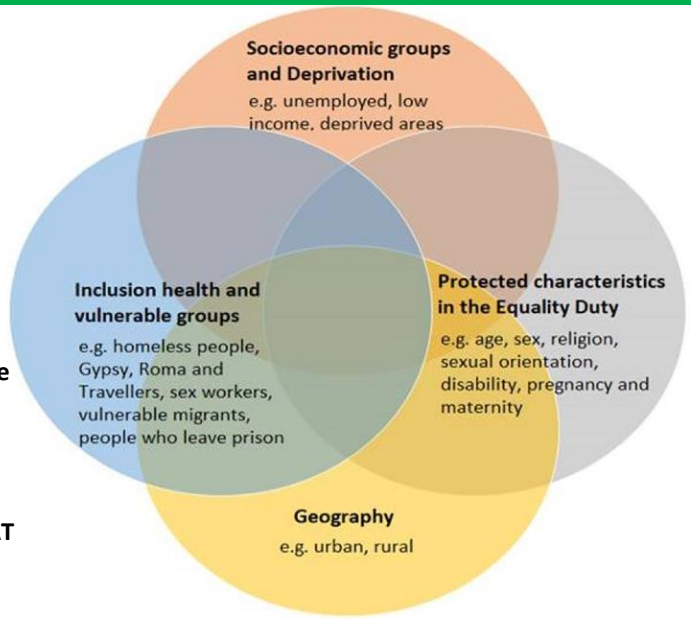


Figure 1: The overlapping dimensions of health inequalities Source: HEAT PHE 2021[1]

A note on types of impact:
The COVID pandemic has had both direct (from COVID illness) and indirect (from COVID restrictions) impacts on individuals and groups of people in Ealing. Examples include:
Direct impacts – acute illness, long COVID, mental ill-health, or death, not being able to work, unemployment, debt, homelessness, impacts of self-isolation as a case.
Indirect impacts – challenges working from home, impacts of self-isolation as a contact, strain on domestic relationships, mental ill-health, physical inactivity, unhealthy nutrition, addictive behaviours, social isolation, changes in air quality exposure, green space access, access to health services, long term medical condition management, bereavement, furlough, unemployment, precarious employment, support service access, children's education, training access, economic impact on local businesses.

Governance and Process

The COVID Inequalities Integrated Impact Assessment has been a multi-component, cross-council effort overseen by a cross-council steering group. The work had three main pillars: quantitative data analysis; literature review and community conversations and engagement.

Quantitative data analysis

The quantitative data analysis has focussed on the direct impact of COVID from infection, hospital admission and death, and which demographic groups and characteristics have been most severely affected. Most of the data has been sourced from PHE, DHSC, NHS and ONS. For the purposes of this analysis we used the same disparity categories as PHE's report "*Disparities in the risk and outcomes of COVID-19*"[2], published in 2020, namely age, sex, ethnicity, presence of long term health conditions, deprivation, urban living, and occupation. Wherever possible the data covers a whole year period of the pandemic - March 2020 to April 2021. For Children and Young People, a more detailed analysis of data formed the Joint Strategic Need Assessment chapter on Children and Young People's health and wellbeing 2021.

Literature synthesis

The literature review included synthesis of literature summarising the national, regional or local impact of the COVID pandemic on different population groups, highlighting important inequalities in impact and experience.

Community conversations

The community conversations and engagement have ensured that the learning from this impact assessment is localised and grounded in the experience of people living in Ealing, such that the system-wide principles and themes have been shaped by ideas of collective action across the borough to tackle inequalities. These community conversations and learnings occurred through three main routes: four area-based task group meetings established as part of Ealing Council's COVID operational response; a series of conversations in voluntary sector forums and partnership board meetings; and a series of conversations had with social science academics from London School of Economics (LSE) conducting live time research in the borough.

Cross council steering group

Short-term recommendations for COVID response and longer term approaches to tackle inequalities

Influence upon Ealing Council strategy and policy

Points of influence – Strategic links

The learning from the COVID Inequalities Integrated Impact Assessment will help shape future strategy and policy for Ealing Council and partners, increasing the focus on addressing health inequalities.
Since many of the root causes of health inequalities can be traced to the wider determinants of health as depicted by figure 2 below, tackling inequalities requires an system-wide approach, recognising the structural determinants and how they contribute to and impact on the health of the population.

Figure 3. Illustrates the key strategies and policies which this work will link to, helping to embed a whole system approach to tackling health inequalities.

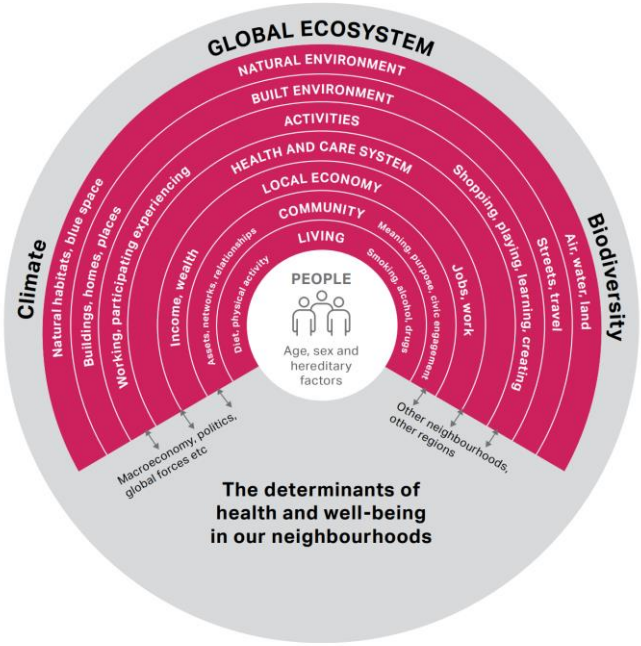


Figure 2: The London Health Inequalities Strategy (adapted from Dahlgren and Whitehead 1991; Barton and Grant 2006)[3]

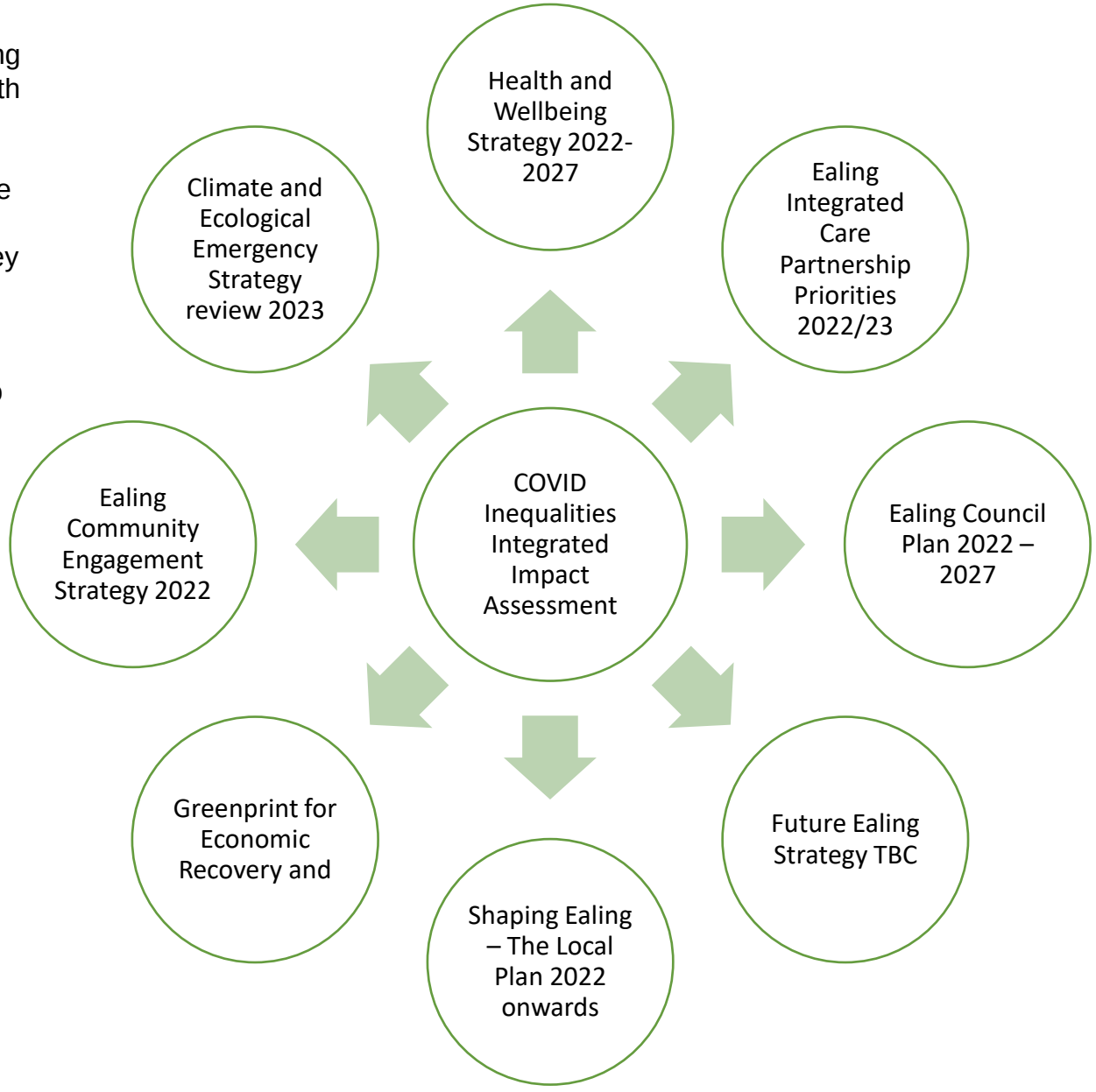


Figure 3: Diagram showing the key Ealing Council strategies and policies which are opportunities for influence

Learning from national evidence (1)

There has been considerable national evidence published on the impact of COVID, including much on inequality. PHE's report "*Disparities in the risk and outcomes of COVID-19"[2], from* 2020 highlighted the impact of COVID has replicated existing health inequalities, and, in some cases increased them (summary below). PHE also highlighted a disproportionate risk to vulnerable migrants, people with no fixed abode and people living in care homes. PHE "Beyond the Data: Understanding the Impact of COVID-19 on BAME communities"[4] provided insights from stakeholders and a wider literature review, that addressed the probable reasons for the disparity of COVID impact by ethnicity. In addition to immediate structural factors for why people identifying with Black Asian and Minority Ethnicity had an increased COVID risk (occupational exposure, population density, use of public transport, household composition and housing conditions). The report also considered intermediate clinical factors that potentially contributed to increased risk of complications and death from COVID (e.g. increased prevalence of long term conditions that increase the risk of severe infection), Stakeholders pointed to racism and discrimination experienced by communities and more specifically by Black Asian and Minority Ethnic key workers as a root cause affecting health, exposure risk and disease progression risk. Local Government UK also summarised the impact of the pandemic in terms of inequality in a report titled 'Perfect Storm: Health Inequalities and Impact of COVID-19. Their report highlighting the disproportionate impacts for those affected by learning disability, mental ill-health, deprivation, particular ethnic groups, older people, those living in particular regions.

Age and sex	**The largest disparity was age.** >80 year olds were 70-times more likely to die than < 40 year olds. Working age males twice as likely to die as females. **Young people may suffer the most from the economic impact of the pandemic.**
Long term health conditions	**People living with health conditions were more likely to die from COVID.** Diabetes was mentioned on 21% of COVID death certificates.
Deprivation	**People who live in deprived areas have higher diagnosis rates and death rates.** Geographic proximity to infections or high exposure occupations. Death rates were more than double in the most deprived areas.
Ethnicity	Exposed and exacerbated longstanding **inequalities affecting Black Asian and minority ethnic groups in the UK**. PHE stakeholder engagement pointed to **racism and discrimination**.
Urban Living	**Highest diagnoses and death rates in urban area.** Death rates in London 3 x higher than the South West – ethnicity, overcrowding, substandard housing, and income and expenditure poverty.
Front line occupations	ONS reported men in **specific occupations had significantly higher COVID death rates**. Men and women working in social care also.

Figure 4: Table summarising the key findings from the PHE Disparities in the risk and outcomes of COVID-19 report[2]

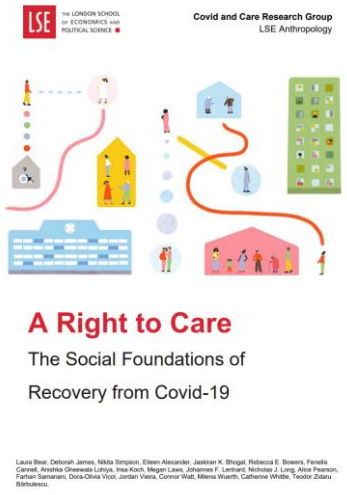
It also highlighted risk factors for those in particular occupations, transgender and non-binary people, and various groups that experienced digital exclusion[5].

Bambra et al[6] examined how the inequalities in COVID impact relate to existing inequalities in chronic diseases and the wider determinants of health, calling it a 'syndemic pandemic' (after the work of Singer 2009), and the *"intersectionality of multiple aspects of disadvantage coalescing to further compound illness and increased risk of mortality"[7].*

Learning from national evidence (2)

'The same pandemic, unequal impacts' by The Health Foundation, drew additional attention to the disproportionate impact upon disabled people, health and social care workers, and also young people when considering the long term economic consequences of the pandemic (see figure 5).

London School of Economics '*A right to care: the social foundations of recovery from COVID-19*' report[9] concluded that government policy could *'improve adherence to restrictions and reduce the negative impacts of the pandemic on disadvantaged groups by placing central importance on the role of communities, social networks and households in economy and social life'.*
Impacts described in the report include an informal care deficit from social distancing measures – that in turn impact mental health, physical health and finances particularly for women who absorbed overall greater care burdens. It described a huge burden on the social infrastructure of communities, the disproportionate impact on workers in the informal economy, and a growth of blame and discriminatory narratives.



In the group's second report *'Social infrastructure for the post-COVID recovery in the UK',* the authors highlight even further reliance on families, neighbourhoods and communities in order to navigate new challenges and burden such as helping people to grieve and recover from losses of life and livelihoods[10].

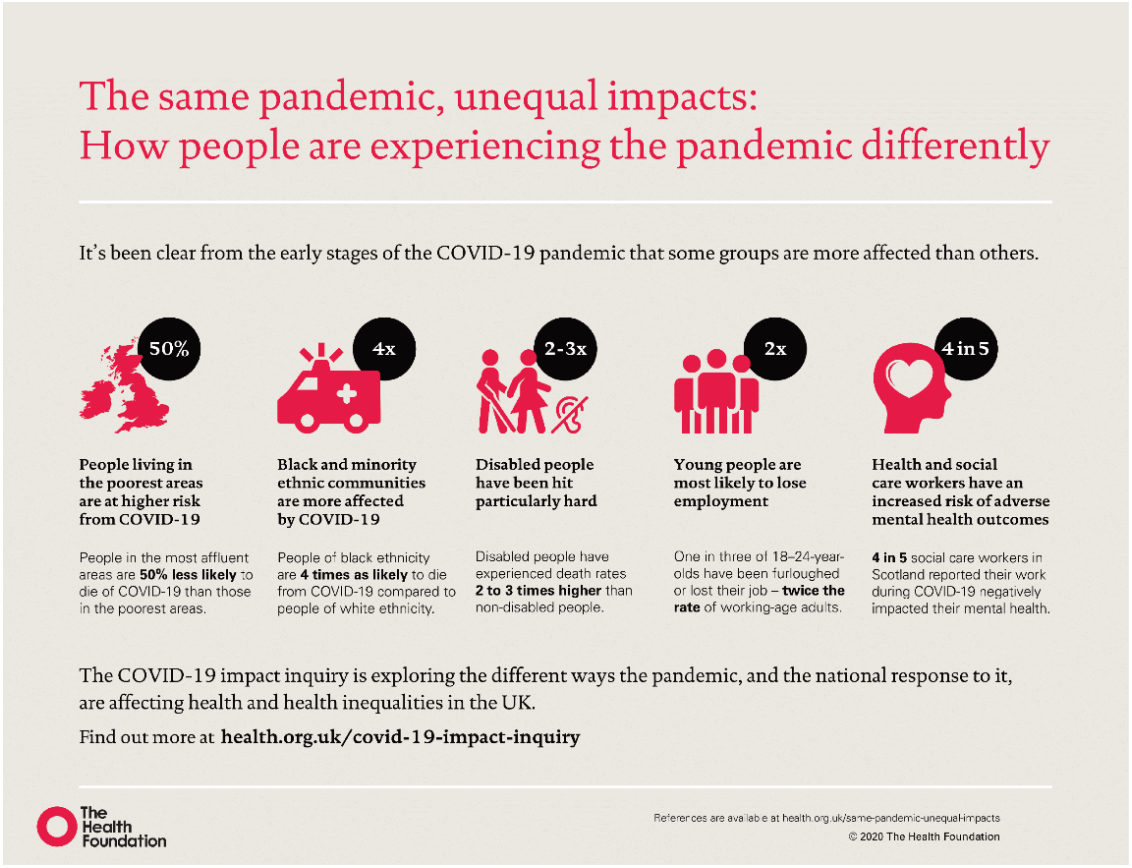


Figure 5: Infographic from The same pandemic, unequal impacts | The Health Foundation 2020[8]

The Institute for Fiscal Studies Deaton Review of Inequalities on the impact of the pandemic focussed on education, employment and the economy[11]. It concluded that the pandemic had exacerbated inequalities between the high- and low-paid and between graduates and non-graduates, hit the self-employed and others in insecure and non-traditional forms of employment especially hard, and increase educational inequalities. It also summarised findings of other reports that COVID death rates were twice as high in the most deprived areas as in the least deprived, and that COVID had very different impacts on different ethnic groups, part related to occupational differences.

Learning from national evidence (3)

Build Back Fairer: The COVID-19 Marmot Review[12] explores factors beyond direct health inequalities from COVID (infection, illness and death) also examining the impact of the COVID-19 crisis on key *social determinants of health (summary below)*.

Wider determinant of health	Inequality in impact
Education	• More disadvantaged children have been disproportionately harmed by closures of early years settings • Parents with lower incomes have experienced greater stress when young children have been at home. • More early years settings in more deprived areas faced closure/staff redundancy as a result of containment measures. • Compared with children from wealthier backgrounds, more disadvantaged children were disproportionately harmed by school closures (Greater loss of learning time; Less access to online learning and resources; Less access to private tutoring and additional materials; Inequalities in the exam grading systems) • Children with special educational needs and their families were particularly disadvantaged through school closures. • School funding continues to benefit schools in the least disadvantaged areas the most, widening educational outcomes.
Broad life opportunities for children and young people	• Child poverty and food poverty among children and young people has increased significantly over the pandemic. • The mental health of young people has deteriorated further and there is widespread lack of access to services. • Exposure to abuse at home has risen through the pandemic, from already high levels beforehand. • Unemployment among young people is rising more rapidly than among other age group
Employment and good work	• Rising unemployment and low wages will lead to worse health and increasing health inequalities. • Rising regional inequalities in employment in England relate to pre-pandemic labour market conditions. • Overall, unemployment has risen slowly, protected by the furlough scheme, but will rise considerably after March 2021. • Low-income groups and part-time workers most likely to have been furloughed, 20% wage cuts from already low wages. • Older Pakistani and Bangladeshi people were more likely to be working in shutdown sectors, compared with other groups. • Over 2 million jobs were paid below the legal minimum in April 2020, more than four times the 409,000 jobs a year earlier.
Standards of living and income	• Young people and BAME groups have been most affected by decreases in income. • Poverty is increasing for children, young people and adults of working age. • Increases to benefit payments have not benefitted the second lowest income quintile of the population sufficiently. • The two-child limit and the benefit cap are harming families and pushing people into greater poverty.
Place and community	• Resilience of most deprived regions, undermined by austerity measures, has been further depleted during the pandemic • Pre-pandemic cuts to local authorities were higher in more deprived areas, leading to greater losses in services there. • Continuing high costs of housing are pushing even more people into poverty as incomes fall. • Rough sleeping was eliminated early in the pandemic, showing what is possible. However, it is already increasing again. • The number of families in temporary accommodation has increased. • Private and social renters live in unhealthier conditions and have struggled more with lockdown.

Figure 6. Wider determinant impacts from the pandemic; Source: Build Back Fairer: The COVID-19 Marmot Review[12]

Learning from regional and local evidence (1)

A range of regional and local evidence has been published during the pandemic, describing the impact upon population groups, with important insights regarding health and social inequalities. The following three pages summarise findings from this evidence, including overarching conclusions for London and others that are categorised into themes, with a more direct relevance for Ealing's population.

Mental Health

- Users of *Good Thinking,* London's NHS-approved digital mental wellbeing service, **increased by over 300% during the COVID-19 pandemic** with over 108,00 users visiting the site 150,000 times.
- **Alcohol problems and anxiety** remain the dominant reasons for service need.
- **Issues with sleep have increased**.
- The prolonged limited social interaction of young people aged 14-24 over the course of the pandemic has indicated that **health anxiety may impair a return to a more active life**

Source: Good Thinking COVID-19 Insights Report June 2020 – London[13]

Living conditions

- Greater COVID impact on those living in **overcrowded housing** and those **people over the age of 70 who share a home with people of working age.**
- Londoners facing '**unaffordable' housing are at risk of eviction and homelessness** post pandemic.
- **Negative impacts of increased time spent at home are distributed unequally** (limited space for work, pressure on relationships, increased abuse, social isolation, increase exposure to indoor air pollution etc.)

Source: People and places in London most vulnerable to COVID-19 and its social and economic consequences :: New Policy Institute (npi.org.uk)[15]. *Wider impacts of the COVID-19 pandemic and recovery of population health outcomes for London; Greater London Authority (GLA)*[14]

Environmental impacts and transport

- **Increased inequalities in access to private, safe and quality green space** due to travel restrictions – particularly for those living in greater deprivation and those identifying as Black Asian or Minority ethnicity.
- Risk of **increased air pollution and reduced active travel**, both with widening inequalities, if a more permanent mode shift from public transport and modal share to private cars continues.
- **Increased use of single-use plastics organic and inorganic waste** – disposable masks, increased deliveries, banning reusable coffee cups - and short-term suspension of some recycling activities, affecting environment.
- **Inequalities in health impacts of climate change** increased by pandemic – in terms of age (older people at risk of temperature change), income (lower income groups living in poorer quality housing and not able to move), people who rent their homes (less able to modify homes and prepare for climate events).

Source: Wider impacts of the COVID-19 pandemic and recovery of population health outcomes for London; Greater London Authority (GLA)[14]

Maternal, Antenatal care and Children and young people

- Reduced **support in pregnancy** and to new parents
- Reduced **routine immunisation** uptake
- Lack of opportunity for early years **socialisation and development**
- Reduced **educational attainment** as result of school closures
- Inequality in **home schooling provision**
- Limits to **future opportunities** as a result of disruption to education, and exams
- **Safeguarding concerns** harder to identify and monitor during pandemic

Source: Wider impacts of the COVID-19 pandemic and recovery of population health outcomes for London; Greater London Authority (GLA)[14]

Learning from regional and local evidence (2)

Race and Ethnicity

- **Race and ethnicity impact on health and social outcomes** (deep anger, loss, fear and anxiety on impact in BAME community)
- **Systemic inequalities exist despite transformation investment** (physical social, mental health, economic disadvantage, diabetes, multiple long term conditions)
- **Consistent disparities across systems**, services, and opportunities
- Barriers to good quality health and social care service **lack of trust, stigma, stereotypes**
- The pandemic exposed and **exacerbated longstanding inequalities affecting BAME groups in the UK** (overcrowding, un-employment, access to green space, feeling safe in your neighbourhood)

Source: Community Voices NWL 2020[16]

- Black, Asian and Minority Ethnic individuals in Ealing report negative mental health impacts and have **significant outstanding mental health support needs**
- Case studies describing Black, Asian and Minority ethnic individuals' **precarious housing status**, and **gaps in care provision**, infer inflexibilities within the welfare system.

Source: GOS&D report Ealing 2020[17]

Disability

- Over 60% of Disabled people **struggled to access food, medicine and necessities** during pandemic.
- Over 35% of respondents talked about **increasing levels of psychological distress**.
- Nearly half respondents mentioned **inaccessible information, confusing guidance and lack of advice.**
- Disabled people **feel abandoned and neglected** e.g. regarding PPE access, cuts to care packages, delayed assessments or lost social care support.
- Disabled people **feel valued less** when it came to the right to life and the rationing of resources.
- **Structural and systemic flaws within the social care system**.
- Significant **discrimination and exclusion** faced by Disabled people.
- Employers are **failing to introduce reasonable adjustments** to enable Deaf and Disabled people to work from home.

Source: Inclusion London Abandoned Forgotten and Ignored report 2021[18]

Homeless and rough sleeping

- **Homeless people were 4x more likely to have COVID in Wave II compared to Wave I** (5.6 times higher than for those in emergency hotel accommodation, and 2-fold higher than general population.
- **Wave 2's 'Protect' programme led to increased density of occupancy and mixing of cohorts.** Increased transmission in hostels compared to emergency hotel accommodation even with more transmissible variant.
- **Continued flow of rough sleepers onto the streets over the summer and autumn,** comprising of people who had either left, been evicted or excluded from Emergency Hotel or Hostel accommodation, or people new to the streets due to loss of jobs, housing tenure, relationship breakdown, domestic abuse, prison release and other reasons linked to increasing social and economic insecurity.
- **Insufficient application and effectiveness of IPC measures** resulted from inadequate provision of frontline health and social care workforce support, consequential high rates of infection and 'burnout', and the reliance on inexperienced and temporary agency workers.

Source: Collaborative Centre for Inclusion Health, UCL report 2021, London[19]

Learning from regional and local evidence (3)

Skills and Employment

Unemployment from 6% in 2019 to 9% in 2021 – largest increase in West London

Youth unemployment likely to increase further still – entry level work unavailable

Background of **long term unemployment** – highest in West London (March 2021 ONS) – will also increase – labour market more competitive

Those with lower skills, or limited employment records within elementary occupations will likely find it hardest to return to work.

Ealing has **high exposure to at-risk sectors** such as manufacturing, wholesale & retail and transport, as well as a high proportion of micro firms and self employed residents.

Ealing has a corresponding under-representation of workplace jobs in finance, digital and professional services roles.

Young people, black and ethnic minority residents, over 55's and those with low skills and poor employment records (already the most affected by deprivation) are likely to be at greatest risk.

Furloughed employees have lost income during the pandemic, with highest risk sectors for long term impact including construction, hotels and restaurants, retail and distribution, recreation, and entertainment and the arts.

School disruption and soaring unemployment will have adverse impact on young adults gaining qualifications and finding a job

Source: Oxford Economics report for West London – June 2020[20]
Wider impacts of the COVID-19 pandemic and recovery of population health outcomes for London Greater London Authority (GLA)[14]
A detailed study of unemployment in London | London Councils; Volterra; 2021[21]

Discrimination

Many Londoners entered the pandemic already disadvantaged. **Some groups experience a heavier negative impact because of the structural and everyday racism, ageism, sexism, homophobia, transphobia and discrimination that are a central component of their lives.** Overall, the pandemic is having a devastating impact on black, Asian and minority ethnic communities. As well as the risk of COVID-19 infection being notably higher evidence is growing that **economic hardship and mental health issues** arising from the pandemic are also disproportionately affecting people from these communities.

A digital divide

Coronavirus has seen much of our life – work, shopping, socialising, education - move online. But for some Londoners access to the internet is not easy and this 'digital divide' risks leaving already marginalised people even further behind.

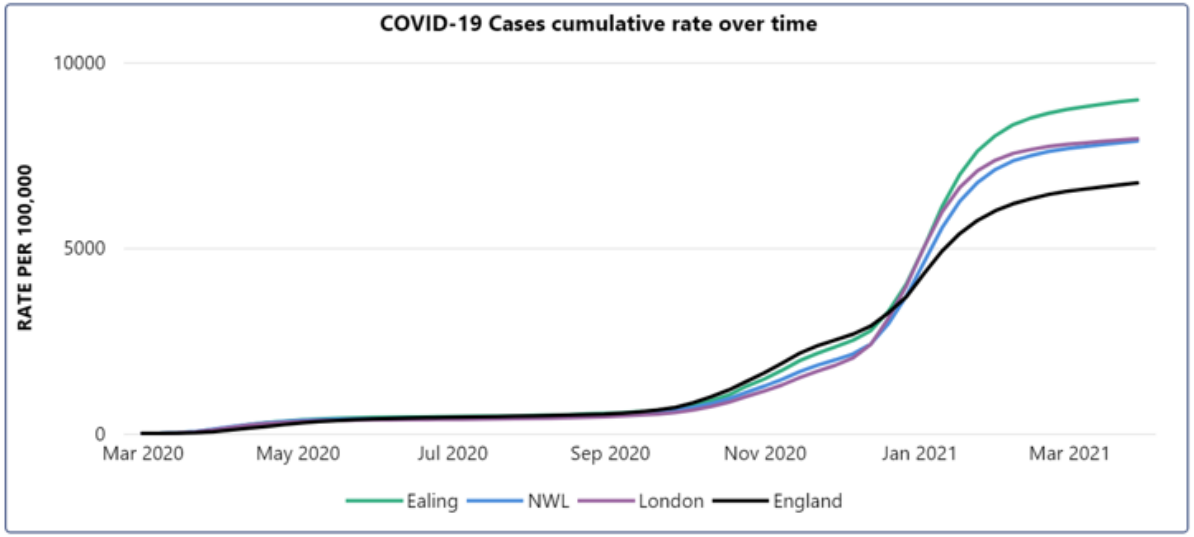
Community and social networks

The London response during the first national lockdown was rooted in voluntary and community action. However this sense of togetherness may have frayed as the pandemic has continued. There is a clear relationship between resilience and coping with uncertainty, and the power of relationships, collectivising, and social networks.

Source: Thrive LDN's Thrive Together: lessons from the most challenging year of Londoners' lives report[22]

Ealing data: borough level COVID infection

Figure 7. Graph of COVID-19 cases cumulative rate per 100,000 over time for Ealing, NWL, London and England for March 2020 to April 2021



Ealing's population has been significantly impacted by the COVID-19 pandemic. Between March 2020 and March 2021, Ealing had a total of 31,482 cases of COVID-19 confirmed via testing. Since these figures capture only those who were tested (limited to healthcare settings at the start of the pandemic) this will be an underestimation of the overall number of infections.

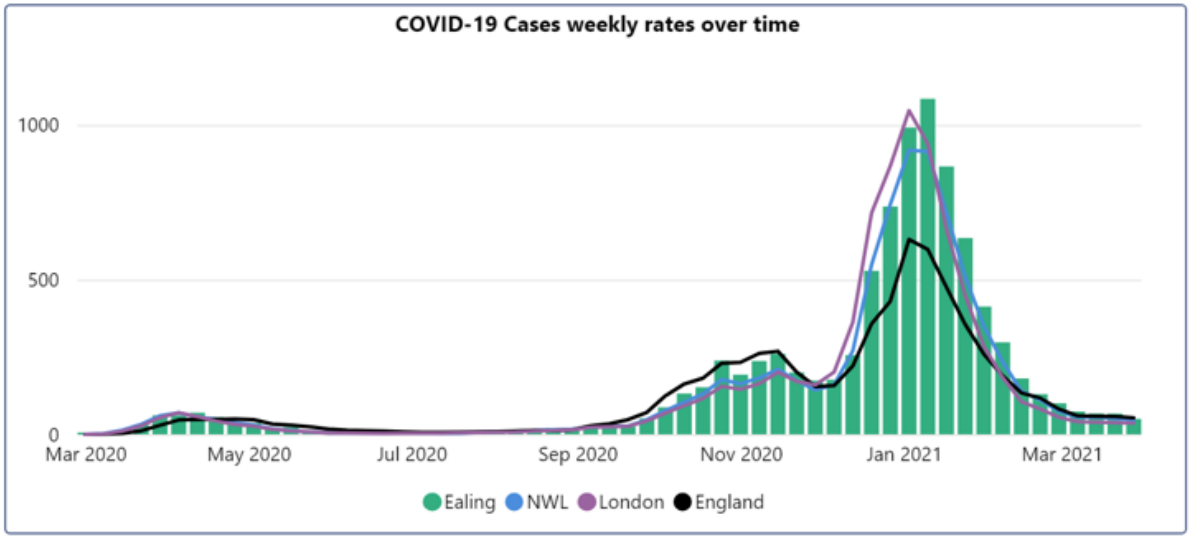
This total number of cases equates to a cumulative infection rate of 9, 251.3 per 100,000 (March 20-March 21), which was statistically higher than England, North West London and London. (figure 7). Both figure 7 (total infection rate per 100,000 over time for Ealing compared to North West London, London as a whole and England) and Figure 8 (weekly infection rate per 100,000 over time for Ealing compared to North West London, London as a whole and England), demonstrate that London's peak occurred earlier than the rest of the country.

Ealing's weekly infection rates were as high and comparable to those of North West London region, London as a whole and England. During the period between January and March 2021, Ealing's rates were often higher, and for several weeks, were one of the highest in London (figure 8.)

There are many reasons for Ealing's significant impact from the pandemic and comparably worse situation for London overall. These include differences in demography, the burden of long-term health conditions in Ealing, socioeconomics and living conditions, different provisions of care services, testing uptake, and regional differences in transmission.

Understanding some of these reasons for the borough as a whole are important, but more importantly we must look within the borough for inequalities by ward population, and the key demographics, or context which might have had a part to play in people's individual, or community level risk.

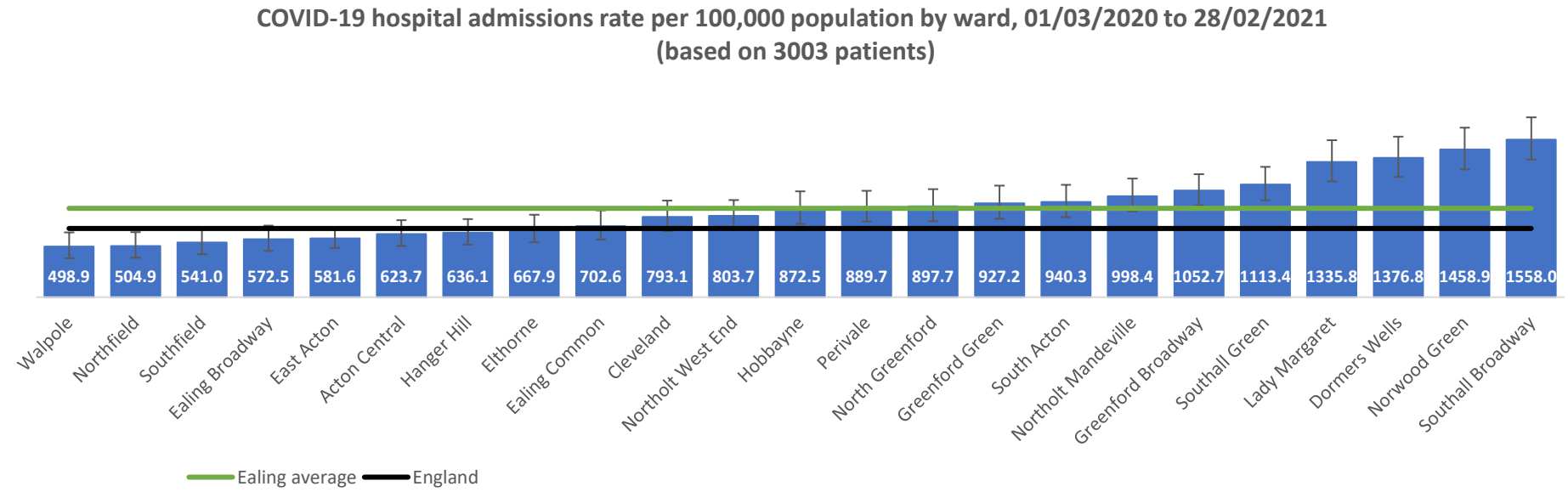
Figure 8: Graph of COVID-19 cases weekly rate per 100,000 population over time for Ealing, NWL, London and England for March 2020 to April 2021



Source: PHE – https://coronavirus.data.gov.uk

Ealing data: borough and ward COVID related hospital admissions

Figure 9: Graph of hospital admissions rate by Ealing ward, from 01/03/2020 to 28/03/2021



Source: SUS - Ealing CCG, Apr 2021

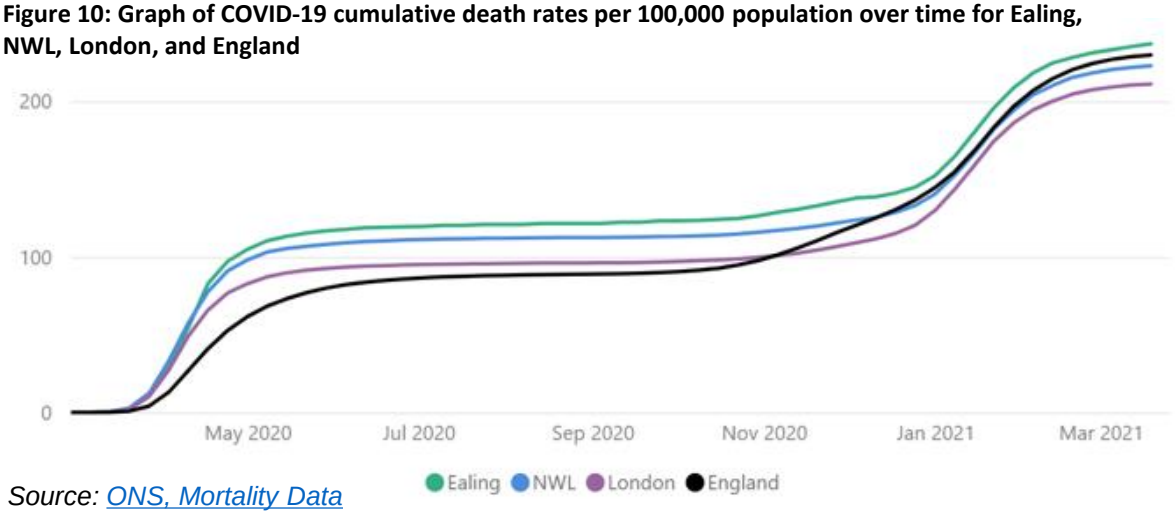
Figure 9. highlights the rates of COVID related hospital admissions per 100,000 population, for the year between March 2020 and March 2021 by Ealing ward population, compared to the average for Ealing borough and England.

Whilst the graph shows that Ealing's average COVID related hospital admission rate for the whole period has been higher than the average for England, this comparison should only be made in the context of many significant population differences between Ealing's population and the population living in England. This graph does not adjust for these important differences.

The graph highlights that the COVID related hospital admission rates have varied substantially by ward in the borough. The statistical confidence interval bars shown on the graph indicate that there may be some overlap in the estimates for wards in the middle, but that there is definitely a difference between the wards with the highest and lowest hospital admission rates for this period. Walpole ward population had the lowest hospital admission rate during this period at 498.9 per 100,000; whilst people living in Southall Broadway experienced the highest rate of hospital admission from COVID at 1558 per 100,000. This variation is likely to be the result of multiple factors, including the age, and the prevalence of long term conditions amongst the people living in each ward, differences in availability of health care facilities to the ward populations, as well as the community infection rates in each ward, which are in turn dependent on community transmission risks in the area such as schools, care homes, workplaces, shopping and other amenities where large groups of people were in contact among other things.

Ealing data: borough level COVID death

Figure 10: Graph of COVID-19 cumulative death rates per 100,000 population over time for Ealing, NWL, London, and England



Source: ONS, Mortality Data

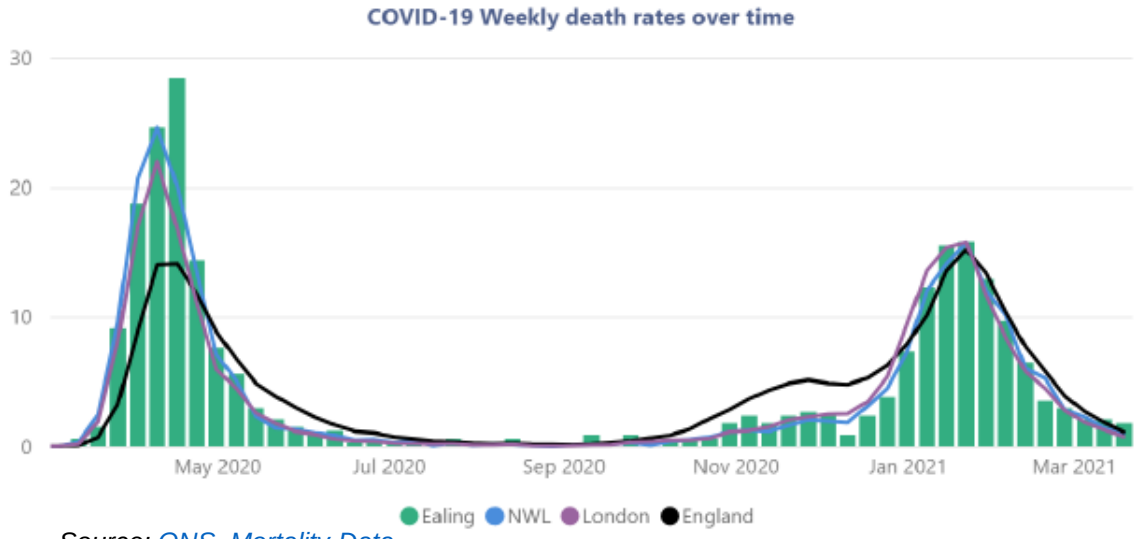
Figure 12: Table of place of death for COVID-19 related and all cause deaths in Ealing residents during the pandemic

Place of death (all deaths from 29th Dec 2019 up to 19th March 2021, registered up to 27th Mar 2021)						
Cause of death	Hospital	Home	Care home	Hospice	Other communal	Elsewhere
COVID-19	570	66	132	34	1	7
	70%	8%	16%	4%	0%	1%
All causes	1,592	851	477	183	4	56
	50%	27%	15%	6%	0%	2%

Figure 12. is a table showing the place of death for all COVID and all cause deaths highlighting that 70% of all COVID deaths in Ealing occurred in hospital, whilst 16% occurred in care homes in the borough. The office of national statistics, in the PHE '*Disparities in the risk and outcomes of COVID-19' report*[2], showed that nationally, 2.3 times the expected number of deaths occurred in care homes between 20th March and 7th May in 2020, equating to around 20,457 excess deaths.

Ealing's population also experienced a high number of COVID-related deaths between March 2020 and March 2021, which followed the pattern of the first and second wave. Figure 10. shows the total COVID death rate per 100,000 over time for Ealing, compared to North West London, London and England. Figure 11. shows the weekly COVID death rate per 100,000 over time for Ealing compared to North West London, London and England.
The peak for COVID-19 mortality in Ealing in the first wave of infection was statistically higher than North West London, London and England. In the second wave, COVID mortality rates for Ealing were statistically similar to that in North West London, London and England.
There will be many reasons for geographic differences in death rate from COVID. These include differences in demography, the burden of long-term health conditions amongst the populations, socioeconomics, different provision, resource and capacity of healthcare services, and regional differences in transmission.

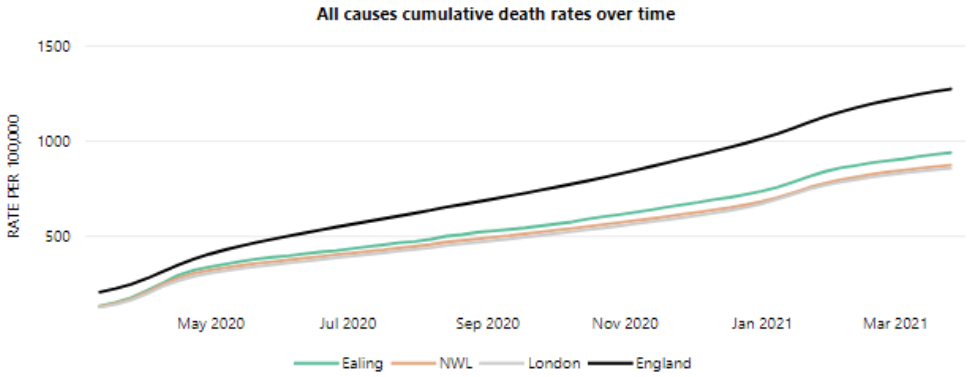
Figure 11: Graph of COVID-19 weekly death rates per 100,000 over time for Ealing, NWL, London and England



Source: ONS, Mortality Data

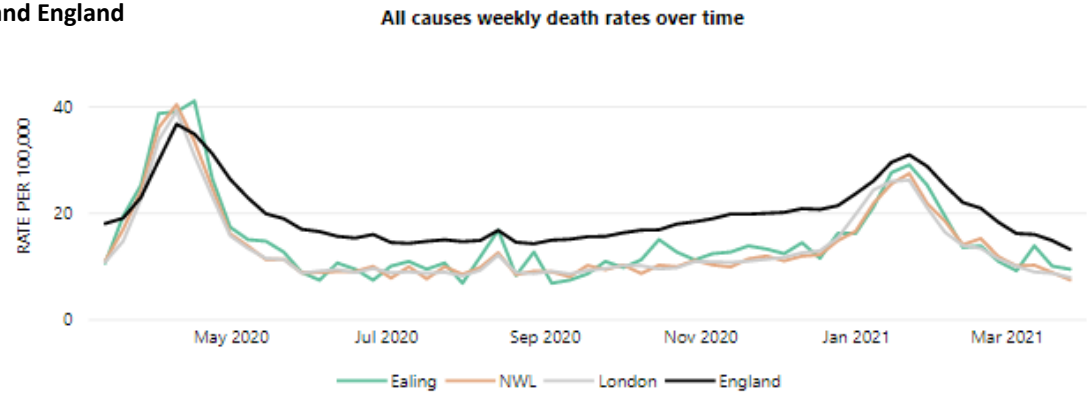
Ealing data: borough level all cause and excess deaths

Figure 13: Graph of all causes cumulative death rates per 100,000 over time for Ealing, NWL, London and England



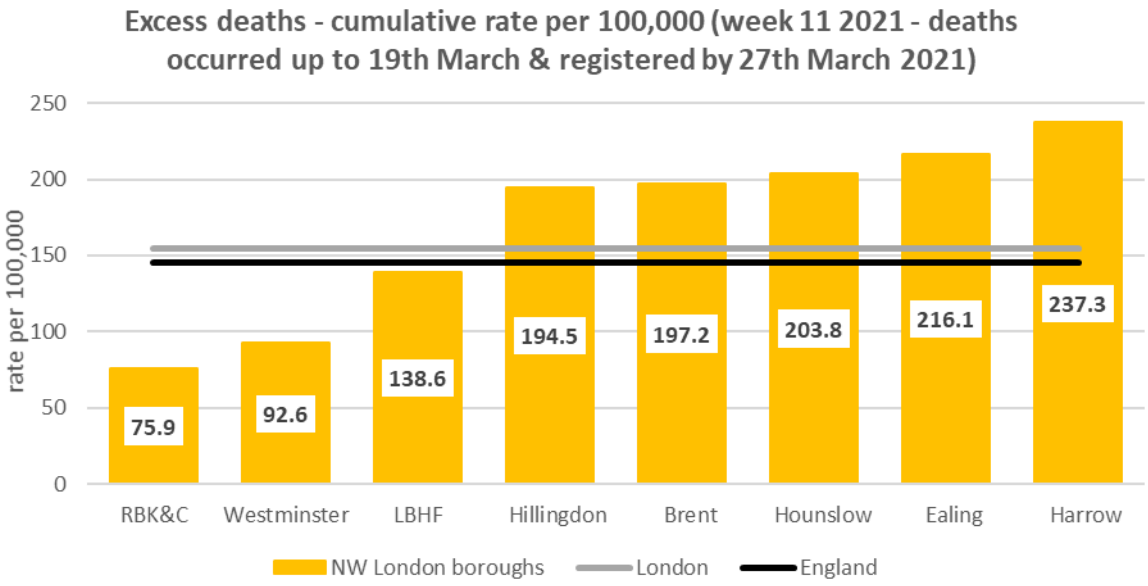
Source: ONS, Death registrations and occurrences by local authority Rate based on ONS 2019 MYE

Figure 14: Graph of all causes weekly death rates per 100,000 over time for Ealing, NWL, London and England



Source: ONS, Death registrations and occurrences by local authority Rate based on ONS 2019 MYE

Figure 15: Graph of excess deaths - cumulative rate per 100,000 (deaths occurred up to 19th Mar and registered by 27th Mar 2021)

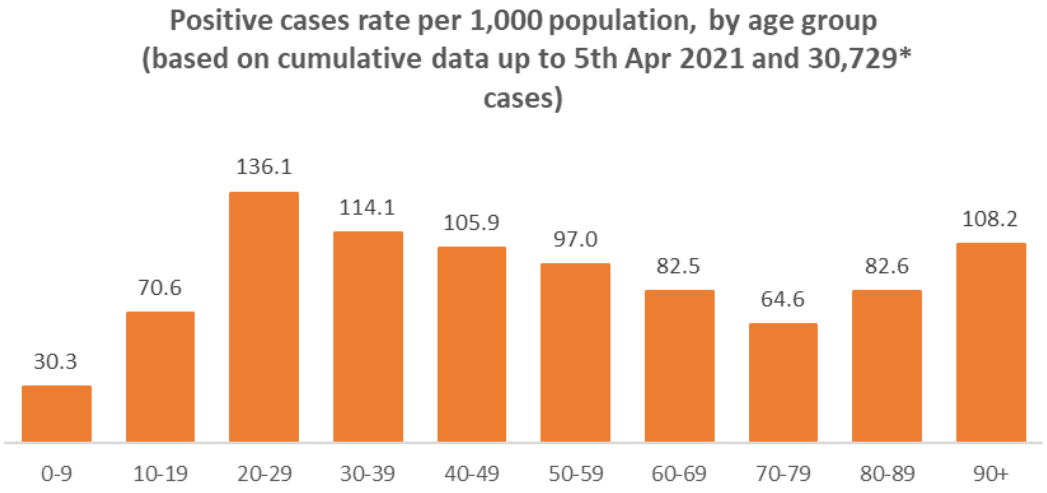


Source: ONS, Weekly mortality data - Excess deaths

The COVID pandemic and restrictions affected the access to timely health care for all health issues. As a result we look at deaths from all-causes as these are also likely to increase during times of high COVID infection, admission and death, such as in the first and second wave of the pandemic. Figures 13. and 14. show total all cause and weekly all cause death rates per 100,000 over time for Ealing compared to North West London, London and England respectively. To understand if the number of deaths from all-causes was greater than expected for that time of year, we look at 'excess death' data shown in figure 15. Nationally, there were two periods when all-cause deaths exceeded expected levels for that time of year, when compared to the last 5 years (end of March 2020 and early June 2020). Figure 15. shows that Ealing had the second highest cumulative rate of excess deaths per 100,000 in North West London which was above the average for London and England. Reasons for this high comparable rate of excess deaths during the course of the pandemic may include deprivation, ethnicity, prevalence of long term conditions, occupational risk, quality and availability of health care, and if COVID was under-diagnosed, particularly in the first few months when testing was less available.

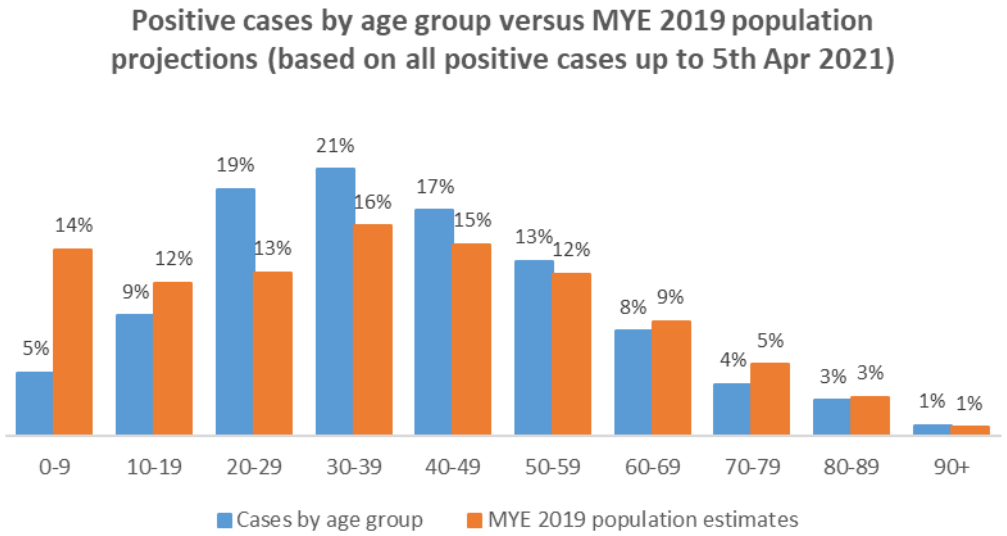
Ealing data: Age and sex

Figure 16: Graph of COVID case rate by age group in Ealing



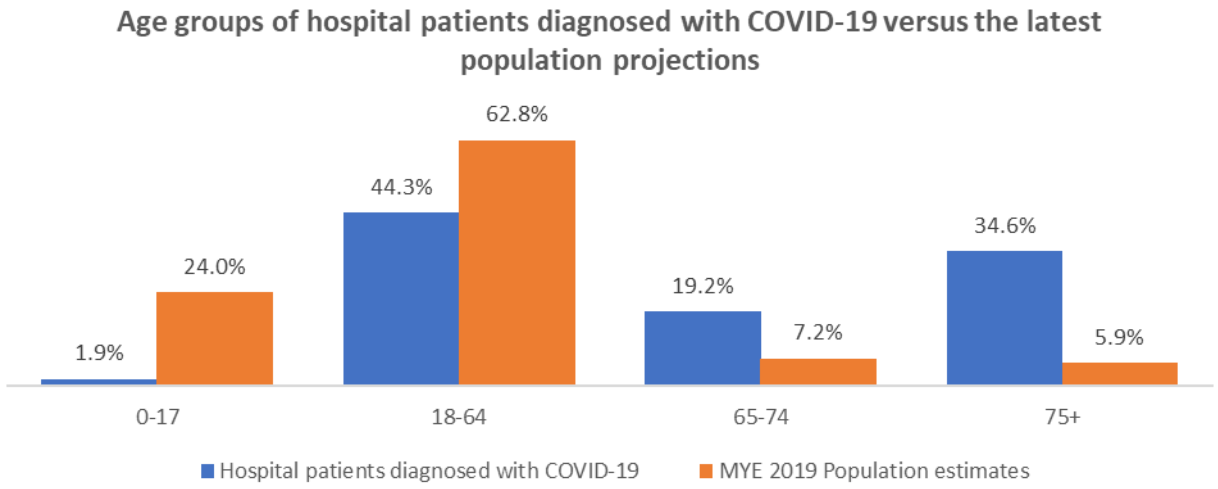
Source: PHE, Line list of positive cases by postcode (extract taken on 6th Apr 2021);
**Please note, age is unknown for further 68 cases.*

Figure 17: Graph of proportion of COVID cases by age group compared to proportion of the population in each group, in Ealing



Source: PHE, Line list of positive cases by postcode (extract taken on 6th Apr 2021); MYE 2019

Figure 18: Graph of proportion of Ealing residents admitted to hospital for COVID in each age range



Source: SUS - Ealing CCG, Nov 2020 and MYE 2019 population estimates

Nationally, and locally, age has been the biggest risk factor for COVID infection, severe illness and death. Figures 16 and 17 show that overall in Ealing 20-59 year olds have been over-represented in those testing positive. However, nearly 50% Ealing residents admitted to hospital were 65 years or over (34.6% over 75) as shown by figure 18. Men accounted for 63.9% of all deaths in hospitals compared to 36.1% Women (1st wave data only). 78.6% of Ealing residents who died in hospital were over 65 years (1st wave data only).

Ealing data: COVID infection in those with long term health conditions

Figure 19: Table showing the proportion of people admitted to hospital with COVID, who also had a long-term condition(s)
Source: SUS - Ealing CCG, Apr 2021

With long-term condition(s)	% of admissions
Yes	91.4%
No	8.6%
Grand Total	100.0%

Figure 20: Table showing the proportion of people admitted to hospital with COVID with multiple long-term conditions
Source: SUS - Ealing CCG, Apr 2021

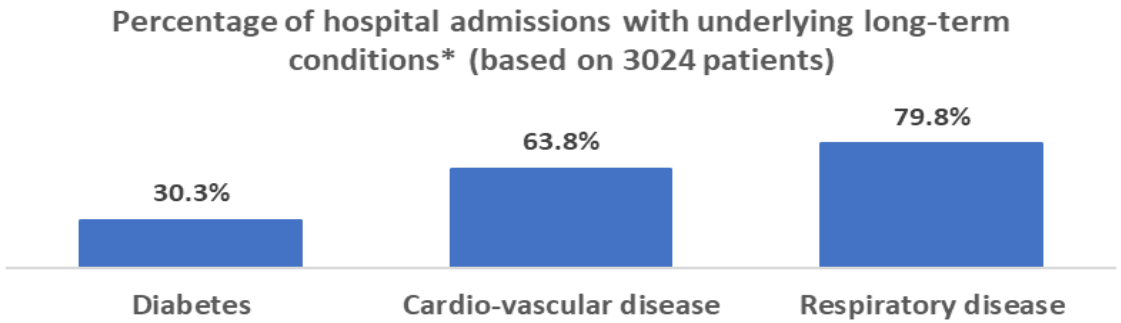
Multiple long-term conditions	% of patients
Yes	61.6%
No	38.4%
Grand Total	100.0%

Figure 22: Table showing the proportion of people admitted to hospital with both COVID and a long term condition in each ethnicity category, compared to the proportions with the Ealing population
Source: SUS - Ealing CCG, Apr 2021; GLA Population Projections 2016

Ethnicity	% of patients	GLA projections for 2020
Asian or Asian British	31.4%	30.0%
White	29.8%	46.3%
Other ethnic groups	27.0%	8.2%
Black or Black British	10.5%	10.6%
Mixed	1.3%	4.9%
Grand Total	100.0%	100.0%

Several pre-existing long term health conditions increase the risk of COVID infection, severe illness and death. There is no data to describe the proportion of overall COVID cases in Ealing that have underlying health conditions, however there is data to describe this relationship in those who were admitted to hospital with COVID. Figure 19. shows that 91.4% of people admitted to hospital with COVID in Ealing had at least one long term health condition, with figure 20 showing that 61.6% had 2 or more.
In terms of which conditions were most common amongst those diagnosed in hospital with COVID, figure 21. shows that 79.8% of those with long term conditions had respiratory disease, 63.8% had cardiovascular disease and 30.3% had diabetes.

Figure 21: Graph of proportion of people with each type of long term condition amongst those admitted to hospital with COVID.



** Note that 61.6% of admitted patients had more than one long-term condition*
Source: SUS - Ealing CCG, Apr 2021

Figure 22. shows that those identifying in 'other ethnic groups' were disproportionately represented in those admitted to hospital with COVID and a long term condition. It is likely that those selecting 'other ethnic groups' disproportionately represent Black, Asian and Minority ethnic groups as opposed to white ethnic groups. The same data shows that white ethnic groups were underrepresented in those admitted to hospital with COVID and a long term condition.

Ealing data: Deaths from COVID in those with long term health conditions

Figure 23: Table showing the proportion of people who died following an admission to hospital for COVID who had 2 or more long term conditions.
Source: SUS - Ealing CCG, Apr 2021

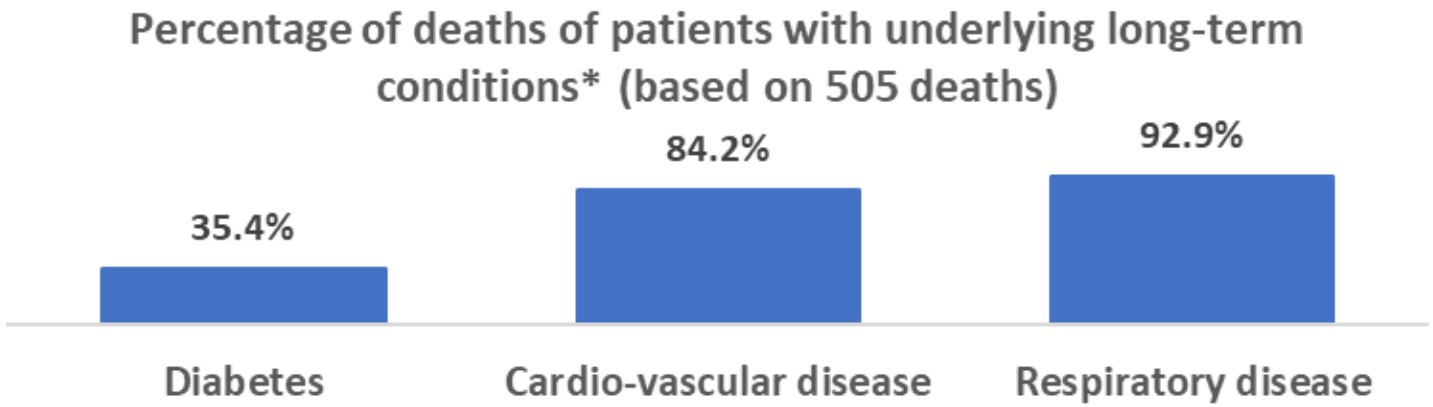
Mortality with multiple long-term conditions	% of patients
Yes	83.4%
No	16.6%
Grand Total	100.0%

Nationally, among people who died from COVID there was a higher proportion of people with diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than for those dying of all causes (Ref PHE disparities report). Diabetes occurred in 21% of people dying of COVID, and this proportion was higher in all Black and Asian minority ethnic groups than in white ethnic groups. The same pattern was seen for hypertensive disease.

Several studies have reported an increased risk of death from COVID in those with a Body Mass Index in the 'obese' or 'morbidly obese' category (Ref PHE disparities report).

In Ealing, figure 23. shows that, 83.4% of those who died of COVID in hospital had 2 or more long term conditions, and figure 24. shows that of this cohort, 92.9% had respiratory disease, 84.2% had cardiovascular disease and 35.4% had diabetes.

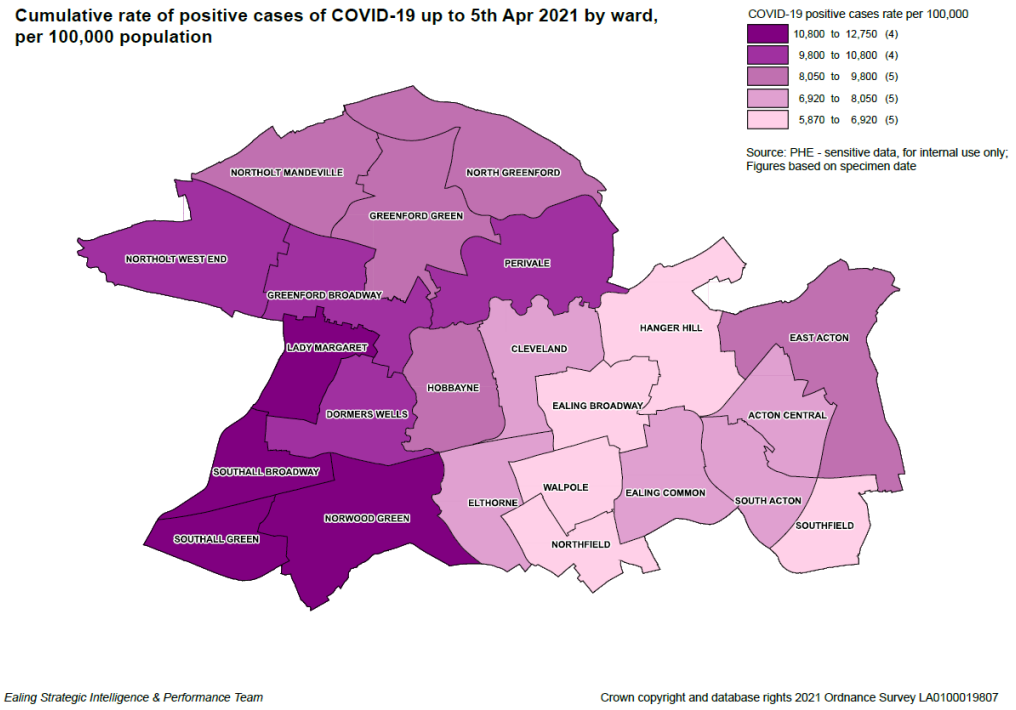
Figure 24. Table showing the proportion of people who died from COVID in hospital who had either diabetes, cardiovascular or respiratory disease.



** 61.6% of admitted patients had more than one long-term condition*
Source: SUS - Ealing CCG, Apr 2021

Ealing data: Deprivation and COVID infection

Figure 25: Map of cumulative rate of positive COVID-19 cases per ward per 100,000, up to 05th Apr 2021

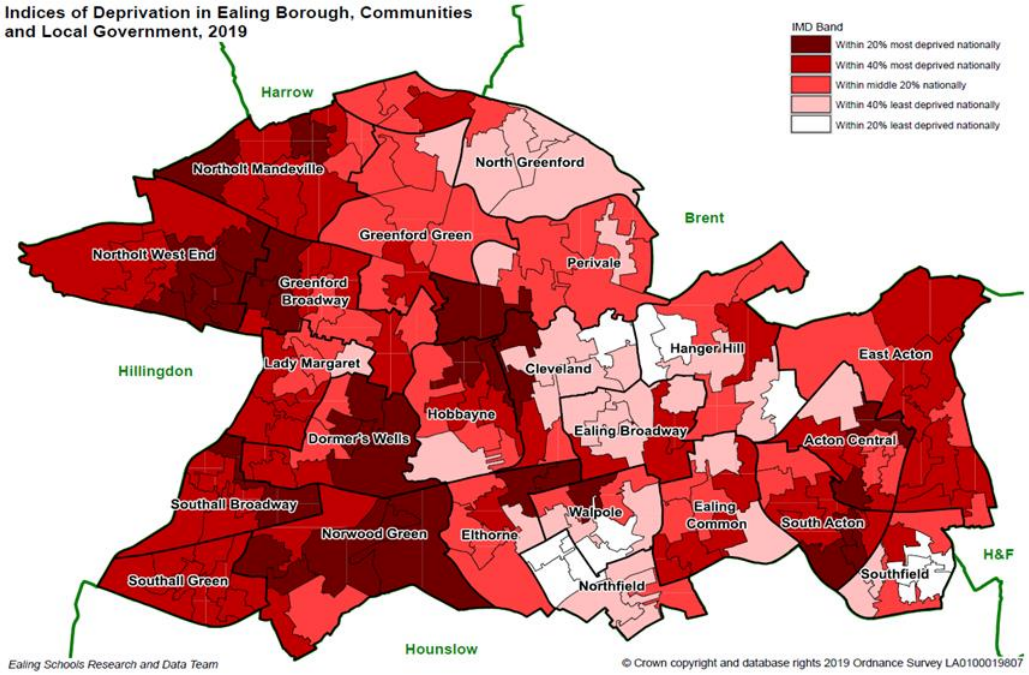


Contributory factors include a greater degree of clinical vulnerability (created by a greater prevalence of long term conditions, worse nutritional status, and worse general health and well-being), higher proximity to infections (from occupational risk, or via household) perpetuating higher rates of transmission, a higher proportion of people living in overcrowded housing, including households of multiple occupancy, a high proportion of workers in occupations that are more likely to be exposed with precarious employment conditions depleting support to self-isolate safely, and a greater proportion of Black Asian and Minority Ethnic groups affected by structural disadvantage beyond income.

In line with national findings, Ealing's COVID infections appear to have been concentrated in the West of the borough (Southall and Greenford wards) and South Acton ward in the East of the borough (figure 25), where the levels of deprivation are some of the greatest also (shown in figure 26).

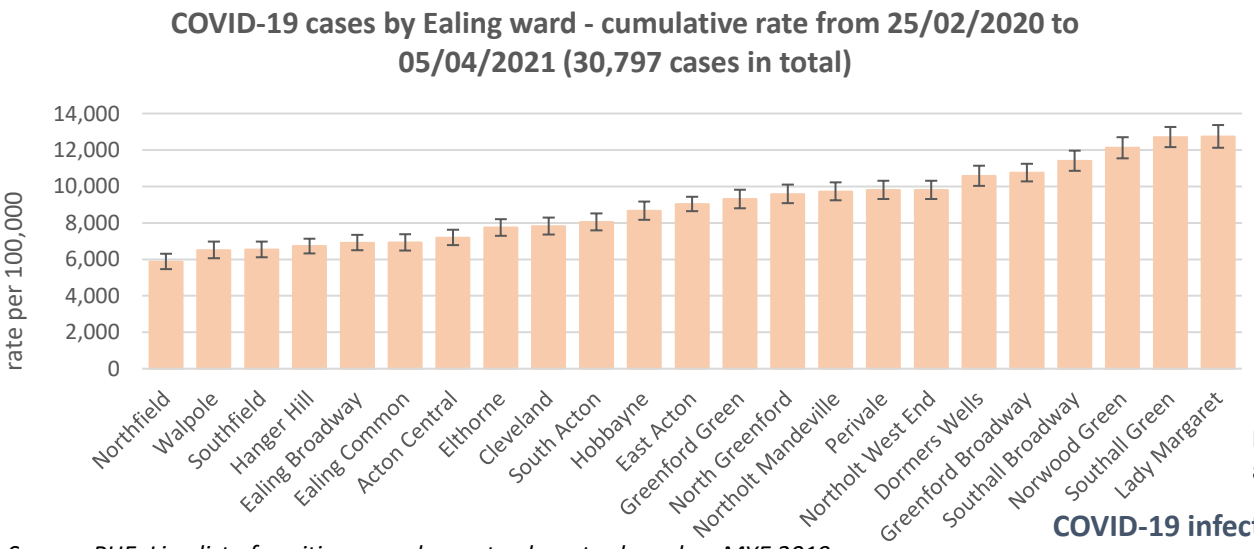
Whilst this relationship would need to be confirmed by statistical analysis adjusting for similarities in other demographics, and it is often difficult to separate the impact of deprivation from other factors, the widespread pattern of association here would support a strong link between greater deprivation and greater risk of COVID infection for many multiple reasons.

Figure 26: Map of Indices of Multiple Deprivation for Ealing Lower Super Output Areas 2019



Ealing data: Deprivation and COVID infection

Figure 27: Graph of cumulative COVID-19 rates per 100,000 by Ealing ward (25/2/20 to 05/04/21)



Source: PHE, Line list of positive cases by postcode; rates based on MYE 2019 Ward population estimates

Figure 27 shows COVID infection rates by ward in a graph as opposed to a map. Statistical analysis supports that there is a true approximately 2-fold difference between the infection rates of those wards with the lowest and highest rates. Similar to figure 25. this data has not been adjusted for other factors, however, despite this the relationship remains convincing. Figure 28. also provides evidence for the relationship between greater deprivation (higher IMD scores) and greater COVID infection rates at ward level, particularly with the correlation coefficient of r= 0.64[1] . Figure 29 helps us to determine which point on figure 28. refers to which ward by giving a 'reference key' of IMD scores by ward.

Figure 28: Graph of linear regression analysis of Indices of Multiple Deprivation and cumulative infection rate by ward

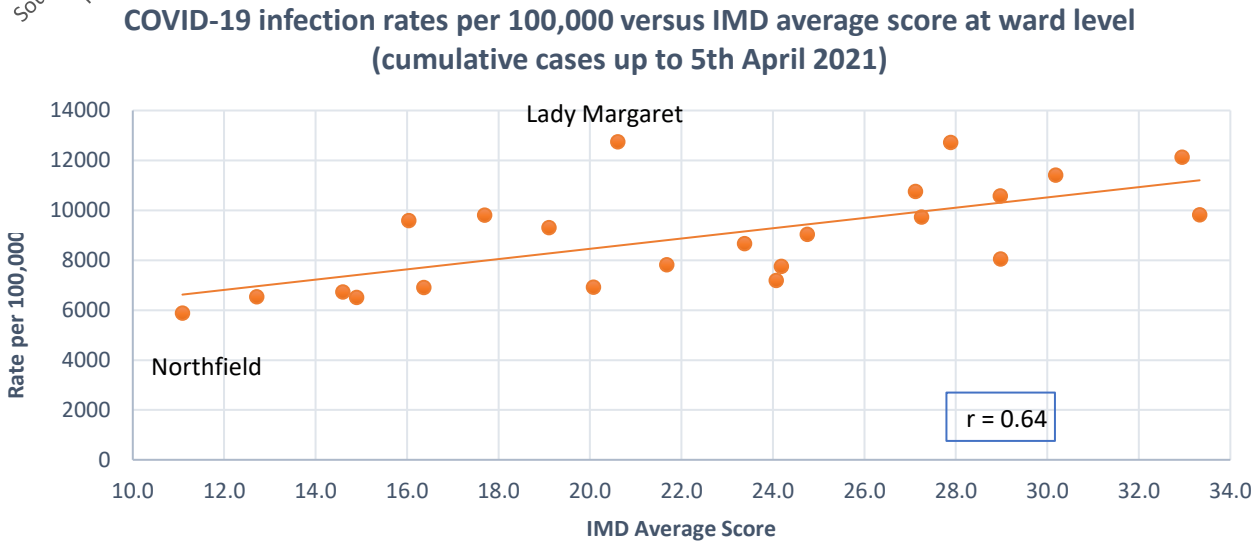
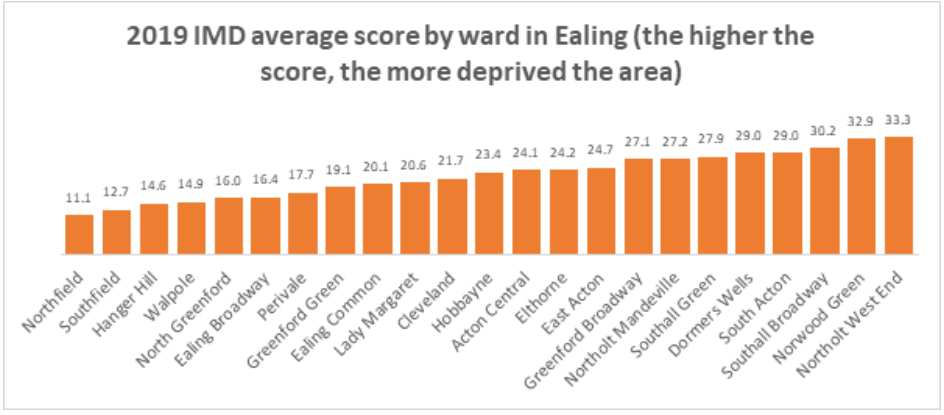


Figure 29: Ealing 2019 IMD average scores by ward

Source: London Datastore - IMD 2019 London Wards Summary Measures

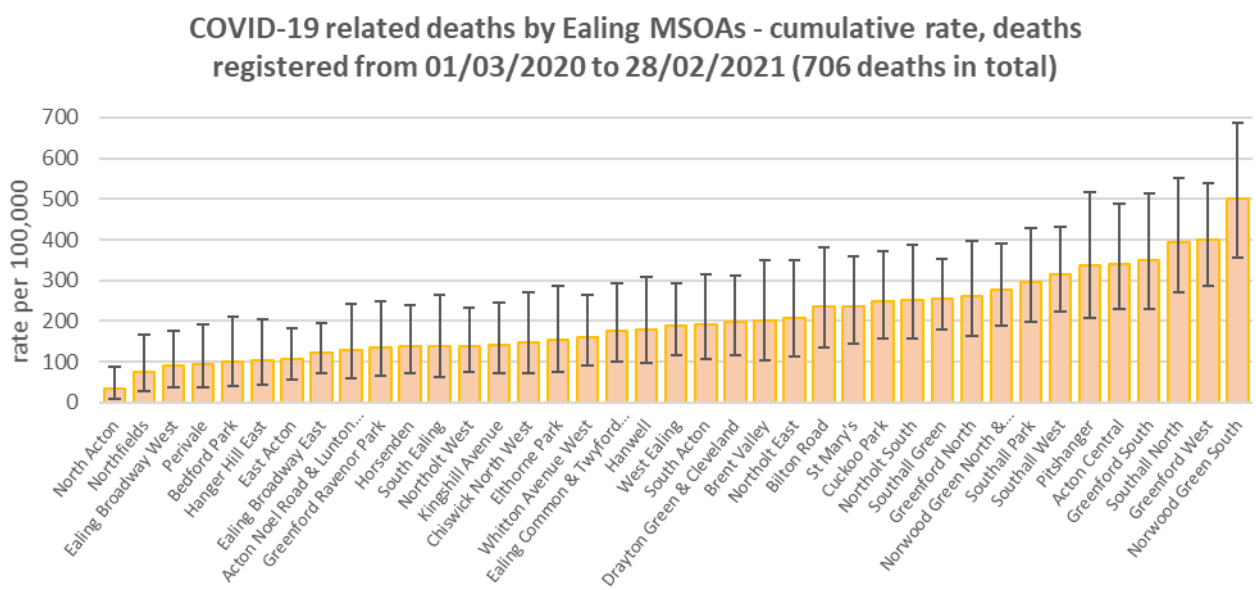


Source: PHE, Line list of positive cases by postcode; rates based on MYE 2019 Ward population estimates; London Datastore - IMD 2019 London Wards Summary Measures; r = correlation coefficient [1]

[1] Correlation coefficient is presented by values between -1 and +1; the closer the correlation coefficient is to ± 1, the stronger correlation between the two variables; the closer correlation coefficient is to '0', the weaker correlation, so for any r values in the range between -0.25 & +0.25, there is no statistically significant relationship between the two compared variables.

Ealing data: Deprivation and COVID death

Figure 30: COVID-19 related deaths by Middle Super Output areas (MSOA)



Source: ONS - Deaths involving COVID-19 by local area and socioeconomic deprivation (published 18th Mar 2021)

Figure 30. shows a smaller degree of variability in COVID death rates per Middle Super Output Area (MSOAs) in Ealing between March 2020 and March 2021 than infection rates. Whilst statistical analysis indicates that the MSOAs in the middle may have similar rates (due to small numbers), there is a 5-fold difference between the MSOAs with the highest and those with the lowest COVID death rates for this period.

Like with the previous figure 25 for infection rates, figure 31 looks at COVID related death rates on a map of the borough.

This enables a visual comparison with Figure 32, a map of IMD deprivation scores for Ealing regions. This comparison suggests that areas of greater deprivation experienced higher COVID death rates between March 2020 and March 2021. This would fit with national reports.

Figure 31: Map of COVID-19 cumulative death rate by MSOA

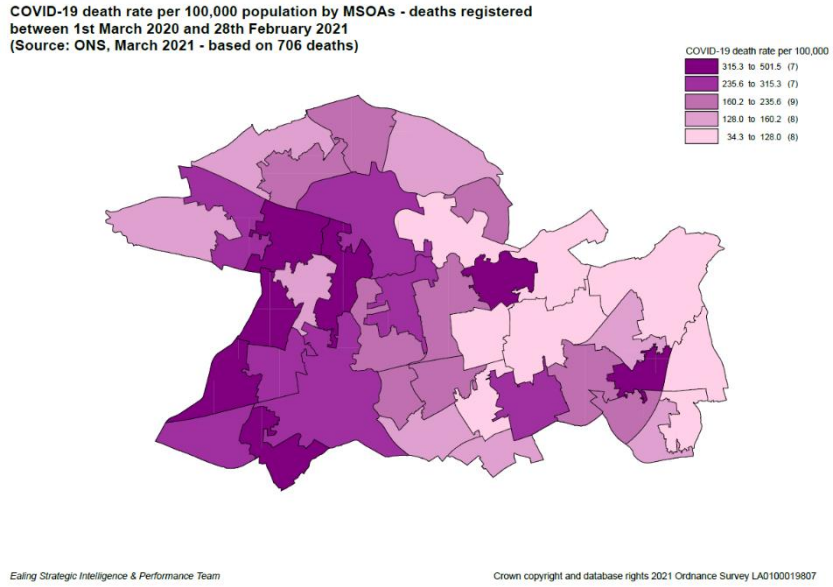
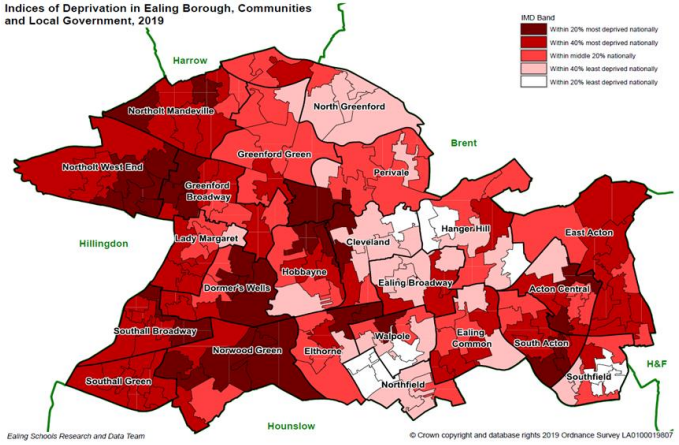
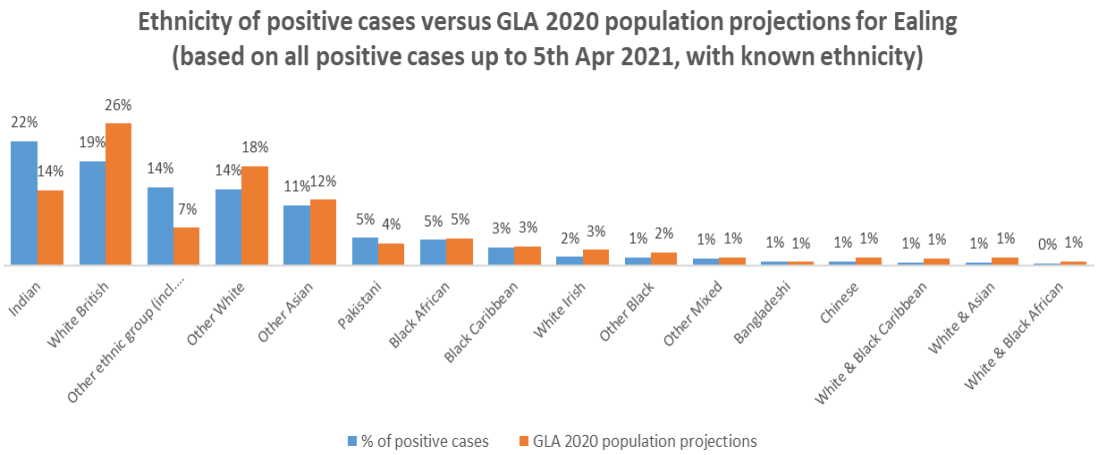


Figure 32: Map showing Indices of Multiple Deprivation for Ealing Lower Super Output Areas 2019



Ealing data: Ethnicity and COVID infection

Figure 33: Graph of ethnicity of positive cases in comparison to GLA 2016-based housing-led population projections for 2020



Source: PHE, Line list of positive cases by postcode (extract taken on 6th Nov 2021); GLA 2016-based Housing-led Ethnic Group 2020 Population Projections; The GLA 16 ethnic groups are the 2011 Census ethnic groups, with the exception that the White Gypsy or Irish Traveller group is aggregated into the Other White group & the Arab group is aggregated into the Other Ethnic group

Figure 33. shows the comparison between the proportion of people with COVID identifying in specific ethnic groups compared to the proportion of people identifying with these ethnic groups living in the borough overall. Where the proportion of positive cases is greater than the proportion of the overall population, this would suggest that this particular ethnicity is over-represented in those testing positive for COVID. This includes those in the Indian and Pakistani ethnicity categories. This is also the case for those reporting in the 'other ethnic group' category which traditionally is overrepresented by Black Asian and minority people. This relationship between particular ethnic groups and COVID infection is well-documented nationally. Without further statistical analysis however we are unable to be more confident in our local findings around the relationship between COVID infection and ethnicity from this data.

Additional evidence of the link between ethnicities in Black Asian and Minority ethnic categories and COVID infection risk incudes figure 34. This graph shows a strong relationship[1] between those wards with the highest proportion of residents identifying with Black, Asian or and Minority Ethnicities, and the highest cumulative COVID infection rates for the borough. Figure 35 helps us to determine which point on figure 34. refers to which ward by giving a 'reference key' of the proportion of residents identifying with Black Asian and Minority ethnicity by ward.

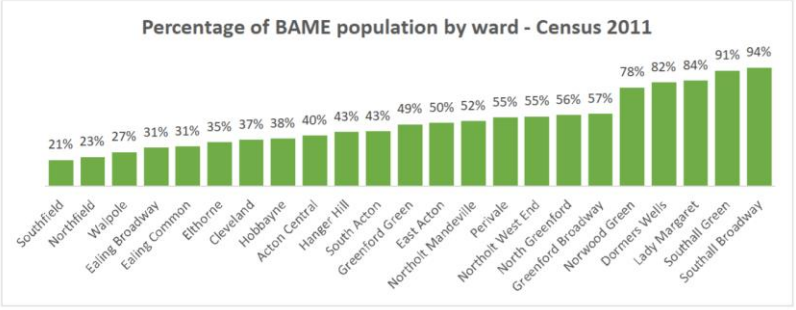
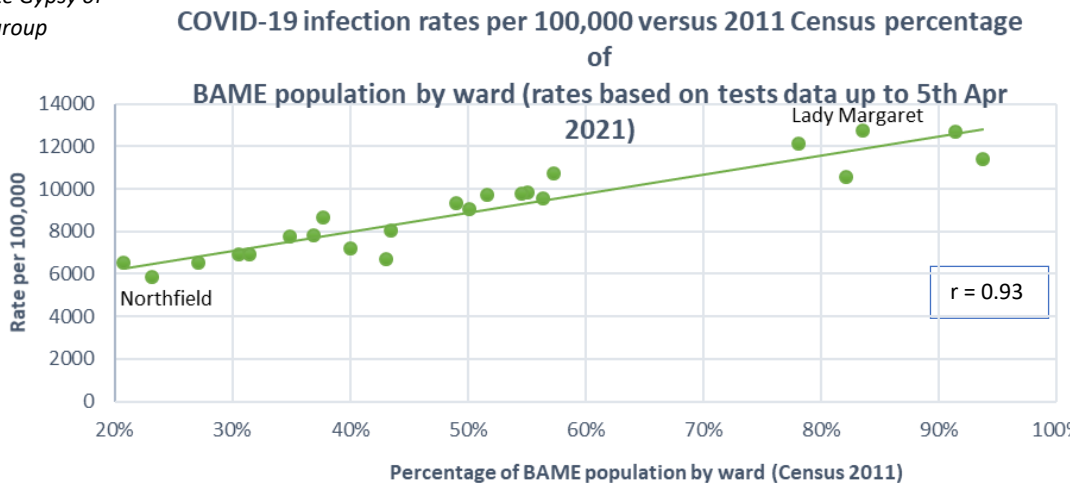


Figure 35: Graph showing Percentage of population in each ward identifying with Black and Minority Ethnicity (Census 2011)

Source: National Census 2011

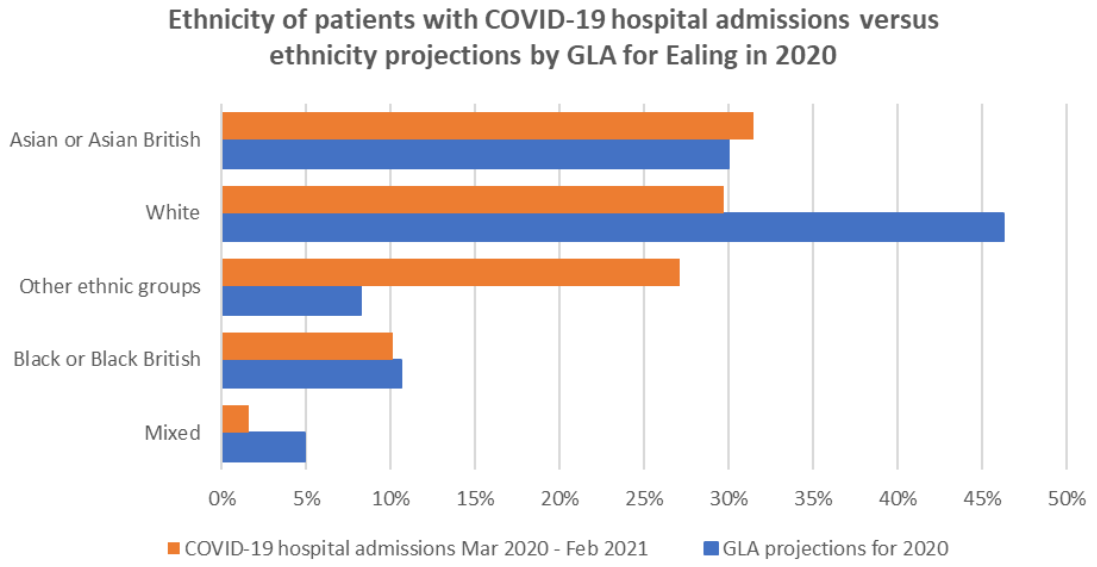
Figure 34: Linear regression analysis of ethnicity and cumulative infection rate by ward



Source: PHE, Line list of positive cases by postcode; rates based on MYE 2019 Ward population estimates; BAME population (based on Census 2011) excludes White British and White Other ethnic groups; r = correlation coefficient; [1] Correlation coefficient is presented by values between -1 and +1; the closer the correlation coefficient is to ± 1, the stronger correlation between the two variables; the closer correlation coefficient is to '0', the weaker correlation, so for any r values in the range between -0.25 & +0.25, there is no statistically significant relationship between the two compared variables.

Ealing data: Ethnicity and COVID admissions and death

Figure 36: Graph of proportion of Ealing residents admitted to hospital for COVID by ethnicity, compared to the ethnicity projections for Ealing in 2020

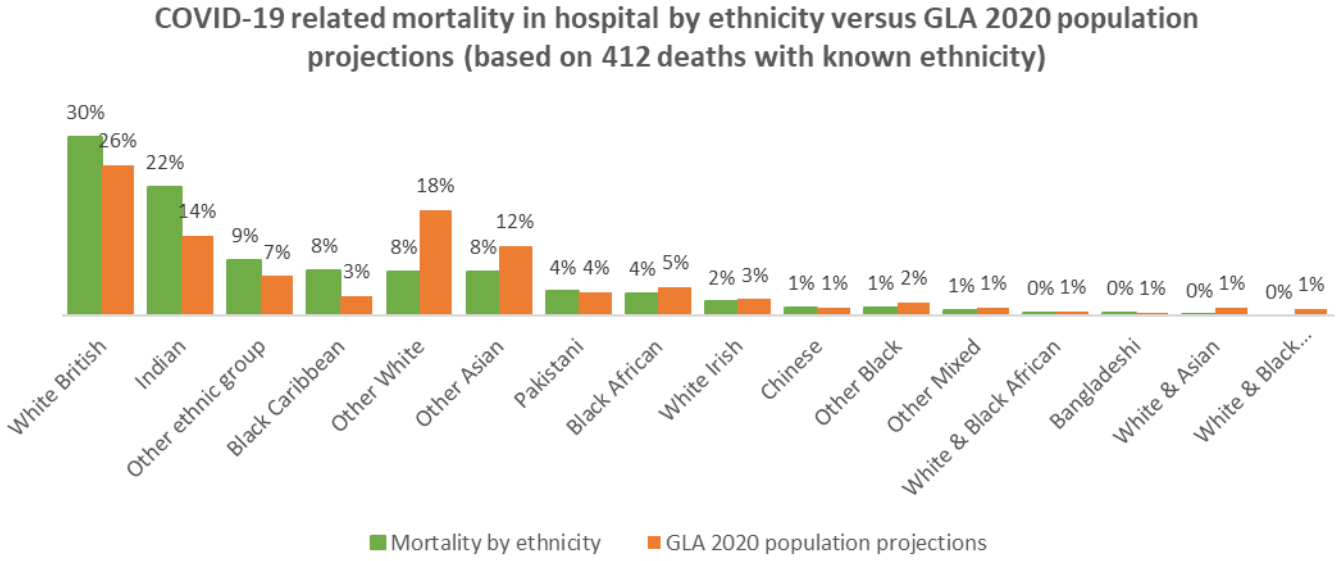


Source: SUS - Ealing CCG, Apr 2021

A similar graph is shown for COVID related death and ethnicity in figure 37. The proportion of those who died from COVID by their stated ethnicity is compared with the proportion of people identifying with this ethnicity overall in the borough. Where the proportion of COVID related deaths is greater than the proportion of the overall population, this would suggest this particular ethnicity is over-represented in those who died from COVID. This includes those in the White British, Indian, Black Caribbean categories. Again, this is also the case for those reporting in the 'other ethnic group'. The link between particular ethnic groups and the risk of death from COVID is well-documented nationally. Without further statistical analysis however we are unable to be more confident in our local findings for the relationship between death from COVID and ethnicity from this data.

Figure 36. shows the proportion of those Ealing residents admitted to hospital with COVID identifying in different ethnicity categories, compared to the proportion of Ealing residents identifying in these categories overall.
Where the proportion of hospital admissions is greater than the proportion of the overall population, this would suggest that this particular ethnicity is over-represented in those admitted for COVID. This includes those in the broad Asian or Asian British category. This is also the case for those reporting in the 'other ethnic group' category which traditionally is overrepresented by Black Asian and minority people. This relationship between particular ethnic groups and hospital admission as an indicator for more severe illness is well-documented nationally. Without further statistical analysis however we are unable to be more confident in our local findings around the relationship between severe illness from COVID and ethnicity from this data.

Figure 37: Graph of proportion of COVID deaths in hospital by ethnicity in comparison to GLA 2016-based housing-led population projections for 2020



Source: SUS - Ealing CCG, Apr 2021; GLA 2016-based Housing-led Ethnic Group 2020 Population Projections; The GLA 16 ethnic groups are the 2011 Census ethnic groups, with the exception that the White Gypsy or Irish Traveller group is aggregated into the Other White group & the Arab group is aggregated into the Other Ethnic group

Ealing data: Urban living and occupation

Urban living

National data identified local authorities with the highest diagnoses and death rates as mostly urban. Death rates in London from COVID-19 were more than 3-times higher than the region with the lowest rates, the South West. The 'urban effect' in London is thought attributable to multiple factors including London having the highest proportion of people identifying with Black, Asian and minority ethnicities, higher levels of overcrowding than other areas of the country, high degree of substandard housing, and some of the highest rates of income and expenditure poverty in the country.

A similar situation can be described for Ealing itself. 14% of Ealing households are classed as overcrowded which is the 8th highest borough in London, and above the averages for London at 11%, and England at 4.5% (Source: GLA)

Table 1.3: number and proportion of people aged 70 or over living in a household with working-age adults, by borough, 2018 Number of people aged 70+ living in a mixed household | People aged 70+ living in a mixed household as a proportion of all people aged 70+

B&D	5,100	35%
Barnet	12,400	29%
Bexley	2,800	11%
Brent	9,100	44%
Bromley	4,500	12%
Camden	7,200	29%
Croydon	4,000	14%
Ealing	8,100	25%
Enfield	6,700	22%
Greenwich	6,400	29%
Hackney	2,400	20%
H&F	4,000	21%
Haringey	4,200	25%
Harrow	6,600	24%
Havering	5,600	20%
Hillingdon	5,400	19%
Hounslow	4,100	16%
Islington	4,300	18%
K&C	4,300	18%
Kingston	3,000	18%
Lambeth	8,100	45%
Lewisham	6,000	32%
Merton	4,400	22%
Newham	7,500	40%
Redbridge	4,400	20%
Richmond	1,700	9%
Southwark	5,000	34%
Sutton	4,000	20%
Tower Hamlets	2,900	35%
Waltham Forest	6,700	35%
Wandsworth	5,900	30%
Westminster	6,500	21%
Median	5,050	22%

Figure 38: Table of number and proportion of people over 70 living with working age adults by borough 2018 (Source: NPI)[15]

As well as overcrowding, intergenerational living was also cited as increasing the risk of severe outcomes from COVID. In early research in 2020[15], the proportion of the over-70s sharing a household with people of working age was found to be a significant factor in accounting for the variation in the number of COVID cases between English local authority areas. The theory being that if working-age people are more at risk of catching the virus, then the over-70s who live with them are more likely to catch it than the over-70s who do not.

Figure 38 shows Ealing had 8,100 people over-70 living in a household with working age adults, which equated to 25% of all people aged over 70 in the borough. This was the 5th top borough in London, greater than the average for London of 24%, and also demonstrated significant interborough inequality. Whilst multigenerational households can reflect resident choice and may enable the provision of care and support between the generations, the high rates of such households in Ealing is also likely to reflect the high demand for and cost of housing.

Occupation

Office of National Statistics (ONS) reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants had significantly high rates of death from COVID than other occupational groups. In addition, men and women working in social care also had significantly high rates of death from COVID. Whilst there is no local data on the occupational group of those in Ealing testing positive, being admitted with COVID or dying of the disease, Ealing has a higher proportion of people employed in low skilled, elementary occupations at 11.7%, compared to London overall at 8%, and England at 10%. Elementary occupations are also at greater risk of job loss, inability to work from home, and loss of income during the pandemic meaning that the same groups experience the worst direct AND indirect impacts from the pandemic.

Summary of direct impact of COVID and inequalities for March 2020 to 2021 Ealing

The table below provides a high level summary of the quantitative data findings for Ealing with regards to COVID inequalities in infection, severe illness and death by the six categories listed in the PHE disparities report. These findings demonstrate key health inequalities in direct impact from COVID according to various demographic and socioeconomic circumstances.

Age and sex	Overall 20-59 year olds have been over-represented in those testing positive in Ealing. However, nearly 50% Ealing residents admitted to hospital were 65 years or over (32.6% over 75) Men accounted for 64% of all deaths in hospitals compared to 36% Women (1st wave data only) 79% of Ealing residents who died in hospital were over 65 years (1st wave data only)
Long term health conditions	91% of Ealing residents admitted to hospital with COVID also had one or more long term conditions. 35% of Ealing residents who died in hospital had diabetes and 83% had more than one long term condition.
Deprivation	In Ealing, higher infection rates appear concentrated in West of the borough (particularly Southall and Greenford). Wards with the highest COVID related hospital admission rates are statistically significantly higher when compared to a group of wards with the lowest COVID related hospital admission rates. A clear gradient exists between the Middle Super Output Areas (MSOAs) with the highest and lowest COVID death rates (x 5 approx.). MSOAs with the highest COVID related death rates are statistically significantly higher when compared to a group of wards with the lowest COVID related death rates.
Ethnicity	Wards with higher proportion of residents identifying as Black Asian or minority ethnicity had higher cumulate infection rates. Asian and Asian British groups appear to be disproportionately affected by hospital admissions for COVID, with a large proportion of those admitted for COVID identifying as 'other ethnic groups'. Need hospital admission rates by ethnicity to draw solid conclusions.
Urban Living	In Ealing, 14% households overcrowded - 8th highest in London (11%), England (4.5%). In Ealing, 8,100 (25%) people over 70 live in a household with working age adults. Ealing in top 5 Boroughs in London
Front line occupations	Ealing has a higher proportion of people employed in low skilled, elementary occupations 11.7% compared to London (8%) and England (10%)

Ealing data: Indirect impact – homelessness and housing

The economic fallout from the pandemic may lead to an increase in evictions and homelessness, particularly as protective policies such as the eviction ban, and the *'Everyone In'* policy, which provided emergency accommodation in hotels during periods of the pandemic, are now withdrawn.

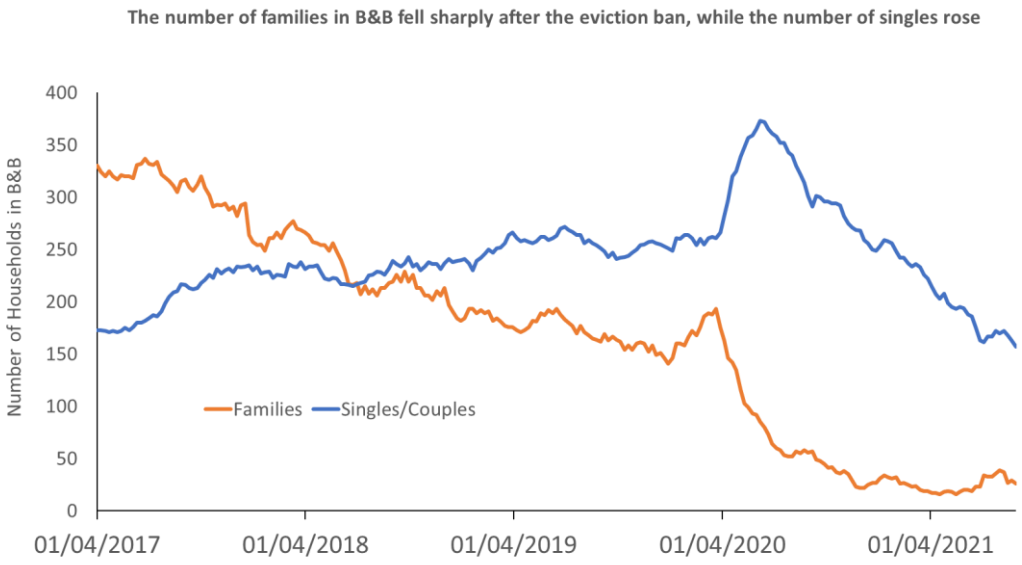
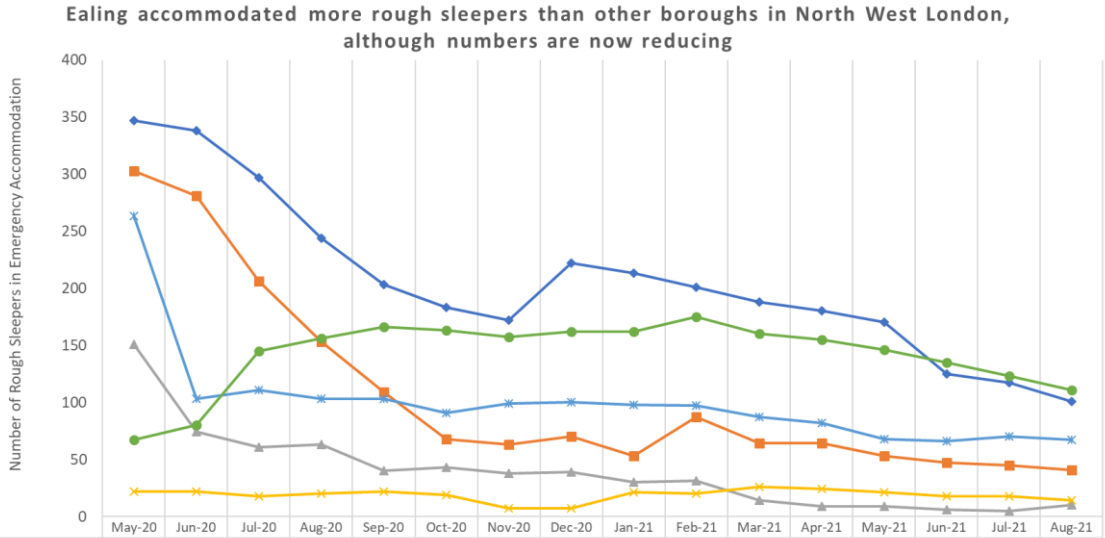


Figure 39: Graph showing the number of families and singles/couples accommodated in B&Bs prior to and during the COVID pandemic.

Figure 39. shows that the number of families in B&B accommodation in Ealing fell sharply after the eviction ban was introduced in April 2020. This reflects that families weren't being being evicted from private rental properties. Now that the eviction ban has ended, there is much greater risk of families losing their homes and we may see this trend reverse, with a time lag due to court processing time. The numbers of singles or couples rose steeply after April because of the Everyone In campaign for rough sleepers and people at risk of sleeping rough allowing the provision of accommodation to people with no recourse to public funds whom are mostly single people. The increase for singles particularly may also have been due to pressures in the family home leading to parental eviction during the pandemic.

Figure 40: shows the number of rough sleepers accommodated in Ealing compared to the other NWL boroughs. Numbers have been reducing since May because Ealing have either successfully rehoused people in long term accommodation, or because, since the end of the Everyone In campaign, Ealing is no longer lawfully able to accommodate people with no recourse to public funds. Longer term we would expect these numbers to change as the numbers of people potentially at risk from homelessness will rise as a result of the post COVID economic situation.



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Ealing	347	338	297	244	203	183	172	222	213	201	188	180	170	125	117	101
Brent	303	281	206	153	109	68	63	70	53	87	64	64	53	47	45	41
Hammersmith and Fulham	151	74	61	63	40	43	38	39	30	31	14	9	9	6	5	10
Harrow	22	22	18	20	22	19	7	7	21	20	26	24	21	18	18	14
Hillingdon	263	103	111	103	103	91	99	100	98	97	87	82	68	66	70	67
Hounslow	67	80	145	156	166	163	157	162	162	175	160	155	146	135	123	111

Figure 40: Graph showing the number of rough sleepers accommodated in Ealing compared to other NWL boroughs during 2020 and 2021.

Ealing data: Indirect impact – homelessness and housing

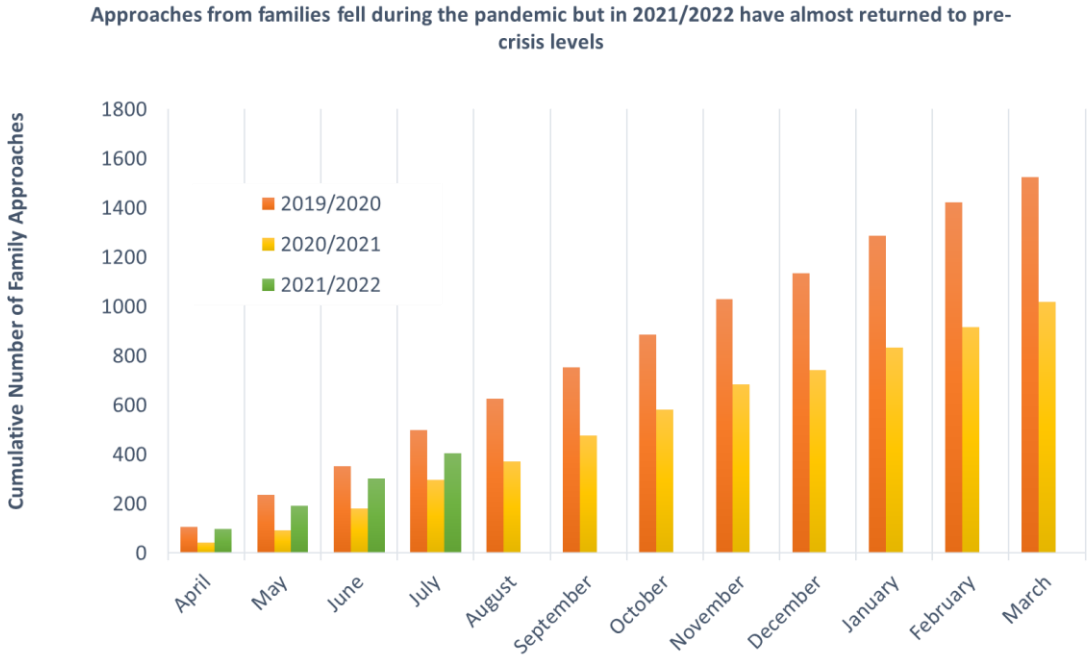


Figure 41: Graph showing the total number of approaches for housing support from families and singles/couples prior to and during the COVID pandemic in Ealing.

Figure 41. shows that the eviction ban led to a reduction in the number of approaches for support from families. Whilst the eviction ban has now ended, the numbers are not yet back at pre COVID levels. We expect an increase with time, but when this will occur is unpredictable. In recent months (late summer 2021), we have had high numbers of Afghan families approaches the council for housing support.

The pandemic has highlighted the health implications of housing quality also. Poor housing conditions such as overcrowding and high density are associated with greater spread of COVID-19, and people have had to spend more time in homes that are overcrowded, damp or unsafe. Families living in poor quality housing and in overcrowded conditions are much less able to self-isolate if necessary and are therefore much more likely to pass on covid-19 to other family members, especially if somebody has a job where they cannot work from home and have to use public transport. We also understand that self-isolation is harder in multi-occupied homes, where people from different households will often share kitchens, bathrooms and common areas. Property licensing is recognised as a useful tool to help tackle poor housing conditions, improve management and reduce overcrowding in private rented accommodation, making homes healthier and more COVID-safe .

Changes to property licensing – indirect impacts of COVID.

Property licensing applies to private rented dwellings and requires landlords to apply to the local authority for a licence. There are three different types of property licensing schemes: Mandatory HMO licensing that operates nationwide and this applies to certain larger houses multiple occupation (HMOs); Additional HMO licensing, for up to 5 years for smaller HMOs; and Selective licensing, which helps tackle issues such as low housing demand, poor conditions, antisocial behaviour, deprivation, migration, crime. Like with additional licensing, selective licensing can only last for up to 5 years.

As well as mandatory HMO licensing, Ealing Council currently operatives a boroughwide additional HMO licensing scheme and a selective licensing scheme in the wards of Acton Central, Acton South, East Acton, Southall Broadway and Southall Green. These schemes came into force on 01 January 2017 and are due to expire on 31 December 2021. We are currently reviewing our evidence base to determine whether we should introduce new additional and selective property licensing schemes

Ealing data: Indirect impact - employment

Ealing borough is projected to experience the largest increase in unemployment within West London, rising by three percentage points from 6% in 2019 to 9% in 2021, with West London Alliance forecast to be the worst hit sub-regional partnership in the whole of London. An estimated 7,000 jobs will be lost. Young people, black and ethnic minority residents, over 55's and those with low skills and poor employment records are likely to be at greatest risk.

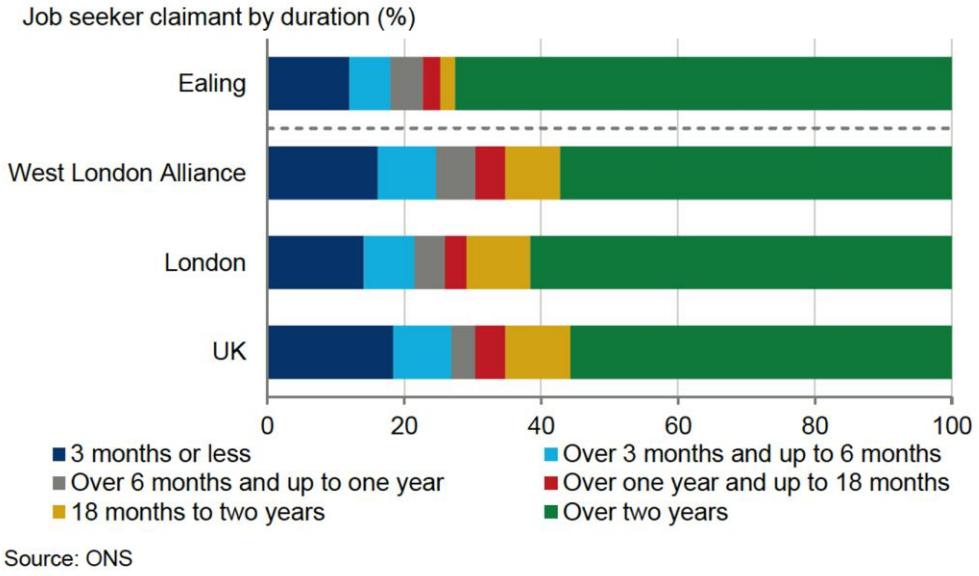


Figure 42: % Job seeker claimants in March 2020 in Ealing compared to WLA, London and UK

Given that many job losses are in shops, bars and restaurants, which typically employ younger staff and students, it is likely that youth unemployment will continue to increase in coming months/year. Many entry level jobs that young people (non-graduates) would typically use as first steps will not be available or will become more competitive. In contrast, and in part because of its industrial heritage, high levels of long-term unemployment are well-established in Ealing, with notable rates of economic inactivity, particularly among certain ethnic minority groups. Figure 42. shows that close to three-quarters of claimants have been unemployed for more than two years. This figure will not rise immediately, but the ability of such people to find new work will be reduced by there being an increased number of short-term unemployed, also seeking work, who are likely to be looked on more favourably by employers than the long-term unemployed.

Ealing has high proportions of residents employed in at-risk sectors such as manufacturing, wholesale and retail and transport, as well as a high proportion of micro firms and self employed residents. The Park Royal industrial estate is particularly important: it contains a lot of food manufacturers, a sub-sector generally not much affected by COVID lockdowns, but many of which serve Heathrow, which is massively affected.

Ealing has a corresponding under-representation of workplace jobs in finance, digital and professional services roles. Nevertheless, many Ealing residents do commute to central London for higher-paid office jobs, and may have had a degree of protection, because of their scope for homeworking. However, overall, Ealing has higher numbers of people who 'have never worked from home' than London average

As of 31st January 2021, 33,300 working residents in Ealing were still relying on the COVID Job Retention Scheme. This was the second highest absolute number of all London boroughs and the highest within WLA. This high proportion of furloughed workers is most likely linked to the types of industries that Ealing residents work in. For example, 18% of Ealing residents work in the transport and communications sector, many of which are linked to Heathrow Airport, which recorded a significant decline in economic activity whilst international travel restrictions were in place. Ealing's high reliance on the job retention scheme drives a relatively high forecast in unemployment peak for Ealing (12.0%)

Source: Oxford Economics report – June 2020 and A detailed study of unemployment in London, Volterra Partners for London Councils March 2021

Ealing data: Indirect impact – Domestic violence

The number of reported domestic abuse offences in Ealing rose in 2020 and are projected to have risen even further for 2021. This trend may be a continuation (whilst markedly more acute for 2020 and 2021) of a gradual rise since 2014 (see figure 43). This is likely to be a national trend due in part to the pressures from the pandemic - including the increased time spent at home in difficult circumstances/exposure to difficult relationships, increased unemployment and mental ill-health, all on the background of a general trend to increase reporting of events and several years of the effects of austerity. Whilst the number of offences has seen a rise, the proportion of domestic abuse violence with injury appears to have decreased in Ealing over the past 5 years suggesting changes to people's reporting of, or a material rise in, emotional and psychological abuse.

There is a clear correlation between increasing deprivation and increasing number of reported domestic abuse offences in Ealing (see figure 44.) highlighting a significant inequality in this area.

In keeping with the same trends, the proportion of total child safeguarding referrals attributable to domestic violence increased from 33% in 2019/2020, to 42% in 2020/2021, with a month on month increase seen towards the end of 2020 (see figure 45).

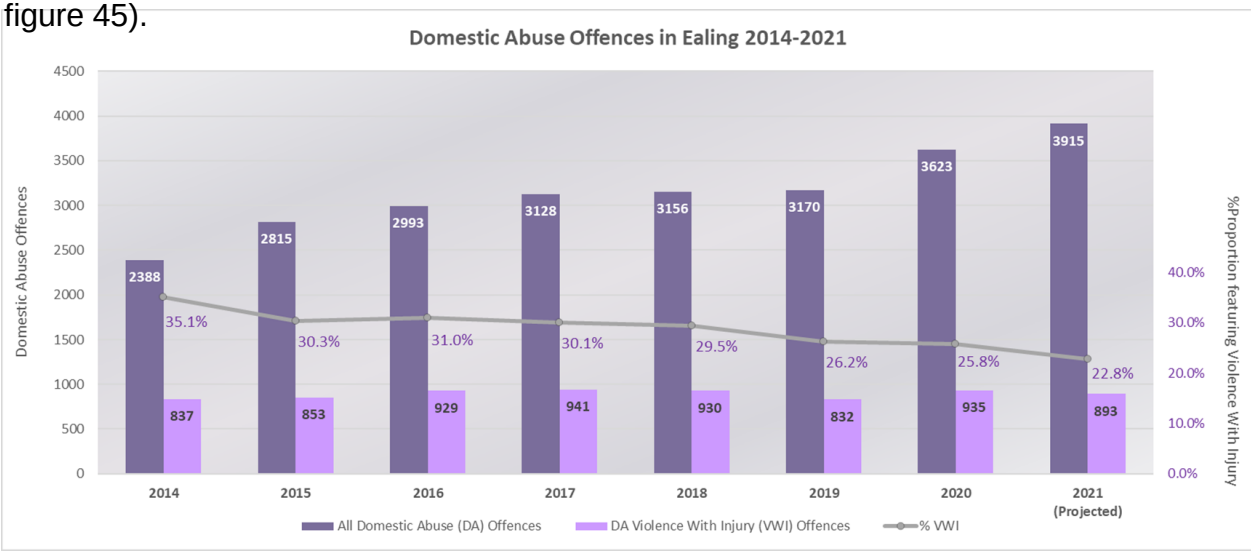
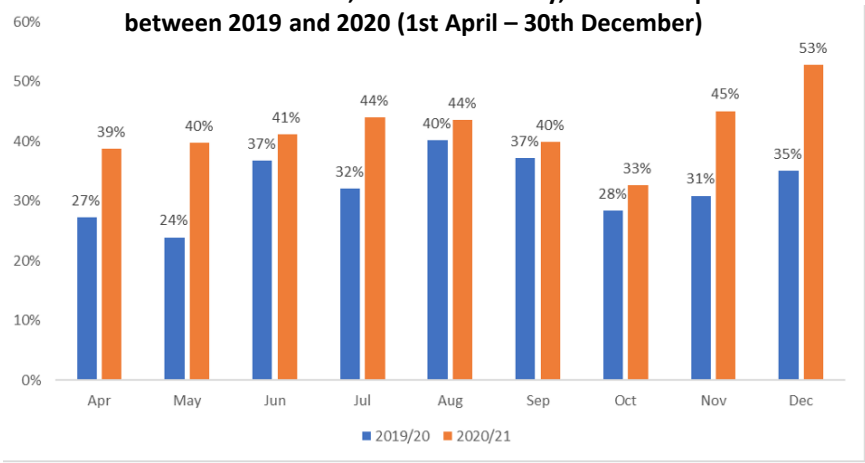


Figure 43: Graph of number of reported domestic abuse offences for Ealing from 2014 to 2021, with the proportion of those offences involving violence with injury (VWI) also shown.

Figure 45: Proportion of total child safeguarding referrals which were domestic violence referrals, recorded monthly, with a comparison between 2019 and 2020 (1st April – 30th December)



Source: LBE Child safeguarding team

Figure 44: Graph showing correlation between increasing deprivation and increasing number of reported domestic abuse offences as a total over 3 years for Ealing.

Community conversations

Conversations with community members were an essential part of the Integrated Impact Assessment process. These community conversations and learnings occurred through three main routes:

1. Adopting the four area based task group meetings (Acton, Southall, Northolt and Greenford and Perivale) in March 2021 for bespoke conversations

Community members were invited to participate in one of four reflective discussions in March 2021 that adopted the area based task groups for Acton, Southall, Northolt and Greenford and Perivale, which had been used as part of the community engagement infrastructure throughout the COVID pandemic. Meetings for these specific four areas had been established as part of the council's COVID response as they were identified as geographical areas of greatest COVID impact, and greatest deprivation and economic inequality. The purpose of these discussions was to jointly reflect on what people's lived experience of inequality was in their area/town, why and how they felt these inequalities were being exacerbated during the pandemic and what ideas we could generate for collective action to tackle these during the pandemic and beyond. These conversations were independently facilitated to break down some traditional barriers between the council and community members creating a more open space for reflection and an opportunity for coproduction of solutions.

An independent illustrator was commissioned to join each meeting and capture the discussion themes, comparing and contrasting the four areas. This illustration (figure 46.) vividly captures the concerns discussed and the ideas for collective action.

2. Series of conversations in voluntary sector forums, partnership board meetings and through the EACH consortium*

(*a partnership of voluntary sector organisations and community groups engaging residents of the borough throughout the pandemic, sharing the council's COVID communication and feeding back insights from the communities). At each forum the findings from the quantitative data analysis and emerging national, regional and local literature were presented and the community membership's thoughts on the patterns of inequality seen were collated through the discussions that followed.

3. Series of conversations with social science academics from London School of Economics (LSE)

LSE academics conducting research in Ealing amongst community members and voluntary sector organisations regarding inequalities, shared general insights provided through conversations with community members in real time, and through independent conversation. These provide additional depth of insight to the COVID Inequalities Integrated Impact Assessment process.

Insights from all three processes are shared in the following sections and have directly influenced and shaped the system-wide principles and themes for tackling inequalities.

Community conversations

The illustration below reflects themes from discussions within four area based task groups in March 2021. It incorporates both community views on causes of inequality by area basis, as well as community members ideas for collective action to address these.

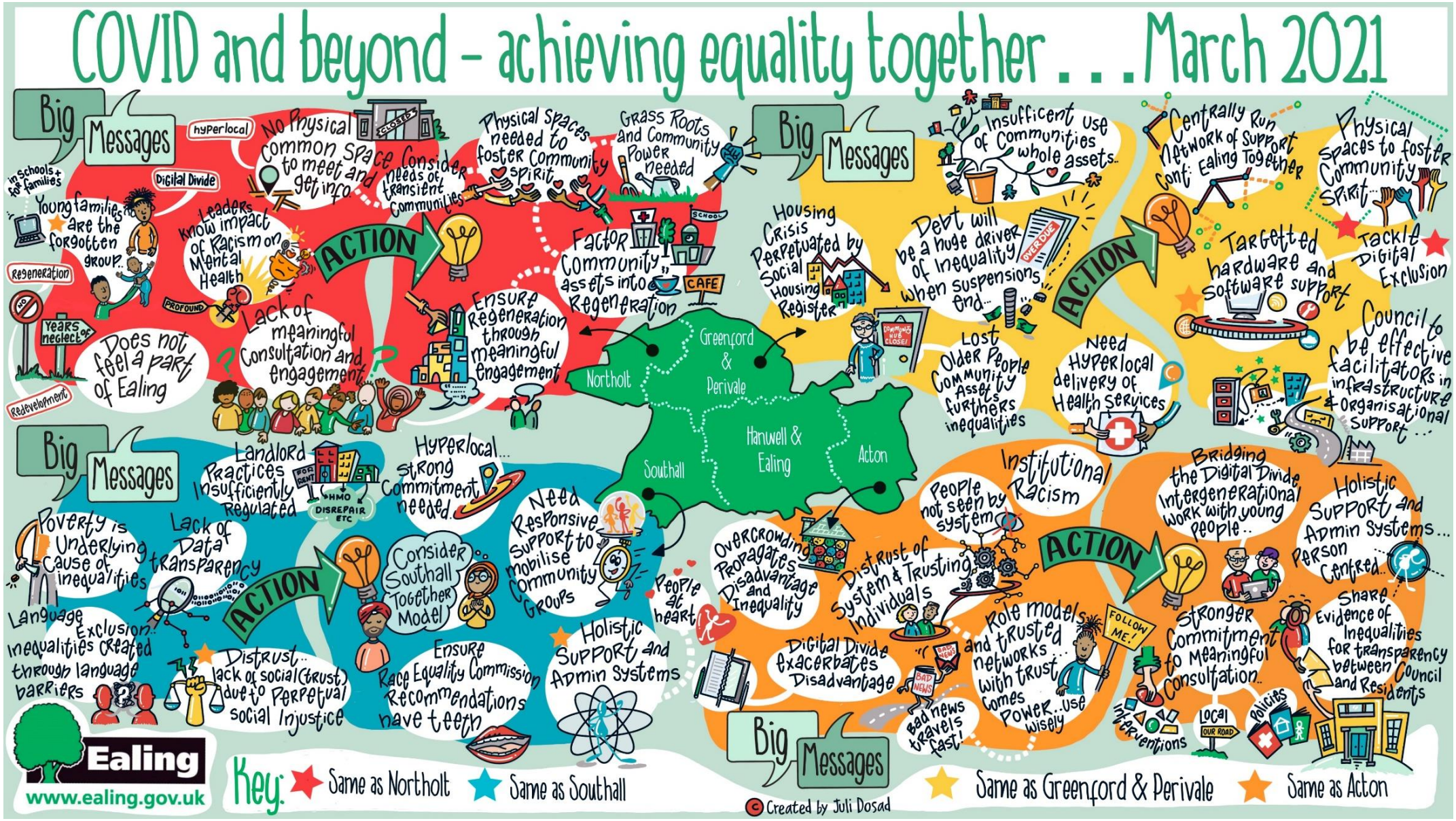


Figure 46: Illustration highlighting community conversations in area based task groups in March 2021

Community conversations – Health and Exclusion

These additional insights in three themes: Health and Exclusion; Social Infrastructures and Funding; and Trust, Engagement and Coproduction; were generated via conversations in community forums, partnership boards and with academics working in the borough.

Communities feel that many gains made prior to the pandemic regarding health promotion and the prevention of long-term conditions will have to be "repeated" or will be "lost". They also articulated their concerns that increases in poverty and deprivation in some communities will have had adverse lifestyle impacts, particularly regarding risks to mental health promotion and unhealthier nutrition.
Voluntary sector leads raised concerns regarding three 'super-excluded' groups, who they are most concerned about as we emerge from a year of COVID related restrictions. These groups are:

1. *Those who are 'housebound'* – including the elderly, disabled, severely mentally ill and their families and/or carers. Voluntary sector leads indicated that for many elderly people, the need to shield has left them entirely cut off from networks of social support, resulting in a "crisis of loneliness and isolation". Leads feel that those who are still in their own accommodation have been underserved, with the closure of day centres and other drop in services mean many such people feel invisible to social services. Leads expressed fears that contracting out of food delivery and other social care services to private providers will reduce the "social value" that these services can provide. Voluntary Sector leads feel that 'opening up' will have resulted in parallel lives – where some are able to return to participating in society, and others – as a result of cognitive decline, mobility issues and lack of confidence or support – will never emerge. They stressed the importance of opening up social and day centres, and the provision of bespoke support.

2. *People in extreme poverty with no fixed home address* – Voluntary Sector Leads expressed concerns about those people who are not visible to social services because they have no fixed address, or only access service informally. They voiced that the closure of drop-in centres has had a major impact for these individuals, and they feel that many will have been pushed into homelessness or further poverty as they are unable to navigate the systems alone. Leads highlighted the importance of food banks and other services that have stayed open are a key touch point for such people. Voluntary Sector Leads described a paradox of digital exclusion that they feel has afflicted these groups, whereby lack of hardware or knowledge or confidence has meant that they can't get online to access support, whilst also making them invisible to the service providers who could help them. Leads described how poverty compounds these problems meaning people don't have the regular income necessary to pay for broadband or technology maintenance.

3. *Some minoritized groups and people with No Recourse to Public Funds (NRPF)* – Voluntary Sector Leads expressed concerns about the poor social infrastructure available to minoritized groups who are not on the radar of social services. Leads feel that a lack of funding has meant information materials have been translated into fewer spoken languages, delivery services are stretched in capacity, and both broadband and transportation are overlooked as essential parts of service provision. Leads identified 'fear of the state' as a big barrier to accessing services for new migrants and existing migrants with ambivalent migration status – of which there are many more after Brexit and the current situation in Afghanistan.

Community conversations – Social Infrastructure and Funding

Community participants and voluntary sector leads herald the local authority response to the pandemic in "Ealing Together" as a watershed moment for a range of community and voluntary sector organisations. Voluntary sector leads felt that the provision of unrestricted funds and the suspension of procurement processes left organisations feeling *"liberated",* able to "*get the job done*", able to "*form new collaborations and partnerships"* and able to deliver successfully layers of care. In addition, they voiced that the alignment around a common set of objectives and strong communication networks such as CACHE and other forums had been instrumental. Voluntary sector and community leads described that a multitude of such partnerships emerged in this moment which would not have been possible before – for instance, between Age UK and Ealing Community Transport; or between the Met Police and Cape Project Mental Health Care. They also highlighted a range of innovations that emerged as a result of such partnerships – for instance getting the runners clubs to drop in information pamphlets, providing information and advice numbers in food parcels, and providing barbers with vaccination information.

However, voluntary sector and community leads raised concerns that there is a sense that some communities are 'hard to reach' because they don't have sufficient social infrastructure already in place. They gave the example of South Asian communities have a plethora of services that are already formally working and known to authorities, compared to newer migrant groups such as the Somali community who they describe as having lesser infrastructure, perceived as "informalised" and lacking in the "knowledge" to be able to access funds and support from key voluntary sector and local authority organisations. Community leads feel that if they were given the support and know how – for instance in setting up websites, setting up governance structures and audited accounts – they would be able to access funding. Leads highlight this as "insufficient use of the communities' whole assets" and feel that this is part to blame for making inequalities worse.

Community leads stated that they felt it there was a "political nervousness" to single out areas and community groups which have been more neglected than others, and therefore more formally identify them as needing greater support.

Other, school-based community leads described a significant digital divide amongst children in schools, with their view that interventions and support were targeted at only the very extremely disadvantaged. School community leads shared their perspective that in reality there were many tiers of disadvantage ad that thresholds of 'disadvantage' were often unhelpful and insufficient.

Community leads expressed concerns that the whole context of the person's life was not taken into account due to "internal fractionality of the council", and that this perpetuated inequality in the borough. Leads elaborated that they felt that bits of the system were set up to address only one problem, neglecting to see how interdependent these issues are upon other support needs which were not being addressed.

Funding: Voluntary sector and community leads described that where mediator organisations that are deeply embedded in communities and know the eco-systems of smaller organisations receive funding, they felt they have supported a wider network of organisations serving more minoritized and underserved groups. The main reasons that community leads identified for this was because the mediator organisations were able to do the "relational work" and ensure equitable provision across groups.

Data and Impact: Voluntary Sector and Community leads expressed confidence in collecting their own data and evidence of need and their ability to critique evidence sources provided by others. They felt that evidence of inequalities should be shared with general population more frequently and meaningfully for greater impact. They felt that funders and authorities should set up more manageable and flexible monitoring and evaluation frameworks accounting for relational work that is less measurable, whilst critiquing current frameworks for their failure to capture the social value added by voluntary sector over private providers.

Community conversations – Trust, Engagement and Coproduction

Community leads reported that institutional racism has been felt as an acute problem during the pandemic, where processes and responses have left people feeling ignored or treated differently. They feel that the pressures of the pandemic have also made it harder for people to face this discrimination with their usual help and coping mechanisms constrained. There was a collective call from community leads to everyone to 'dig deep', show honesty and humility, and be prepared for difficult conversations. Voices from Somali, and more generally Black Caribbean and Black African communities in Ealing, shared that they felt the experience of structural racism was pervasive, and the experience of daily racism in accessing services to be ubiquitous.

Community leads shared their views that community engagement efforts had appeared inauthentic and 'performed' in the past and felt co-production was used as another 'buzz word'. The same community leads described their feeling of long-standing neglect in terms of a lack of sufficient consultation and engagement on issues of regeneration and re-development of services.
Community leads highlighted particular language that can hinder engagement. For instance, the BAME category which was seen as both discriminatory of black and brown communities, and exclusive of the needs of other precarious minority groups such as the Polish community who also experience historical exclusion. They also reflected that they felt that too often, ethnic minority communities were imagined as 'closed' without sufficient attention paid to the many other axes of identity. They also described that language was in their view often lacking in terms of conceptualising long-term health inequities that they feel are bound up with deprivation, housing issues, mental distress and other factors. Communities themselves strongly resist the language of their being "hard to reach". Community leads described that they didn't feel the concept of 'communities' works, if people within different interest groups are seen as discrete communities, and not just the people living in a shared area as part of their own other self-defined communities with intersectionality.

Community leads expressed a hesitance to trust intangible systems which they felt "lose their humanity". Instead they could described being able to relate more through individual connections which they perceived as much more powerful. This was especially the case if they felt there had been a history of the system dis-serving the person or group in question.

Community leads feel that the diversity of the population needs to be more reflected by the make-up of staff in organisations of authority, which requires proactive recruitment of people who are embedded in their communities. They stated that they feel humans inherently trust those which they recognise and can feel a connection with. Community leads suggested that people in positions of authority took more time to immerse oneself in their communities, and to build new alliances in order to facilitate people taking initiative and action for themselves.

Community leads expressed their view that the health system needs to be "relational rather than transactional". They described challenges whereby there is "not enough space" to do important relational work and give space for people's persuasion. They felt that this could be achieved by further empowering the voluntary sector.

System wide principles of working

The following section describes a set of system-wide principles of working for tackling inequalities, that emerged from this impact assessment process. These principles have been developed following consideration of the findings from:

- quantitative direct impact data
- national and local literature
- Community conversations

These were considered by a COVID inequalities integrated impact assessment cross-council steering group.

There were additionally some short-term recommendations made throughout Autumn and Winter of 2020/2021 to the cross-council Outbreak Prevention and Control Cell, which operationalised the council's COVID response, to ensure timely learning, and the ability to take immediate action by adapting the council approaches in response. The slides that follow describe progress against these short-term recommendations.

The system-wide principles of working for COVID recovery, aim to ensure that we have a strong emphasis on improving the wider determinants of health and health inequalities across Ealing's population. Many of these approaches are well-evidenced in the national literature but they also have specific relevance to us in Ealing, which has been highlighted by the quantitative data findings and community conversations during the process of the integrated impact assessment.

Recommendations for the short term COVID response (1)

Short term recommendations have already influenced the council's COVID response work. Progress on these at September 2021 below.

SHORT TERM RECOMMENDATIONS FROM THE COVID INEQUALITIES INTEGRATED IMPACT ASSESSMENT	Progress on these recommendations. What has been taken forward and how? Where are the gaps?
Engage with Ealing's Black, Asian and Minority Ethnic and disadvantaged populations to ensure their experiences inform the ongoing pandemic response and recovery – through area task group meetings and EACH consortium	Has been taken forward through the area task group meetings and the EACH consortium of VCS partners focussed on providing support to Black Asian and Minority Ethnic Groups in the borough.
Care homes - Maintain effective multi-agency response at varying degrees of intensity (IPC, outbreak management, market & staffing, testing, PPE, vaccinations, enhanced GP support)	Continued Care Coordination Cell approach with sub-cell for more clinical discussions throughout. Moved to monthly meetings and sub-cell by exception for incident management team meeting discussions but continued partnership working with Ealing Community partners, TACHS, PHE and the market providers.
Tackle issue of digital exclusion ensuring people are able to access key advice, services and support.	Ealing Digital Steering Board set up and Digital support programme running through Citizens Online
Maintain strong operational response with health partners particularly for the COVID vaccination delivery	Connections with health partners strengthened through NHS Gold, NWL surveillance group, Ealing Integrated Care partnership, Joint working on vaccine delivery through vaccine working group and sub group for Homeless and Inclusion health groups re: vaccine.
Continue to communicate clear and consistent messaging from national guidance especially to older people and people with health conditions in Ealing.	Weekly communications messages disseminated widely across community engagement networks. Includes messaging delivered by oral presentation to Older adults, disabilities and long term conditions partnership board. Equally collaborative work on messaging with NHS partners.
Target asymptomatic testing in groups to achieve most impact (e.g. occupation/geography)	Targeted testing to geographic and demographic groups of inequality, including working with Ealing Foodbank who are distributing kits to volunteers, faith settings distributing after prayer in west Ealing, Acton and Southall, RISE alcohol and drug service distributing to service users, 17 pharmacies doing assisted testing, and 10 libraries as community collect sites. Future focus may be to look at how to target key occupational risk groups.
Vaccination delivery - work with partners to ensure access and engagement is targeted to the most vulnerable.	Vaccine working group and sub group to target Homeless and Inclusion health groups. Mobile/pop-up vaccination clinics and targeted communications in collaboration with health partners.

Recommendations for the short term COVID response (2)

SHORT TERM RECOMMENDATIONS FROM COVID INEQUALITIES INTEGRATED IMPACT ASSESSMENT	Progress on these recommendations. What was taken forward and how? Where are the gaps?
Work with our communities to understand and address barriers to self-isolation & adherence to guidance	This has been taken forward through the area task group meetings, the answering of enquiries re: guidance through the public health mailbox, Ealing Together providing support to self-isolate, and advice and guidance given through LECT also. Requires ongoing community conversation.
Implement a host of children and young people focussed actions, such as the following:	
• Building on the review of parenting programmes to ensure availability in multiple languages and to provide good access for disadvantaged children.	Ealing Parenting service provides targeted workshops in multiple languages, has access to interpreters if required and have recently supported a parent by meeting with the interpreter before each group to ensure they understood the purpose and were able to translate the content/session for that week. Ealing Parenting Service also works closely with Parenting U, a community service who's objective is to; 'ensure that all members, in particular Muslim, South Asian and Black, Asian and Minority Ethnic communities, and those who are affiliated with the customs and religious background of these communities, are informed about positive parenting practices'. Ealing Parenting Service have commissioned their targeted programmes such as Family Links with Islamic Values and Family Links with additional needs for communities in Punjabi, Hindi and Urdu, to widen our reach and offer to Ealing families.
• Support early years settings to deliver "catch up" programme for disadvantaged children.	School readiness support includes leaflets distributed to all Children's Centres and partner organisations, workshops prepared for Autumn term 2021 targeting those most at need, with extra capacity in high need areas i.e. Southall, Northolt, and Acton. New School readiness coordinator being recruited for the borough.
• Support schools to address inequalities in the home learning environment for disadvantaged students including access to broadband and devices.	Hardware was provided to pupils most affected by digital poverty. Focus now on addressing lost learning and variance in impacts on different groups of children -supporting schools with strategies to re-build pupil resilience. Also focus on securing full engagement of our most vulnerable learners
• Through community engagement mechanisms – address parent's anxiety regarding COVID-safety of services.	Appropriate guidance, information and support for parents and children who were looking to return to school but had anxieties was provided. Ealing's attendance team prioritised families who remain overseas, families where there are still high levels of anxiety about school return and those who require additional support from health and social care teams to return to school. A programme of home visits has helped support these families.
• Engage parents of children with SEND to scope out return to pre-pandemic access and provision.	Teams are engaged in identifying SEND needs earlier through children's centre activities, development checks and in nursery classes and settings. Ealing Learning Partnership is working with schools to explore alternative models of support for a broader range of pupils' needs and to increase SEN support.

System wide Principles of Working on Health Inequalities (1)

Community Participation and ownership - Prioritise a truly participatory model of community engagement that is open, transparent and inclusive, ensuring community-centred, led and owned development is at the heart of all local policy, strategy, and action.
Whole systems approach for health, wellbeing and community support – council officers and partners to collaborate on opportunities for improving health and wellbeing (e.g. Integrated Care Partnership/Integrated Care System) with common goals to reduce inequalities and improve outcomes for all in the borough. This will involve embedding a whole systems approach to tackling inequalities, based on a full understanding of the place-based and community context of residents' lives.
Tackle structural racism - Identify structural racism and unconscious bias in all areas of the system and deliver recommendations from the 2022 Race Equality Commission report, working transparently and openly across local organisations. Work to interrupt and correct this discrimination for residents and staff.
Use the learning from the COVID pandemic - Reflect on learning to improve future approaches to address health inequalities, including improved community engagement and targeted provision of advice and services. The pandemic has highlighted the importance of accessible community-based and outreach service delivery models.
Tackle and prevent digital exclusion - Promote and help build local digital skills and accessibility. Develop proportionate use of digital tools, processes and communications to help reduce inefficiency and to free up resources for those in greatest need. Ensure non-digital options are available for those who need these, to help prevent digital exclusion and support the tackling of inequalities.
Tackle the causes of the causes - Identify the root causes of inequalities and address these through local policy change to strengthen capacity to thrive. Prioritise the maintenance of healthy places and environments, healthy homes, healthy work, and healthy social connections.
Prioritise prevention - Work across the system to ensure an explicit and proportionate prioritisation of prevention. Whilst working to tackle the immediate issues, also create strategies and services which focus on independent living, prevention and early intervention of ill-health.
Deliver universal health and social care support to all, and also scale in proportion to need – health and care services should be delivered universally as a baseline for all, with an intensity of provision available beyond this baseline, according to need. This principle should also apply when developing local strategy and policy to tackle inequalities.
Embed equity and fairness - Put equity at the heart of local strategy and policy and performance by ensuring we collect equalities data across services, and monitoring the gap in health and wellbeing outcomes between different groups via an agreed number of key measures and ensuring that programmes are in place to reduce the gaps.

System wide Principles of Working on Health Inequalities (2)

Improve local data collection and use - Ensure local data collection is fit for the monitoring and evaluation of health inequalities. Advocate (nationally) and develop (locally) data collection processes that support our understanding of health inequalities - particularly the collection and completeness of ethnicity data to aid the tackling of ethnic inequalities. For example the collection of ethnicity data on business ownership, receipt of business support, and/or grant funding. Ensure data collection is coordinated across the system and robust data sharing processes are in place to help reduce repeat information requests of residents.
Prioritise hyperlocal - Prioritise hyperlocal place-based needs assessment, community engagement, and strategy development, which will require access to relevant data at a neighbourhood level in the borough.
Work across the life course - Implement services and policies which work across the life course (from birth through to older age) to help ensure a commitment to longer-term prevention and early intervention.
Prioritise accessibility for all - Ensure support, services and place-making is delivered through the approach of accessibility for all, to ensure age-friendly, disability-inclusive urban spaces, services, and opportunities in the borough, for example dementia-friendly high streets. Continually reassess these access and development models to ensure they continue to tackle inequalities as these evolve.
Asset-based approach – maximise opportunities to work with the full range of community-based groups and assets available in the borough, and particularly to tap into resident's skill sets, expertise, knowledge and enthusiasm for strengthening their local community.
Incorporate action to address the unequal impact from climate change – Focus on viewing climate change and any action to address the impact of the climate emergency through the lens of inequality.
Use and create the evidence base - Ensure that any approaches taken are based upon the best available methods and evidence. What constitutes good evidence will depend on the context and action being proposed.
Set an intention to tackle poverty locally, and also lobby to tackle poverty and inequality nationally – Setting a local intention will help to consolidate efforts to tackle poverty within the borough. Alongside this, work across London to lobby national Government on effective measures to tackle poverty and the extremes of inequality. E.g. continuing targeted work such as the 'Everyone In' campaign to break cycles of homelessness and poverty and support more sustainable welfare of the worst affected population groups.
Take full responsibility as anchor institutions – Prioritise the building of community wealth and support and influence all employers and workplaces in the borough to do the same. As well as the creation of local employment and skills opportunities, ensure that we leverage via all local procurement, commissioning and delivery activity to tackle public health, prevention and inequalities issues.
Promote and support volunteering – harness and build upon the local community networks and ties that grew during the pandemic response. Help maintain resilience of these community networks beyond the crisis response via a whole system commitment to supporting volunteering in Ealing, recognising the huge value of hyperlocal and culturally distinct support that can be offered within communities.

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