COVID-19 Health Impact Assessment (HIA)

A summary of the direct and indirect impacts of the COVID-19 pandemic in Kensington and Chelsea following the first wave in 2020.

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

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Foreword

Public Health has been at the forefront of local, national and international news in the last year and the Covid-19 pandemic has changed all of our lives. This report shares some of what we know about the impact of Covid-19 on the health and wellbeing of local residents and communities following the first wave of the pandemic.

The devastating effects of the pandemic have been felt by everyone from all walks of life. I would like to express my deepest sympathy to every one of our residents who has suffered. Be it through falling ill themselves, losing a loved one, losing employment or wellbeing impacted by many months of restrictions on our daily lives.

One of the most important things that the public health system can do is to highlight problems that affect the health of disadvantaged population groups, so that we collectively repurpose our efforts from treating ill health to dealing with the causes, and collaborating on prevention and solutions to stop them arising in the first place.

In this Health Impact Assessment, we highlight what data and community intelligence shows as the impact on residents in the borough. We set out commitments to work together to bring about recovery and lasting change.

Our health is determined by where we live, learn, work, study, play and age. To address the impacts of COVID-19, we need to act on these wider determinants of health and focus more intensively on those with the greatest needs. Professor Sir Michael Marmot articulated why it is so important for Public Health to focus our attention on reducing health inequalities when asking: “What good does it do to treat people and send them back to the conditions that made them sick?”

Recovery will take time and this report provides the basis of a useful resource to help galvanise our collective focus for addressing the challenges ahead.

Russell Styles
Interim Director of Public Health

Introduction

This Health Impact Assessment (HIA) provides a snapshot of what local and national evidence tells us about the direct, and indirect, impacts of the first wave (approximately March to September 2020) of COVID-19 on the health and wellbeing of residents in Kensington and Chelsea.

The report considers the impact of COVID-19 on a range of characteristics as well as certain population groups and people with a particular health condition. For the purposes of this summary these have been summarised into the following chapters:

1. **Health and wellbeing**
2. **Protected characteristics**
3. **Wider determinants of health**
4. **Inclusion health**
5. **Healthy lifestyles**

Of course, people do not fall neatly into one protected characteristic or another and will have many of the attributes considered in this report.

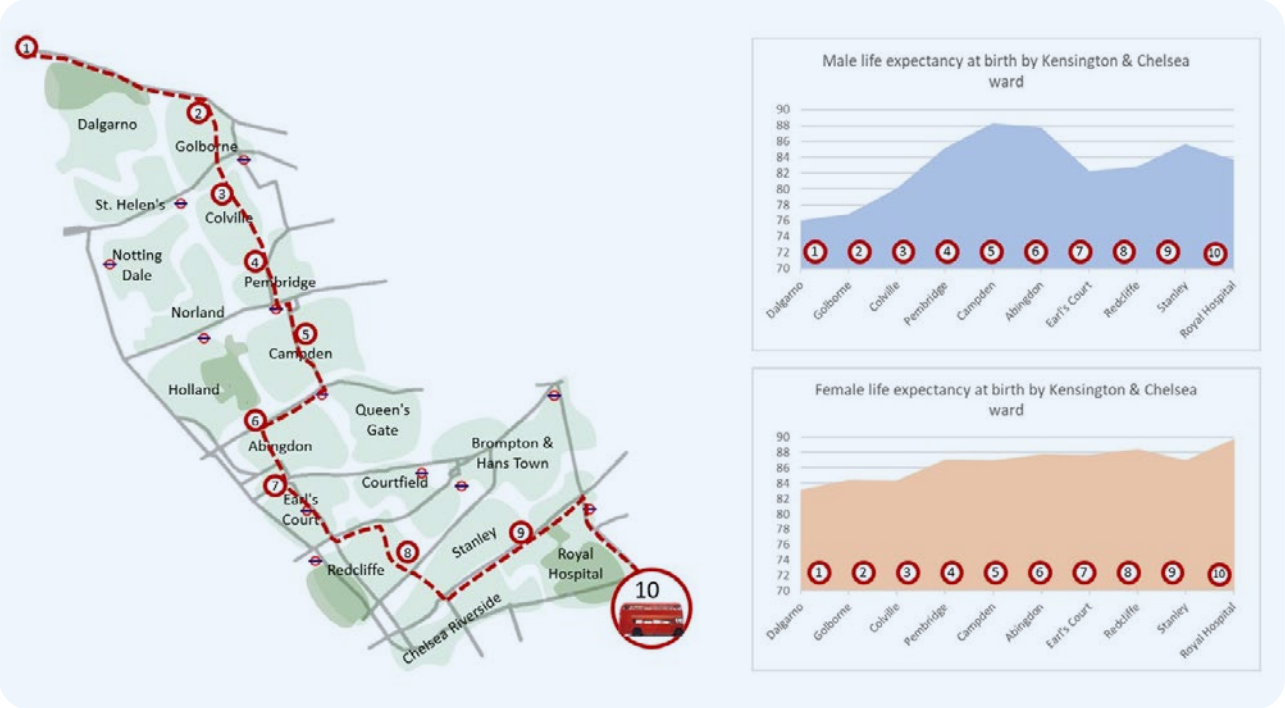
We remain committed to building our understanding of the local impact of COVID-19, through continued engagement with residents and communities, and analysis of data remains ongoing.

Background

Life expectancy is one of the key measures of health inequalities. Many of our residents live long lives, with some of the longest life expectancy in the country. However, there is also significant variation within the borough. This map shows that as you travel across Kensington and Chelsea, the life expectancy for residents fluctuates, depending on where you live. This reflects the variation in health between the most and least deprived parts of our borough.

Health inequalities existed before COVID-19. For example, the life expectancy of a baby boy born in Dalgarno is 76.1 years. This is compared to 90.4 years for a baby boy born in Courtfield.

Covid-19 has exposed and exacerbated existing inequalities.



Source: Public Health England (PHE) Fingertips, 2013-17

How has COVID-19 impacted on health and wellbeing?

Covid-19 has impacted all aspects of life. The table below highlights some of these impacts and the initial horizon scanning which informed the scope of the analysis.

Direct impacts on health	Indirect impacts on health	Economic impact	Early Years, Development and Education	Social and cultural impact	Environment/ Travel/ Air Quality	Workforce/Key Workers	Services	Inequalities
Cases of COVID-19. Deaths from COVID-19. Long Covid.	Impact on mortality and morbidity from other causes. Impact on mental health and wellbeing e.g. • Anxiety and fear • Isolation and loneliness • Bereavement • Concerns of job/financial security • Suicide • Stigma Impact on healthy lifestyles and behaviours e.g. • Alcohol/drug misuse • Smoking • Physical activity • Sedentary behaviour and screen time • Healthy eating • Gambling • Sexually transmitted infections • Unintended pregnancies Impact on uptake of childhood immunisations/vaccinations and screening programmes.	Increase in unemployment. Increase in benefits claimants. Loss of income/ financial insecurity. Increase in use of food banks/ food poverty. Impact on local businesses (applications for grants). Longer term economic consequences. Impact on housing and homelessness.	Children's mental health and wellbeing/ Anxieties. Impact of children's education, development delays, supported vulnerable children including SEND. Decline in uptake of Early Years offer. Risk of abuse and criminal exploitation as children not in school.	Initial reduction in crime levels during first lockdown/ gangs adapting to new ways to make money. Significant increase in antisocial behaviour reporting (largely non-compliance with social distancing). Impact on family relationships. Increase in domestic violence.	Reduction in air pollution - NO2 concentrations during first lockdown. Reduction in road traffic. Changes in active travel/ walking and cycling (see also indirect impacts). Impact on noise complaints.	Staffing levels in health and care. Staff wellbeing.	Impact on Public Health commissioned services. Use of health services (e.g. GPs, A&E). Emergency admissions e.g. diabetes. Cancelled appointments and procedures. Reduction in uptake of cancer screening services. Reduction in face to face services e.g. Health visiting.	Digital exclusion. Increasing inequalities in shielded families.

Chapter 1:
Health and Wellbeing

This chapter focuses on the implications of COVID-19 on certain conditions and aspects of health and wellbeing.

Cancer

What we know:

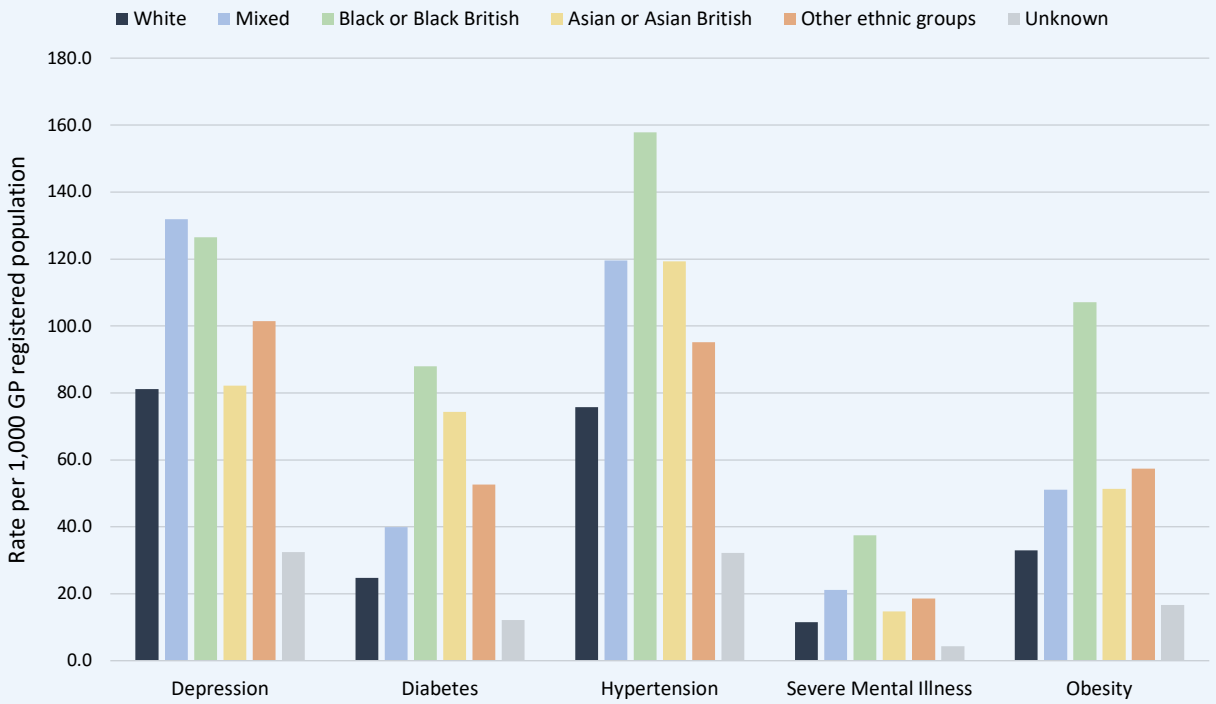
- We know nationally that people with cancer are more at risk from COVID-19 *(Public Health England (PHE), 2020)*
- During the first wave of the pandemic, cancer screening services were paused across England. Patients with suspected cancer may not be accessing services that they desperately need, with national evidence that urgent referrals have dropped, although these have picked up again more recently.
- For those with cancer, the pandemic has restricted access to essential services and support.
- Locally, bowel, cervical and breast cancer screening rates in the borough are some of the worst in London and in the country. For example, only half (50 per cent) of women registered with the local GPs attend breast screening within six months of receiving an invitation (70 per cent across England). *(PHE Fingertips, 2019/20)* . However, despite these low screening rates, cancer outcomes are some of the best in the country *(PHE, 2017-19).*

Long Term Conditions

What we know:

- People with conditions such as diabetes or respiratory disease are more at risk from COVID-19. The majority of people dying from COVID-19 in the borough had an underlying health condition (89 per cent)
- Just under half of local GP registered patients aged 16+ have at least one long-standing health condition (lower than England average)
- National research shows that people with a long- term condition are more likely to have experienced a negative impact on mental health and wellbeing as a result of COVID-19 *(ONS, 2020)*
- National evidence indicates increased risk of exacerbation of long-term conditions as routine management of conditions is interrupted with lockdown measures
- Around five per cent of patients registered with local GPs have diabetes, lower than the London (6.8 per cent) and England (7.1 per cent) average. Prevalence of Chronic Obstructive Pulmonary Disease (COPD) is below the England average (1.2 per cent in the borough, 1.9 per cent across the country). However, there is variation across wards in the borough, for example diabetes prevalence is around 10 per cent in Golborne (*PHE Fingertips 2019/20; JSNA Ward Health Profiles 2019)*

Kensington and Chelsea: Rate of specific Long-Term Conditions (LTCs) per 1,000 population by ethnic group



Patients with type 2 diabetes in West London CCG (GP practices in Kensington and Chelsea plus Queens Park and Paddington)

White

Minority ethnic

Source: National Diabetes Audit, 2018/19. Data is only reported as 'White'; 'Minority Ethnic Origin' and 'Ethnicity Unknown/Not stated

Mental health and wellbeing

What we know:

- Kensington and Chelsea as a whole has higher estimated prevalence of common mental health disorders in 16+ year olds (18.1 per cent) and in over 65s (11.3 per cent) compared to the England average (16.9 per cent and 10.2 per cent respectively). However, for 16+ year olds this is lower than the London average (19.3%). For 65+ year olds it is line with the London average (also 11.3%) *(PHE Fingertips 2017)*
- Nationally, we know that there is an association between poor mental health and deprivation *(PHE Mental Health JSNA Toolkit, 2019)*
- From research in North Kensington, we know that participants who identified themselves as being from a Mixed or other ethnic background were less likely to report excellent/good health in comparison to those who identified themselves as being from a Black or Asian background
- Local community intelligence has highlighted concerns around the negative impact on mental health and wellbeing, including isolation and loneliness, anxiety and stress, fear and stigma, suicide and bereavement
- From national research, it is likely that the mental health and wellbeing of certain groups of people will be particularly affected e.g. young adults, women, people with lower educational attainment or income, people living alone, and adults with long term conditions or disabilities

Dementia

What we know:

- Dementia including Alzheimer's Disease is the most common pre-existing health condition amongst people dying of COVID-19 in England and Wales *(PHE, 2020)*
- Locally, 19 per cent of death certificates for Kensington and Chelsea residents which mentioned COVID-19, also mentioned Dementia or Alzheimer's Disease *(NHS Digital, PCMD 2020)*
- It is estimated that around 1,086 people over the age of 65 were living with dementia in Kensington and Chelsea in 2019
- People living with dementia and their carers have reported negative impact on their mental health and wellbeing; increased sense of isolation and loneliness; and reduced access to services and support groups or activities *(Alzheimers Society, 2020)*

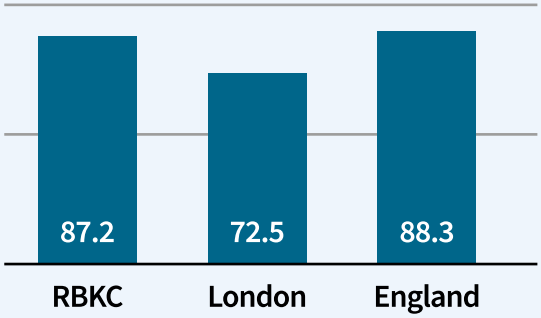
Prevalence of severe mental illness

1.5%
GP practices in West London CCG

1.1%
London

Source: Quality and Outcomes Framework (QOF), NHS Digital, 2019/20

Hospital admissions for mental health conditions for 0-17 year olds per 100,000 population 2018/19



Source: Hospital Episode Statistics, 2018/19

Chapter 2:
Protected Characteristics

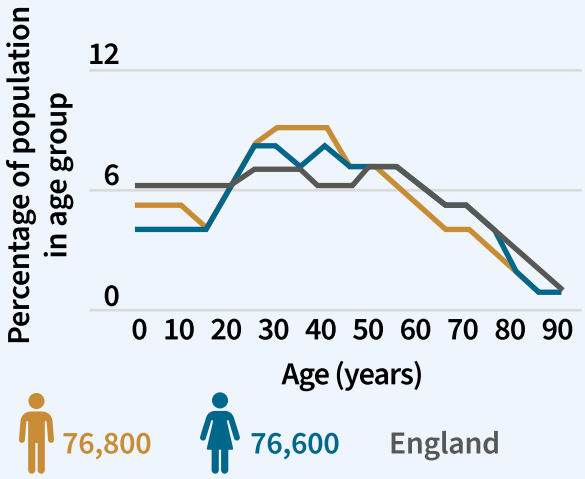
This chapter focuses on the implications of COVID-19 on the protected characteristics as defined by the Equality Act 2010.

Age

What we know – Older People:

- Around 24,481 residents in Kensington and Chelsea are aged 65+ (just under 16 per cent of the population).
- Local analysis has identified that 85 per cent of borough residents who have died from COVID-19 were aged 65+ *(NHS Digital, PCMD 2020)*.
- Care homes have been particularly affected. By the end of August 2020 around 21 per cent of COVID-19 registered deaths in the borough were among care home residents *(ONS, 2020)*.
- From March to July, around half (49 per cent) of residents who tested positive for COVID were aged 65+ *(ONS, 2020)*.
- National research by the Office for National Statistics (ONS) has shown that older people have been more anxious, stressed, and worried about the future since the pandemic *(ONS, 2020)*
- There is national evidence that most cases of coinfection of flu and COVID-19 were among older people, and more than half of them died *(Stowe et al, 2020)*. Locally, flu vaccine rates in autumn 2020 were good amongst older people but there is an opportunity to improve uptake further among social care staff.

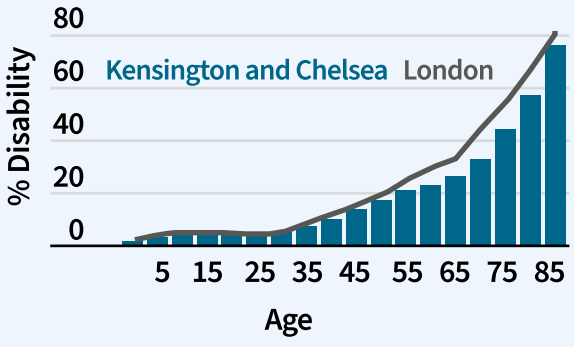
Age and sex



Kensington and Chelsea has a large working age population and relatively few children.

Source: Populations projections for 2021, based on GLA 2018 SHLAA

In Kensington and Chelsea (and elsewhere), older age is associated with poorer health and chronic disease



Source: ONS, Census 2011

Age

What we know – Children and Young People:

- Around 28,678 residents in RBKC are aged 19 years old and under (just over 18 per cent of the population)
- National research has shown a negative impact on the uptake of childhood immunisations *(Jones et al, 2020)*. Childhood immunisation rates are already among the lowest in London and England
- Nationally, vulnerable children may also be at increased risk of domestic abuse *(Jones et al, 2020)*
- There is potential for a significant longer-term impact on children and young people with disruption to education and disproportionate impact of unemployment on young people

Marriage and civil partnership

30% married, civil partnership or cohabiting

22% of Kensington and Chelsea residents are married or in a civil partnership and 8% is cohabiting.

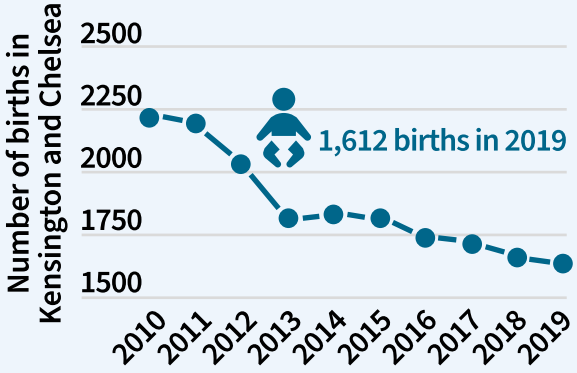
Source: ONS, Census 2011

Pregnancy and maternity

What we know:

- In 2019 there were 1,612 live births in Kensington and Chelsea *(ONS, 2020)*
- Locally, early community intelligence suggests that pregnant women and new mums reported being very anxious about giving birth in hospital or being at home with a newborn with no-one visiting to help. This may increase the potential for social isolation
- According to national research 10 to 20 per cent of new mothers suffer from mental health issues (LSE & Centre for Mental Health, 2014)
- The first 1,000 days of life are critical to life and health outcomes. During the lockdown Early Years education and support was reduced
- Flu vaccine uptake is lower in Black pregnant women (only 11 per cent) in the borough in comparison to other ethnic groups *(WSIC, 2020)*
- National research *(Knight et al, 2020)* reported that more than half of pregnant women (56%) admitted to hospital with COVID-19 between 1st March and 14th April 2020 were from Black, Asian or other ethnic minority groups (Black 22%; Asian 25%; Chinese/other 7%; Mixed 2%)

Pregnancy and maternity



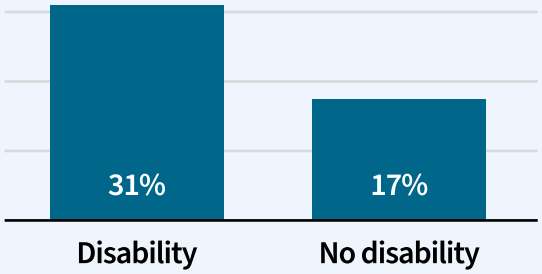
Source: ONS Live Births data, 2020

Disability

What we know:

- An estimated 2,554 adults in Kensington and Chelsea have severe hearing impairment, and 2,295 adults have a visual impairment *(POPPI, estimate applied to local population)*
- At the time of the 2011 Census, 19,569 people in Kensington and Chelsea reported having a long-term health problem or disability
- National research has shown that disabled adults are already more likely to report poor mental wellbeing
- ONS research found that disabled adults were more likely (45 per cent) to report being very worried about the effects of COVID-19 than non-disabled adults (30 per cent) in the early part of lockdown. They were also more likely to report spending too much time alone *(ONS, 2020)*

People with high anxiety score (national data)



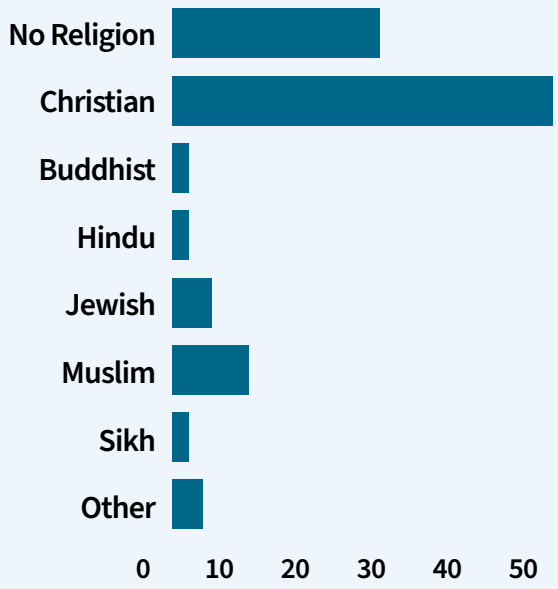
Source: ONS Personal wellbeing and protected characteristics, 2013-15

Religion

What we know:

- Just over a quarter (27 per cent) of residents report as having no religion with the main reported religion being Christianity at 49 per cent. 10 per cent of residents are Muslim, five per cent are Jewish, two per cent are Hindu and two per cent are Buddhist.
- During lockdown, social isolation and loneliness for vulnerable individuals who engage in regular organised faith bases activities, such as Friday's prayers at the Mosque, and Sunday church services, has been reported
- Faith organisations have formed a crucial part of the Covid-19 response, supporting vulnerable and shielding groups with food and other essentials, disseminating information and advice, and supporting many residents.

Religion or belief



Of the Kensington and Chelsea population almost half is Christian, 27% has no religion and 10% is Muslim.

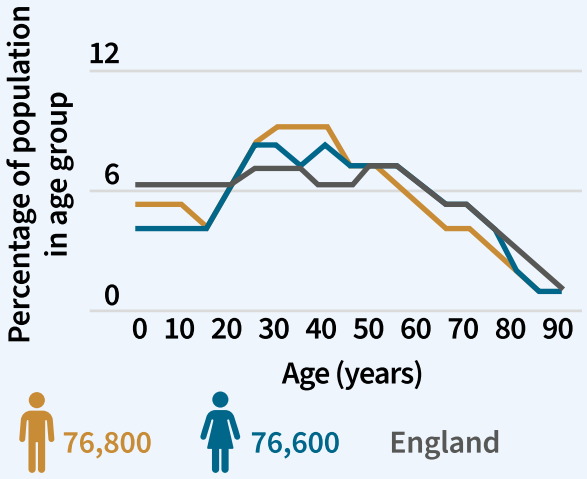
Source: GLA, 2018 population projections

Sex

What we know:

- Nationally, almost 60 per cent of COVID-19 deaths were men, despite accounting for 46 per cent of cases. In the 45 to 84 years age groups, deaths were significantly higher in males than females. It is not yet fully understood what drives the difference between men and women, it could be down to differences in risk of acquiring the infection (e.g. behavioural or occupational), or in accessing healthcare and diagnosis, or biological and immune response *(PHE, 2020)*
- Locally, between March and July 2020, 60 per cent of COVID-19 deaths were men and more men are testing positive

Age and sex



Kensington and Chelsea has a large working age population and relatively few children.

Source: Populations projections for 2021, based on GLA 2018 SHLAA

Sexual orientation

What we know:

- 2.8 per cent of the population in London identified themselves as lesbian, gay, or bisexual in 2018, the highest proportion of any English region *(ONS, 2020)*. This could be explained by the younger age structure or the diversity of the population of London
- There is no data on COVID-19 by sexual orientation
- There may be an increased risk of LGBTQ+ people feeling lonely due to lockdown. A national survey found that 27% of respondents reported that increased isolation was one of their top concerns during the pandemic *(LGBT Foundation, 2020)*
- National research shows that LGBTQ+ residents are already more likely to face poorer health outcomes and may be impacted disproportionately by COVID-19 *(LGBT Foundation, 2020)*

LGBTQ+ groups are more likely to experience poor mental health and to self-harm.

For example the risk of depression and anxiety is 1.5 times higher and suicide attempts are twice as high as in heterosexual people according to national research.

Source: King et al, 2008

Gender identity

What we know:

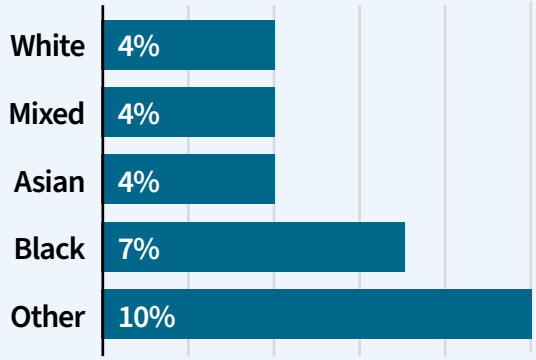
- There is no data showing the number of transgender people living in the UK, although a 2017 LGBTQ+ survey showed that 13 per cent of respondents were transgender *(Government Equalities Office, 2018)*
- There were 370 applications for gender recognition certificates in 2018/19. This has remained relatively stable over the last 3 years. Further national and local measures are in development, including as part of the 2021 Census (Ministry of Justice, 2019)
- There is little evidence on how COVID-19 and lockdown has affected the transgender community in the first wave of the pandemic.

Race and ethnicity

What we know:

- Kensington and Chelsea is an ethnically diverse borough, with Notting Dale and Dalgarno wards being among the most diverse.
- Other than English, the main languages spoken in our borough are French (five per cent), Arabic (three per cent), Spanish (three per cent) and Italian (two per cent). Recent research in North Kensington highlighted nearly a quarter of residents did not have English as the main language spoken at home with Arabic, Portuguese, Somali, Spanish and Polish being the main languages spoken. Earls Court has the highest proportion of residents with English as a second language, with French and Arabic being the main languages spoken. In Courtfield and Queen's Gate one in 11 residents speak French as a main language.
- In Kensington and Chelsea the prevalence of depression, diabetes, hypertension, obesity and severe mental Illness in the GP registered population is, overall, higher amongst people who identify themselves as being from a Black, Asian or minority ethnic background compared to residents of a White ethnic background. Asian and Asian British residents have similar rates of depression *(WSIC DID, 2020)*.

Ethnicity (Source: GLA ethnic group housing led population projections for 2021)	% of population
White British	33%
White Irish	2%
Other White	34%
White & Black Caribbean	1%
White & Black African	1%
White & Asian	2%
Other Mixed	2%
Indian	2%
Pakistani	Less than 1%
Bangladeshi	Less than 1%
Chinese	3%
Other Asian	5%
Black African	3%
Black Caribbean	2%
Other Black	1%
Arab	5%
Other Ethnic Group	3%



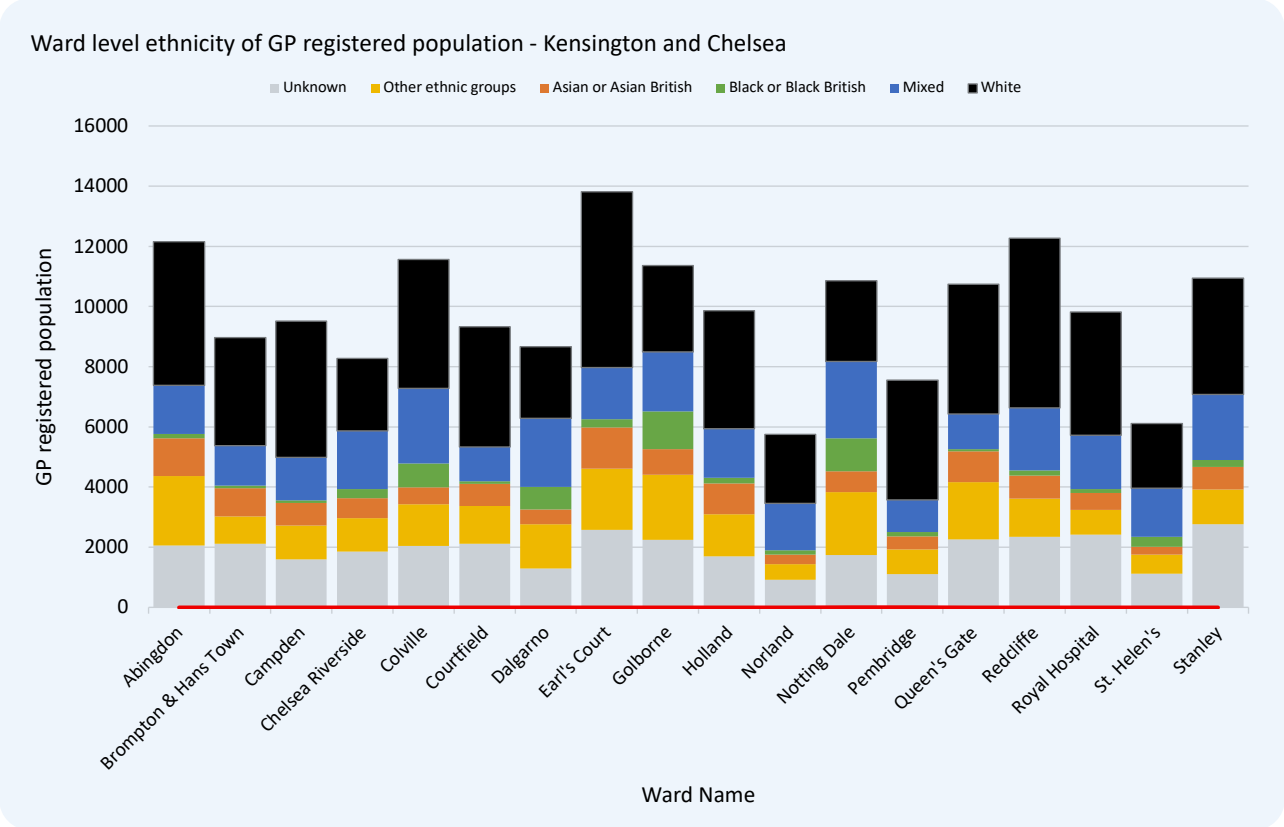
% Bad or very bad general health

People in Kensington and Chelsea identified themselves as Black or Other in the 2011 Census are more likely to report that their overall health is bad or very bad.

Source: Census 2011

- National evidence demonstrates that there has been a disproportionate impact of COVID-19 on people who identify themselves as being from a Black, Asian or minority ethnic background. People from a Black ethnic background were most likely to be diagnosed with COVID-19 and people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity *(PHE, 2020)*.
- Overcrowding is an issue which disproportionately affects households where people identify themselves as being from a Black, Asian or minority ethnic background. Overcrowding can make it more difficult to effectively self-isolate *(Ministry of Housing, Communities and Local Government, 2020)*.
- Initial analysis of local registered deaths data between March and July 2020 reveals that there has been a higher rate of deaths (both Covid-19 and non-Covid-19) among people who identify themselves as being from a Black, Asian or minority ethnic background, when compared to last year. This conclusion should be treated with some caution due to the relatively small numbers of people who have sadly died. Further analysis of cause of death will be undertaken in 2021 to better understand any differences
- National research from Public Health England has reported that people who identify themselves as being from a Black, Asian or minority ethnic background are more likely to work in occupations with higher risk of COVID-19 exposure *(PHE, 2020)*.

Based on 2011 Census data the **GLA Detailed Ethnicity Ward Tool** allows you to explore London's multicultural population by viewing where people of different ethnicity live.



Source: WSIC, 2020

Chapter 3:
Wider Determinants of Health

While health services are vital, our health is determined by where we live, learn, work, study, play and age.

Employment

What we know:

- Universal Credit claimants in the borough more than doubled between March and October 2020, going from 4,869 to 10,402. This is a 114 per cent increase and varies by ward *(DWP, 2020)*
- Young people aged under 25, women, and low earners are more likely to work in sectors affected by lockdown *(Adams-Prassl et al, 2020)*
- It has been estimated that 1.1 million more people across the UK could face poverty at the end of 2020 as a result of the pandemic *(IPPR, 2020)*
- Some residents may be more vulnerable to the long-term socioeconomic impacts of COVID-19. The RBKC Resident Survey showed that half of the respondents were either 'significantly' or 'slightly' worse off – with higher proportions for those aged up to 34 (71%) or residents who identified themselves as being from a Black, Asian or minority ethnic background (62% compared to 42% of White respondents.)

Tenure and overcrowding

What we know:

- 8.5 per cent of households are overcrowded across the borough. For three quarters of wards there is overcrowding in 10 per cent of households *(ONS, 2011)*
- The top three wards for overcrowding are Golborne, Notting Dale, and Dalgarno, all among the more deprived wards in the borough (17.8 per cent in Golborne, 15 per cent in Notting Dale, and 13.5 per cent in Dalgarno)
- The proportion of over 70s who share a household with people of working age is confirmed to be a significant factor in the variation of the number of COVID-19 cases in England *(New Policy Institute, 2020)*
- National research shows that poor housing conditions can lead to increased risk of cardiovascular disease, respiratory disease, depression and anxiety which can lead to worse outcomes if a person become infected with COVID-19 *(Health Foundation, 2020)*
- Risk of homelessness is likely to increase nationally due to economic downturn following the pandemic, resulting in job losses, financial insecurity, and rising personal debt levels *(Clair A, 2020)*.

Domestic violence

What we know:

- Domestic abuse is a wide-spread issue and can affect anyone, however data shows that women and girls are disproportionately affected *(ONS, 2020)*.
- Approximately 30 per cent of women will experience domestic abuse at some point in her lifetime. This would equate to 20,586 women in the borough.
- Nationally, there has been an increase in demand for services, despite the restrictions women faced in accessing support during lockdown. From March to May 2020 there was a 42 per cent reduction in the number of refuge vacancies added to the UK wide Routes to Support database compared with 2019 *(Women's Aid, 2020)*.
- This increase started to be seen towards the end of last year in Kensington and Chelsea with 211 referrals to local services between July and September 2020, the highest level in three years.

Environment

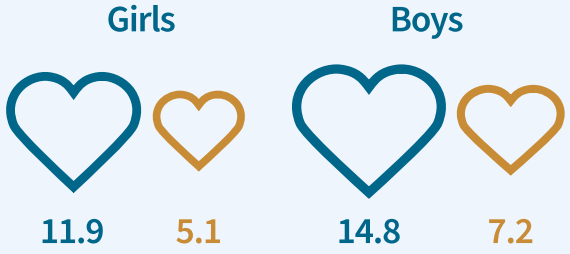
What we know:

- In Jan and Feb 2020 concentrations of nitrogen dioxide (NO2) and particulate matter (PM10) were already down on 2019 levels (possibly due to measures such as ULEZ and increased use of electric vehicles)
- The introduction of national measures to tackle the spread of the virus saw a dramatic reduction in traffic levels and consequently an improvement in air quality
- The most significant change in air pollution was the reduction in levels of NO2

Deprivation

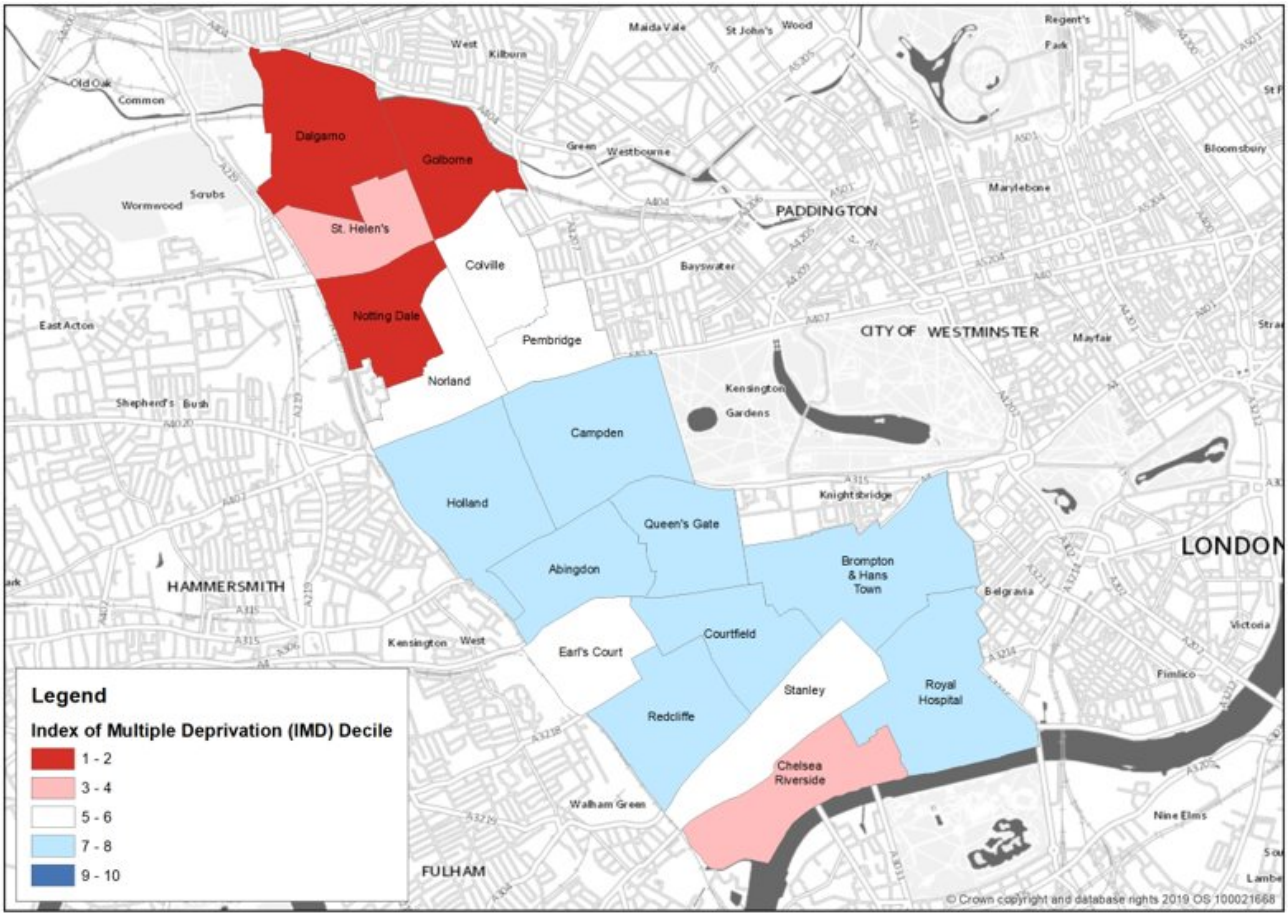
What we know:

- Health inequalities exist between the most deprived and least deprived areas with those living in the most deprived areas generally having poorer health and a reduced life expectancy *(Marmot M, 2010).*
- Many of our residents live long lives, with some of the longest life expectancy in the country however, variation exists and the gap in life expectancy has increased *(PHE Fingertips, 2020)*.
- National research has indicated that COVID-19 has had a disproportionate impact on people living in more deprived areas. This has been reflected locally, as is demonstrated in the maps shown on the next page.
- Between 1 March and 31 July 2020, 26 per cent of deaths from all causes in Kensington and Chelsea, and 31 per cent of Covid-19 deaths occurred in the 20 per cent most deprived areas. This is in contrast to 28 per cent of deaths from all causes during the same period in 2019. This finding suggests a substitution of cause of death in the most deprived areas from other causes to Covid-19. Further analysis of cause of death will be undertaken in 2021 to better understand any differences.



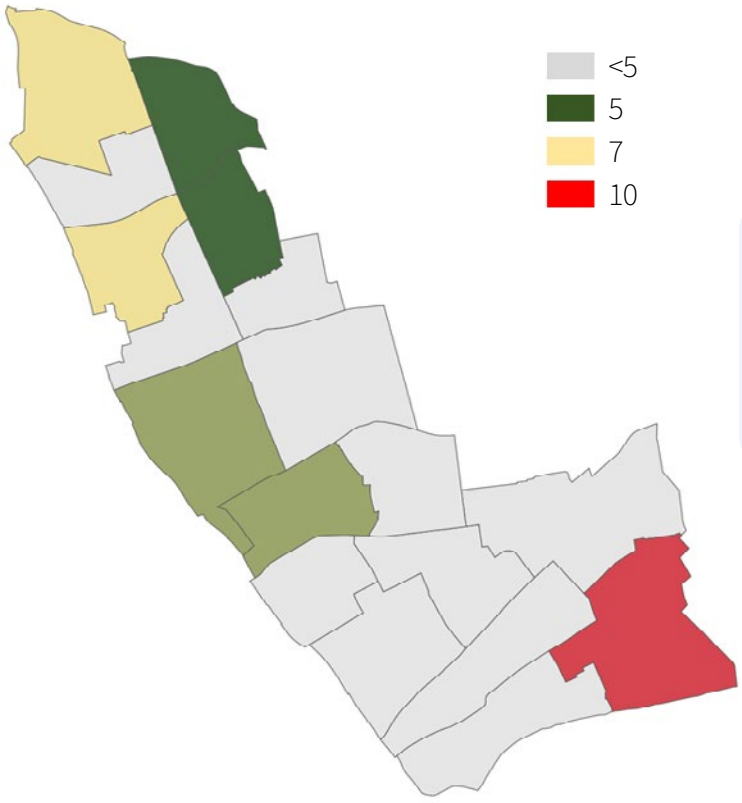
A baby boy born in the most deprived areas of Kensington and Chelsea is expected to die 14 years sooner than a boy born in the least deprived areas. The gap in life expectancy in Kensington and Chelsea has increased while the London average has remained stable.

Source: PHE Fingertips, 2017-19



Source: Ministry of Housing, Communities and Local Government, 2019

COVID-19 deaths by Ward (data suppressed where <5)



Care homes have been particularly affected. By the end of August 2020 around 21% of COVID registered deaths in RBKC were among care home residents *(ONS, 2020)*

Chapter 4:
Inclusion Health

People who are socially excluded tend to have poor health outcomes, putting them at the extreme end of health inequalities.

Homeless and rough sleepers

What we know:

- Homelessness is defined as not having a home available and reasonable to occupy. This includes sleeping rough, but also staying in temporary or insecure accommodation
- CHAIN (Combined Homelessness and Information Network) reported 66 new rough sleepers in Kensington and Chelsea between Apr to June 2020 and 21 counted as living on the streets (i.e. high number of contacts over three weeks or more)
- Research by Public Health England tells us that COVID-19 severity is associated with pre-existing health conditions including cardiovascular diseases, diabetes, respiratory diseases and cancer *(PHE, 2020)*. These diseases are common among homeless people
- Homeless people have a lack of access to basic facilities that would enable the person to reduce their risk to COVID-19 e.g. by self-isolating or washing their hands *(Clair A, 2020)*
- Nationally, we know that homelessness increases the risk of poor mental health and wellbeing, including self-harm, drug and alcohol misuse *(Rough Sleepers JSNA, 2013)*
- Risk of homelessness is likely to increase nationally due to economic downturn following the pandemic, resulting in job losses, financial insecurity, and rising personal debt levels *(Clair A, 2020)*.

Refugees and migrants

What we know:

- Internationally, refugees and vulnerable migrants could be at heightened risk of adverse impacts from Covid-19 and lockdown measures due to their ethnicity, pre-existing conditions, poor mental health and wellbeing, lack of knowledge of the healthcare system and support networks, language barriers, and lack of access to technology *(Kluge H et al, 2020)*.
- Medium and longer-term economic impacts of COVID-19 will likely have a disproportionate impact on refugees and migrants

Homeless people and rough sleeping

9 households per 1000 are homeless in Kensington and Chelsea

Homeless people experience poorer levels of general physical and mental health than the general population, and are more likely to have multiple and complex health needs. Life expectancy for rough sleepers is around 30 years shorter than the general population in the UK. Nationally, the homeless population use about four times more acute hospital services, and seven times more A&E services than the general population. Rough sleepers face structural and attitudinal barriers to accessing healthcare.

Source: Rough sleepers – health and healthcare JSNA, 2013

Carers

What we know:

- The 2011 Census reported 1,954 unpaid carers providing 50+ hours of unpaid care per week in Kensington and Chelsea
- Nationally, 70 per cent of unpaid carers in the UK are having to provide more care for their loved ones during the coronavirus outbreak *(CarersUK, 2020)*
- There has also been an impact on carers mental health and wellbeing, and they are at risk of 'burnout' and increased sense of isolation *(CarersUK, 2020)*
- Nationally, long-term pressures of COVID-19 could lead to delays in carers receiving the support they need

Travelling community

What we know:

- Nationally, we know that the health status of Gypsies and Travellers is much poorer than that of the general population *(Parry G et al, 2007)*
- Poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health *(UK Parliamentary Report, 2019)*
- In the 2011 Census, there were 119 people in Kensington and Chelsea who identified as Gypsy or Irish Traveller, 0.08 per cent of the local population
- Travellers may face significant financial insecurity and poverty as likely to be self-employed, and lower paid. They are also less likely to have bank accounts and more reliant on cash *(Scottish Government, 2020)*
- National research tells us travellers are more likely to have a long-term condition which could impact on their risk of and outcomes from COVID-19 (42 per cent compared to 18 per cent of population) *(UK Parliamentary Report, 2019)*

Drug and alcohol

What we know:

- Nationally, drinking habits have changed as a result of COVID-19 and lockdown. Around one in five people are drinking more *(Alcohol Change UK, 2020)*. However, some local evidence indicates that service users have been taking the opportunity to reduce alcohol or drug use
- In 2017/18 there were an estimated 1,738 dependent drinkers in Kensington and Chelsea and in 2016/17 there were an estimated 1,451 opiate and/or crack cocaine users
- Based on national research of risk factors for COVID-19 there could be an increased risk among people who use drugs due to higher levels of comorbidity. Sharing drug using equipment may also increase the risk of infection
- Local services reported that COVID-19 and lockdown measures had a negative impact on mental health and wellbeing, and an increase in sense of isolation among service users

Chapter 5:
Healthy lifestyles

Lockdown is likely to have impacted on people's activity levels and on eating habits. It is recognised that obesity is a risk factor not just for COVID-19 but also for other severe illness.

Smoking

- National research suggests that many smokers have taken the opportunity to reduce (36 per cent) or quit (two per cent) during lockdown *(YouGov/ASH, 2020)*
- In North Kensington, 28 per cent of residents smoke cigarettes daily
- While local data on smoking quit rates in the borough during the pandemic is not yet available, the One You service has been continuing to support residents to quit smoking and are expected to meet their 2020/21 targets. Prior to the pandemic the borough had the 10th highest smoking quit rates in the country

Those in lower socio-economic groups are

3.5 times

more likely to smoke

Source: Public Health England

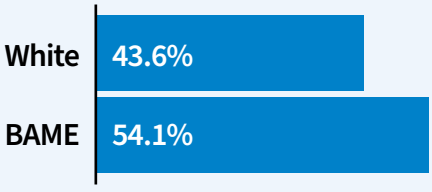
Healthy eating

- International evidence suggests lockdown has had a negative impact on health behaviour such as diet among children and adults. Obesity prevalence, already higher in deprived areas, may be impacted

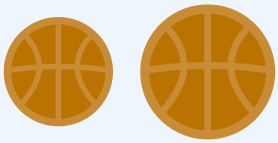
Physical activity and active travel

- Research in the first wave of the pandemic by the Office for National Statistics *(ONS, 2020)* suggested people were walking and cycling further during lockdown. However, locally, people reported not going out at all and not letting children out, with physical activity dropping completely for many residents
- Nationally, older people report coping with lockdown through gardening and exercise *(ONS, 2020)*
- There may be an increased profile of physical activity and increased levels within some sections of the community
- Pre-Covid-19, in North Kensington, 30 per cent of residents reported no moderate of vigorous physical activity in the last seven days

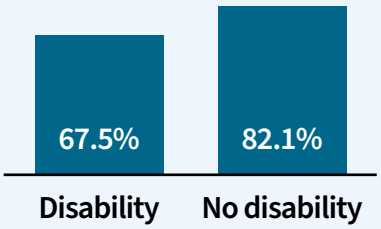
Regular sport participation (at least once per week)



Proportion inactive adults (less than 30 mins activity per week)



Sport participation (at least twice in last 28 days)



A survey with residents of Kensington and Chelsea has shown that those residents who identify themselves as being from a Black, Asian or minority ethnic background, and those without a disability, are more likely to participate in sport than other groups.

Sources: Active People Survey 2017/18; Physical activity and sport profiles, 2017; PHE Fingertips 2019/20

Proportion of children identified as obese as part of National Child Measurement Programme (three year average)		
Year	Kensington and Chelsea	England
Reception (age 4 to 5)	9.2%	9.7%
Year 6 (age 10 to 11)	22.5%	20.4%

Commitments

The findings of the Health Impact Assessments will be taken forward through the Kensington and Chelsea recovery programme. The Council is committed to focussing on groups with the greatest needs, continuing to consult residents on their health and wellbeing to direct our effort, and innovating by co-designing campaigns and actions to bring us closer to the communities we serve.

By working together, and focussing and committing to long-term change, we can begin the journey of making significant in-roads to address the levels of inequality that are highlighted in this report.

Our commitments outlined below detail what we will do in the future to work together to bring about recovery and lasting change to achieve far greater health equity across all of our communities.

To make sure our work contributes to long term change Public Health will work to:

1. Focus attention on areas and communities with the greatest needs
2. Ask residents about their health and wellbeing to direct our efforts
3. Innovate by co-designing campaigns and actions to bring us closer to the communities we serve
4. Invest £3m of our Public Health grant into local COVID-19 Recovery programmes to address health inequalities through action on the wider determinants of health.

The pandemic is far from over. The Public Health department will continue to monitor population health, with a greater focus on working with residents to improve our understanding of their needs, barriers and experiences. This is key to preventing ill health and identifying health disparities and emerging trends.