The London Borough of Hammersmith and Fulham

Annual Report of the Director of Public Health

One Year On: The Impact of COVID-19 in Hammersmith and Fulham March 2020 – March 2021

Part 2 – Wider Impact of COVID-19 on Health, Healthcare Services and the Community

August 2021

CONTENTS

ABBREVIATIONS

BAME	Black, Asian and Minority Ethnic
CAN	Community Aid Network
CCG	Clinical Commissioning Group
CEV	Clinically Extremely Vulnerable
DPH	Director of Public Health
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
LBHF	London Borough of Hammersmith and Fulham
LSOA	Lower Layer Super Output Area
MDT	Multidisciplinary Teams
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHE	Public Health England

Summary

The COVID-19 pandemic has presented a large challenge for public health. The pandemic has had large direct and indirect impacts on health and wellbeing, as well as the National Health Service (NHS) and other services. These impacts have resulted in life expectancy decreasing both nationally and locally in the London Borough of Hammersmith & Fulham (LBHF).

The pressure COVID-19 has enacted on the NHS has had widespread repercussions on waiting times. Whereas the proportion of patients waiting six weeks or more for a diagnostic procedure was an average of 1 percent per month between February 2019 and February 2020 in Hammersmith and Fulham Clinical Commissioning Group (CCG), by June 2020 the proportion had reached 63 percent. Data regarding cancellation of elective and urgent operations is unavailable due to a pause in the collection and publication of the official statistics due to COVID-19[1].

The disruption and change which the COVID-19 pandemic has exacted on the delivery of healthcare services has in turn raised significant concerns about the health care needs of residents, especially those with long-term conditions. The impact of delayed cancer diagnoses is of particular concern and the knock-on effects that cancellations of NHS services will have as NHS services are resumed.

Lockdown has also impacted stress pathways associated with the adoption of unhealthy behaviours, including substance misuse. Fewer residents have been interacting with specialist alcohol misuse services and the number of deaths by drug poisoning has reached an all-time peak. So far, the pandemic does not appear to have had an effect on the rate of smoking.

The isolation and uncertainty caused by the pandemic has contribute to higher levels of anxiety and stress according to UK-wide research, particularly in older adults required to shield. In addition, loneliness has risen since March 2020 with individuals reaching out to LBHF Council via Community Aid Network (CAN) during lockdown periods.

Post-COVID-19 syndrome is also a growing concern with the Office for National Statistics (ONS) estimating 21 percent of cases continuing to report symptoms at five weeks in the UK as of 6 March 2021. Inferring from these figures, an estimated 1,525 women and 1,085 men have Long COVID in LBHF at any one time. It is essential services are commissioned to respond to the need for Post-COVID-19 care and treatment.

Clinically extremely vulnerable (CEV) individuals were advised to shield in March 2020 and as of 12 March 2021 14,562 LBHF residents were shielding. The CAN and Shield team contacted all residents who had registered for shielding support and assisted them with access services they needed. As of 12 March 2021, LBHF CAN and Shield had received 13,071 support requests. The Conversation Matters

[1] NHS England (2021) Cancelled elective operations.

telephone platform was also established to aid older and disabled adults (as well as unpaid carers) to maintain their independence.

The impact across LBHF has been varied and the communities that have been disproportionately impacted by COVID-19 – in terms of the number of people claiming benefits, the proportion of residents testing positive, vaccination uptake, vaccination refusal and COVID-19 deaths – are those with higher levels of deprivation. LBHF's COVID-19 recovery plan must focus on these communities to ensure an equitable borough in the coming decades.

2.1 Life Expectancy and Mortality

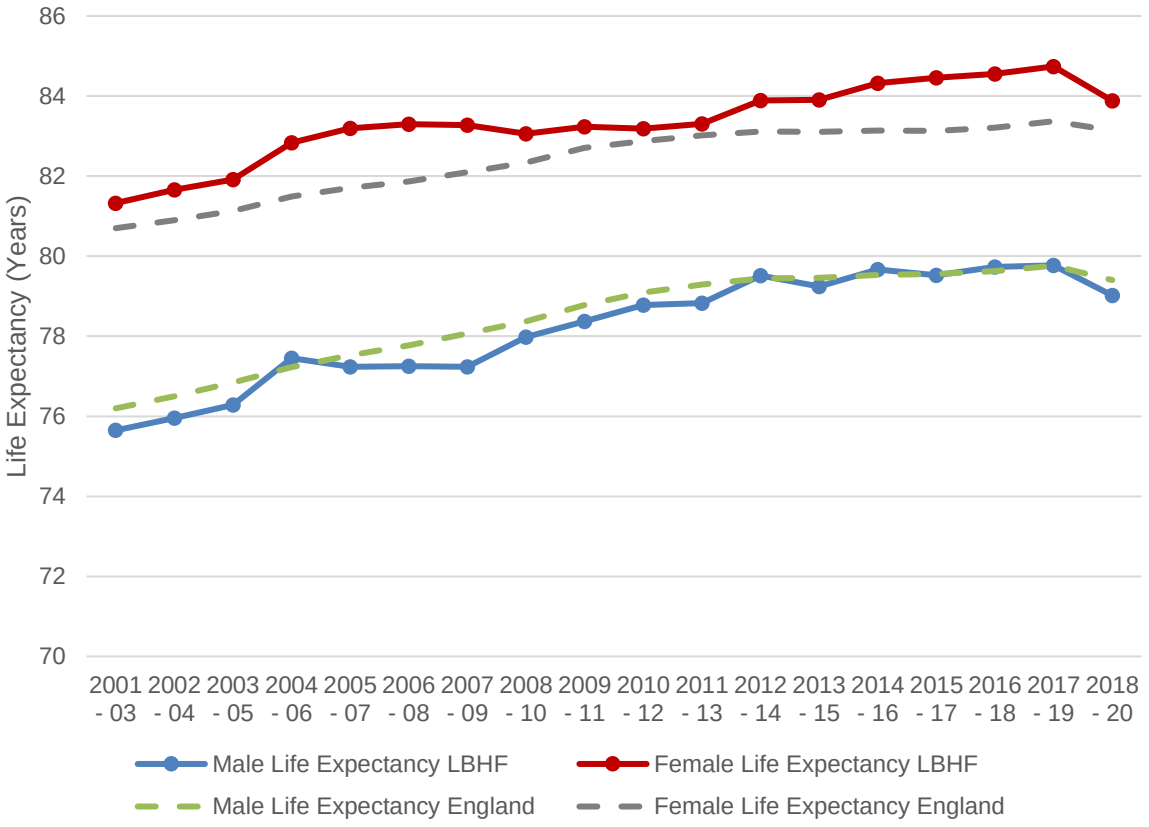
2.1.1 Life Expectancy

The life expectancy in Hammersmith & Fulham has decreased since the start of the pandemic.

Over the last century, life expectancy in the UK has increased. However, the COVID-19 pandemic lead to a higher number of deaths in 2020 compared with recent years, especially among males. Nationally, this resulted in life expectancy estimates for males falling back to levels reported in 2012 – 2014 (79.4 years). Life expectancy remained unchanged nationally for females from 2015 – 2017 at 83.1 years[2].

In LBHF, male life expectancy at birth decreased slightly to 79.0 years in 2018 – 2020 from 79.8 years in 2017 – 2019. In LBHF, the life expectancy for females also decreased slightly to 83.9 years in 2018 – 2020 from 84.7 years in 2017 – 2019 (Figure 22).

Figure 22. Life expectancy at birth among males and females in Hammersmith & Fulham, and England, 2001 – 2003 to 2018 – 2020.



Data source: Office for National Statistics (2021) Life expectancy estimates, all ages, UK.

[2] Office for National Statistics (2021) Life expectancy estimates, all ages, UK.

2.1.2 Mortality from non-Covid causes

In 2020, there was an increase in both premature and preventable deaths compared to 2019.

While an excess of total deaths occurred in England and Wales between March 2020 and March 2021, driven by the large number of COVID-19 deaths, the number of deaths from causes other than COVID-19 was lower in this time period. Across England, during 80 percent of the pandemic, the number of deaths from causes other than COVID-19 was approximately 9 percent lower than the expected number[3].

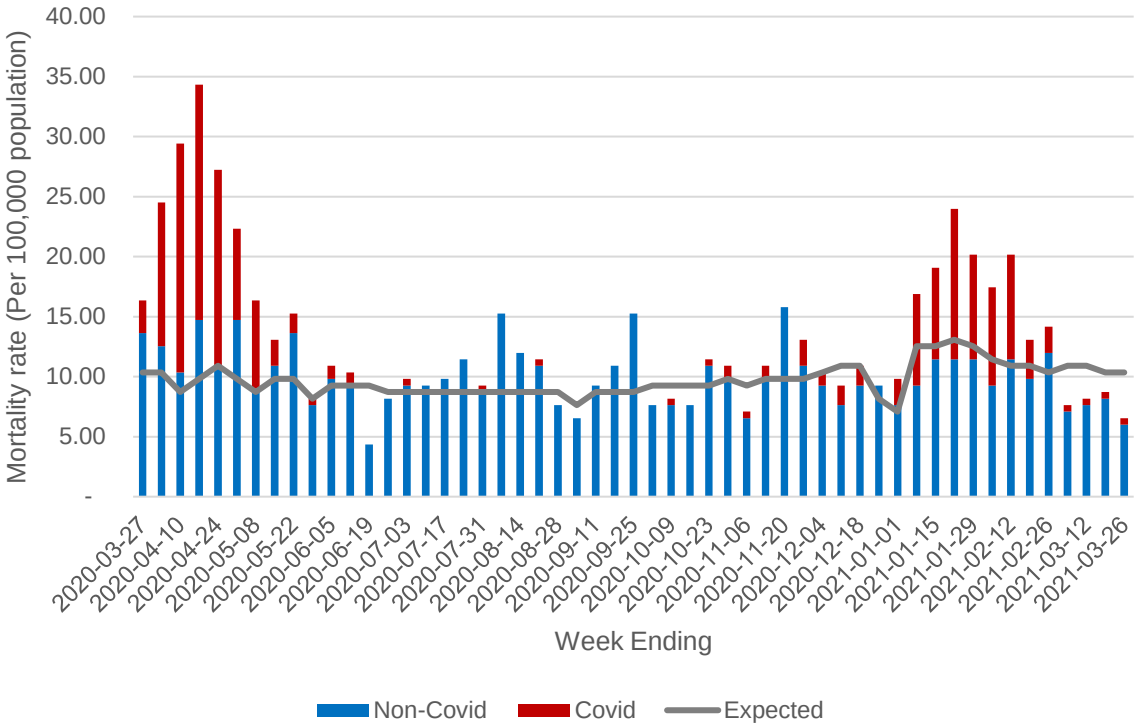
Some of this reduction can be explained by 'displaced mortality' – a phenomenon where a period of high mortality is followed by below-average mortality. Mortality displacement occurs predominately among vulnerable people, including older people and those with certain medical conditions, who die sooner than expected from COVID-19 as opposed to another cause.

Nationally, the greatest reductions were seen among deaths from influenza and pneumonia (48 percent reduction) and chronic lung conditions (25 percent reduction). As well as displaced mortality, reductions in mortality from these conditions are likely due to the lower prevalence of infectious disease as a result of social distancing measures put in place.

In LBHF, between March 2020 and March 2021 there was an excess of 334 deaths compared to the 5-year average for this time period[4]. Of these, 301 deaths are attributable directly to COVID-19 (Section 2.6).

[3] Office for National Statistics (2021) Monthly mortality analysis, England and Wales.
[4] Public Health England (2021). COVID-19 Situational Awareness Explorer.

Figure 23. LBHF resident COVID-19 and non-COVID-19 mortality rate per 100,000 population, compared to the expected mortality rate (week ending 2020-03-27 to 2021-03-26).

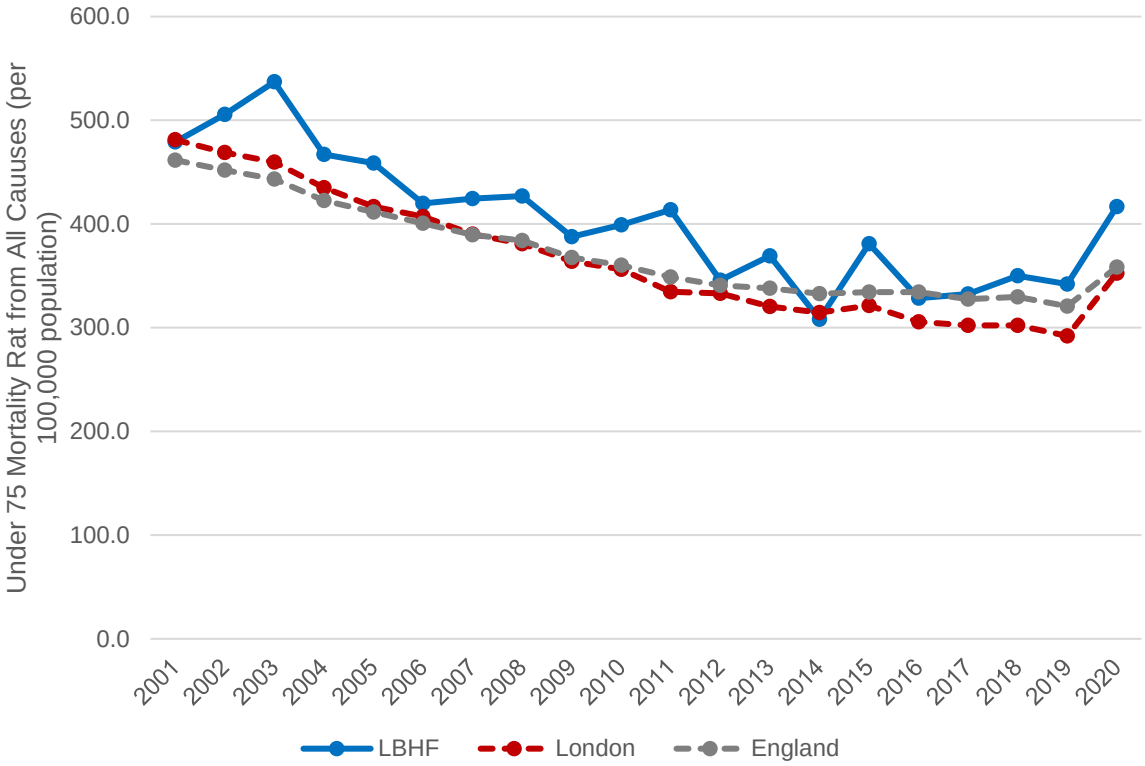


Data source: Public Health England (2021). COVID-19 Situational Awareness Explorer.

2.1.2.1 Premature Mortality

In LBHF, mortality among residents aged under 75 years old from all causes increased in 2020 compared with previous years (Figure 24). Between 2019 and 2020, the mortality rate in LBHF rose from 342.0 deaths per 100,000 population (under 75 years) to 416.8 deaths per 100,000 population (under 75 years). The mortality rate among residents aged under 75 years old was significantly higher than the mortality rate in London (352.6 deaths per 100,000 population) and across England (358.5 deaths per 100,000 population).

Figure 24. LBHF, London and England resident all-cause mortality rate among under 75 years old, per 100,000 population (2001 to 2020).

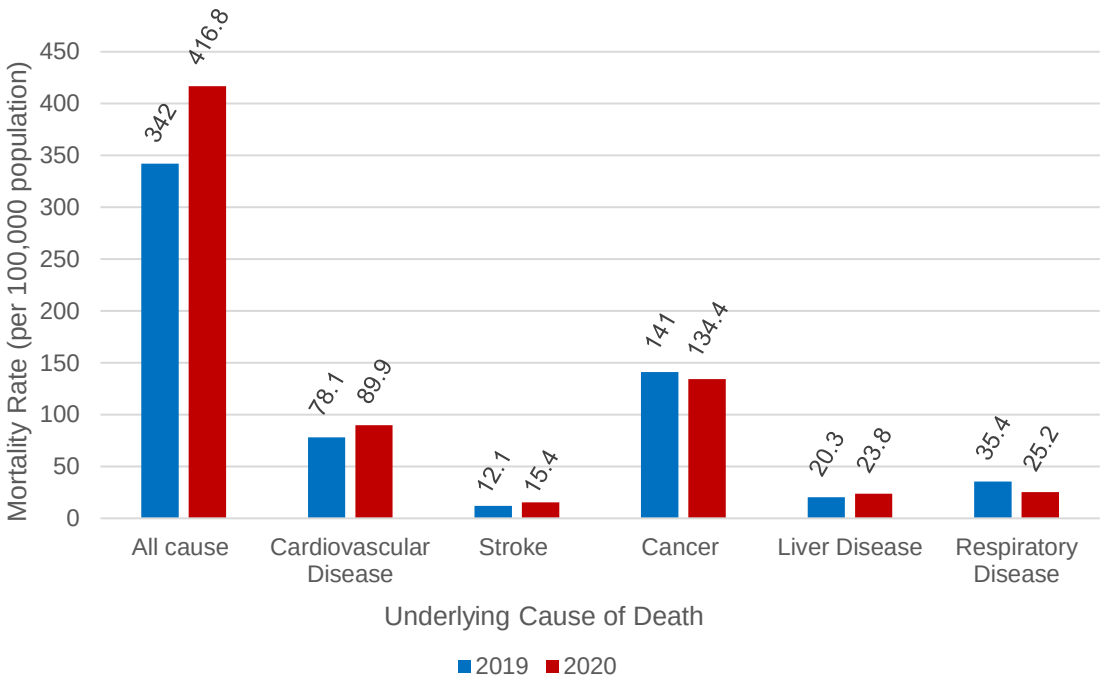


Data source: Office for Health Improvement and Disparities (2021). Under 75 mortality rate from all causes.

In LBHF, while all-cause mortality among residents under 75 years old increased in 2020, the mortality rate from certain causes decreased between 2019 and 2020. The mortality rate among residents aged under 75 years from cancer decreased by 4.7 percent and from respiratory diseases (excluding COVID-19) decreased by 28.8 percent (Figure 25). However, deaths among residents aged under 75 years from cardiovascular disease, stroke and liver disease all increased between 2019 and 2020[5].

[5] Office for Health Improvement and Disparities (2021). Under 75 mortality rate

Figure 25. LBHF resident mortality rate among under 75 years olds by underlying cause, 2019 to 2020.



Data source: Office for Health Improvement and Disparities (2021). Under 75 mortality rate

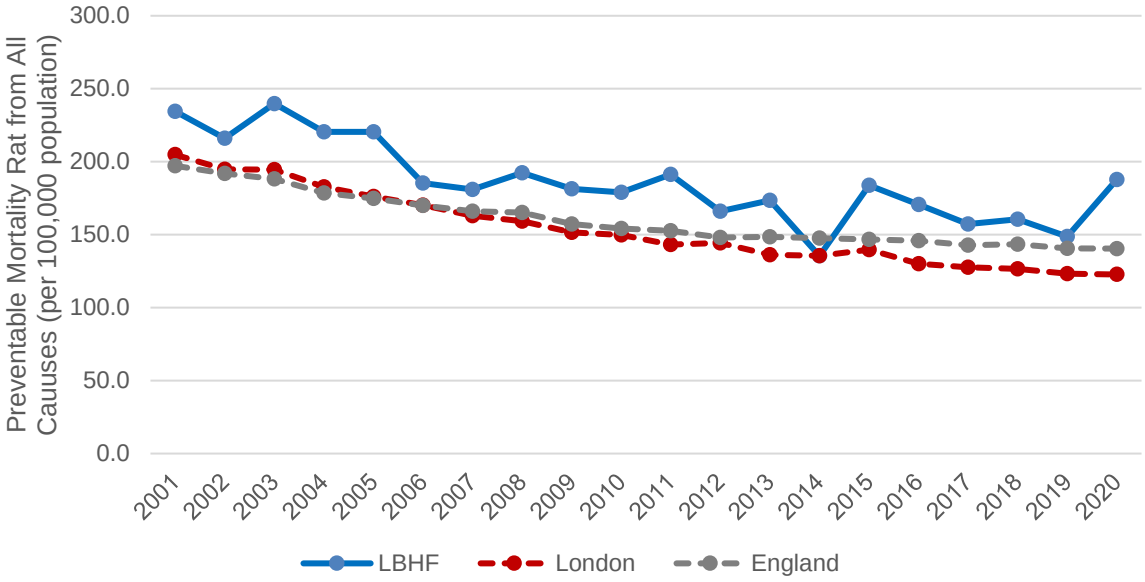
2.1.2.2 Preventable Mortality

Deaths which are considered preventable are those that in the light of the understanding of the determinants of health at the time of death, deaths from the underlying cause (subject to age limits where appropriate) could have been avoided through effective public health and primary prevention interventions. Preventable mortality differs from treatable mortality in which the cause of death could potentially be avoided through effective healthcare intervention including secondary prevention and treatment.

Across London and England, the rate of death from preventable causes remained the same between 2019 and 2020. However, in LBHF between 2019 and 2020 the rate of death from preventable causes increased from 148.8 per 100,000 population to 187.7 per 100,000 population[6].

[6] Office for Health Improvement and Disparities (2021). Preventable mortality rate.

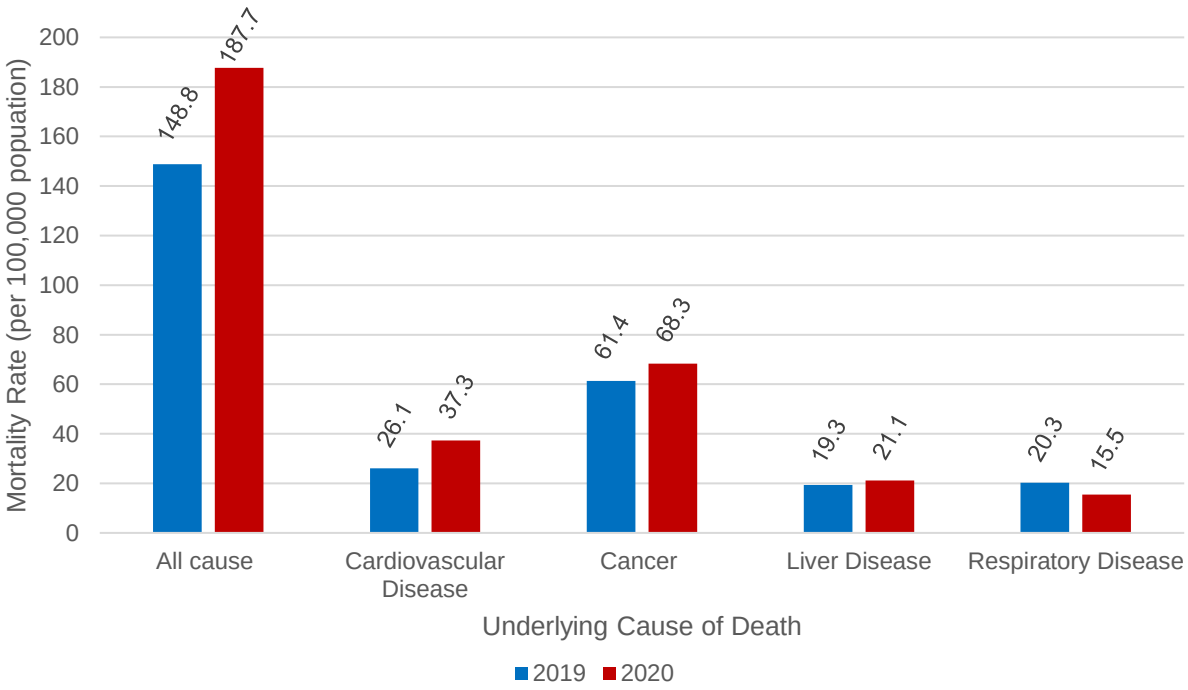
Figure 26. LBHF, London and England resident all-cause preventable mortality, per 100,000 population (2001 to 2020).



Data source: Office for Health Improvement and Disparities (2021). Preventable mortality rate.

In LBHF, the preventable mortality rate increased among certain underlying causes including cardiovascular disease, cancer and liver disease. The preventable mortality rate decreased for deaths from respiratory diseases which decreased by 23.6 percent between 2019 and 2020[7].

Figure 27. LBHF resident preventable mortality rate by underlying cause, 2019 to 2020.



Data source: Office for Health Improvement and Disparities (2021). Preventable mortality rate.

[7] Office for Health Improvement and Disparities (2021). Preventable mortality rate.

2.2 Access to Health Care

The COVID-19 pandemic has challenged the provision of healthcare services and their accessibility. Due to significant strain on healthcare services during the pandemic, many resources and staff were diverted from routine service provision to treatment of COVID-19 cases. The diversion of staff and resources, combined with fewer patients seeking care during lockdowns, means that there have been a significant drop in elective procedures, cancer referrals, cancer treatment, sexual health screening as well an increase in diagnostic waiting times.

In particular there have been significant disruptions to NHS services for residents with long-term health conditions, particularly hospital and outpatient care[8]. However, during the pandemic community-based care has remained available for residents managing long-term conditions. According to the COVID-19 survey, conducted as part of the UK Household Longitudinal Study, it was found that in April 2020 across the UK 63 percent of respondents with long-term health conditions who needed NHS treatment did not receive it as the NHS had temporarily stopped their treatment, and a further 10 percent of respondents cancelled appointments themselves. For respondents with a long-term health condition receiving outpatient services, 42 percent of appointments were cancelled by the NHS and 7 percent cancelled by the patient themselves.

By contrast community services, including General Practitioner (GP) services and pharmacies, were largely able to continue throughout the pandemic, with 98 percent of respondents to the COVID-19 survey being able to still obtain prescription medications, 73 percent of respondents were able to receive GP services and 65 percent of respondents were able to see a pharmacist.

Furthermore, a YouGov survey of over 6,000 people with long-term conditions across the UK found that some of the largest falls in health service use were among people receiving mental health services and cancer treatment, with a fall of 25 percent and 22 percent respectively[9]. Some of this was due to patients not wanting to access services due to either fears of over-burdening the NHS or being afraid of contracting COVID-19. These concerns were particularly high among people with diabetes, heart disease and mental illness. The survey also found that 10 percent of respondents had not been able to access services despite wanting to access them.

2.2.1 Diagnostic Waiting Times

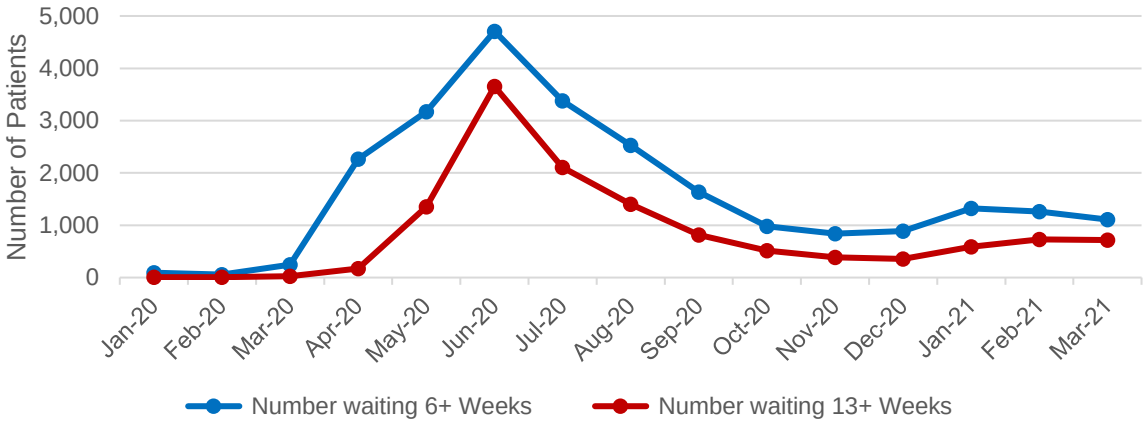
The proportion of individuals waiting six weeks or more for a diagnostic procedure in Hammersmith and Fulham CCG peaked at 63 percent in June 2020.

[8] Understanding Society (2020) Understanding Society COVID-19 survey.
[9] The Health Foundation. (2021) Early insight into the impacts of COVID-19 on care for people with long-term conditions. Available from: https://www.health.org.uk/news-and-comment/blogs/early-insight-into-the-impacts-of-covid-19-on-care-for-people-with-long-term

COVID-19 has substantially impacted diagnostic waiting times and activity across England. The NHS collects data on monthly waiting times for 15 key diagnostic tests: magnetic resonance imagery (MRI); computed tomography; non-obstetric ultrasound; barium enema; DEXA scan; audiology assessments; echocardiography; peripheral neurophysiology; respiratory physiology (sleep studies); urodynamics (pressures and flows); colonoscopy; flexi sigmoidoscopy; cystoscopy; gastroscopy[10].

On average 1 percent of individuals on waiting lists in Hammersmith and Fulham CCG had to wait six weeks or more for a diagnostic test each month between February 2019 and February 2020. However, the onset of COVID-19 in March 2020 increased the proportion waiting six weeks or more to 9 percent and reached a peak of 63 percent in June 2020. After June 2020, the proportion of individuals decreased steadily to reach 20 percent in November 2020. The surge in COVID-19 cases in December 2020 and January 2021 has also contributed to a rise in the proportion of individuals waiting six weeks or more to 30 percent in January 2021. The wave of COVID-19 cases in December 2020 and January 2021 did not lead to such a severe increase in waiting times as the initial wave of COVID-19. The number of individuals on the waiting list waiting for 13 weeks or more followed a similar pattern to the number waiting six weeks or more (Figure 28).

Figure 28. Number of individuals waiting 6+ weeks and 13+ weeks for a diagnostic procedure in Hammersmith and Fulham CCG (January 2020 – March 2021).



Data source: NHS England (2021), Monthly diagnostics waiting times and activity.

2.2.2 Cancer Screening

Between 2019/20 and 2020/21 Breast Cancer Screening uptake decreased by 11.4 percent. However, there was no significant change in uptake for Cervical Cancer Screening between 2019/20 and 2020/21 and there was a 4.4 percent increase in Bowel Cancer Screening in this time period.

NHS England commissions three national population cancer screening programmes: the breast screening programme; and the cervical screening programme; and the bowel cancer screening programme[11]. Breast screening is offered to women aged 50

[10] NHS England (2021) Monthly Diagnostic Waiting Times and Activity.
[11] UK Government (2018) NHS Screening programmes.

to 70 years old. Cervical screening is offered to women aged 25 to 64, with routine screening being offered every three years for those aged 25 to 49, and every five years for those aged 50 to 64. As part of the NHS Bowel Cancer Screening Programme, men and women aged 60-74 are sent a home testing kit every two years to collect a small faecal sample[12].

COVID-19 impacted both uptake (the proportion of individuals invited to screening who participate) and coverage (proportion of eligible population screening within a time frame) of the cancer screening programmes in England in 2020[13].

In Hammersmith & Fulham CCG, cancer screening uptake has been consistently lower than the England average for all three cancer screening programmes since 2009/10. However, since the beginning of the pandemic the greatest reduction in screening uptake was observed in the Breast screening programme. Between 2019/20 and 2020/21 there was a 11.4 percent reduction in the proportion of eligible females being screened for breast cancer; the proportion of eligible women being screened decreased from 58.8 percent in 2019/20 to 47.4 percent in 2020/21[14].

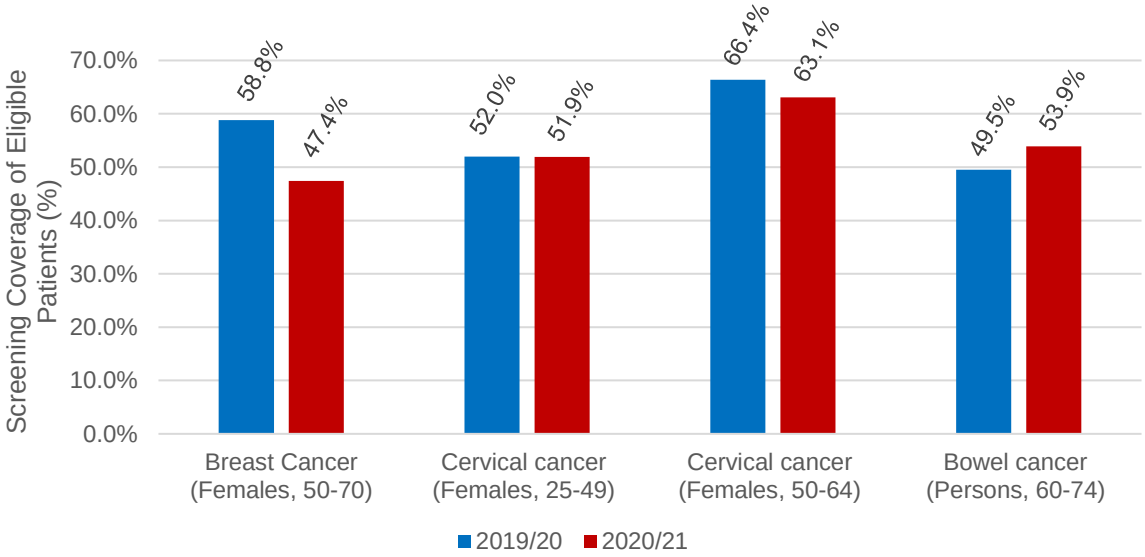
Between 2019/20 and 2020/21, the proportion of eligible women attending cervical cancer screening remained fairly stable. There was no decrease in the proportion of women aged between 25 and 49 attending cervical cancer screening. There was however a 3.3 percent reduction in the proportion of women aged between 50 and 64 who attended cervical screening[12]. As the cervical screening programme is delivered via GPs, there may have been more continuation of the service at the start of COVID-19.

Conversely there was a 4.4 percent increase in bowel cancer screening in H&F CCG from 49.5 percent in 2019/20 to 53.9 percent in 2020/21[15]. This reflects the continuous upwards trend in proportion of eligible patients taking part in bowel cancer screening since 2009/10. Unlike other cancer screening programmes in the UK, participating in bowel screening does not involve any contact with a health professional. Therefore, the bowel screening programme could continue as normal throughout the pandemic.

Research suggests avoidable cancer deaths in England will substantially increase in the medium (one year) and longer term (five years) due to diagnostic delays arising from the COVID-19 pandemic[16]. It is essential to introduce locally-led interventions to increase routine diagnostic capacity in LBHF and to emphasise public health messaging focussed on the importance of attending screening appointments[16].

[12] NHS England. (2021) Screening and earlier diagnosis. Available from: https://www.england.nhs.uk/cancer/early-diagnosis/screening-and-earlier-diagnosis/
[13] Richards, M. (2019) Report of the Independent Review of Adult Screening Programmes in England.
[14] National Health Application and Infrastructure Services (2021) NHS Cancer Screening Programme
[15] Bowel Cancer Screening System (2021) NHS Cancer Screening Programme
[16] Maringe, C., Spicer, J., Morris, M., Purushotham, A., Nolte, E., Sullivan, R., Rachet, B. and Aggarwal, A., 2020. The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study. *The lancet oncology*, *21*(8), pp.1023-1034.

Figure 29. Annual cancer screening uptake between 2018/19 to 2020/21 for Breast cancer, Cervical Cancer and Bowel Cancer among Hammersmith & Fulham CCG patients.



Data source: National Health Application and Infrastructure Services (2021) NHS Cancer Screening Programme
Bowel Cancer Screening System (2021) NHS Cancer Screening Programme

2.2.3 Sexual Health Services

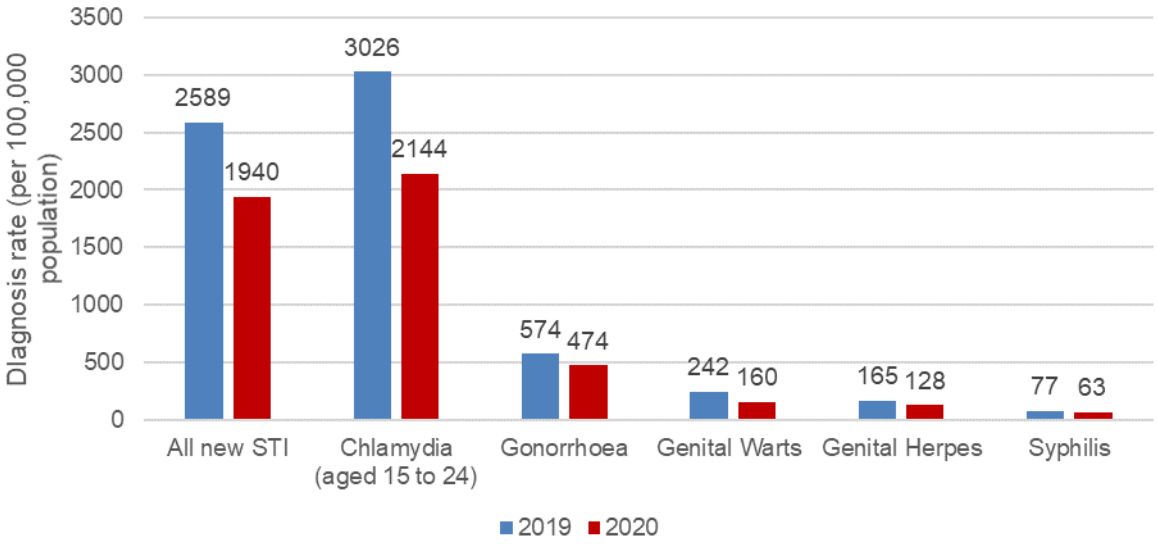
There was a 25.1 percent decrease in Sexually Transmitted Infections between 2019 and 2020 in LBHF.

Due to the government introducing social and physical distancing measures and redeploying health staff to the pandemic response, there was a reduction of clinical services providing care for Sexually Transmitted Infections (STIs)[17]. Between March and May 2020 there was a national decrease in the number of consultations undertaken by Sexual Health Services (SHSs), a decrease in testing for STIs and a decrease in STI diagnosis.

In LBHF, the STI diagnosis rate decreased by 25.1 percent between 2019 and 2020 from 2,589 new STI diagnoses per 100,000 population to 1,940 new STI diagnoses per 100,000 population[18]. Genital warts saw the largest decrease in diagnosis rate between 2019 and 2020; genital wart diagnoses decreased by 33.8 percent between 2019 and 2020 from 242 per 100,000 population diagnosis rates in 2019 to 160 per 100,000 population diagnosis rate in 2020 (Figure 30).

[17] Public Health England (2020), COVID-19: impact on STIs, HIV and viral hepatitis
[18] Public Health England (2020), GUMCAD STI Surveillance System, Public Health England

Figure 30. Diagnosis rate of Sexually Transmitted Infections in LBHF in 2019 and 2020.



Data source: Public Health England (2020), GUMCAD STI Surveillance System, Public Health England

2.2.4 Routine Immunisations

In 2020/21 flu vaccine uptake increased by 5.8 percent from 2019/20. Childhood immunisations decreased by 2 percent between 2019 and 2020. Flu vaccine uptake was lowest in more deprived areas and areas with a higher non-white population. Childhood immunisation uptake was lowest among Black residents.

2.2.4.1 Influenza Vaccination

Seasonal influenza (flu) vaccination helps provide protection against flu strains likely to be circulating in the current year. Flu can lead to hospitalisation or death for some individuals; therefore, flu vaccination is an effective intervention to reduce pressure on the health and social care system[19]. Widespread flu vaccination in the 2020-21 flu season provided a critical opportunity to alleviate the impact on the health and social care system struggling due to COVID-19.

Flu is likely to be more severe if an individual has a long-term health condition or is elderly. Consequently, individuals with long-term health conditions (e.g. diabetes) or aged 65 years and older are eligible for the NHS funded flu vaccination programme. The NHS funded programme also includes pregnant women, children aged between two and eleven, health and social care workers, and individuals required to shield from COVID-19 (and anyone living with them)[19]. Free flu vaccinations extended to individuals aged 50 and over from 01 December 2020 due to COVID-19[20].

The proportion of patients eligible for a free flu vaccination in H&F CCG substantially increased between the 2019-20 and 2020-21 flu season due to the addition of

[19] HM Government (2020) The flu vaccination winter 2020 to 2021: who should have it and why.
[20] HM Government (2020) Press release: Free flu vaccinations rolled out to over 50s from December.

individuals aged 50 and over becoming eligible for the NHS-funded flu vaccination programme. Excluding the 50-64 cohort, the total flu vaccination uptake increased from 40.3 percent in 2019-20 to 46.1 percent in 2020-21 for individuals eligible for a free flu vaccination (Table 11).

Flu vaccination uptake for individuals aged 65 and over in H&F CCG in 2020-21 (60 percent) did not achieve the WHO target uptake for individuals aged 65 and over of 75 percent (Table 11). Individuals aged 65 years and above had the smallest increase with an additional 2.8 percent of eligible individuals receiving the vaccine in 2020-21 compared to 2019-20. The relatively low increase for individuals aged 65 and above is partially due to the category having the highest base uptake. Children aged between two and three had the largest increase in uptake between the 2019-20 and 2020-21 season increasing from 30 percent to 41.3 percent. The proportion of pregnant women and individuals with chronic health conditions receiving the vaccine increased by an additional 4.6 percent and 9.2 percent respectively between the vaccination periods.

Table 11. Flu vaccination uptake among eligible patients (%) 2019-20 and 2020-21.

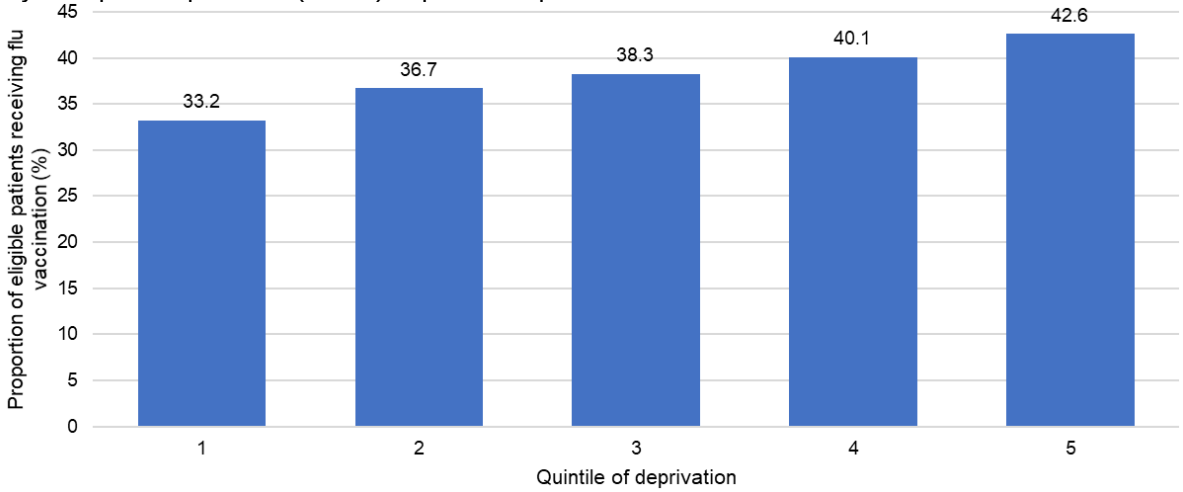
	Individuals aged 65+	Individuals with chronic health condition	Pregnant women	Children aged 2 - 3	Individuals aged 50-64	Total
2019-20	58.3	28.7	29.6	30	-	40.3
2020-21	61.1	37.9	34.2	41.3	17.9	46.1*

Data source: North West London Collaboration of Clinical Commissioning Groups (2021). Whole Systems Integrated Care (WSIC) Dashboards, Flu vaccinations 2020-21; Public Health England (2020) Vaccine uptake guidance and the latest coverage data. Data updated as of 9:00 on 11 March 2021.
*Excluding 50-64 years cohort

Males, individuals living in more deprived area and in areas with a higher proportion of non-White residents have been shown to have marginally lower flu vaccination rates in the UK[21]. Analysis of the flu vaccination uptake in 2020-21, indicate individuals living in LBHF neighbourhoods classified as the 20 percent most deprived in England have lower rates of flu vaccination uptake (Figure 31).

[21] Coupland, C., Harcourt, S., Vinogradova, Y., Smith, G., Joseph, C., Pringle, M. and Hippisley-Cox, J., 2007. Inequalities in uptake of influenza vaccine by deprivation and risk group: time trends analysis. Vaccine, 25(42), pp.7363-7371.

Figure 31. Proportion of individuals eligible for the flu vaccination vaccinated in 2020-21, by Lower Layer Super Output Area (LSOA) deprivation quintile.



Data source: North West London Collaboration of Clinical Commissioning Groups (2021). Whole Systems Integrated Care (WSIC) Dashboards, Flu vaccinations 2020-21. Data updated as of 9:00 on 11 March 2021; Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2019.

2.2.4.2 Childhoods immunisations

The proportion of children receiving routine childhood immunisations substantially decreased in 2020 compared to 2019 in England, according the Public Health England (PHE)[22]. The analysis using ImmForm data, indicated vaccination coverage for the first measles, mumps and rubella (MMR1) vaccine measured at 18 months was 2 percent lower in 2020 than 2019. The decrease may be associated with stay at home messaging, despite stipulations that childhood immunisations would continue operating[22].

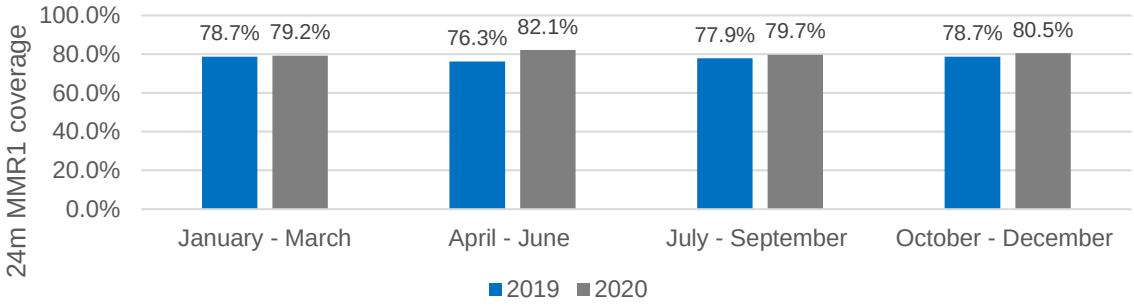
However, quarterly data pertaining to LBHF from the Cover of Vaccination Evaluated Rapidly (COVER) program indicated coverage for MMR1 by 24 months was higher in 2020 compared to 2019 (Figure 32a). Coverage for DTaP/IPV/Hib (combination vaccine for diphtheria, tetanus and pertussis – DtaP; inactivated polio vaccine – IPV; haemophilus influenzae type b – Hib) by five years was lower between January – March 2020 compared to the same period in 2019 (Figure 32b). However, between April and June 2020, and July and September 2020, DTaP/IPV/Hib coverage exceed coverage in the same months in 2019. The results therefore indicate COVID-19 did not substantially impact childhood immunisation coverage

The contrast in results between LBHF and England may be due to PHE analysis referring to ImmForm and referring to coverage at different age points. Furthermore, the COVER programme data is quarterly therefore the aggregated results may mask weekly variations in vaccination coverage between 2019 and 2020.

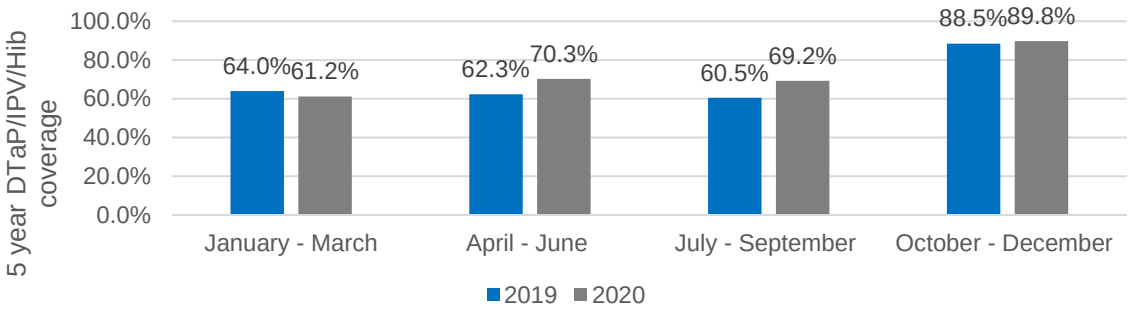
[22] Public Health England (2021) Impact of COVID-19 on childhood vaccination counts to week 4 in 2021, and vaccine coverage to December 2020 in England: interim analyses.

Figure 32. Childhood immunisation coverage in 2019 and 2020 for **(a)** MMR1 coverage at 24 months and **(b)** DTaP/IPV/Hib coverage at five years.

32a)



32b)



Data source: Public Health England (2021) Cover of vaccination evaluated rapidly (COVER) programme: quarterly data.

The proportion of children receiving flu immunisations varies between socio-demographic groups. Evidence from across the UK indicates marked differences in childhood immunisation uptake between ethnic groups[23]. Analysis of childhood immunisation uptake in LBHF using Child Health Information Services (CHIS) data indicated African, Caribbean and Black British communities had the lowest uptake of childhood vaccinations at 12 months, 24 months and five years in 2020[24].

CHIS do not provide detailed data on ethnicity, therefore cultural-specific factors cannot be explored with accuracy through the available data. A focus group conducted in LBHF with Somali parents revealed some individuals had concerns surrounding the MMR vaccine in particular. However, participants still immunised their children despite concerns due to the prevailing view that vaccinations were beneficial for their children's overall wellbeing[24].

Further research is essential to understand the barriers to vaccination uptake between ethnic communities and identify priorities that will lead to system-wide change.

[23] Forster, A.S., Rockliffe, L., Chorley, A.J., Marlow, L.A., Bedford, H., Smith, S.G. and Waller, J., 2017. Ethnicity-specific factors influencing childhood immunisation decisions among Black and Asian Minority Ethnic groups in the UK: a systematic review of qualitative research. *J Epidemiol Community Health*, *71*(6), pp.544-549.

[24] Hammersmith and Fulham Council (2021). Childhood Immunisation JSNA 2021.

2.3 Individual Health Behaviours

Increased levels of stress, due to COVID-19 is a risk factor for the onset of alcohol and substance misuse. Compounded by advice to avoid social contact, increased isolation may lead to excessive alcohol consumption and relapse in addicted individuals.

2.3.1 Alcohol-Related Health Problems

In 2020/21 there was a 25.6 percent decrease in the number of adult LBHF residents in contact with specialist alcohol misuse services compared to 2019/20.

In the weeks prior to the initial lockdown in the UK, alcohol sales were up by 67 percent, meanwhile general supermarket sales increased by only 43 percent. Several studies have also found that between a fifth and a third of people reported drinking more during lockdown[25].

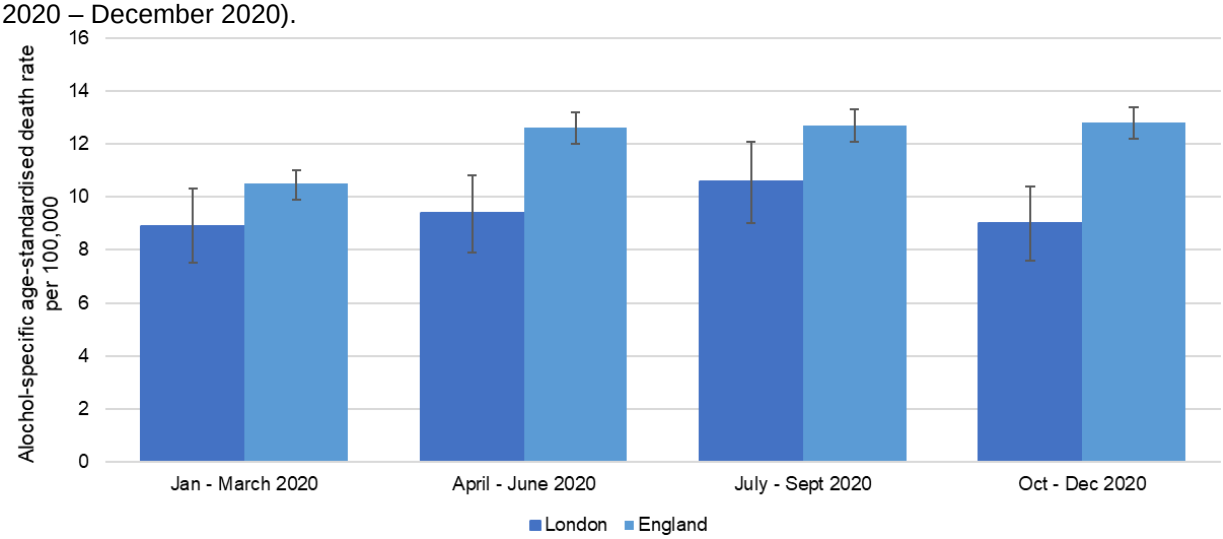
However, between 2019/20 and 2020/21 there was a 25.6 percent decrease in the number of adults in contact with specialist alcohol misuse services in LBHF; from 390 residents in 2019/20 to 290 residents in 2020/21[26]. However, presented with the national increase in alcohol sales, this reduction in the number of residents in contact with specialist alcohol misuse services may not be due to a decrease in need but rather an increase in barriers to services including the redeployment of health staff, as well as a reduction in the provision of client facing services due to social distancing requirements. Alcohol misuse services must be reinforced in order to avoid an increase in alcohol-related health problems exacerbated by the COVID-19 pandemic.

Between April and December 2020, alcohol-specific deaths in England exceeded all levels on record. Age-standardised deaths alcohol-specific deaths peaked between October and December 2020 at 12.8 per 100,000 in England. Rates were lower in London comparatively to England, peaking at 10.6 per 100,000 between July and September 2020 (Figure 33)[27].

The increase in alcohol-specific deaths relative to the same periods in previous years, as well as the jump in deaths before and after the national lockdown restrictions, suggests COVID-19 may have contributed to the increase in alcohol-specific deaths. However, the complexity of the interaction and other social factors is complex and further research is required to understand the mechanisms behind the rise in alcohol-specific deaths the data indicates.

[25] Alcohol Consumption during the COVID-19 lockdown; summary of emerging evidence from the UK (2020) Institute of Alcohol Studies
[26] Adults in Treatment (2021) National Drug Treatment Monitoring System
[27] Office for National Statistics (2021). Quarterly alcohol-specific deaths in England and Wales.

Figure 33. Alcohol-specific age-standardised death rate per 100,00 for London and England (January 2020 – December 2020).



Source: Office for National Statistics, 2021. Quarterly alcohol-specific deaths in England and Wales.

2.3.2 Drug-Related Health Problems

The number of adults receiving treatment for drug addiction remained stable compared to 2019. However, the number of residents who died from drug poising reached the highest number since records began in 1993.

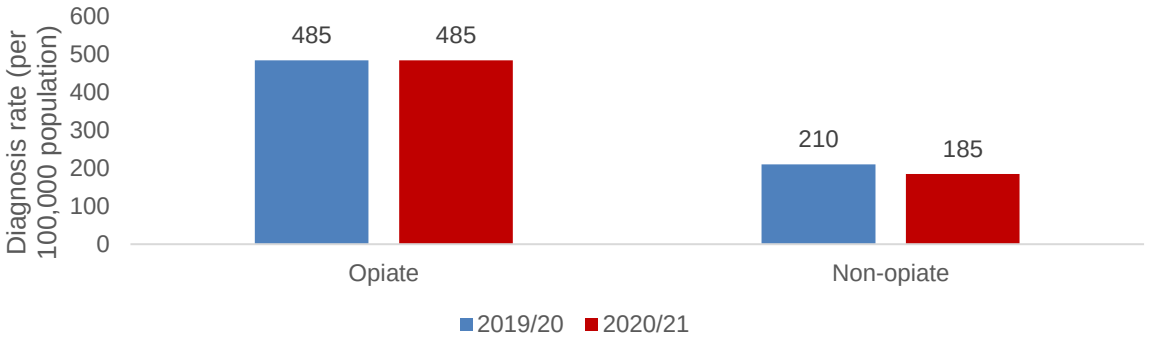
During the COVID-19 pandemic, residents with substance use disorders have faced difficulties including access to clinical services, as well as the psychological impacts of COVID-19 and related lockdowns. Moreover, social and economic changes caused by the pandemic have also impacted residents with substance use disorders.

In LBHF, 485 residents received treatment for opiate addiction and 185 received treatment for non-opiate addiction. This does not present a significant change from 2019, when 485 LBHF residents received treatment for opiate addiction and 210 received treatment for non-opiate addiction (Figure 34). Across England, there was a 0.2 percent increase in the number of adults receiving treatment for an opiate addiction and a 9.4 percent increase in the number of adults receiving treatment for a non-opiate addiction[28].

Across England and Wales 4,561 deaths related to drug poisoning were registered in 2020, which is the highest number since records began in 1993, and a 3.8 percent increase since 2019. In LBHF, there were 34 deaths in 2020 related to drug poisoning, which is the highest number from all London Boroughs. This is the highest number on record since 1993 in LBHF, and a 161.5 percent increase since 2019[29].

[28] Adults in Treatment (2021) National Drug Treatment Monitoring System
[29] Office for National Statistics. Drug-related deaths by local authority, England and Wales [Internet]. Ons.gov.uk.2021. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority

Figure 34. The number of adult residents in LBHF who are in treatment for opiate and non-opiate addiction, 2019 & 2020.



Source: Adults in Treatment (2021) National Drug Treatment Monitoring System

2.3.3 Smoking

There has been no change in the proportion of smoking mothers in LBHF since the beginning of the pandemic.

According to a World Health Organisation (WHO) study, evidence suggests that smoking is associated with increased severity of COVID-19 disease as well as an increased risk of death among hospitalised COVID-19 patients[30].

Nationally, between the first quarter of 2020 (January to March) and quarters 2 to 3 (April to December) of 2020, the proportion of adults in the UK smoking dropped from 13.8 percent to 12.3 percent[31]. Furthermore, according to a survey by YouGov and Action on Smoking and health, more than 300,000 adults may have quit smoking during the pandemic, with smokers showing an increased motivation to quit and to stay smoke free during the pandemic. This is likely due to fears of smoking making people more vulnerable to COVID-19[32].

In 2020, 10.1 percent of adult residents recorded themselves as current smokers[33]. However, there is no historical data regarding smoking prevalence in LBHF, therefore we cannot determine whether the pandemic has had any impact on smoking prevalence. However, among mothers at the time of delivery there has been no change in the prevalence of smoking since the beginning of the COVID-19 pandemic. In 2019/20, 2.8 percent of mothers in LBHF were smoking at the time of delivery, and in 2020/21 this remained the same with 2.8 percent of mothers reporting that they were current smokers at the time of delivery[34].

[30] World Health Organisation. (2020) Smoking and COVID-19
[31] Office for National Statistics. (2020) Smoking prevalence in the UK and the impact of data collection changes: 2020.
[32] Action on Smoking and Health (2020) ASH Daily News for 4 May 2020
[33] Office for National Statistics. (2020) Annual Population Survey
[34] NHS Digital. (2021) Statistics on Women's Smoking Status at Time of Delivery

2.3.4 Physical Activity and Diet

Before the pandemic, LBHF residents were more physically active and has a lower prevalence of obesity than the local and national average. We do not yet know how the pandemic has affected this in LBHF.

The COVID-19 pandemic has disrupted physical activity among children and adults. Sport England has found that groups that were least active before lockdown, including those on low income, found it harder to be physically active during lockdown[35]. Furthermore, StreetGames found that over two-thirds (68 percent) of young people reported that their activity levels had dropped[36].

In LBHF, 74.3 percent of adults reported being physical active in 2019/20. This is higher than the London prevalence (65.2 percent) and the England prevalence (66.4 percent). However, no data is yet available to show the impact of COVID-19 on physical activity.

The COVID-19 pandemic has increased food insecurity in many areas and further exacerbated diet-related health inequalities. The Food Foundation estimated that the number of adults experiencing food insecurity in Britain quadrupled under lockdown[37]. However, the National Diet and Nutrition Survey found that diet during the COVID-19 pandemic was broadly similar at a population level to pre-COVID-19 surveys[38].

Excess weight has shown to be associated with an increased risk of COVID-19 hospitalisation, more advanced levels of treatment (including mechanical ventilation) and death. Furthermore, according to PHE 41 percent of adults in England have gained weight during the pandemic[39]. This is likely due to disrupted daily routines impairing physical activity, as well as some people reporting an increase in snacking and comfort eating during this time period. In 2019/20, 41.6 percent of adults and 34.6 percent of children in Year 6 were classified as overweight or obese[4041]. Among both adults and children, the prevalence of being overweight or obese is lower than the London average (55.7 percent for adults and 38.2 percent for children) and the England average (62.8 percent of adults and 35.2 percent for children). However, no data is yet available to show the impact of COVID-19 on weight in LBHF.

2.4 Mental Health and Wellbeing

[35] Sport England. (2022) Coronavirus
[36] StreetGames. (2020) The experience of the coronavirus lockdown in low-income areas of England and Wales.
[37] Loopstra R. (2020) Vulnerability to food insecurity since the COVID-19 lockdown. Preliminary report. London: The Food Foundation, Kings College London.
[38] Public Health England. (2021) NDNS: Diet and physical activity – a follow-up study during COVID-19.
[39] Public Health England. (2021) Campaign launched to help public get healthy this summer.
[40] Sport England (2021) Active Lives
[41] NHS Digital. (2021) National Child Measurement Programme

The impact of COVID-19 on mental health in the UK remains unclear as new evidence emerges. Studies analysing the UK Household Longitudinal Study (UKLHS) data found average mental distress was 8 percent higher in April 2020 than the average between 2017 and 2019[42], and the proportion of individuals experiencing sleep problems increased from 16 percent before the pandemic to 25 percent in April 2020[43].

Studies indicate women and young adults (aged 18-34) were more likely to report a decline in mental health during the first national lockdown in March 2020[44]. One study indicated males identifying as Black, Asian and Minority Ethnic (BAME) were identified as reporting a larger decline in mental health than males identifying as White British during the first national lockdown[45].

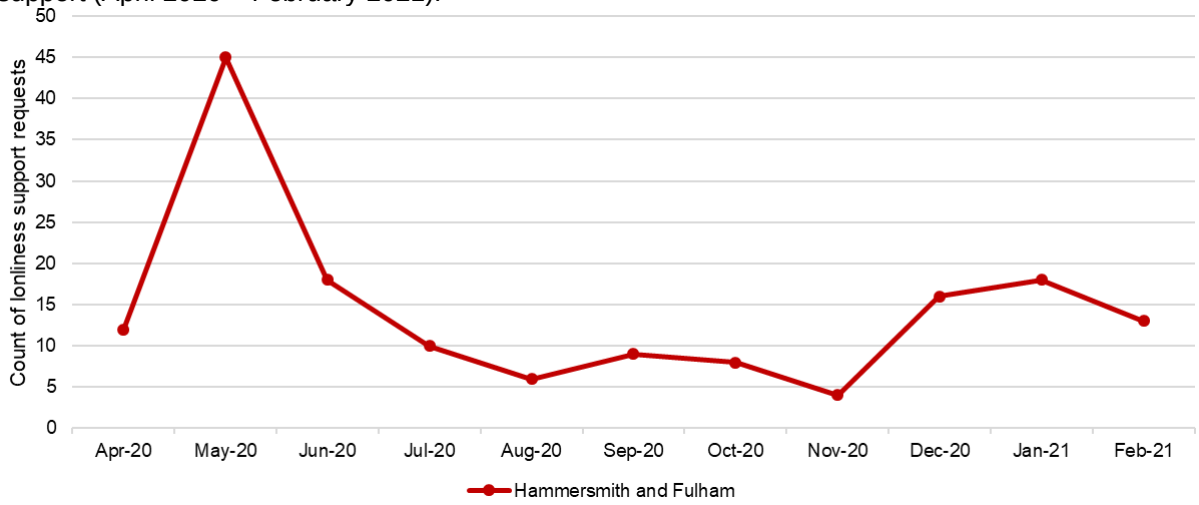
2.4.1 Loneliness

LBHF CAN and Shield received 163 support requests for loneliness from residents between 30 April 2020 and 08 March 2021. Monthly requests peaked in May 2020 at 45 support requests.

Between 30 April 2020 and 08 March 2021, CAN and Shield received a total of 163 support requests concerning loneliness in LBHF (Figure 35). Monthly support requests for loneliness peaked in May 2020, before declining in the summer months. The second peak in monthly support requests for loneliness occurred in January 2021 during the national lockdown restrictions, reflecting the impact of these measures on mental health. Detail concerning referral type and demographics of residents requesting support for loneliness is not available. However national data suggests between June and July 2020, older adults who were shielding were more likely to report high levels of depression, anxiety and loneliness[46]. The CAN and Shield call centre organises 'buddy' phone calls for individuals suffering from loneliness after support is requested to provide them with support through difficult times.

[42] Banks J, Xu X. The mental health effects of the first two months of lockdown and social distancing during the COVID-19 pandemic in the UK. The IFS; 2020
[43] Falkingham J, Evandrou M, Qin M, Vlachantoni A. Sleepless in Lockdown: unpacking differences in sleep loss during the coronavirus pandemic in the UK. medRxiv. 2020 Jul 21;2020.07.19.20157255.
[44] HM Government (2021) COVID-19: mental health and wellbeing surveillance report.
[45] Proto E, Quintana-Domeque C. COVID-19 and Mental Health Deterioration among BAME Groups in the UK. 2020;56
[46] Steptoe and Steel (2020). The experience of older people instructed to shield or self-isolate during the COVID-19 pandemic.

Figure 35. Shield and Community Aid Network (CAN) completed and pending requests for loneliness support (April 2020 – February 2021).



Data source: Hammersmith and Fulham Council (2021). Shield and CAN Completed and Pending Support Requests for Loneliness.

2.4.2 Improving Access to Psychological Therapies (IAPT)

The number of individuals referred to talking therapies across all providers in Hammersmith and Fulham CCG substantially decreased between February and March 2020 from 895 to 145 referrals.

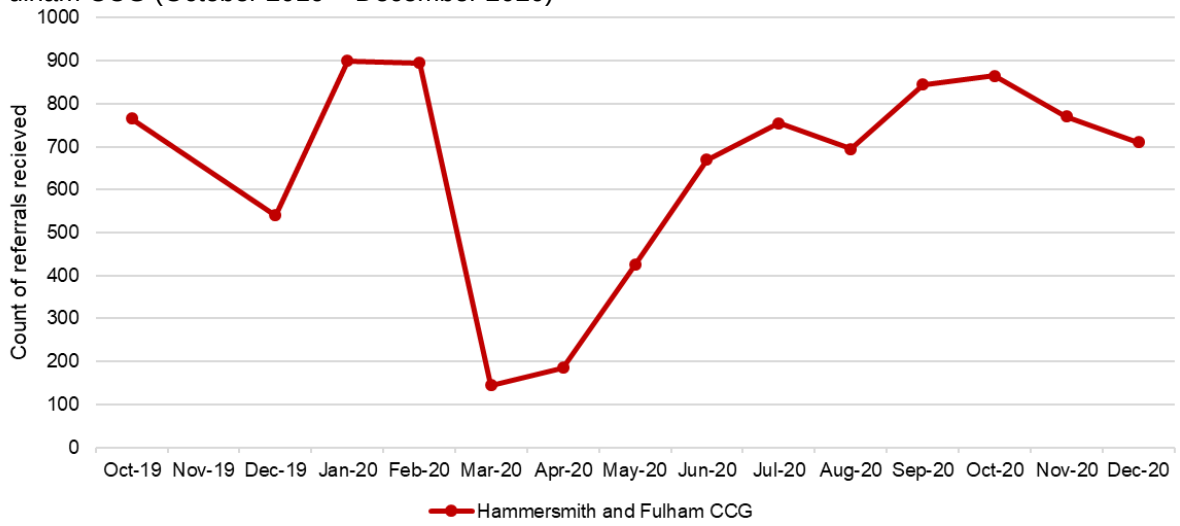
Improving access to psychological therapies (IAPT), delivered by NHS England, offers The National Institute for Health and Care Excellence (NICE)-approved therapies to individuals with depression or anxiety[47].

The number of individuals referred to talking therapies across all providers in Hammersmith and Fulham CCG decreased by 83.8 percent between February 2020 and March 2020 from 895 to 145 (Figure 36). Referrals rapidly increased between May and October 2020 to levels prior to COVID-19, before declining in November and December 2020.

Although internet enabled therapy sessions allow psychological therapies to continue during COVID-19, the decrease in referrals to IAPT across all providers in Hammersmith and Fulham CCG during lockdowns indicate these restrictions impact access to mental health services. The increase in average mental distress during the COVID-19 pandemic emphasises the importance of patients receiving mental health support during these times. It is likely the current levels of need are higher than prior to the pandemic, yet referrals did not increase to the same level in January and February 2020.

[47] NHS Digital (2021) Psychological Therapies, Report on the use of IAPT services.

Figure 36. Count of referrals received for talking therapies across all providers in Hammersmith and Fulham CCG (October 2019 – December 2020)



Data source: NHS Digital (2021) Psychological Therapies, Report on the use of IAPT services.

2.4.3 Dementia Diagnosis

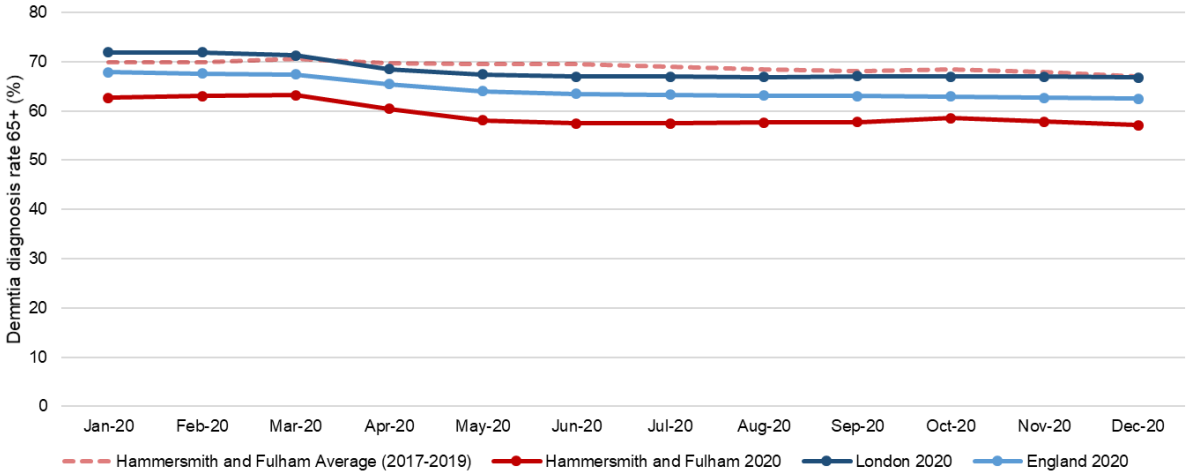
In 2020 Dementia diagnoses rates fell by 9.7 percent in LBHF compared to the 2017-2019 average.

The dementia diagnosis rate is the percentage of individuals estimated to have dementia who have a diagnosis of dementia. Between March 2020 and April 2020, dementia diagnosis rate for individuals aged 65 years and older fell by 2.8 percent in Hammersmith and Fulham, and London, and 2 percent across England[48] (Figure 37). The trend is likely due to decreased access to services in which assessment and diagnosis for dementia occurs[49].

The dementia diagnosis rate for individuals aged 65 years and older in Hammersmith and Fulham between January and December 2020 was lower than the average in the same months in 2017 to 2019. The marginal difference between the two diagnosis rates over the 12-month period was 9.7 percent. However, the marginal difference increased between April to December, compared to January to March. Without a dementia diagnosis, individuals are unable to access practical, financial and emotional advice regarding their condition.

[48] NHS Digital (2021) Recorded Dementia Diagnosis December 2020.
[49] Office for Health Improvement and Disparities (2020) Wider impact so COVID-19 on health monitoring

Figure 37. Dementia diagnosis rates for individuals aged 65 years and older (January 2020 – December 2020).



Data source: NHS Digital, Recorded Dementia Diagnoses December 2020

2.5 Multidisciplinary Teams

Local investigations of outbreaks and COVID-19 complex cases indicate individuals with chaotic lives and dual diagnosis are often concomitant with the need for mental health and substance misuse support.

In March 2020, Multidisciplinary Teams (MDTs) were established to aid individuals with complex support needs testing positive by delivering integrated and person-centred care.

Individuals were referred to the Director of Public Health (DPH) for LBHF by a range of organisations (e.g. Metropolitan Police, Community Safety Team) when an individual with complex support needs had been identified. The DPH then mobilised a core MDT to address the support needs of the individual.

The success of MDT interventions was evaluated qualitatively which illustrated the process enabled efficient delivery of integrated care and support.

Multidisciplinary Teams: Case Study

- In July 2020, PHE contacted DPH to notify them about a man in his 50s who was discharged from hospital however had tested positive to COVID-19.
- The individual did not want to isolate and had complex health support needs:
    - Wheelchair user
    - Required mental health support
    - Complex social needs but refusing care
    - Alcohol user
    - Incontinent
- DPH assembled MDT including an A&E consultant, individuals from LBHF Council housing team, Adult Social Care and PHE.
- The MDT arranged:
    - Several care visits daily and care review from senior ASC manager
    - Enhanced cleaning
    - Care review from senior ASC manager
    - Licencing action for corner shop where individual purchased alcohol.
- The individual now lives in extracare accommodation.

2.6 Long COVID

Long COVID modelling indicates 1,525 women and 1,085 men have Long COVID (symptoms after 5 weeks) in LBHF at any one time.

NICE defines Long COVID as "signs and symptoms persisting after the first four weeks"[50]. Long COVID therefore encompasses both ongoing symptomatic COVID-19 (signs and symptoms of infection from 4–12 weeks) and post-COVID-19 syndrome (signs and symptoms of infection consistent with COVID-19 lasting longer than 12 weeks).

Long COVID symptoms are wide ranging and may include: generalised symptoms (fatigue, fever, pain); respiratory symptoms; cardiovascular symptoms; neurological symptoms; gastrointestinal symptoms; musculoskeletal symptoms; psychological symptoms; ear, nose, and throat symptoms; and dermatological symptoms.

The ONS Coronavirus (COVID-19) Infection Survey (CIS) investigated prevalence of Long COVID with a nationally representative sample of the UK population. Analysis based on over 20,000 CIS participants who tested positive for COVID-19 from a swab sample during study follow-up between 26 April 2020 and 6 March 2021 found 21 percent of individuals who tested positive for COVID-19 from a swab sample continued to report a symptom at least 5 weeks after time of infection[51].

[50] NICE (2021) Scenario: Managing long-term effects.
[51] ONS (2021) Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 April 2021

LBHF conducted a short modelling exercise on the prevalence Long COVID based on COVID-19 positive cases with complete age and gender data. The modelling based estimates on 12,438 positive tests recorded in LBHF.

At 5 weeks, a higher percentage of female study participants (23.0 percent) reported persistent symptoms than male participants (18.7 percent) in the UK[51]. When extrapolated to the LBHF population, estimates suggest approximately 1,525 women have experienced or are experiencing Long COVID, compared to 1,085 men in LBHF.

The ONS CIS study found the age group that experienced the highest prevalence of Long COVID, at 5 weeks after a positive test, was 35-49 age group, at 25.6 percent[51]. When extrapolated the LBHF population, an estimated 811 LBHF residents aged 35 to 49 have experienced or are experiencing Long COVID (Table 12).

Table 12. Prevalence of Long COVID in UK population extrapolate to LBHF population, by age group (1 April 2021).

Age group (years)	**Prevalence of Long COVID, UK Study (%)** (5 weeks post infection)	**Estimated number of LBHF residents who have experienced or are experiencing Long COVID** (5 weeks post infection)
2-11	9	55
12-16	13	58
18 - 24	17	291
25-34	23	783
35-49	26	811
50-69	25	561
70+	16	139

Data sources: ONS (2021) Coronavirus (COVID-19) Infection Survey, 1 April 2021.

NHS England and NHS Improvement published a Five-Point Plan[52] for 'Long COVID support' in 2020 including:

1. New guidance on a clinical case definition.
2. Establishment of Your COVID Recovery platform, a tailored online rehabilitation programme enabling patients to be monitored by local rehabilitation teams.
3. Designated post-COVID assessment services.
4. National Institute for Health Research (NIHR) funded research on Post-COVID-19 syndrome.
5. Establishment of NHS Long COVID taskforce.

[52] NHS England. Post-COVID syndrome (Long COVID) [Online]. Available from: https://www.england.nhs.uk/coronavirus/post-covid-syndrome-long-covid/. Accessed 01 July 2021.

2.7 Shielding

As of 12 March 2021, 14,562 LBHF residents were shielding and LBHF CAN & Shield had received 13,071 support requests.

The UK government advised CEV individuals to shield throughout most of the COVID-19 pandemic. The UK government sent letters to CEV individuals which were received by 29 March 2020 advising them to stay at home as much as possible[53]. Unlike the general population during the third national lockdown, the government advised CEV individuals to not attend work if they were unable to work at home.

Shielding CEV individuals are able to register for shielding support via the government website. The service enables individuals to ask for priority access to supermarket deliveries and their local authority to contact individuals about any support that they are entitled to[53]. LBHF introduced two initiatives to support shielding residents and other residents with support needs arising due to COVID-19 in March 2020: Conversation Matters and the CAN.

2.7.1. CAN and Shield

In March 2020, LBHF identified the need for a CAN to support residents impacted by COVID-19. Support was essential for individuals at high risk (clinically extremely vulnerable) from COVID-19 who were advised to shield. LBHF CAN launched on 18 March 2020, prior to the announcement of national lockdown restrictions, illustrating the early and proactive response of LBHF. Assistance provided included support with food, loneliness, isolation, mental health, domestic abuse, and addiction.

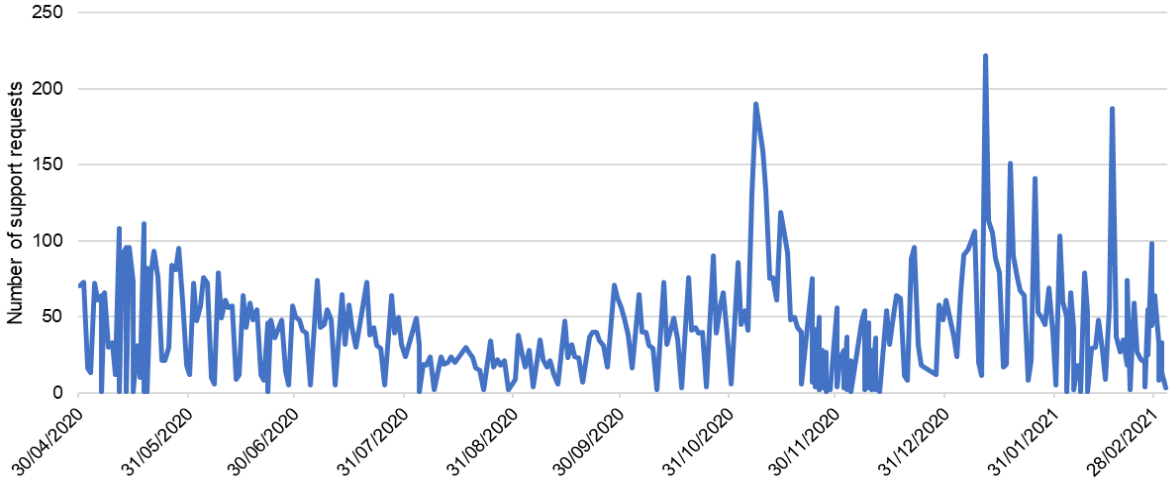
Teams across the council were mobilised to establish a local CAN and shield contact centre established to act as a first point of contact for residents in need. Call centre employees were then recruited and trained. The LBHF Council website advertised recruitment of CAN volunteers. Volunteers could apply for a variety of roles and went through the relevant compliance checks. Volunteers were then deployed to residents requiring support and to signpost residents to relevant services. LBHF CAN worked closely with existing and independent organisations – including charities, food banks and mutual aid groups to provide the best service to residents.

Dashboards enabled the success of the CAN and Shield initiative to be evaluated in real-time. Customer and volunteer feedback were assessed, and relevant learning points fed back into the CAN and Shield system. The CAN and Shield team emphasised the importance of clear descriptions for CAN volunteer roles and a focus on recruiting a small number of dedicated volunteers. 13,071 support requests have been made to CAN and Shield between March 2020 and March 2021. Support requests peaked during the second national lockdown (November 2020) and the

[53] Department of Health and Social Care and Public Health England (2021). Guidance on shielding and protecting people who are clinically extremely vulnerable.

third national lockdown (January 2021 onward) (Figure 38). The outcome for the majority of support requests was referral to a food bank (61 percent) (Figure 39).

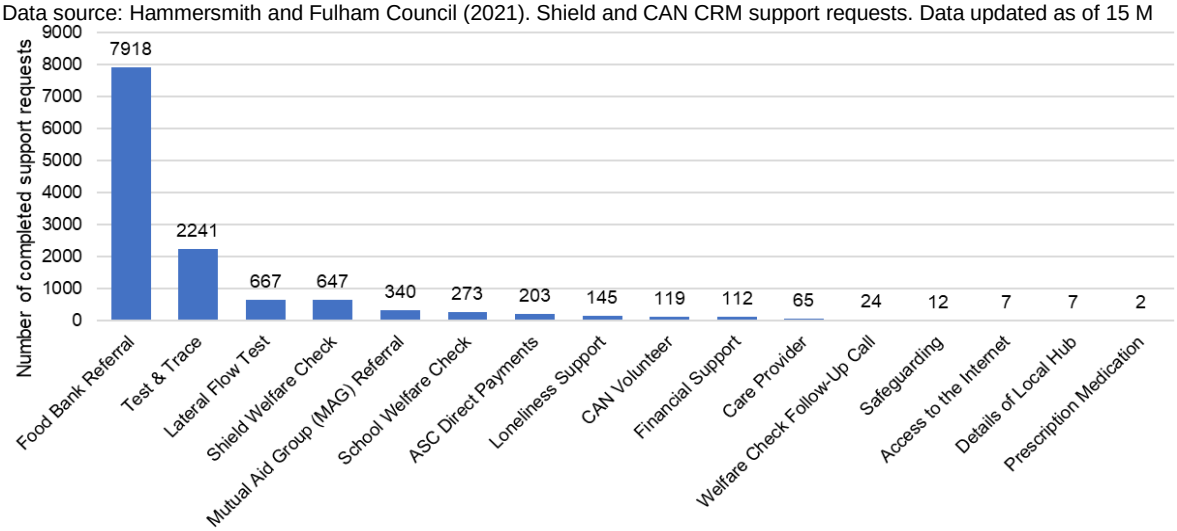
Figure 38: Support requests to CAN and Shield by month (01 March 2020 – 15 March 2021).



Data source: Hammersmith and Fulham Council (2021). Shield and CAN CRM support requests. Data updated as of 15 March 2021.

Figure 39: Outcome of support requests to CAN and Shield (01 March 2020 – 15 March 2021)

Data source: Hammersmith and Fulham Council (2021). Shield and CAN CRM support requests. Data updated as of 15 M



Data source: Hammersmith and Fulham Council (2021). Shield and CAN CRM support requests. Data updated as of 15 March 20

CAN and Shield: Case Study

The following comments give an overview of resident's feedback regarding the CAN volunteer service:

- "Just keep doing what you are doing. 100 percent happy with service received from the whole team"
- "Positivity and helpfulness is needed at this time. Want nothing more than a smiley face over the phone or at your door. Being able to feed your child with what he needs means a lot. This service was my saviour."
- "Yes, would without a doubt recommend this service to a friend"
- "The volunteer was on time, understanding, respectful, efficient and managed to keep a professional manner without losing a sense of kindness and care. Her experience and age was a comfort that she understood the correct respect, manners and approach when someone is vulnerable and worried."

2.7.2. Conversations Matters

In addition to CAN, Conversations Matters was also established in March 2020 as a telephone support service for older and disabled adults as well as for unpaid carers. The service is for any adult with care and support needs; however, the adult does not have to be eligible, or in receipt of Care Act provisions to access the service. Individuals who are shielding and require support are also able to access the Conversations Matter service.

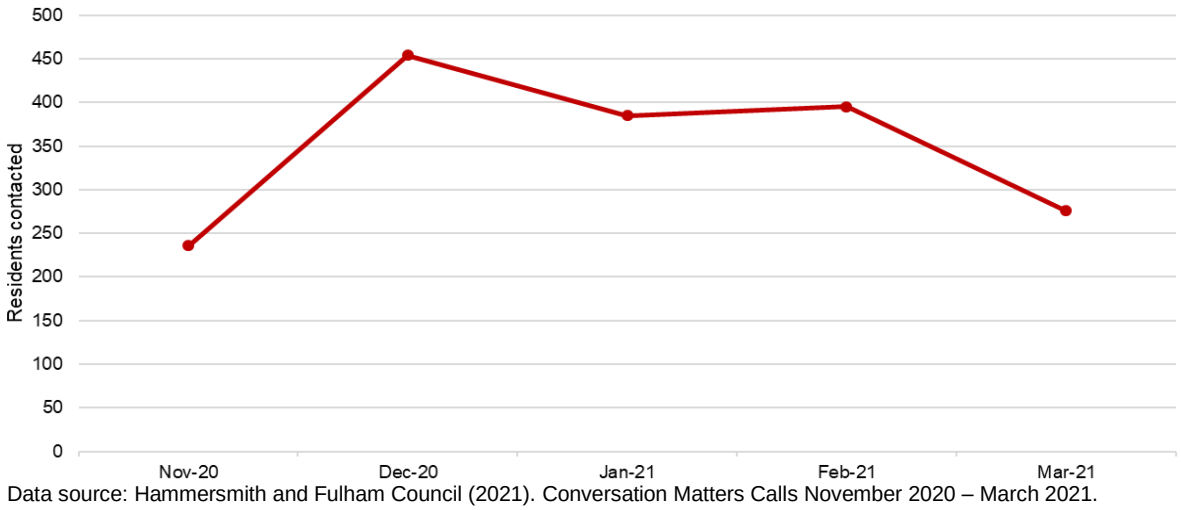
The service aims to ensure individuals received appropriate support to maintain their independence and wellbeing. Support included ensuring individuals had access to food and medication, as well as providing reassurance to residents and support for isolation. In addition to providing information and advice service, Conversations Matter connects people to a range of independent, community and voluntary sector organisations, providing shopping, community meals, domestic cleaning, laundry, gardening services as well as leisure, social and recreational activities, connecting residents to their community, and keeping them active and healthy for longer.

The Conversations Matters Team contacted at-risk residents who had registered for shielding support on the government website. Due to the volume of at-risk residents identified, individuals were given a priority rating to enable prioritisation of those most in need. Phone calls used a wellbeing checklist to identify any issues or risks faced by residents. Once identified, the Conversations Matters team identified the relevant steps required to meet the resident's support needs. Residents could request regular call backs (daily, weekly or monthly) to ensure the service could respond to any changes in support need. Welfare visits were also provided to residents if the need for a visit was identified by the Conversations Matters Team and the team worked with a range of stakeholders within the council (e.g. CAN) as well as third sector organisations, to meet the support needs to residents.

Weekly reports on the Conversations Matters platform monitored key performance indicators (KPIs) to ensure outcomes were consistent and key learning points were fed back to enable improvement. Case management initially relied on spreadsheets to track Conversations Matters calls and outcomes. As the platform progressed, the team moved to use of a social care case management software to improve efficiency.

Between March 2020 and March 2021, the Conversations Matters team contacted 6,168 LBHF residents (Figure 40). The proactive response to at-risk residents' needs has enabled LBHF to adopt an approach which provides support to residents before a crisis point has been reached. As the vaccination programme progresses and restrictions ease, the Conversation Matters Team will become part of the community and reablement service bringing a renewed focus on prevention in adult social care.

Figure 40: Residents contacted by Conversations Matters team (November 2020 and March 2021)



Data source: Hammersmith and Fulham Council (2021). Conversation Matters Calls November 2020 – March 2021.

Conversations Matters: Case Study

The following short case studies give an overview of cases the Conversations Matters platform has been involved with:

(1) Using Conversations Matters to request extra care.

- An individual phoned Conversations Matters regarding his mother whom he cares for with his siblings.
- After discussing his mother's needs, the Conversations Matters team provided him with the contact details for Adult Social care, Bishop Creighton House and Fulham Good Neighbours.
- Since the conversation, the son has contacted Adult Social Care to request extra homecare to support their mother with Meals on Wheels.
- The individual also stated they would enquire about Fulham Good Neighbours gardening and Bishop Creighton House befriending services for his mother.

(2) Signposting support for daily activities

- An individual struggling with activities of daily life contacted Conversations Matters. She was referred to Adult Social Care and for an occupational therapist assessment for home equipment.
- Conversations Matters organised for CAN and Fulham Good Neighbours to assist the individual with installing a bed.
- A style of bed that may be beneficial to her current living situation was also brought to the individual's attention by the Conversations Matters Team.

2.8 Community Impact

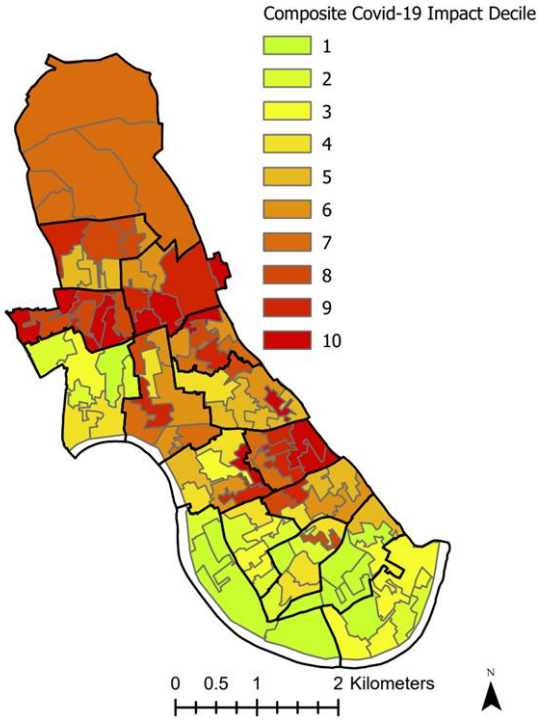
A composite index developed to investigate the effect of COVID-19 on wards indicated more deprived wards in the north of LBHF have been impacted most.

Reductions in footfall and retail spending in town centres in LBHF has severely impacted local businesses. Although grants have been made available, many businesses will be unable to reopen after restrictions lift due to lost income.

However, businesses that are able to reopen will benefit from the renewed focus on shopping locally and within neighbourhoods, as promoted by the Shop Local, Shop Safe scheme. Additionally, shopping locally promotes a green COVID-19 recovery in which cycling and walking short distances are encouraged. Some wards have been disproportionally impacted by COVID-19. Wards with higher levels of deprivation tend to have higher numbers of COVID-19 cases and deaths, as well as higher vaccination decline rates. Consequently, some wards may take longer to recover as outbreaks will likely continue in unvaccinated populations.

A composite score determined by the number of residents claiming benefits (claimant count), COVID-19 positive test rate, vaccination uptake, vaccination refusal and COVID-19 deaths indicate that wards in the north and centre of LBHF have been impacted hardest by COVID-19 (Figure 41; Table 13). It is essential resources are concentrated in these areas to enable an equitable COVID-19 recovery.

Figure 41. COVID-19 impact composite score, by Lower Layer Super Output Area (LSOA) (January 2021)



Data Source: Claimant Count, Office of National Statistics, Jan 2021; Public Health England 2021, Jan 2021; Census 2011 Ethnic Groups, Office for National Statistics; Index of Multiple Deprivation 2019, Ministry of Housing, Communities and Local Government; GP Level Data, 28.01.2021; Registrar Death records, Hammersmith and Fulham Council

Table 13. COVID-19 Impact Matrix, by ward (January 2021)

Ward	Claimant count	Positivity rate	Vaccination uptake	Vaccination refusal	Covid-19 deaths
Addison	7	4	8	3	5
Askew	3	3	13	2	1
Avonmore And Brook Green	8	9	6	10	4
College Park And Old Oak	6	12	12	12	9
Fulham Broadway	10	10	11	9	6
Fulham Reach	11	8	5	5	10
Hammersmith Broadway	4	11	15	6	7
Munster	15	14	2	7	13
North End	5	6	9	1	2
Palace Riverside	16	16	1	15	15
Parsons Green And Walham	14	4	3	16	16
Ravenscourt Park	13	15	7	13	12
Sands End	9	2	10	14	14
Shepherd's Bush Green	2	7	14	4	3
Town	12	13	4	8	11
Wormholt And White City	1	1	16	11	8

Data Source: Claimant Count, Office of National Statistics, Jan 2021; Public Health England 2021, 28.01.21; Census 2011 Ethnic Groups, Office for National Statistics; Index of Multiple Deprivation 2019, Ministry of Housing, Communities and Local Government; GP Level Data, 28.01.2021; Registrar Death records, Hammersmith & Fulham Council