COVID-19

Please note there may be minor discrepancies in the COVID-19 data described here compared to the JSNA 2021, due to changes and/or updates in wave definitions and other references.

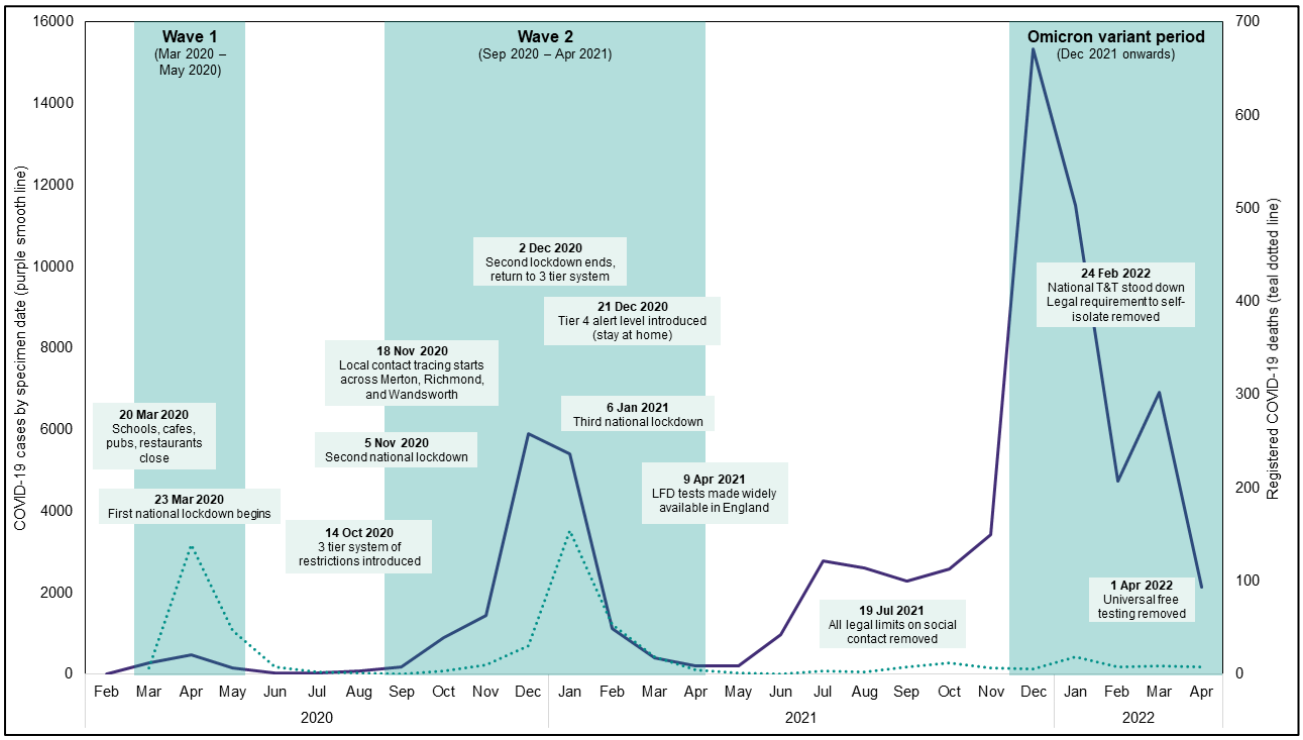
The COVID-19 pandemic

Merton reported its first COVID-19 case in February[1] 2020 and first known COVID-19 death in the week ending 20th March 2020[2]. The World Health Organization (WHO) declared COVID-19 to be a pandemic on 11th March 2020.

The UK experienced three waves of COVID-19: Wave one (alpha variant, March 2020 to May 2020), Wave two (delta variant, September 2020 to April 2021), and the Omicron variant period from December 2021 onwards. As part of the national COVID-19 outbreak management, Merton residents experienced three national lockdowns. The first lockdown in England started on 23 March 2020, the second lockdown started on 5 November 2020 ending on 2 December 2020 and the third lockdown started on 6 January 2021 and ended on 31 March 2022. The timeline of COVID –19 events that affected Merton residents are all illustrated in figure 1. Despite the large surge of Omicron cases in 2022, the COVID mortality rate was much lower. This is the result of two factors: there is a lower rate of serious complications after Omicron infections, and a large proportion of the UK population is vaccinated, which further reduces complications[3]. Figure 1: The number of COVID-19 cases and deaths in Merton across the pandemic, between February 2020 and April 2022. Source: Coronavirus dashboard, Office for National Statistics,'.

Figure 1: The number of COVID-19 cases and deaths in Merton across the pandemic, between February 2020 and April 2022. Source: Coronavirus dashboard, Office for National Statistics[4,5,6].

Please note, cases are shown by a smooth purple line and accompany the left hand y axis. COVID deaths are those with COVID-19 on the death certificate and are shown in a teal dotted line, accompanying the right hand axis. Dates of interest are from OHID and Merton Council.



COVID-19 in Merton (Infections, Hospitalisations, and Deaths)

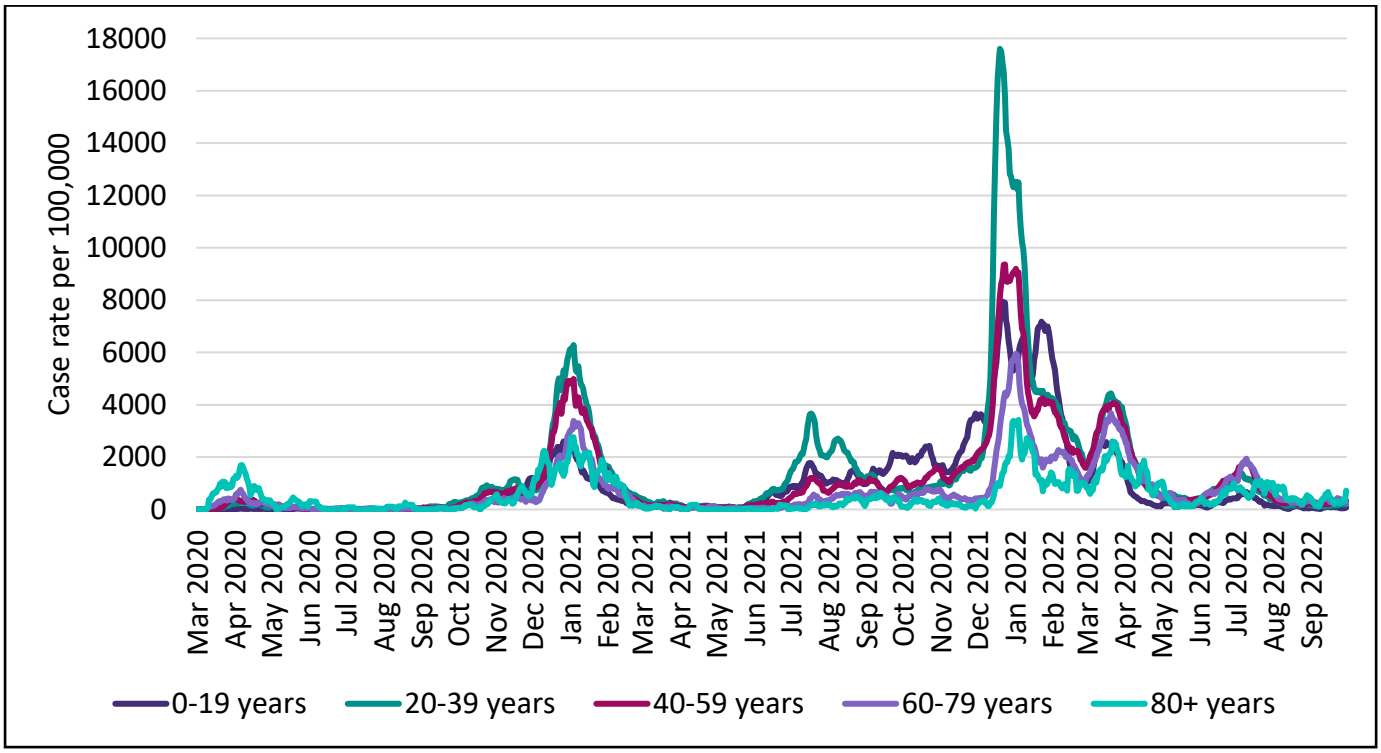
As of the 30th September 2022, more than 19.9 million people had tested positive for COVID-19 in England, of which almost 3.1 million were resident in London[7]. In Merton, 77,316 residents tested positive for COVID-19 and there were 598 COVID-19 related deaths registered up to the 23rd September 2022[8]. The majority of those with COVID-19 will have experienced mild to moderate illness, with more severe cases more common among older people and those with pre-existing medical conditions.

Infections

The trends of recorded COVID cases in Merton by age from March 2020 to March 2022 can be seen in Figure 2. During the first wave older people in Merton aged 80+ were more likely to be diagnosed with COVID-19. During the second wave the 20-39 and 40-59 age groups were the most likely to be diagnosed. The youngest age group of 0–19-year-olds had the highest recorded rates from September 2021 to December 2021[9]. It is important to note that these infection patterns are likely to be greatly reduced by the initial low availability of

testing e.g., the lack of community testing in the early stages of the pandemic, and by greatly reduced testing rates over the summer of 2022.

Figure 2: Recorded COVID case rates per 100,000 by age group in Merton between March 2020 and September 2022. Source: Coronavirus Dashboard, GOV.UK[10].

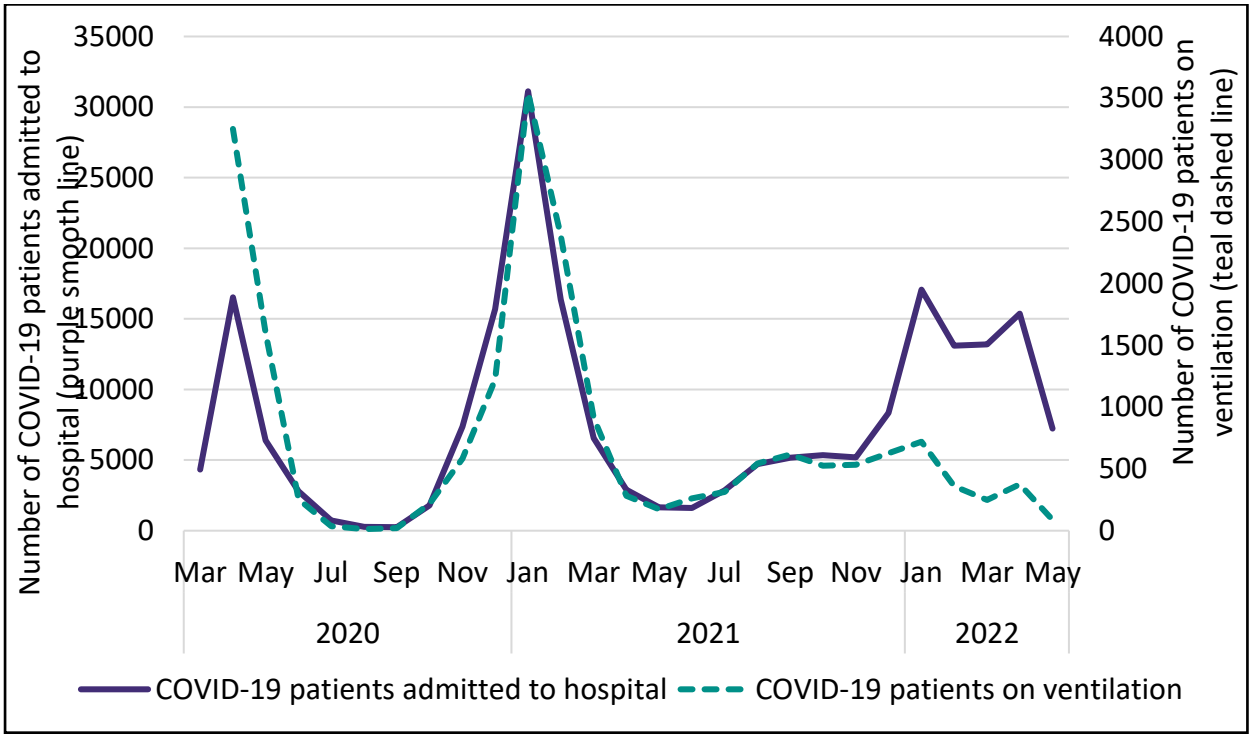


Admissions

The number of people admitted to Southwest London hospitals who tested positive for COVID-19 first peaked in April 2020 which coincided with the first COVID-19 wave followed by a second peak in December 2020 /January 2021[11]. The number of patients in hospital on mechanical ventilation during the first and second wave was high but decreased during the third wave as illustrated in Figure 3, likely reflecting the improvement of COVID-19 treatments and the roll out of the COVID-19 vaccine programme and its associated reduced risk of severe disease and death. Although recorded cases were very low in summer 2022 (Figure 3), admissions rates were still quite high demonstrating that a continuing surge of prior infections had taken place in spring and summer.

Figure 3: Number of COVID-19 patients admitted to hospital and on ventilation in South West London hospital trusts, March 2020 – September 2022. Source: Coronavirus dashboard[11].

Please note, this counts people admitted to SW London hospital trusts who tested positive for COVID-19 in the 14 days before their admission, or during their stay in hospital. SW London hospital trusts comprise of: Croydon Health Services NHS Trust; Epsom and St Helier University Hospitals NHS Trust; Kingston Hospital NHS Foundation Trust; Royal Marsden NHS Foundation Trust; and St George's University Hospitals NHS Foundation Trust.



Deaths

In Merton, 598 COVID-19 related deaths were registered (a rate of 289.7 per 100,000) up to the 23rd September 2022 (Figure 4)[12,13]. There was a slight increase in COVID-19 deaths registered during January 2022 although COVID-19 deaths did not exceed the average number of deaths seen in previous years. Merton's all cause and COVID-19 mortality rates have been comparable to other SWL boroughs during the pandemic. The COVID death rate for SWL boroughs ranged between 203.2 – 324.0 per 100,000, while the death rate for London was 268.9 per 100,000.

Figure 4: Number of deaths of Merton residents by week of registration between 28 March 2020 and 4 February 2022. Source: Office for National Statistics[14].

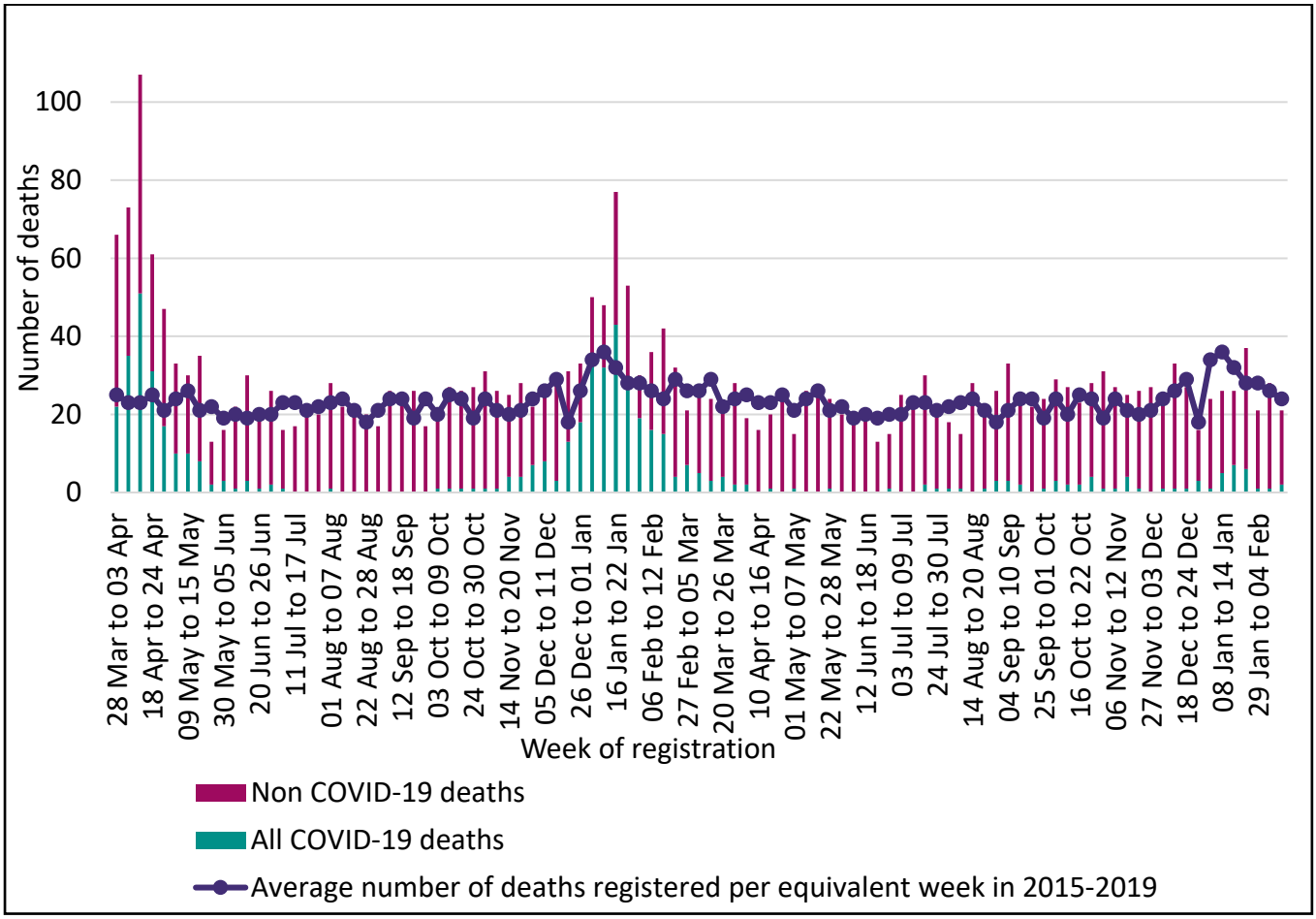
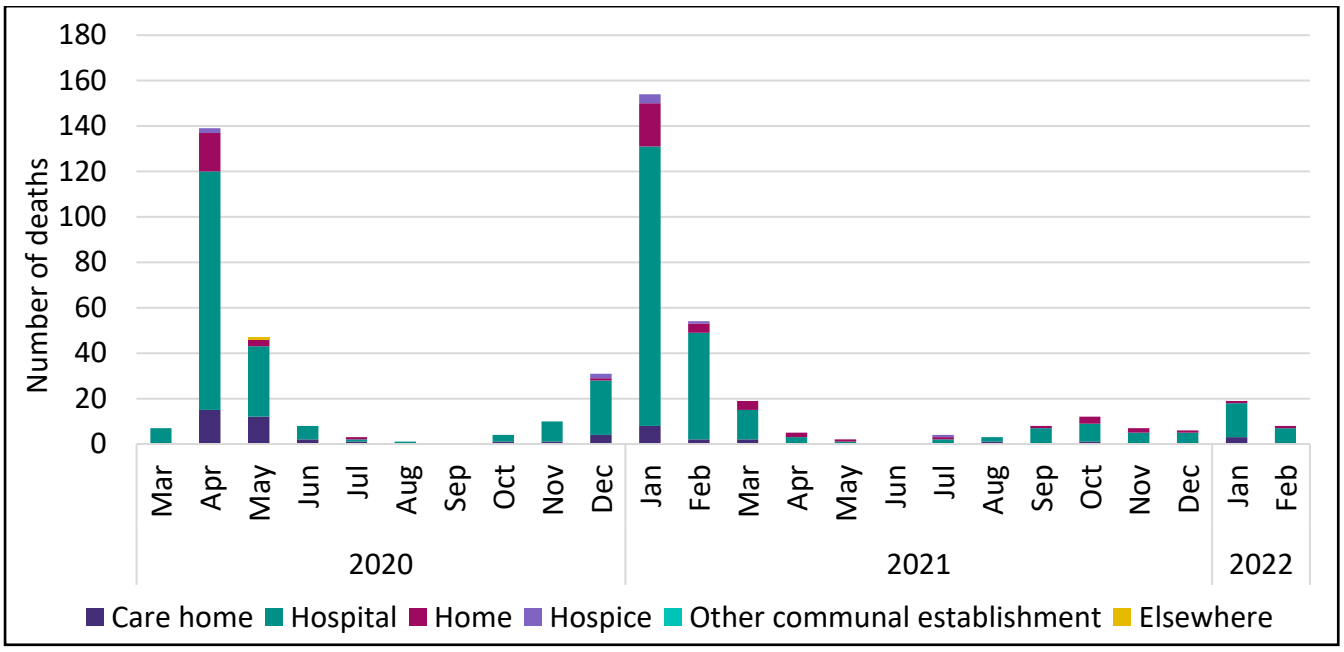


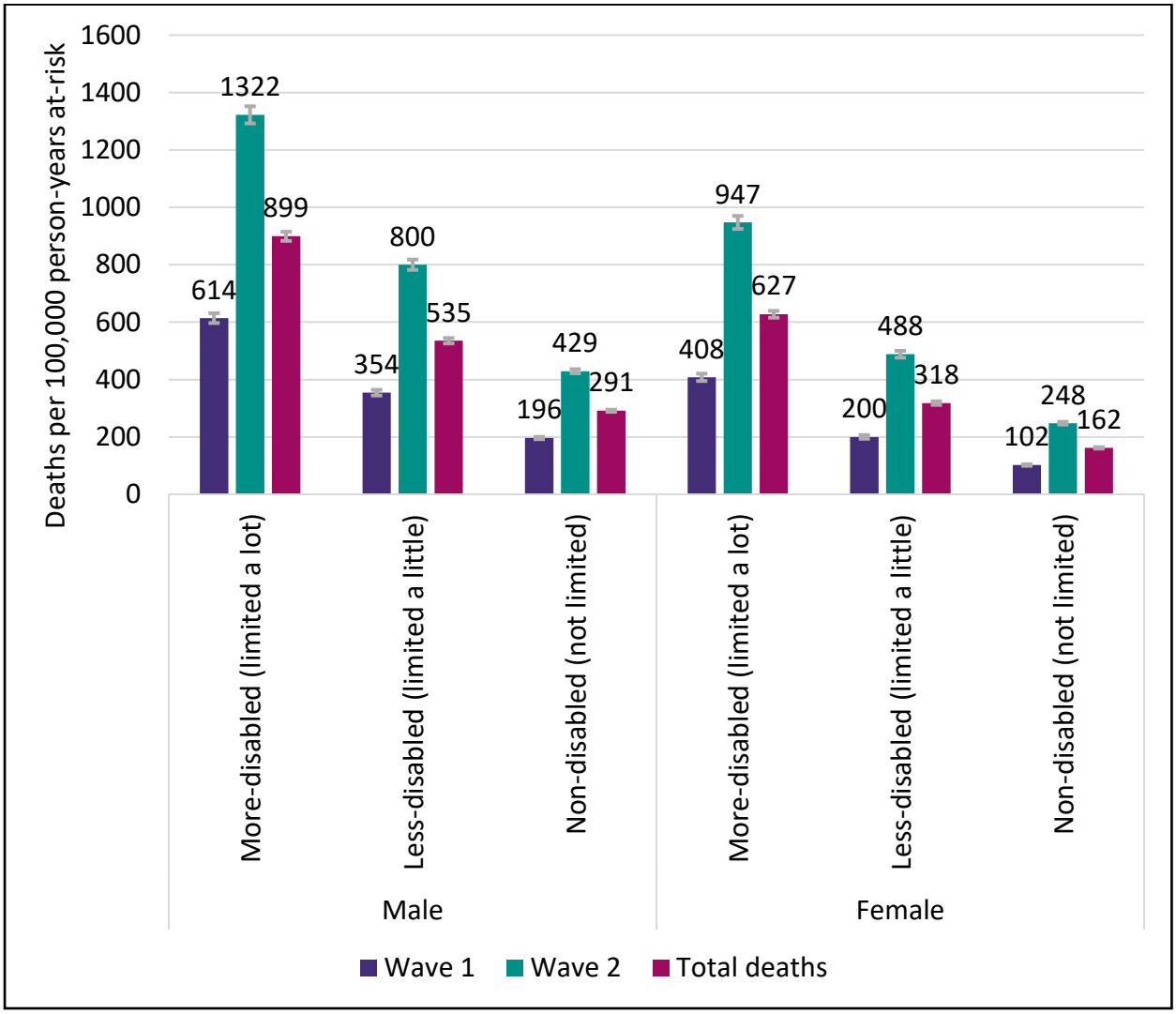
Figure 5 shows the number of COVID-19 deaths of Merton residents by place of death between March 2020 and February 2022. Most deaths during this period occurred in hospitals and a larger proportion of deaths occurring in care homes during the first wave.

Figure 5: Number of COVID-19 deaths of Merton residents by place of death between March 2020 and February 2022. Source: Office for National Statistics[15].



In England, COVID-19 related mortality is estimated to have been consistently higher among individuals with greater disability in wave 1, wave 2, and across the pandemic up to 28 Feb 2021 (see Figure 6).[16]

Figure 6: Deaths per 100,000 person-years by disability limitation, gender, and COVID wave for those aged 30 to 100 years old in England. Source: Office for National Statistics[17].



A greater proportion of deaths among people with a learning disability were COVID-19 related compared to the general population in England, based on data between December 2020 and January 2021. Please note, data represents age-standardised mortality rates (deaths involving COVID-19) by self-reported disability status among 30 –100 year olds in England. Data is based on registrations of deaths involving COVID-19 of people aged 30 to 100 years that could be linked to the 2011 Census and General Practice Extraction Service (GPES) Data for Pandemic and Planning Research. COVID-19 deaths are defined as deaths where COVID-19 was mentioned on the death certificate. Disability was measured using responses collected in the 2011 Census.

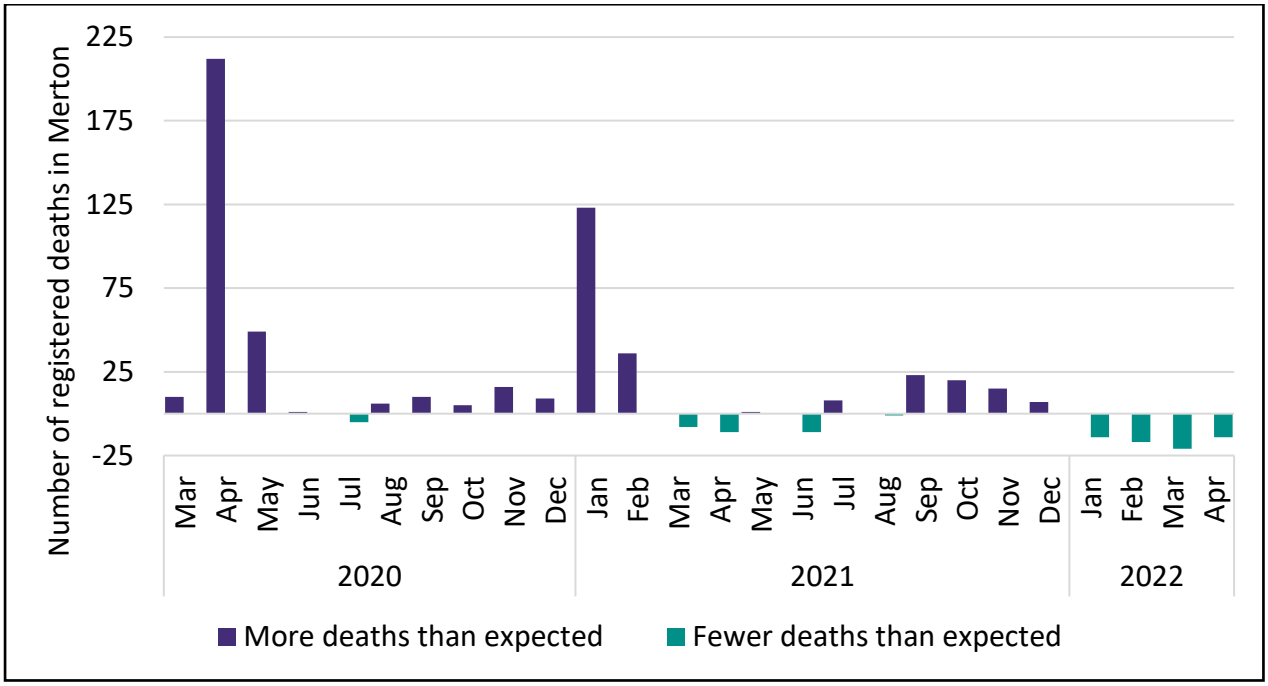
Excess mortality

In order to look at the overall impact of COVID-19 on mortality in Merton, we can look at excess mortality, which estimates the number of expected deaths in a given period. This is

calculated by comparing the number of observed (actual) deaths with the number of expected deaths, based on historical data.

In Merton, there were more deaths than expected compared to previous years (2015-19) during wave 1 (Mar – May 2020) and partly in wave 2 (Sep 2020 to Apr 2021) of the pandemic (Figure 7). There were more deaths than expected in the latter part of 2021 (Sep – Dec 2021) but in the first part of 2022, there were fewer deaths than expected[18]. This is similar to London and England.

Figure 7: Modelled number of excess mortalities in Merton during the pandemic (March 2020 to April 2022): Source: Office for National Statistics[19].



Wider and disproportionate impacts of COVID-19

Additional messages on the wider impacts e.g., impact of educational attainment, impact of physical activity levels and uptake of screening programmes of the COVID-19 pandemic on residents are included in the start well, live well and age well chapters.

COVID-19 has affected all communities across England and in London, including Merton; however, COVID-19 has had a disproportionate impact on a number of ethnic minority groups, those living in areas of deprivation, those with underlying health conditions, older people and residents with a learning disability.

Ethnicity

National data indicates hospitalisation rates, and mortality rates in non-White populations have been higher compared to White populations throughout the pandemic[20]. Similar

patterns have been observed in London, where hospitalisation and mortality rates have been consistently higher among Black, Black British, Asian, and Asian British ethnic minority groups during the pandemic compared to other ethnicities[21]. These differences are likely to represent both greater exposure and transmission of COVID-19 (due, for example, to overcrowding or employment in jobs with a greater risk of COVID transmission) among these communities, and differences in risk (related to the prevalence of underlying long term health conditions)[22,23].

Commissioned on behalf the Merton Health and Wellbeing Board, an assessment of the impact of the COVID-19 pandemic on Ethnic Minority groups was conducted by the Black, Asian, Minority Ethnic Voice, a local Voluntary and Community Sector organisation[24]. This 'bottom-up' approach helped to develop trust, understand lived experience, and identify a number of recommendations for future work with communities and informs Merton's Local Outbreak Management Plan (LOMP).

Deprivation

Hospitalisation and mortality rates were highest among people in the most deprived areas of Merton throughout the pandemic compared with the least deprived areas. The gap in hospitalisation rates have increased over time, notably widening from January 2021 (part of the second wave of the pandemic)[25]. This is shown in Figure 8 and Figure 9.

Figure 8: Cumulative rate of hospitalisations for COVID-19 per 100,000 by deprivation quintile in Merton between March 2020 and January 2022. Source: UK Health Security Agency[26].

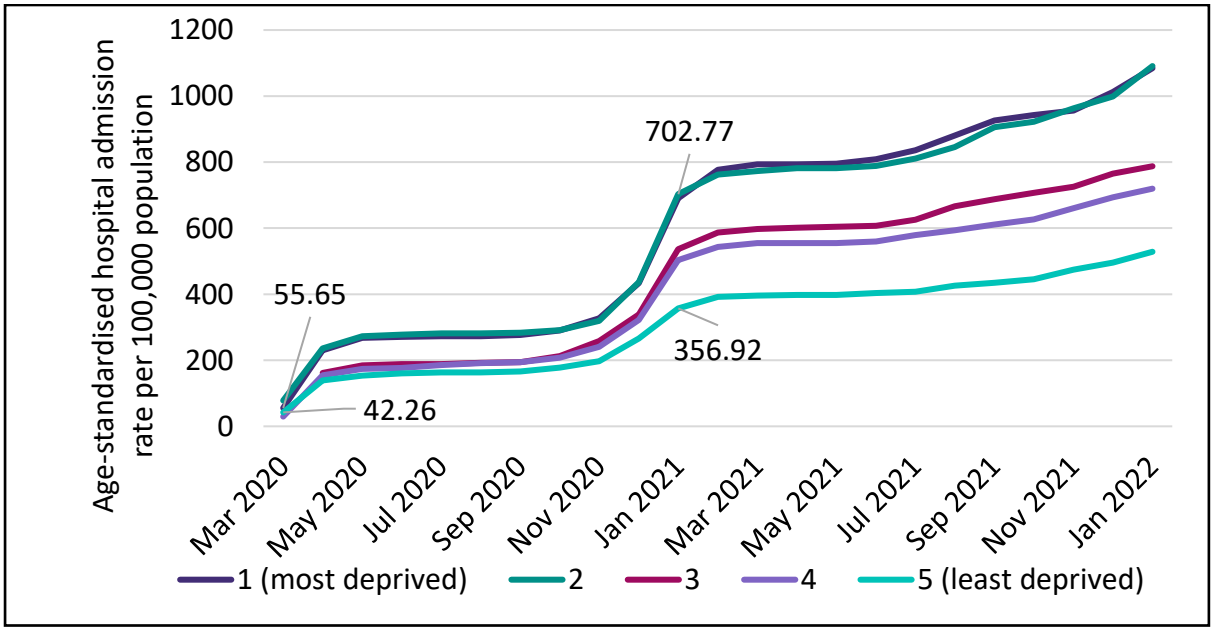
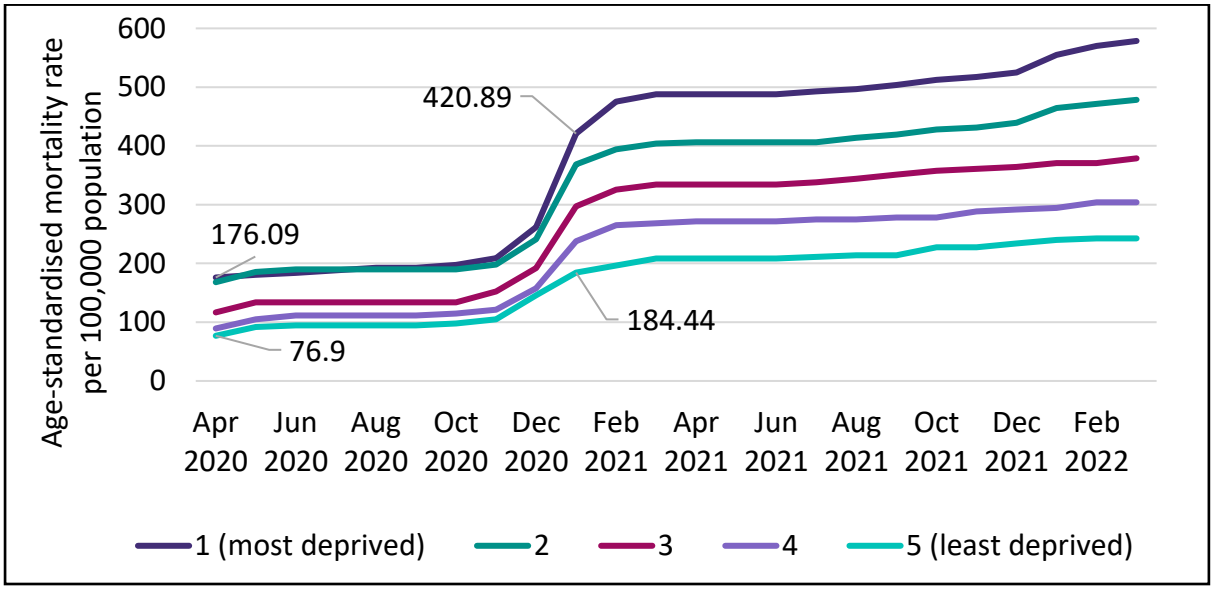


Figure 9: Cumulative rate of deaths involving COVID-19 per 100,000 by deprivation quintile between April 2020 and March 2022 in Merton. Source: UK Health Security Agency[27].



Please note, data has been directly age-standardised in order to allow for comparison across the deprivation quintiles (1st quintile = most deprived 20% of the population based on the Index for Multiple Deprivation). Hospital admissions where COVID-19 was recorded as the primary reason for admission to hospital were included. This means that people who contracted COVID-19 during their stay in hospital are not included. COVID-19 deaths are defined as deaths where COVID-19 was mentioned on the death certificate.

Underlying health conditions/People at risk due to long term conditions

Research has shown that individuals with certain long-term conditions particularly diabetes, obesity, anxiety related disorders, and cardiovascular diseases are at greater risk of hospitalisation[28,29]. In England, mortality rates for other causes excluding COVID-19 were higher in 2020 than mortality rates observed in 2015–19[30,31].

England-wide data on access to care during the pandemic indicates that[32]:

- Around one in two (52%) people did not seek advice for a worsening health condition during the first lockdown, though this remained quite high during the second and third lockdowns and December tiers.
- Over half of respondents stated that they had not sought medical advice to avoid putting pressure on the NHS; this was noted across all age groups.

This wider and longer-term impact on residents with undiagnosed or established long term conditions will need to be monitored to understand the health need of these groups.

People with disabilities, including learning disabilities

People with a disability and those with learning disabilities have been impacted directly and indirectly by the pandemic. There is some overlap between long-term conditions and disability but there are many disabled people who do not have any underlying health problems, for example people who are deaf.

Findings from the ONS Opinions and Lifestyle Survey (February 2022) indicate that in Great Britain[33]:

- A greater proportion of disabled people reported poorer well-being ratings than non-disabled people across life satisfaction, feelings that things done in life are worthwhile, happiness, and anxiety.
- Two in five (40%) disabled people reported feeling lonely often, always, or some of the time which is more than twice the proportion of non-disabled people (18%).
- Almost one in five (18%) disabled people reported that they thought life would never return to normal, compared to one in ten (11%) non-disabled people.
- 17% of disabled people reported perceiving a very high risk of COVID-19 infection compared to 7% of non-disabled people.
- 29% of disabled people reported being very worried about new COVID-19 variants compared to 16% of non-disabled people.

Commissioned on behalf of the Merton Health and Wellbeing Board, an assessment of the impact of the COVID-19 pandemic on residents with a learning disability was conducted by Merton Mencap, a local Voluntary and Community Sector organisation[34,35]. This report stated that, at that time, mental health is the most significant health issue reported by the individual and their parent and guardian. The link to this report can be found here: [Engagement Work for Public Health Merton (merton.gov.uk)]

Shielding

As of 20th May 2021, there were 13,680 Merton residents who were on the shielding list, with increasing numbers throughout the pandemic. Shielding, which officially ended on 15th September 2021, was advised as a measure to reduce the risk of COVID-19 infection but had wider consequences including impacts on mental health and loneliness.

National-level data collected in April 2022 on clinically extremely vulnerable (CEV) people indicated that[36]:

Overall effect of the pandemic and changes to behaviour:

- Only a minority of CEV individuals said the pandemic had had a positive effect (11%) while 59% said it had had a very or slightly negative effect.
- 13% of CEV individuals were continuing to follow previous shielding guidance in order to protect themselves while 69% of CEV individuals stated they were not shielding but taking extra precautions.

- More than four-fifths (82%) of CEV individuals said they were taking additional measures or actions to prevent getting infected with COVID-19.

The effect of the pandemic on physical and mental health

- 54% of CEV individuals thought the pandemic posed a significant or major risk to their physical health, while 44% stated that they were somewhat or very worried about the long-term effect of the pandemic on their physical health.
- 25% stated that the pandemic posed a significant or major risk to their mental health, while 33% stated that they were somewhat or very worried about the long-term effect of the pandemic on their mental health.
- 37% of respondents said shielding had a negative effect of their wellbeing and mental health, though 53% of respondents said it had no effect.
- Many routine healthcare services were interrupted or cancelled to prioritise the pandemic response and the impact of this will be seen for a number of years to come.

Living safely and equitably with COVID-19

The Government's COVID-19 response: Living with COVID-19 plan, published on 21st February 2022, set out the plan for removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience[37].

Key components of the plan are vaccination, which will continue to protect the most vulnerable and the deployment of treatments e.g., antivirals and therapeutics, which will require on-going support at a local level, specifically looking through the equity lens to work with communities across Merton to increase uptake and awareness of the vaccination and therapeutics programme.

The longer-term impact and distribution of Post COVID Syndrome (long covid) will need to be understood more, as part of Merton's approach to living safely and fairly with COVID-19.

Vaccination

The UK's COVID-19 vaccination programme began on 8th Dec 2020. Most people were offered two doses initially, with a third booster dose offered that began on 16th Sep 2021. People aged 12 and over with severely weakened immune systems are offered a 3rd dose vaccination, which unlike boosters, are considered part of a primary vaccination course. Table 1 below outlines the different types of booster doses.

Table 1: COVID booster doses

Booster type	Eligible groups
1st booster dose	Everyone aged 16+ and some children aged 12–15 years, who have had 2 doses at least 3 months ago.
A booster dose (technically their 4th dose)	Those who had a severely weakened immune system when they had 2 out of 3 doses, with the last dose at least 3 months ago.
A spring booster (2022)	Everyone aged 75+ years, care home residents, and people aged 12+ who have a weakened immune system (offered from 21st Mar 2022 onwards).
An autumn booster (2022)	Eligible: Residents in a care home for older adults and staff working in care homes for older adults, frontline health and social care workers, 65 years of age and over, 5 years and over and at high risk due to a health condition, 5 years and over and live with someone who has a weakened immune system and 16 years and over and a carer.

Vaccine uptake in Merton

Please note data on COVID-19 vaccine uptake presented in this section from UKHSA uses the National Immunisation Management System (NIMS) population as the denominator. As of 30th September 2022, vaccination uptake in Merton residents in all population aged 12 and over are as follows[38]:

- 51.5% are fully vaccinated (received a third dose or booster dose)
- 67.9% have received at least 2 doses
- 71.5% have received at least one dose

Positively most people who had their first dose went onto have their second dose, however the gap between the number of people who have had their second dose and booster (or third dose) is wider, meaning almost 17% did not go on to have their booster. Anecdotal insight suggests reasons for people not taking up their booster includes being unsatisfied with the type of vaccine that was offered (for example if it was a different one to what they had previously), COVID-19 fatigue and people thinking that the vaccine is not working and so there is little benefit.

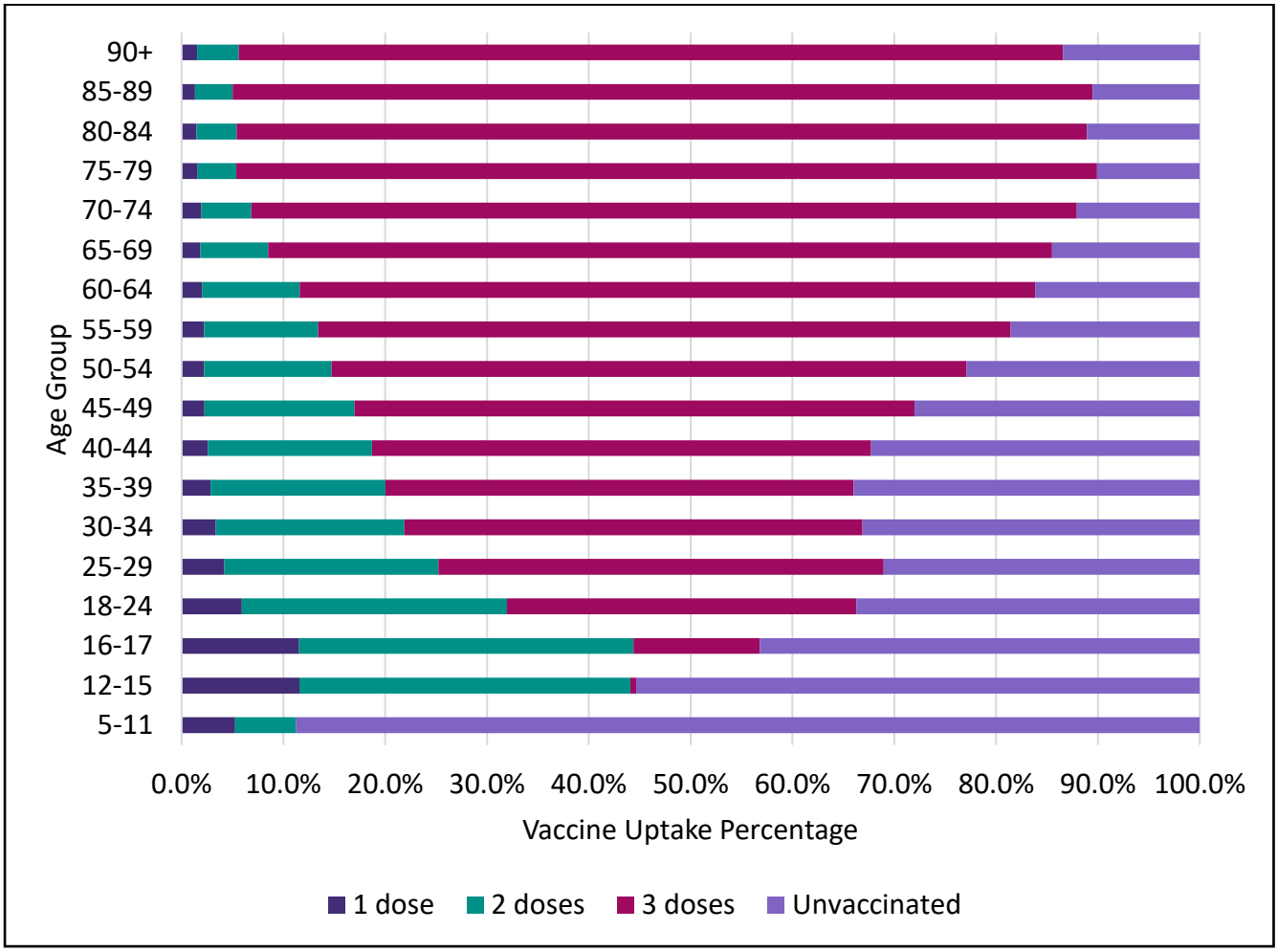
Another way of monitoring uptake of the COVID-19 vaccine by dose is to examine people that have only had 1 dose, only had 2 doses, or had 3+ doses[39]. Data shows that vaccination uptake increases by age – more than 80% of those aged 60 years and over had all three

doses of the vaccine. This is positive as older age is associated with more severe COVID-19 related outcomes. Uptake is lower in younger age groups.

Whilst most children and young people (CYP) are not seriously impacted by COVID-19, taking the vaccine could help reduce the small number of young people who can get seriously ill and hospitalised and mitigate against the indirect impact on CYP such as missed education.

Uptake of the primary course of COVID-19 vaccination was unequal, with lower uptake in East Merton (71% v 73% in the West)[51] Figure 10 shows COVID vaccine uptake by age and dose.

Figure 10: Percentage (%) COVID-19 vaccine uptake among Merton residents by age and number of doses, as of 30th September 2022. Source: Coronavirus Dashboard, GOV.UK[40].



Please note that:

- Unvaccinated: the proportion of individuals that have not received their first dose.
- 1 dose: individuals who have received their 1st dose only but no further doses (partially vaccinated).

- 2 doses: individuals who have received their 1st and 2nd doses only (partially vaccinated).
- 3 doses: individuals who have received their 1st dose, 2nd dose, and 3rd or booster dose (fully vaccinated).
- The presented vaccine uptake estimates should be seen as "at least" estimates as the denominator is from NIMS.

Data for care home residents and other priority groups

Figure 11 shows the percentage (%) uptake of the COVID Autumn Booster dose amongst residents aged 75+ in Merton since September 2022. For residents aged 50+ in Merton coverage was 15.9% as of 30th September, this increased to 47.0% as of 7th December 2022. This is higher than London at 44.3%, yet lower than the rest of SWL at 51.1%.

Figure 11: percentage (%) uptake of the COVID Autumn Booster dose amongst residents aged 75+ in Merton since September 2022. Source: Coronavirus Dashboard, GOV.UK[41].

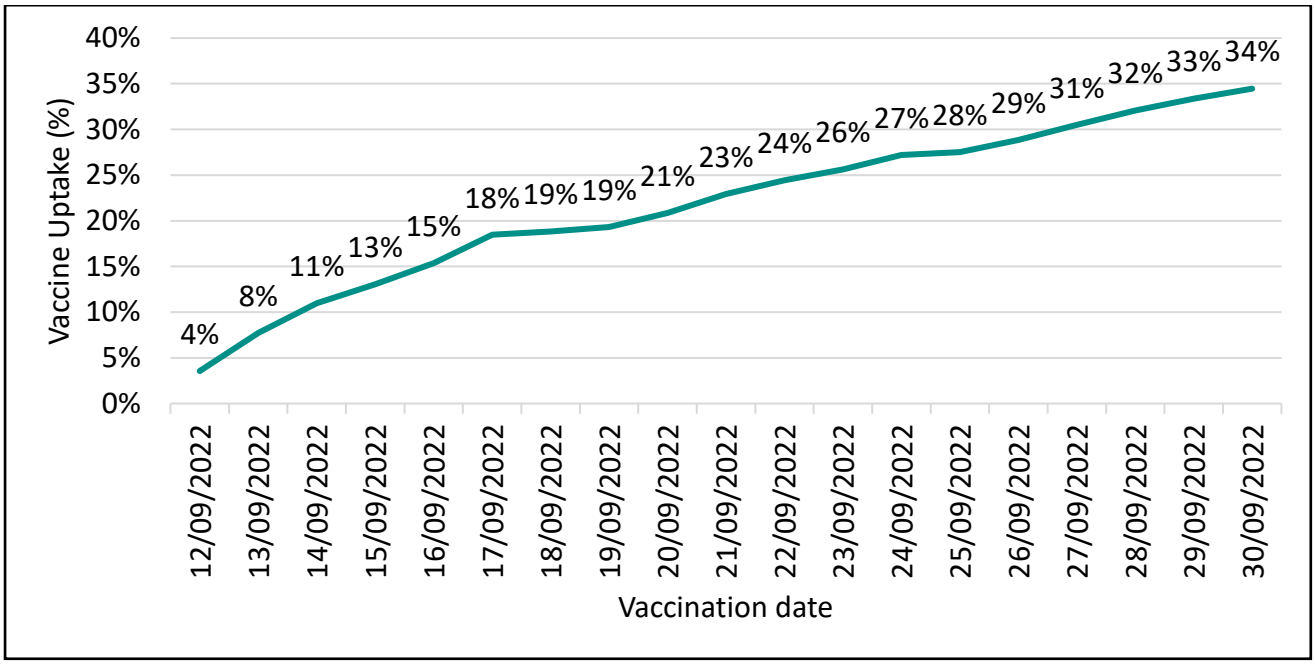
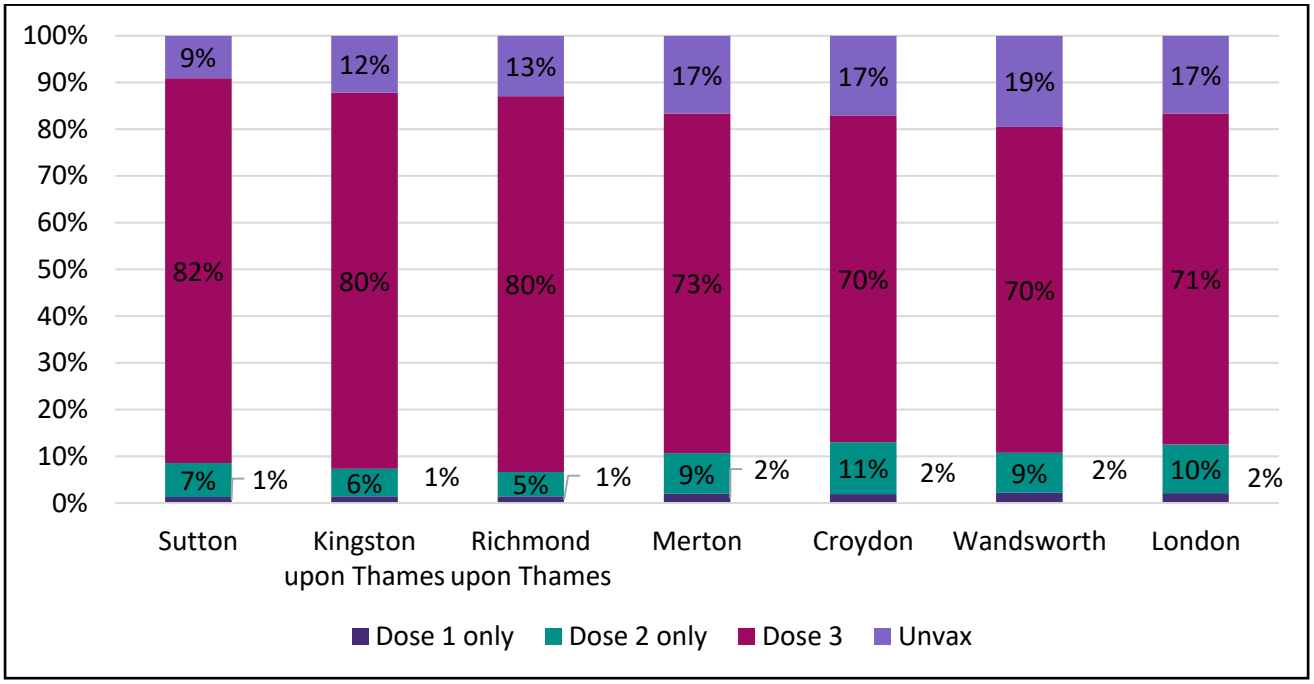


Figure 12 shows that 73% of Merton residents aged 50+ years old have had three doses of the COVID-19 vaccine which is higher than Croydon and Wandsworth but lower than Sutton, Kingston, and Richmond[42]. Approximately one in six (17%) Merton residents have not received any doses of the COVID-19 vaccine which is comparable to the London average (17%) but higher than Sutton, Kingston, and Richmond.

Figure 12: Vaccine uptake status among 50+ year olds in SWL boroughs and London, as of 30th September 2022. Source: Coronavirus Dashboard, GOV.UK[43].



Please note that:

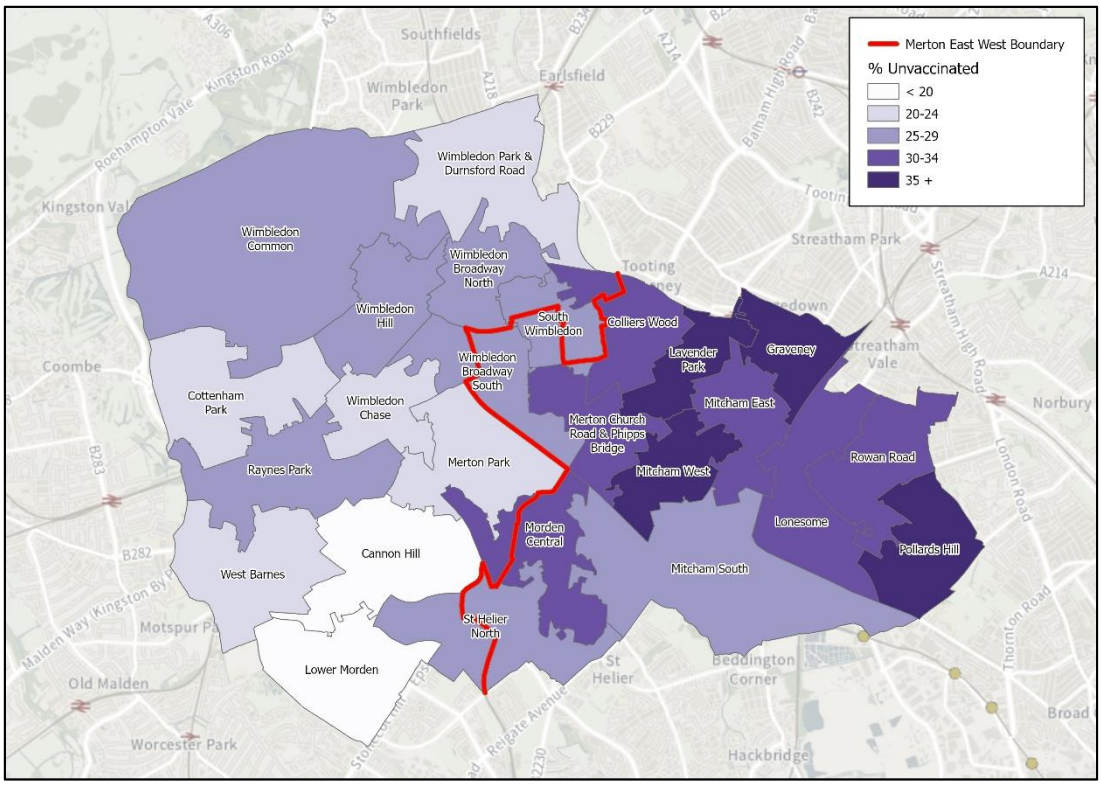
- Unvaccinated means the proportion of individuals that have not received their first dose.
- 1 dose: individuals who have received their 1st dose only but no further doses (partially vaccinated).
- 2 doses: individuals who have received their 1st and 2nd doses only (partially vaccinated).
- 3 doses: individuals who have received their 1st dose, 2nd dose, and 3rd or booster dose (fully vaccinated).
- The presented vaccine uptake estimates should be seen as "at least" estimates as the denominator is from NIMS.

The NHS started vaccinating all 12-15 year olds in September 2021 and all children aged 5-11 years on 4th Apr 2022 – children with underlying medical conditions (or living with immunocompromised household member) were offered vaccination slightly earlier than the universal offer to all children. More than one in three (33%) 12–15 year olds in Merton have received at least two doses of the COVID-19 vaccine (as of 30th September 2022)[44]. This is higher than Croydon and the London average (25% and 28% respectively) but lower than four of the five other SWL boroughs. 11% of Merton's 5–11 year olds have received at least one dose of the COVID-19 vaccine (as of 30th September 2022). This is higher than Croydon, and the London average (8% and 9% respectively)[45].

There are still some areas in Merton with low first course vaccine coverage and some communities where vaccine confidence is low. Figure 13 below illustrates the visible differences in vaccine uptake between the East and West of the borough e.g., individuals who have not received at least one dose of the COVID-19 vaccine[46]. Studies have reported trust as a critical issue, including mistrust in the vaccine itself and in authorities administering or promoting it – this particularly relates to experiences of certain communities such as Black and Caribbean people[47,48,49,50]. These inequalities are likely to be replicated in the autumn booster coverage unless efforts are undertaken to reach groups with low coverage.

Figure 13: Proportion of unvaccinated Merton residents by MSOA in Merton, as of 15th June 2022. Source: Coronavirus Dashboard, GOV.UK.

Please note, the Merton East/West boundary is drawn by ward, but as ward boundaries do not match MSOA boundaries the boundary goes through some MSOAs. Uptake of the primary course of COVID-19 vaccination is unequal, with lower uptake in East Merton (71% v 73% in the West)[51]. However, it should be noted that MSOA data has been used as a proxy to determine the East Merton and West Merton vaccine uptake.



Vaccine uptake among pregnant women is lower than among the general population in England and across the world[52]. In England, latest estimates by UKHSA based on women giving birth in February 2022 show that almost two-thirds (65.9%) of women had received at least one dose of the COVID-19 vaccine, compared to 91% of the general population aged 12 years and older[53]. The report also shows that inequalities in vaccine uptake seen in the

general population are also seen with pregnant women, with women of Black ethnicity, those living in poorer areas, and younger mothers being the least likely to be vaccinated.

Treatments for COVID-19

Since December 2021, patients at highest risk of becoming seriously ill with Covid-19 have been eligible to receive new COVID-19 treatments after they test positive for COVID-19; neutralising monoclonal antibodies (nMABs) for example sotrovimab (Xevudy), and antivirals such as nirmatrelvir and ritonavir (Paxlovid), remdesivir (Veklury), and molnupiravir (Lagevrio). Those eligible include individuals with certain conditions that are at highest risk of getting seriously ill from COVID-19[54].

Regional level data shows that between 9th December 2021 and 18th September 2022, there were 9,667 prescriptions of these treatments in the community across London. Local level data on eligibility or use of these treatments is not available at the time of writing and will be an important component of the plan to live safely and fairly with COVID-19.

Post-COVID Syndrome

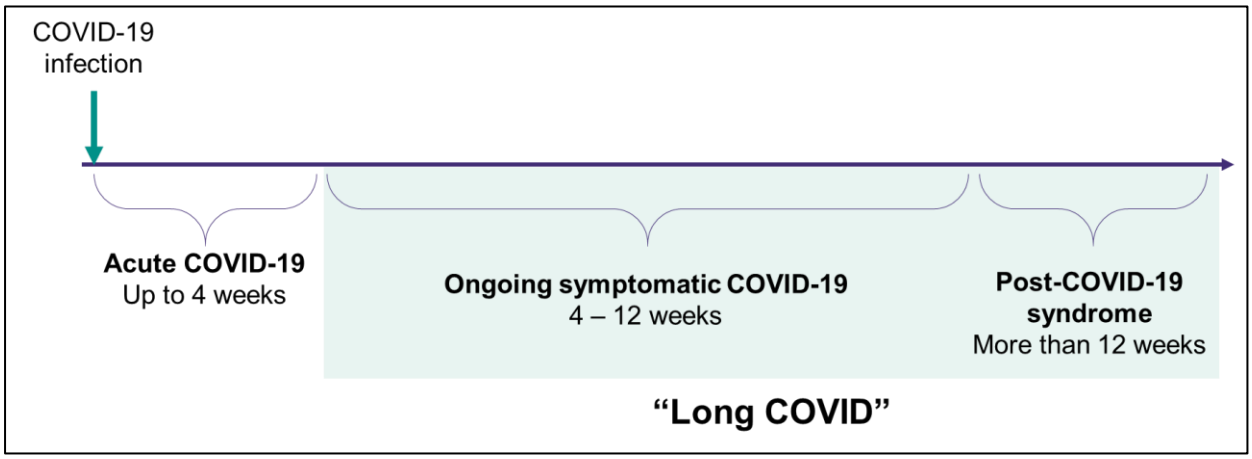
Most people who catch COVID-19 won't become severely ill and get better relatively quickly, but there are a number of people who have long-term symptoms after recovering from the original infection, even if the original infection was not severe. The longer-term impact of the pandemic is still to be understood, but it is likely that there will be a short-, medium- and long-term impact of post COVID on individuals and on local health and care services.

The National Institute for Health and Care Excellence (NICE) use the following clinical definitions for the initial illness and post COVID at different times (see Figure 14).

- Acute COVID-19: signs and symptoms of COVID-19 for up to 4 weeks.
- Ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4 to 12 weeks.
- Post-COVID-19 syndrome: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis.

Please note that while the official definition relates to Post Covid Syndrome, patients may prefer the term Long COVID[55].

Figure 14: Timeline of Long COVID.

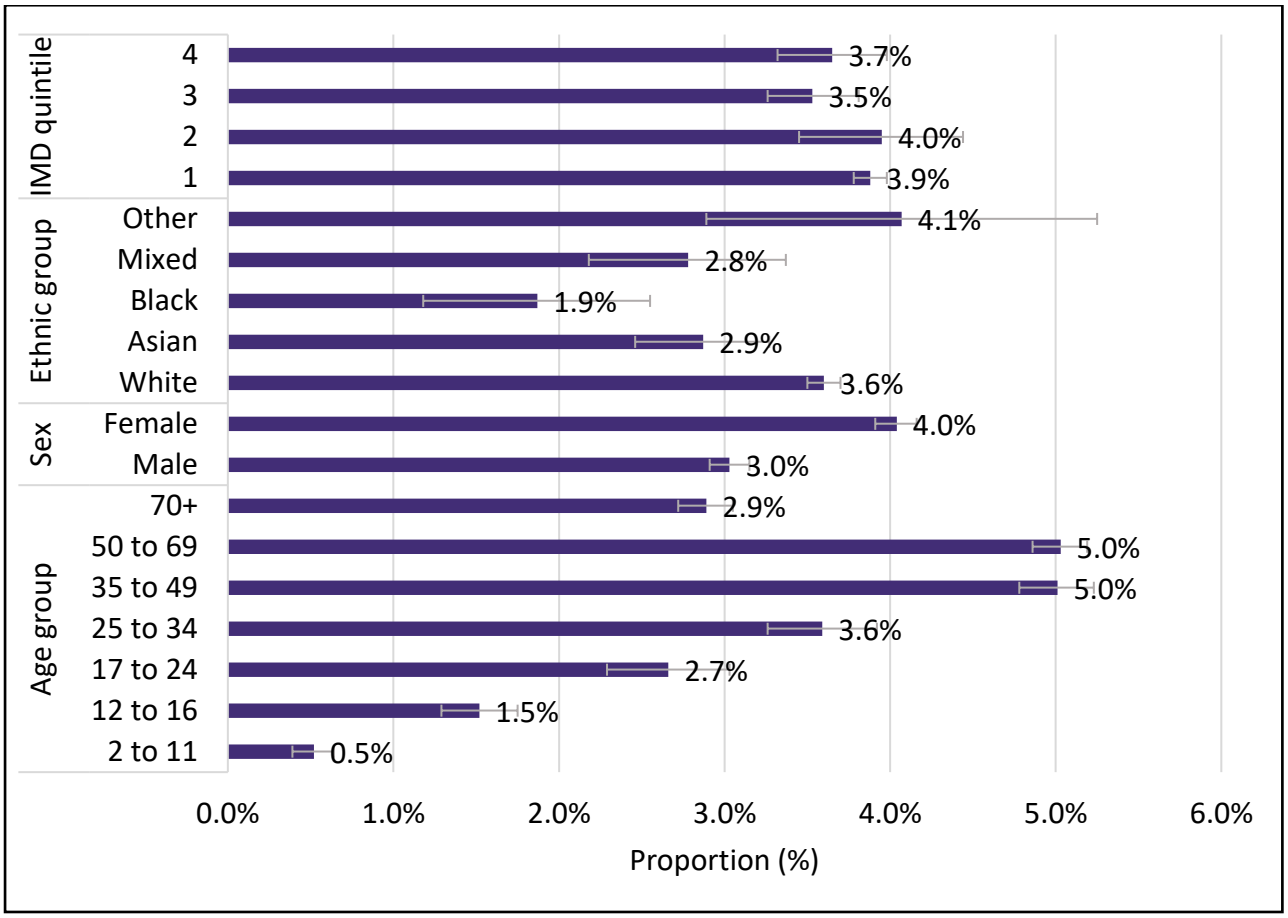


Prevalence of long COVID

Nationally self-reported prevalence of long COVID is 3.1%, this is estimated to be 2,400 residents in Merton and is greatest in people aged 35 to 69 years, females, people living in more deprived areas, those working in social care, those not working, and those with another activity-limiting health condition or disability7 The prevalence of long COVID is also reported more in White populations compared to Asian, Black, and Mixed Ethnic groups[56] (Figure 15). 73% of long COVID patients reported that these symptoms adversely affected their day-to day activities and 19% reporting their symptoms limited their day-to-day activities a lot[57].

Figure 15: Estimated prevalence (proportion, %) of long COVID (any duration) in the four-week period ending 3rd September 2022. Source: Office for National Statistics[58].

Please note, estimates do not account for differing rates of infection between groups. Observed patterns in prevalence rates may therefore partly reflect patterns in coronavirus infection, rather than providing evidence for differential risk of long COVID following infection.



Residents Voice

HealthWatch Merton, along with their colleagues across Southwest London, gathered responses from over 300 people who shared their experiences on long COVID. Key findings included that 80% had not received support, 63% stated long COVID had affected their mental health and 32% reported that it had impacted on their working life. This has affected their lives, the range and severity of symptoms, the support accessed and what else could support their recovery. Resident voice and lived experience would be an important component of Merton's transition to living safely and fairly with COVID-19[59].

Recommendations for future data collection or analysis

- It is recommended that opportunities are explored to obtain data sets for different demographic and high-risk groups which allow for greater shareability and will inform action.
- The use of therapeutics for those whom are vulnerable or have a severe disease in the community is a key part of the plan to live safely and fairly with COVID-19. It is recommended local data sets are explored, including different demographic data.
- Further work to understand the impact of Post COVID Syndrome on individuals and approaches to understand lived experience, to inform future action.

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