



Isle of Wight COVID-19 Health Impact Assessment October 2021

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INTRODUCTION

On 11 March 2020 the World Health Organisation declared COVID-19 a pandemic. Over a year on, this report aims to look at the impact COVID-19 has had on the residents of the Isle of Wight.

SARS-CoV-2 is a newly emergent virus causing COVID-19 disease, and even now there is still much more to understand. The impacts of COVID-19 will be felt for many years, and some may still not yet be realised. Therefore, this report provides a retrospective view of what the pandemic has meant to our local populations, reviewing national guidance and policy to date and what the potential impacts have been and will be on our populations.

COVID-19 has exposed, exacerbated, and created health and social care needs and new inequalities. People across the UK, and indeed the world, have been harmed by the virus in very different ways. Both the first and second waves of the pandemic have brought challenges. We need to understand how the effects have disproportionately affected different population groups (age, gender, ethnicity, occupations, co-morbidities, deprivation) and how we minimise the negative impacts and maximise the positive benefits.

We recognise that as a nation we will now be living with COVID-19 in circulation and as a consequence the disease will become an ongoing demand on our health and social care services. We need to begin to consider how we live safely with COVID-19 in a way that addresses the health and social inequality that it has exposed and exacerbated.

Health inequalities in society are driven and influenced by not just clinical but social, economic, and environmental factors. The Dahlgren-Whitehead rainbow model¹ remains one of the most effective illustrations of health determinants and shows the various influences on a person's health such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions.

Many of the underlying health risk factors for COVID-19 are the result of poor conditions associated with the social determinants of health. This emphasises the need to understand the interaction between the biological and the social determinants of COVID-19.

A Health Impact Assessment (HIA) aims to assess the potential impacts on the health of a population, and the distribution of those impacts within the population. Health is defined not just by the absence of illness or injury but also recognises the influence that the wider social determinants of health, such as employment, education, lifestyles, and behaviours, have on an individual. These can affect people's risks of getting ill, their ability to prevent sickness, or their access to effective treatments.² This approach is key to better understanding the impact of COVID-19.

This report will inform the Joint Strategic Needs Assessment (JSNA) work programme, identifying and recommending topics which require further, more detailed reports. The introduction of this report provides an outline of the strategic context of the pandemic, the population of the Isle of Wight and a summary of the key COVID-19 data. The following sections are structured to reflect the JSNA and discusses the impacts on our populations by the JSNA chapters: Healthy People, Healthy Lives and Healthy Places.

¹ [The Dahlgren-Whitehead rainbow - Economic and Social Research Council \(ukri.org\)](https://www.ukri.org/research-projects/dahlgren-whitehead-rainbow/)

² [Chapter 6: social determinants of health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/social-determinants-of-health)

Strategic context: Key National Policy and Government Actions

In December 2019, a novel coronavirus (SARS-CoV-2) was identified in Wuhan, China. The World Health Organisation declared a Public Health Emergency of International Concern relating to COVID-19 on the 30 January 2020 and the first case was identified in the UK the following day. In the absence of a vaccination at the start of the pandemic, 100% of the population were susceptible to COVID-19. Therefore, the use of non-pharmaceutical interventions (NPIs) was essential to suppress the disease and slow transmission.

Non-pharmaceutical interventions (NPIs) are public health actions that people and communities can take to adapt their behaviour to slow down the spread of viruses such as SARS-CoV-2. Countries worldwide implemented interventions aimed at restricting population movement to reduce social contacts and ultimately infection transmission rates.

Non-pharmaceutical interventions (NPIs)

In March 2020, Imperial College London reported that optimal mitigation policies including the use of NPIs might reduce peak healthcare demand by two thirds and deaths by half.³ Data show that when an NPI is implemented it can take a number of weeks before an epidemiological effect is realised, such as decreasing infection rates.⁴ This delayed effect must be a key consideration when implementing any intervention.

On Monday 16 March 2020, the UK government advised those who were or may be at increased risk of severe illness from COVID-19 to be particularly stringent in following social distancing measures and to stay indoors. A shielded patient list of individuals with specific conditions was subsequently identified and a high-risk flag was marked in their primary care records. Those clinically extremely vulnerable populations identified were asked to shield.

On the 23 March 2020, the UK Government imposed 'Stay at Home' lockdown regulations with the campaign message of 'Stay home, save lives, protect the NHS'. This embodied the principles of the NPIs, the main objective being to suppress the transmission of COVID-19 and prevent the NHS system becoming overwhelmed.

Figure 1 visualises the timeline of key policy decisions and the affected sectors. It also provides expected restrictions up to July 2021 (as of June 2021), based on the road map announced by the UK Government on 22 February 2021⁵ which outlined steps for easing restrictions. A more detailed timeline of key policy decisions is presented in Appendix A.

The red shading represents the times when sectors were closed and orange when restricted. This illustrates a stark picture and shows that throughout 2020 all sectors, and therefore all population groups, experienced restrictions and closures. This was particularly so for hospitality, workplaces and care home visiting. Social distancing has impacted on all our social interaction behaviours and movements since the start of the pandemic in March 2020.

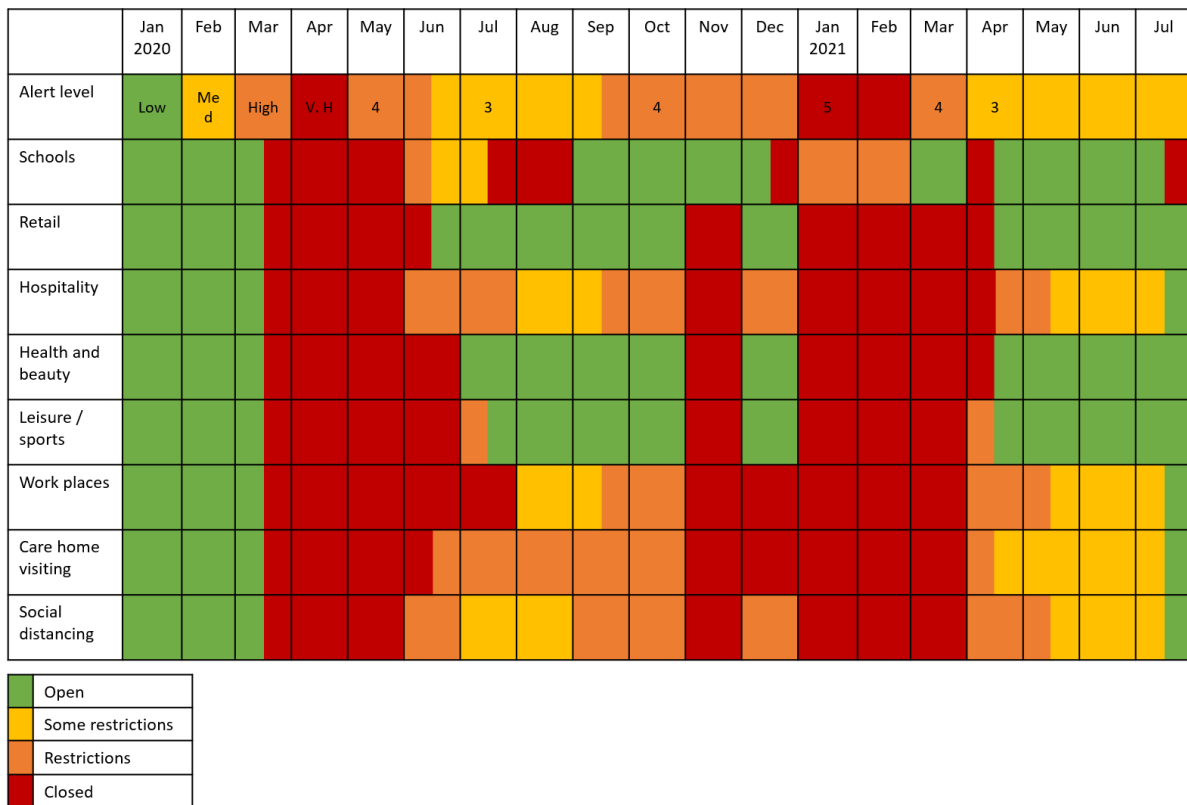
Educational settings were closed in the first lock down and were under significant restrictions for almost a year. School children across all educational phases experienced disruption to their education, missing considerable periods of classroom teaching.

³ [Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf](#)

⁴ European Centre for Disease Prevention and Control. [Infographic: Non-pharmaceutical measures \(europa.eu\)](#)

⁵ [COVID-19 Response - Spring 2021 \(Roadmap\) - GOV.UK \(www.gov.uk\)](#)

Figure 1: Timeline of key policy decisions

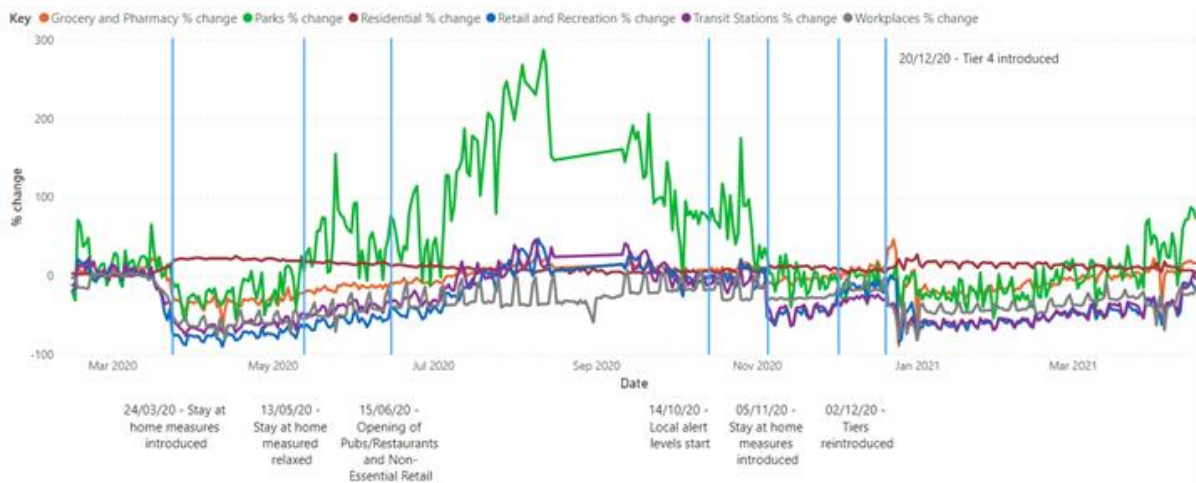


Considering these policies and their impact on how society interacts, works and moves is an important predictor for ensuing healthcare demand. This also helps build a sense of how the social wider determinants of our population’s health may have been impacted. Google mobility data aim to provide insights into what has changed in response to policies intended to combat COVID-19.⁶ Figure 2 below shows population movement trends over time across the Isle of Wight, compared to the baseline data⁷ and across different categories of places such as retail and recreation, groceries and pharmacies, parks, transit stations, workplaces, and residential. A decrease in population movement in all categories is clearly evident from 21 March 2020 and demonstrates the success of lockdown in reducing population movements and therefore decreasing social contacts and the risk of transmission.

⁶ [COVID-19 Community Mobility Reports \(google.com\)](https://www.google.com/covid19/mobility/)

⁷ Baseline day is the median value for each category from the 5 week period Jan 3rd to Feb 6th, 2020.

Figure 2: Population movement trends over time by category of place



Source: Google COVID-19 Community Mobility Reports

On 13 May 2020, the lockdown measures eased to allow garden centres and recycling centres to open and mixing outdoors with one other person. ‘Stay alert, control the virus, save lives’ messaging was introduced. The impact of population mobility after this easing of measures is again clear in Figure 2 which shows a significant increase in population movements in parks from 13 May to mid-August.

Google mobility data show how throughout the pandemic and to date, population movements have been lower than the baseline. This suggests that people have, in general, been compliant with the measures and have adapted their behaviours accordingly for example working from home, shopping online and staying local.

Economic policies

As part of its response to the COVID-19 pandemic the government introduced the Coronavirus Job Retention Scheme (CJRS). The scheme ended on 30 September 2021 and allowed all UK employers with employees on a PAYE scheme to designate some or all employees as ‘furloughed workers’. The aim of the furlough scheme was to allow companies to continue employing and paying workers, even when lockdown meant there was no work to undertake, potentially protecting them from redundancy. Many countries across the world offered a furlough scheme although the policies vary greatly. In the UK cumulatively, 11.2 million jobs have been supported by the CJRS since the start of the scheme.⁸ Despite this economic support available, experimental weekly Labour Force Survey (LFS) estimates suggest approximately half a million employees received no pay while their jobs were on hold and/or affected by the COVID-19 pandemic in April and May 2020, this decreased and remained flat from July but then increased in the first two months of 2021.⁹

The direct health and clinical impacts of these policies are evident. Across the Isle of Wight, high levels of population compliance of measures such as social distancing and ‘Stay at home’ rules resulted in suppressed infection rates and will have undoubtedly resulted in fewer people being hospitalised and dying. However, the social and mental well-being impacts could be less positive, with reports of increased loneliness through reduced social connectiveness and increased anxiety and depression during times of great uncertainty. The long-term impact of school closures on student’s education, health and wellbeing outcomes, and how to re-engage pupils also requires consideration.

⁸ [Coronavirus Job Retention Scheme statistics: February 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/coronavirus-job-retention-scheme-statistics-february-2021)

⁹ [X07: Labour Force Survey weekly estimates - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandwork/employmentandlabourmarket/weeklylabourforcesurvey/weeklylabourforcesurveyweeklyestimates)

Policies addressing businesses and employment, such as the CJRS, have been significant. The long-term impact of unemployment on a worker's ability to find a job will heavily depend on how the economy bounces back from COVID-19. Economic indicators suggest wide reaching, and perhaps long lasting, impacts on the current and future working age population.

COVID-19 Clinical Management

The UK Government have dedicated substantial effort on reducing the COVID-19 impact on mortality and the burden on the healthcare system. There has been a huge investment in research to find therapies to treat COVID-19 or its effects. In March 2020, a £20m funding allocation was announced for COVID-19 therapies and vaccines. This is coordinated through the Government's medical research funders such as the National Institute for Health Research (NIHR) and UK Research and Innovation.¹⁰

Since the start of the pandemic, the NIHR have funded and supported a range of clinical research into potential COVID-19 treatments. The NIHR established a single process to prioritise COVID-19 research as an Urgent Public Health Research. In May 2021, there were 92 studies approved in this program, of which 51 were underway.¹¹ These prioritised studies have put the UK in an important position of global efforts to establish effective treatments against COVID-19.¹² For example, it was through the RECOVERY trial¹³ that dexamethasone was demonstrated as an effective therapy against COVID-19 effects and reduces the risk of dying by a third in ventilated patients.¹⁴ It was shown to be a breakthrough discovery considering the drug's price and availability. According to NHS England, dexamethasone, the world's first lifesaving COVID-19 treatment, had already saved 22,000 lives in the UK and an estimated one million around the world.¹⁵

Despite all progress, there are no specific treatments for COVID-19 disease yet. Researchers worldwide are still working at record speed to find the best ways to treat and prevent COVID-19. Current approaches that will give the quickest result investigate the possibility of repurposing existing drugs used to treat other conditions. Trials to assess the potential effectiveness of these therapeutics are ongoing and evolving.¹⁶ This fast process of building clinical evidence has required trustworthy guidance for healthcare systems and their staff.

In the UK, the National Institute for Health and Care Excellence (NICE) is responsible for producing evidence-based guidance and advice for health and social care services. In March 2020, NICE published the first guideline providing recommendations around COVID-19. Since then, the organisation has developed several rapid guidelines on the care of patients with suspected or confirmed COVID-19, and for patients without COVID-19 who have specific clinical needs.

The current guidance to manage COVID-19 covers children, young people and adults in all care settings.¹⁷ It brings together existing and new recommendation on therapeutics. This is considered a live document due to the fast evolving of therapies and need of frequent

¹⁰ [COVID-19 therapies - POST \(parliament.uk\)](https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2019/covid-19/covid-19-therapies-post/)

¹¹ [Urgent Public Health COVID-19 Studies | NIHR](https://www.nihr.ac.uk/about/urgent-public-health-research/covid-19-studies/)

¹² [Finding new treatments | NIHR](https://www.nihr.ac.uk/about/urgent-public-health-research/covid-19-studies/)

¹³ [Case study: The UK's flagship COVID-19 treatment trial - the RECOVERY trial | NIHR](https://www.nihr.ac.uk/about/urgent-public-health-research/covid-19-studies/)

¹⁴ [Dexamethasone in Hospitalized Patients with Covid-19 | NEJM](https://www.nejm.org/doi/full/10.1056/NEJMoa2021170)

¹⁵ [NHS England » COVID treatment developed in the NHS saves a million lives](https://www.nhs.uk/news/2021/05/covid-treatment-developed-in-the-nhs-saves-a-million-lives/)

¹⁶ [COVID-19 Clinical management: living guidance \(who.int\)](https://www.who.int/publications/m/item/covid-19-clinical-management-living-guidance)

¹⁷ [Overview | COVID-19 rapid guideline: managing COVID-19 | Guidance | NICE](https://www.nice.org.uk/guidance/rapid-guidance/covid-19/rapid-guideline-managing-covid-19)

update. Likewise, the organisation has launched a guideline to cover the long-term effects of COVID-19, often described as 'Long COVID'. It makes recommendations about care in all healthcare settings for people who have new or ongoing symptoms 4 weeks or more after the start of acute COVID-19. It also includes advice on organising services for Long COVID.¹⁸

In addition, NICE has published 35 other products such as guidance, technological appraisals and evidence summaries, to support decision making in health, public health, and social care during the pandemic. These documents have played a crucial role in the provision of evidence-based recommendations over this unprecedented time.

Over the pandemic, commissioners and trusts within the Isle of Wight have used NICE guidelines and other organisation's recommendations such as Medicines and Healthcare Products Regulatory Agency (MHRA) to support their providers. Healthcare settings are working hard to ensure that they are ready to meet the clinical challenges and successfully deliver cost-effective clinical services for the patients that they serve. However, COVID-19 has impacted healthcare settings in distinct ways, especially in terms of services' access and prescribing.

A report from the Association of Directors of Public Health 'Living Safely with COVID' recognises the inequalities that previously existed and have been exacerbated by both NPIs and COVID policy.¹⁹ It stresses the importance of recovery strategies and how these should consider and address the wider health and economic impacts of COVID-19, so recovery benefits everyone in a way that is more equitable than in years before.

The next section provides a summary of the Isle of Wight's population structure including ethnic diversity and place-based deprivation.

Population of Isle of Wight

Age and sex structure of the population

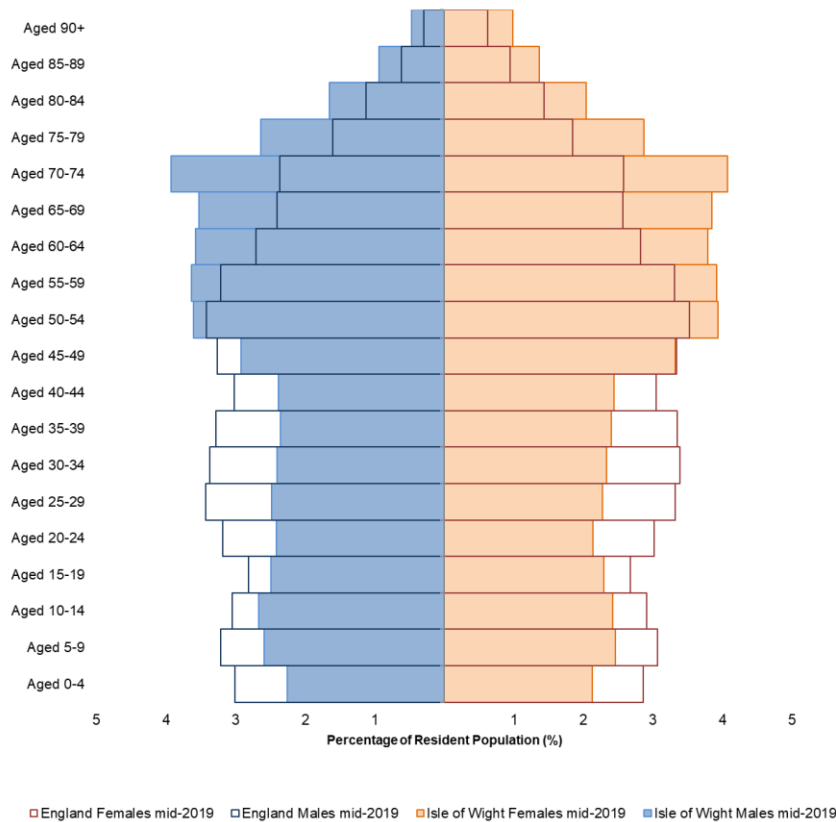
The population of the Isle of Wight is estimated to be 142,296 people. There are slightly more females, 51%, than males. Compared to England, the Isle of Wight has a significantly older population structure, with a greater proportion of the population aged 50 years and over and a lower proportion of children and young people (0-19yrs) and working age, 20 to 49 years.

- Young people (aged 0-19 years) make up 19.3% of the population compared to 23.6% nationally.
- The Isle of Wight has a significantly smaller proportion of young working age people (aged 20-44 years) than England as a whole; 23.6% in Isle of Wight compared to 32.4% in England.
- Over one in five Isle of Wight residents (21.0%) are aged 70 years and over compared to 13.4% nationally.
- 1.5% of the population of the Isle of Wight are classed as the 'oldest old', those aged 90 years and over. This compares to 0.9% of the population in England.

¹⁸ [Overview | COVID-19 rapid guideline: managing the long-term effects of COVID-19 | Guidance | NICE](#)

¹⁹ [Living-Safely-with-Covid-ADPH-Guidance-1.pdf](#)

Figure 3: Isle of Wight resident population age and sex structure compared to England



Source: ONS 2019 mid-year population estimates

Ethnic Minorities

The 2011 Census remains the most robust source of information about the ethnicity of the resident population for the Isle of Wight, although it should be noted that this data is now a decade old.

The population is less diverse than England as a whole, with 97.3% of residents describing themselves as belonging to White ethnic groups compared to the national average of 86%. The diversity of the area’s population is increasing, 2.7% of the population described themselves as of an ethnic background other than White in 2011, up from 1.3% in the previous census conducted in 2001. Overall ethnic populations have a younger age structure when compared to the White population group.

- Young people (aged 0-19 years) make up 39.38% of the population who are from an ethnic minority compared to 20.55% of the population who are from a white ethnic group.
- Younger working people (20-44 years) make up 38.55% of the population who are from an ethnic minority compared to 26.19% of the population who are from a white ethnic group.
- Older people (70+) make up 2.77% of the population who are from an ethnic minority compared to 17.18% of the population who are from a white ethnic group.

Figure 4: Percentage of the Isle of Wight population who are from a non-white ethnic group by LSOA

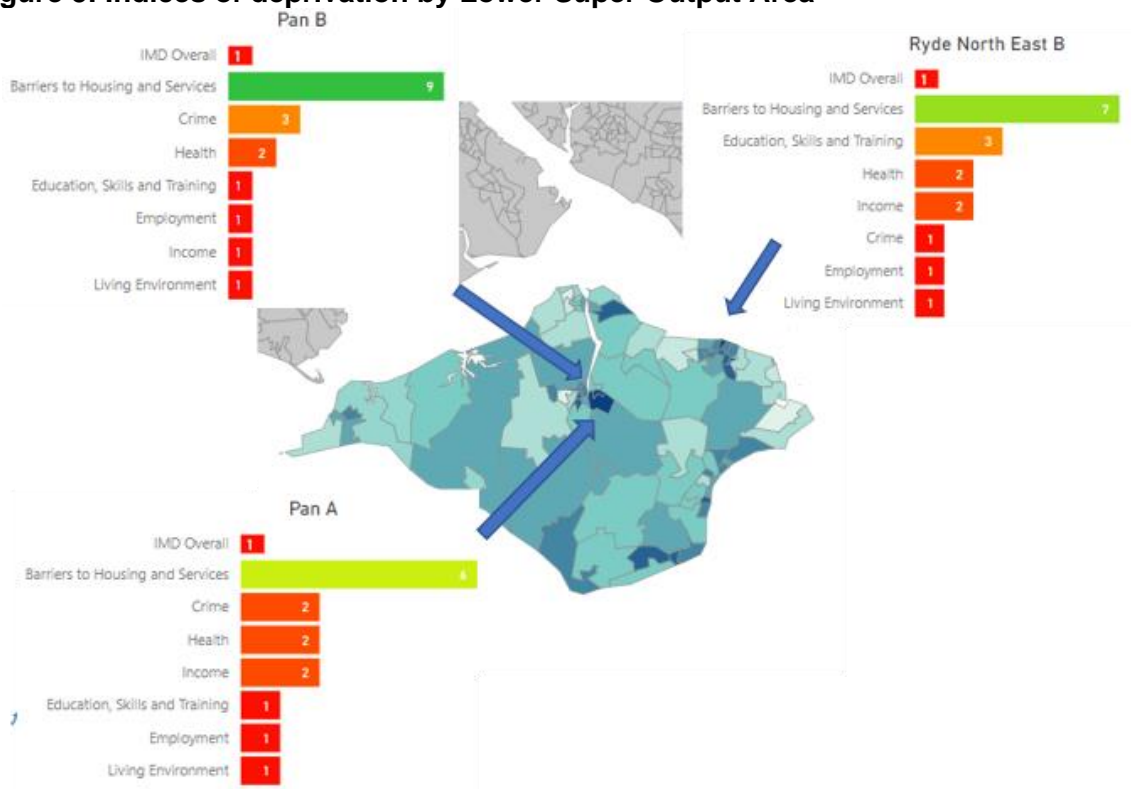


Source: Census 2011

Deprivation

The Isle of Wight is ranked 80 out of 317 (1 being the most deprived) Local Authority areas for average rank. Three LSOAs are in the most deprived decile for IMD overall (1): Pan A, Pan B and Ryde North East B.

Figure 5: Indices of deprivation by Lower Super Output Area



Source: IMD

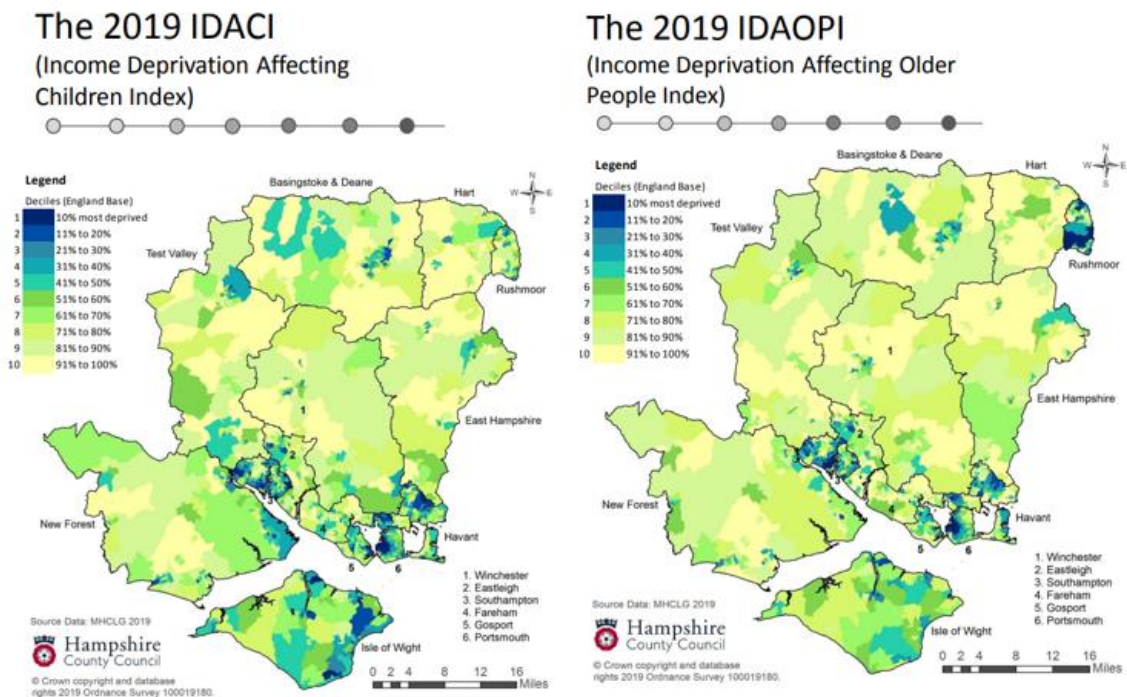
There are two supplementary indexes produced alongside the Income Deprivation Domain:

- Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. Defined as families that either receive Income Support or income-based Jobseekers Allowance or income-based Employment and Support Allowance or Pension Credit (Guarantee) or elements of Universal Credit.
- Income Deprivation Affecting Older People Index (IDAOP) measures the proportion of all those aged 60 or over who experience income deprivation. Defined as adults aged 60 or over receiving Income Support or income-based Jobseekers Allowance or income-based Employment and Support Allowance or Pension Credit (Guarantee) or elements of Universal Credit.

The income subdomains for children and older people suggest:

- 19% of children on the Isle of Wight aged 0 to 15 years are living in income deprived families.
- IDACI ranks six areas on the Isle of Wight in the most deprived decile nationally – Carisbrooke West B, Osborne North, Pan B, St Johns East A, St Johns West A and Ventnor West B.
- 13% of residents aged 60 or over experience income deprivation.
- IDAOP ranks no areas on the Isle of Wight in the most deprived decile nationally, five are ranked in the second most deprived decile – Mount Joy B, Newport North B, Osborne North, Pan B and Ryde South East B.
- Figure 6 shows there is marked inequality across the county with areas of significant deprivation affecting children and older people, again with the darker blue areas showing the most deprived locations within Hampshire and Isle of Wight.

Figure 6: Index of Multiple Deprivation, Income sub domains score (IMD 2019)



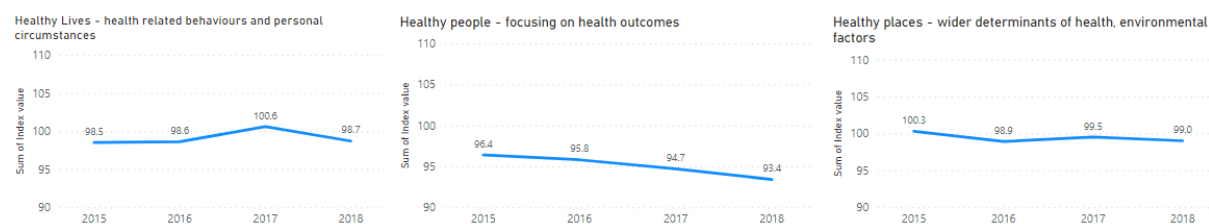
Data source: Hampshire County Council²⁰

²⁰ [EBIS reports | Business and economy | Hampshire County Council \(hants.gov.uk\)](#)

Health Index

The Health Index produced by Office for National Statistics provides a single value for health as well as showing how health has changed over time between 2015 and 2018. Therefore, it acts as a good baseline of our population's health and how it has changed over time before the pandemic.²¹ The index uses a broad definition of health, including health outcomes, health-related behaviours and personal circumstances, and wider determinants of health that relate to the places people live. Figure 7 shows that the Isle of Wight's population health is generally worse than England and has further deteriorated between 2015 and 2018.

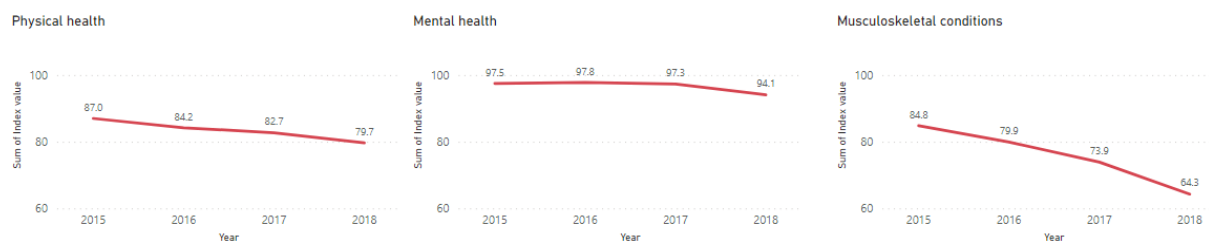
Figure 7: ONS Health Index



Note: Values higher than 100 indicate better health than England 2015, and values below 100 indicate worse health

Exploring sub domains in the Health Index (Figure 8) suggest physical health, mental health and musculoskeletal conditions are all worse on the Isle of Wight than in England and have deteriorated further. These areas will have been significantly impacted upon further due to COVID-19. This pattern is similar to that observed in the national data and suggests that before the pandemic improvements in our population's health had stagnated and even deteriorated in some areas.

Figure 8: ONS Health Index Subdomains



Note: Values higher than 100 indicate better health than England 2015, and values below 100 indicate worse health

Across the Isle of Wight, life expectancy improvements have slowed. This has been particularly noticeable in females and in more deprived areas. While life expectancy is one important indicator of health, how long a person can expect to live in good health is an even more significant measure of quality of life. Isle of Wight healthy life expectancy has decreased for both males and females, but this decrease is greatest in females.

COVID-19 data summary

This section aims to outline high level data about the impact of COVID-19 on our residents.

When analysing this data, it is important to consider the differences in policy context between Wave 1 and Wave 2, such as the change in testing strategies. Clinical treatment was also modified due to advances, for example, the introduction of

²¹ [Developing the Health Index for England - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

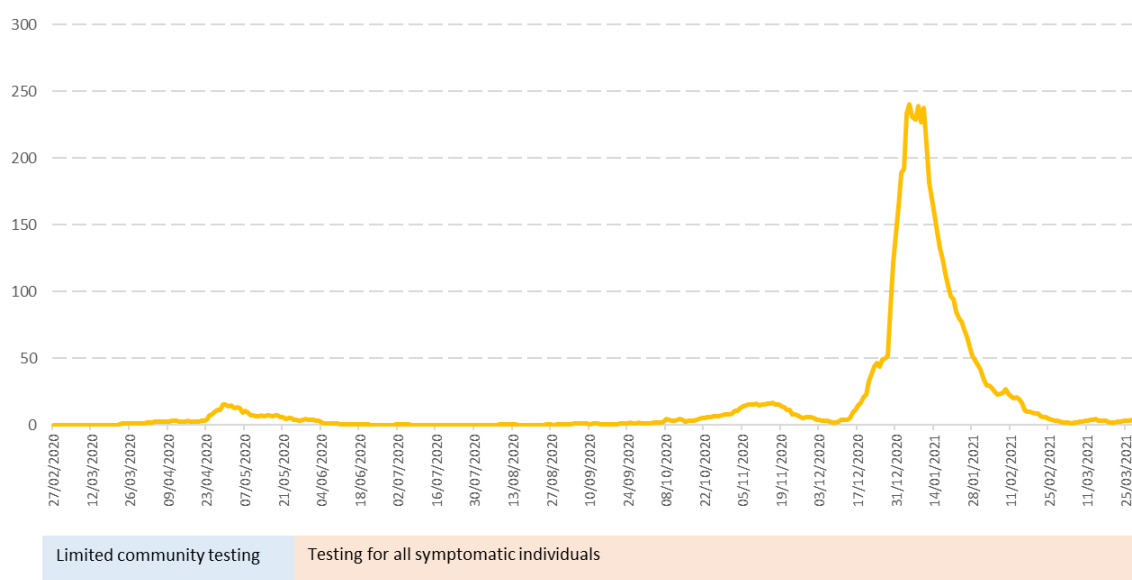
dexamethasone for patients admitted to hospital during Wave 2.²² In addition, Wave 2 was driven by a new dominant variant which originated in Kent, now known as Alpha, which was much more transmissible. This combined with mass community testing presented epi curves far higher and steeper than Wave 1.

How the waves are defined varies is dependent on the data being presented. For local analysis the cases, hospital admissions and mortality wave time periods have been driven by the peak month. Trends observed in the natural progression of the disease have shown that the number of infections peak first, two weeks later the hospital admissions peak followed by mortality cases peaking later.

COVID-19 Infections

From the start of the pandemic until the end of March 2021 there were 6,728 cases on the Isle of Wight which represents a rate of 4,745.7 per 100,000 of the population. During the first wave of COVID-19 in March 2020 very limited community testing was available and therefore a large proportion of COVID-19 infections would not have been identified.

Figure 9: COVID-19 cases (7-day average) from 27/02/2020 to 31/03/2021



Source: PHE COVID-19 Dashboard²³

During Wave 1 limited testing was available, initially only for those admitted to hospital and subsequently expanded to include health care workers. This is clear from the demographics of the cases, there was a higher proportion of cases in older age groups and women (more often working within healthcare settings²⁴). In the second wave, community testing became available and more cases were observed within the working age population. Across the different areas of the island there has been variation in the rate of infections. Increased rates of cases were observed in areas of higher population density. These findings will be discussed in more detail in later sections.

²² See Appendix A table of the key policy decisions.

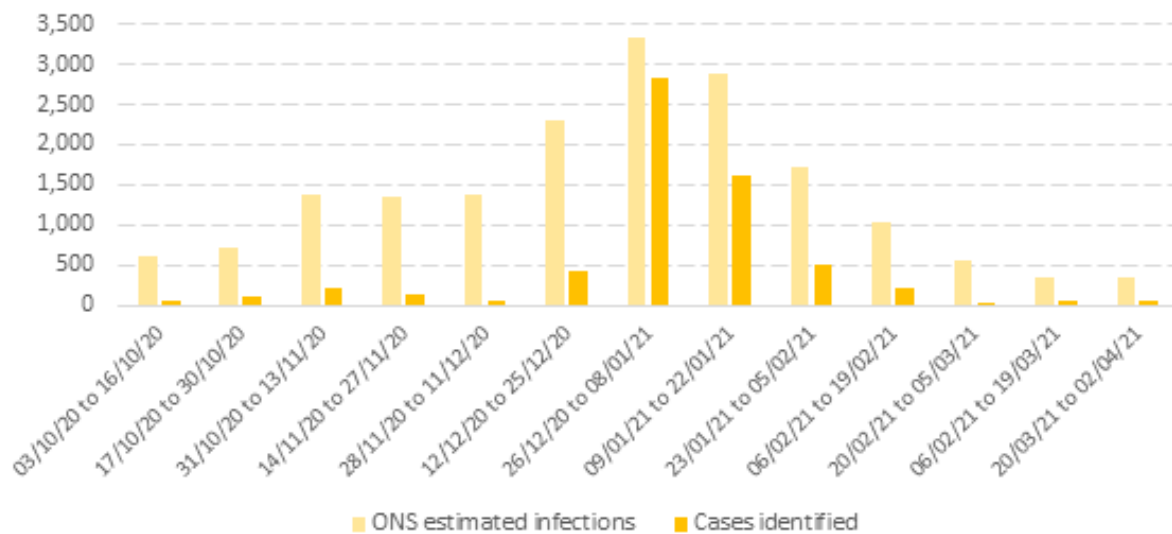
²³ <https://coronavirus.data.gov.uk/>

²⁴

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11>

Even when testing was expanded it is likely that a large number of cases were missed, due to a proportion of cases being asymptomatic. The ONS has carried out a survey²⁵ to provide estimates of the number of infections and Figure 10 compares the estimated number of infections against the number of confirmed cases identified during the second wave. Estimates of the proportion of asymptomatic cases vary across different studies, ONS estimates that around 40% of people with high viral loads will be asymptomatic at the beginning of their infection.²⁶ However, other studies have conducted follow up analysis and reported that almost half of these go on to develop symptoms and revised down asymptomatic cases to between 17 and 20% of infections.^{27,32}

Figure 10: ONS estimated infections against confirmed cases (03/10/2020 to 02/04/2021 in fortnightly periods)



Source: ONS infection survey³⁵ and PHE COVID-19 Dashboard³⁶

Hospitalisations

There were two peaks in monthly COVID-19 admission rates, one in April 2020 and another in January 2021, during the first and second waves of the pandemic. For England as a whole, COVID-19 admission rates peaked in April 2020 at a rate of 1,021.5 admissions per 100,000 population. The South East rate peaked at 775.5 admissions per 100,000. During Wave 2 national admission rates peaked at 1,510.4 per 100,000 and South East at 1,632.30 per 100,000. These rates show that Wave 2 placed a greater burden on hospitals and the population impact was greater with more people suffering from severe illness due to COVID-19 and requiring hospitalisation.

Between 6 March 2020 and 24 May 2021 there were a total of 412 emergency admissions for Isle of Wight residents where COVID-19 was recorded as the patient’s primary clinical

²⁵

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronaviruscovid19infectionsurveydata>

²⁶

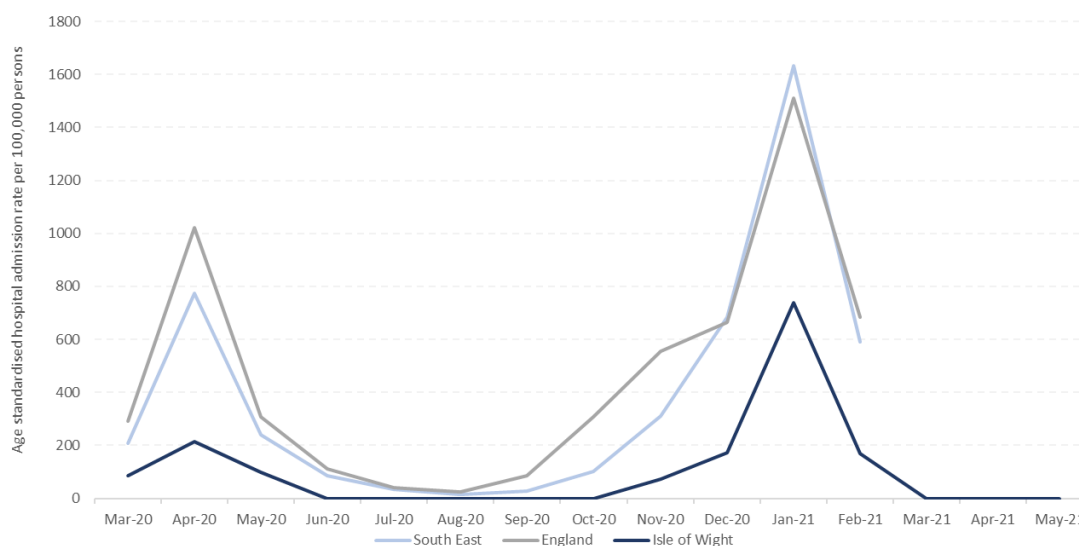
<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19infectionsinthecommunityinengland/characteristicsofpeopletestingpositiveforcovid19incountriesoftheuk5may2021>

²⁷

<https://www.bmj.com/content/371/bmj.m4851>

need.²⁸ Figure 11 shows that during Wave 1, the Isle of Wight's COVID-19 admission rates were lower than the national and regional rate, peaking in April 2020 at 215.0 admissions per 100,00 population and again in January 2021 at 740.0 admissions per 100,000. This rate is lower than that observed in both England and the South East. Monthly trends on the Isle of Wight suggest a greater burden from COVID-19 was evident in our population during Wave 2, similar to the pattern in observed in national and regional rates.

Figure 11: Isle of Wight monthly age-standardised hospital admission rate per 100,000 person-years, for COVID-19 in England, South East March 2020 to February 2021



Source: Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021 and PHE COVID-19 Health Inequalities Monitoring for England (CHIME) tool²⁹

Deaths

There were two peaks in monthly mortality rates nationally, one in April 2020 and another in January 2021, during the first and second waves of the pandemic. For England as a whole, all-cause mortality peaked in April 2020 at a rate of 1,859.6 deaths per 100,000 population and mortality due to COVID-19 was at its highest during the same month, at a rate of 623.2 deaths per 100,000 population.

On the Isle of Wight, mortality rates from all causes were mostly lower than national rates except for slightly higher rates in July and August 2020, a much higher rate in September 2020 (1,173.5 compared to 882.4 nationally) and then another slightly higher rate in February 2021. All-cause mortality peaked in January 2021 at a rate of 1,397.3 deaths per 100,000 population.

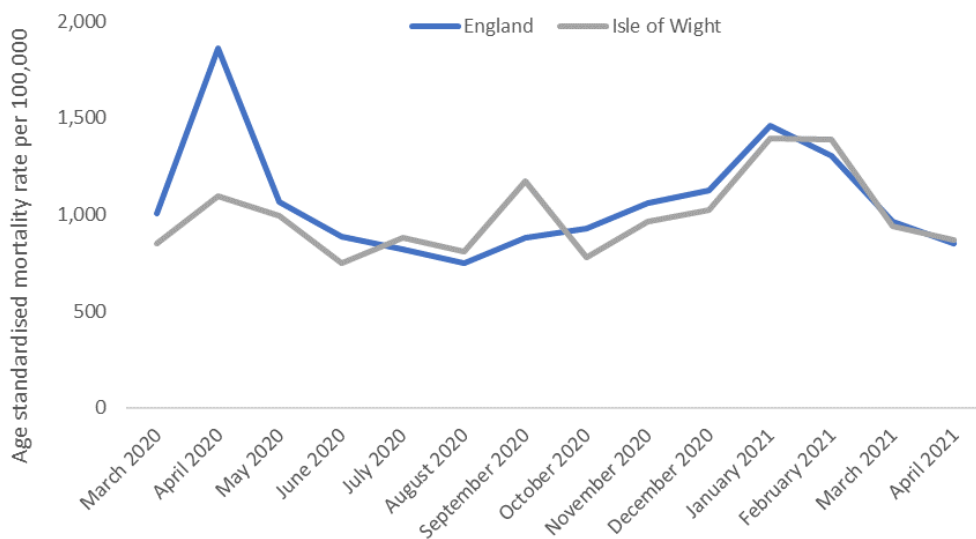
Mortality rates due to COVID-19 were consistently lower than national rates across the pandemic period and were at their highest during the second wave of the pandemic, reaching a high of 440.4 deaths per 100,000 during January 2021.

It should be noted that the local figures quoted in this report are registered deaths and due to the lag in registration processes may not match figures released nationally. This is more likely to disproportionately impact figures for Wave 2.

²⁸ Data relates to the number of admissions and not individuals as over the time period a person may have been admitted more than once.

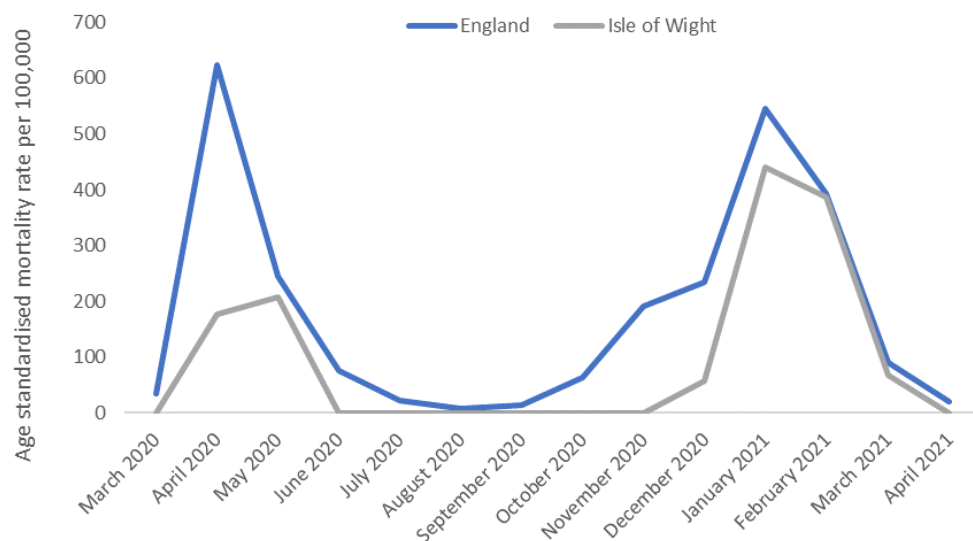
²⁹ [PHE COVID-19 Health Inequalities Monitoring for England \(CHIME\) tool](#)

Figure 12: Age standardised mortality rates from all causes



Source: Deaths due to COVID-19 by local area and deprivation, 20 May release, ONS³⁰

Figure 13: Age standardised mortality rates due to COVID-19



Source: Deaths due to COVID-19 by local area and deprivation, 20 May release, ONS³¹

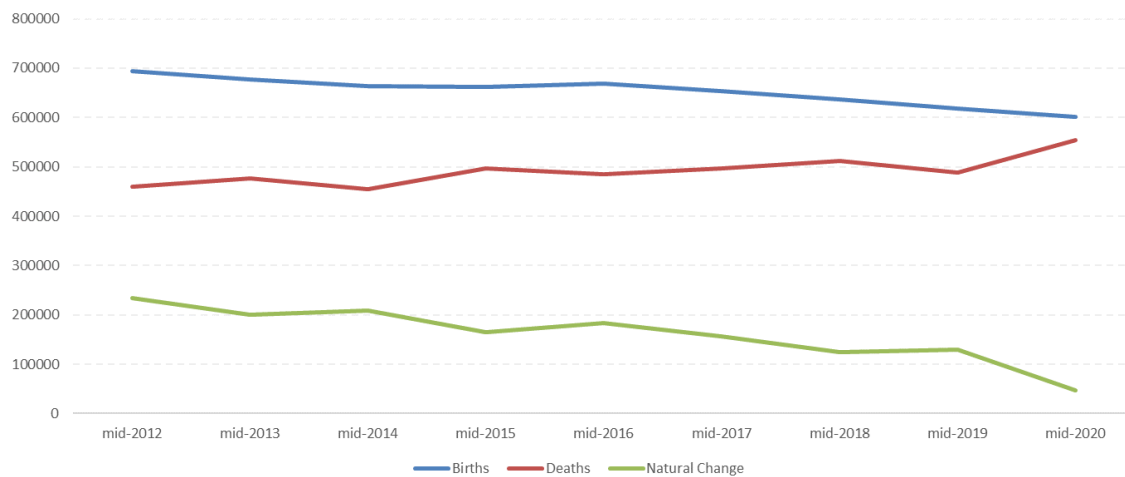
Population change

The Office for National Statistics have recently produced estimates of population change up to mid-2020. Figure 14 shows that natural change (the difference between an area's births and deaths) has decreased significantly during 2020. This is reflective of the impact of the first wave of the pandemic and data for the second half of the year will need to be examined. The need to understand these changes in the population structure will be imperative to understand the implications for future population demand on health and social care.

³⁰ [Deaths due to COVID-19 by local area and deprivation - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

³¹ [Deaths due to COVID-19 by local area and deprivation - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

Figure 14: England components of population change mid-2011 to mid-2020.



Source: Office for National Statistics: Population estimates for the UK, mid 2020³²

Long COVID

Long COVID is currently defined as people who suffer with poor health for 12 weeks or more beyond the initial acute phase of infection. The Office for National Statistics estimate that around one in five people testing positive for COVID-19 exhibit symptoms for five weeks or longer and around one in ten for 12 weeks or longer. One survey reported that nine out of ten people who experienced symptoms for four weeks will continue to experience symptoms for more than 35 weeks.³³

Long COVID is currently a broad term which includes all symptoms which last after the first initial infection. Common symptoms include fatigue, breathlessness, and in the most severe cases, organ failure.³⁴ Four types or cluster of symptoms have been proposed: post-viral fatigue, fluctuating multi-system symptoms, lasting organ damage and post-intensive care symptoms.³⁵

Those experiencing Long COVID will present ongoing challenges for health and social care systems with increased need for care. Of those who were working before being hospitalised for COVID-19 and contracting Long COVID almost 19% reported a health-related change to their occupational status.³⁶

The ONS reported that in the four-week period ending 6 March 2021 674,000 people across the UK self-reported that Long COVID symptoms were adversely affecting their day-to-day activities, with

196,000 people reporting that their ability to undertake day-to-day activities had been limited a lot.³⁷

Applying these proportions to the local population suggests that over 1,500 people on the Isle of Wight were experiencing Long COVID for 12 weeks or longer during the week ending

³² [Office for National Statistics: Population estimates for the UK, mid 2020](#)

³³ <https://www.medrxiv.org/content/10.1101/2020.12.24.20248802v2.full>

³⁴ <https://www.health.org.uk/news-and-comment/blogs/what-might-long-covid-mean-for-the-nations-health>

³⁵ <https://evidence.nihr.ac.uk/themedreview/living-with-covid19/>

³⁶ <https://www.medrxiv.org/content/10.1101/2021.03.22.21254057v2.full>

³⁷ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1april2021>

6 March 2021. Of these, around 280 reported that these symptoms had impacted a lot on their day-to-day activity.

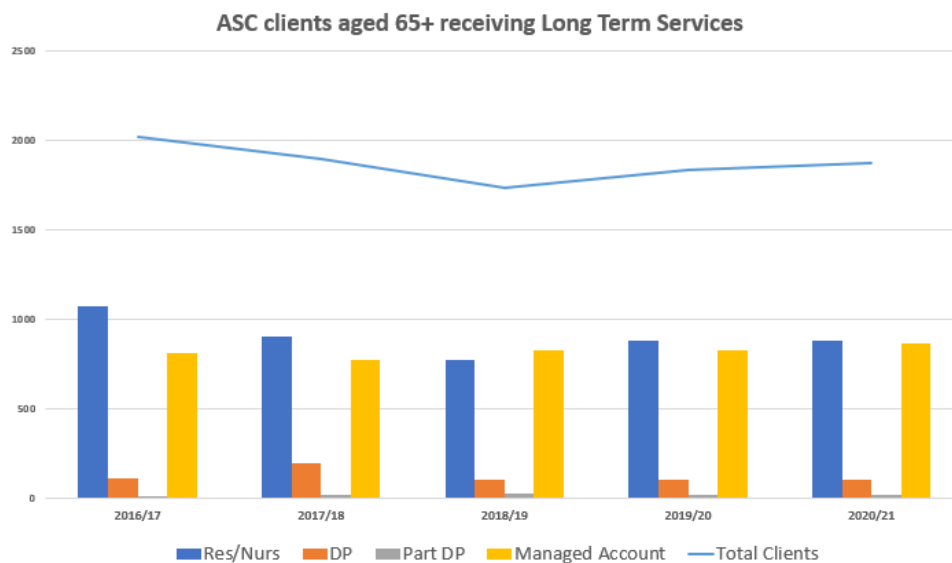
Social Care

Social care covers a range of support provided to adults including residential and nursing home placements as well as care in their own homes (domiciliary care). Some of this care is funded by local authorities, whilst some is organised and paid for privately without the local authority being involved. This section discusses services provided through local authorities and therefore is only a partial picture of the social care needs of the population.

Nationally spending on adult social care has increased between 2016/17 and 2019/20 as has the numbers of people (both those aged 18-64 and older adults aged 65+) requesting support. The number of people receiving long-term support has decreased over this time period, especially among older adults. A similar pattern has been shown for adults living on the Isle of Wight, however with an increase in 2019/20.³⁸

Local data for the Isle of Wight show the number of clients decreased from 2016/17 to 2018/19 and has increased from then on. The largest decrease was in clients placed into residential or nursing care placements. This is shown in Figure 15.

Figure 15: Older adults receiving social care 2016/17 to 2020/21



Source: IOW social care SALT return³⁹

The following sections of the report go on to look at the impact of COVID-19 on the population in more detail. The report is structured into three sections:

- Healthy people: Looks at the impact of the pandemic on different groups, such as age, sex and ethnicity

³⁸ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report>

³⁹ A client is only counted once in the graph above, therefore if a person fell into >1 category during the year they are counted against which service came first in the list in the table above.

- Healthy lives: Considers how different lifestyle behaviours which effect health have in turn been impacted by the pandemic
- Healthy places: Investigates how COVID-19 has impacted populations differently depending on the area they live in

HEALTHY PEOPLE

The burden of illness and death due to coronavirus has not been shouldered equally, disproportionately affecting different population groups.⁴⁰ At the time of writing this report the country is still in response mode to the pandemic and evidence pertaining to the impact of COVID-19 is very much still emerging.

This section of the report looks in more depth at how different demographics of the population have been impacted by COVID-19, both directly and indirectly. It focuses on factors such as age, sex, ethnicity and learning disabilities, other factors such as occupation and living environment will be discussed in later sections.

Direct impacts

Infections

Nationally diagnosis rates increased with age, increasing rates in the over 60 years population was a strong predictor for increasing hospital admission rates.⁴¹ The Isle of Wight has an older population when compared with the national population. Older people, those aged 70 years and over, make up 21.4% of the Isle of Wight population compared with 13.7% nationally. 1.4% of the population are in the 'oldest old' group, those aged over 90 years, compared to 0.9% in England⁴². Cases of COVID-19 on the Isle of Wight were higher in older people in the first wave, mainly due to limited testing and that older people most likely to be admitted to hospital. The number of cases in the second wave, where increased testing was available, was higher in the working age population. However, when calculated as a rate according to age group population size, cases were high in all age groups (see Figures 16 and 17).

⁴⁰ [Inequalities and deaths involving COVID-19 | The Health Foundation](#)

⁴¹ [Disparities in the risk and outcomes of COVID-19 \(publishing.service.gov.uk\)](#)

⁴² [Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland \(Mid-2020\)- Office for National Statistics \(ons.gov.uk\)](#)

Figure 16: Demographics of COVID-19 cases in Wave 1 (4 March 2020 to 31 May 2020) compared with Wave 2 (1 October 2020 to 31 March 2021)

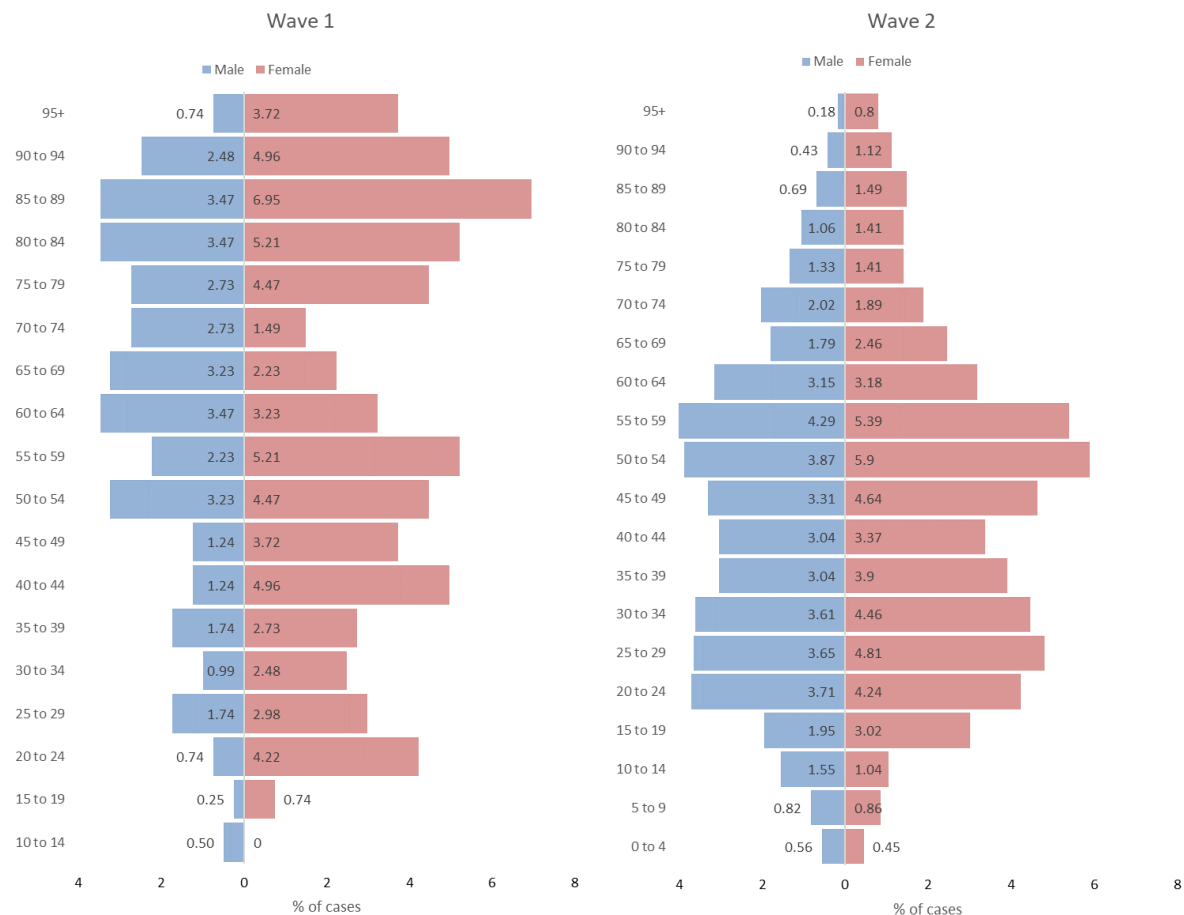
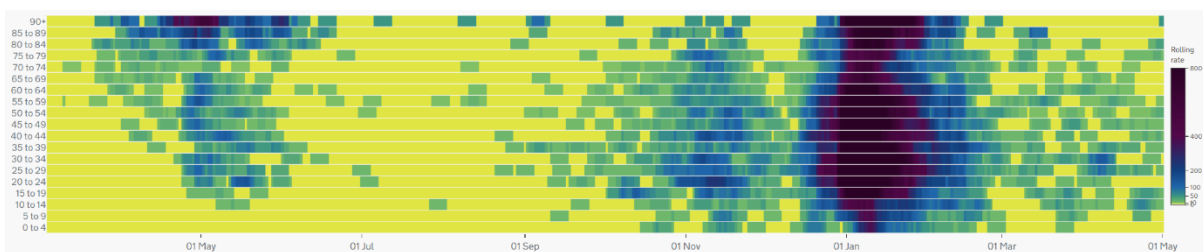


Figure 17: Case rates per 100,000 population (4 March 2020 to 1 May 2021)

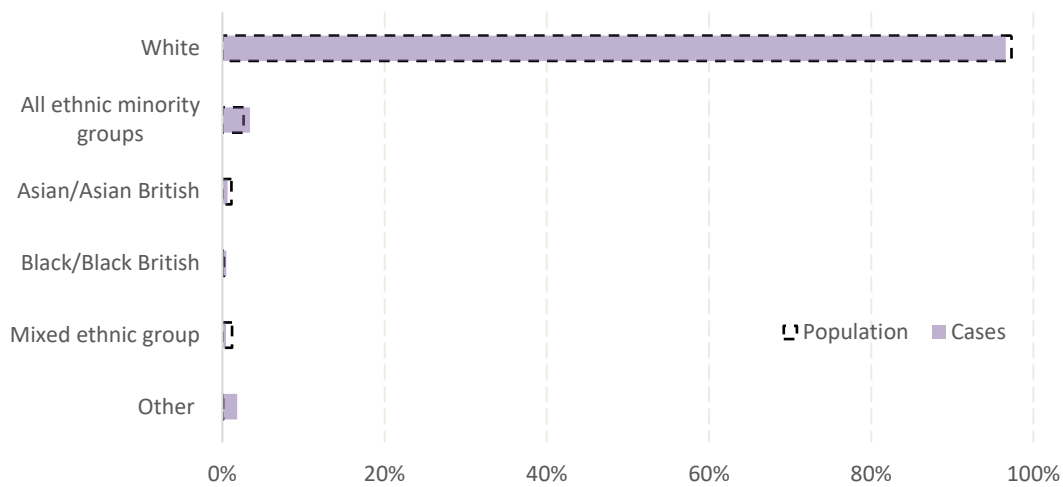


Source: PHE COVID-19 Dashboard

Higher numbers of cases were reported in females when compared to males, which may be linked to occupation (for example, a higher proportion of females work in caring occupations with regular testing). Nationally, people from Black ethnic groups were most likely to be diagnosed with COVID-19⁴³ and whilst the Isle of Wight is less ethnically diverse than England as a whole, a greater proportion of cases were still identified in people from minority ethnic groups when compared with the population (Figure 18).

⁴³ [Disparities in the risk and outcomes of COVID-19 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

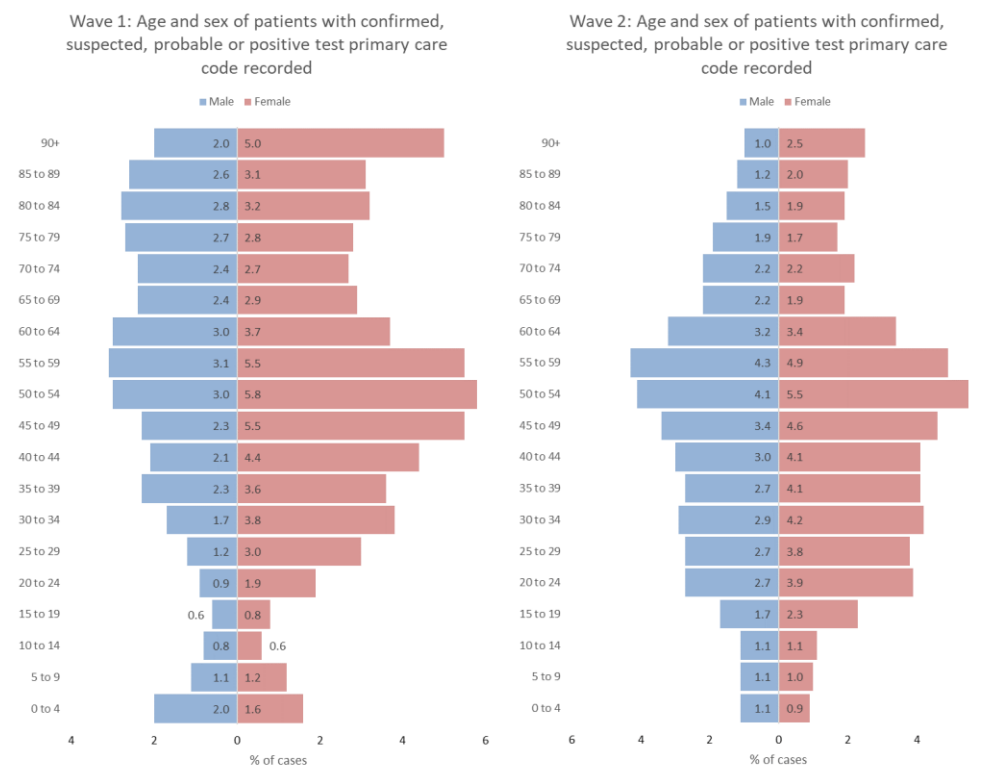
Figure 18: Cases by ethnicity, 4 March 2020 to 31 March 2021



Source: PHE dashboard and Census 2011

Approximately 57% of confirmed cases across Hampshire and the Isle of Wight had a primary care (GP) record with suspected or confirmed COVID-19 on their GP record (39,888 people between 1 February and 31 March 2021). Comparing the age and sex distribution of the primary care case data with the national infection data (Figure 18 above) suggests that the primary care data may underrepresent the working age population and overrepresent the older population who have tested positive for COVID-19. This suggests that the primary care data may be a cohort of the population that were more vulnerable to COVID-19 and the associated poorer health outcomes and therefore more likely to require health care support.

Figure 19: Patients with COVID-19 recorded on GP record



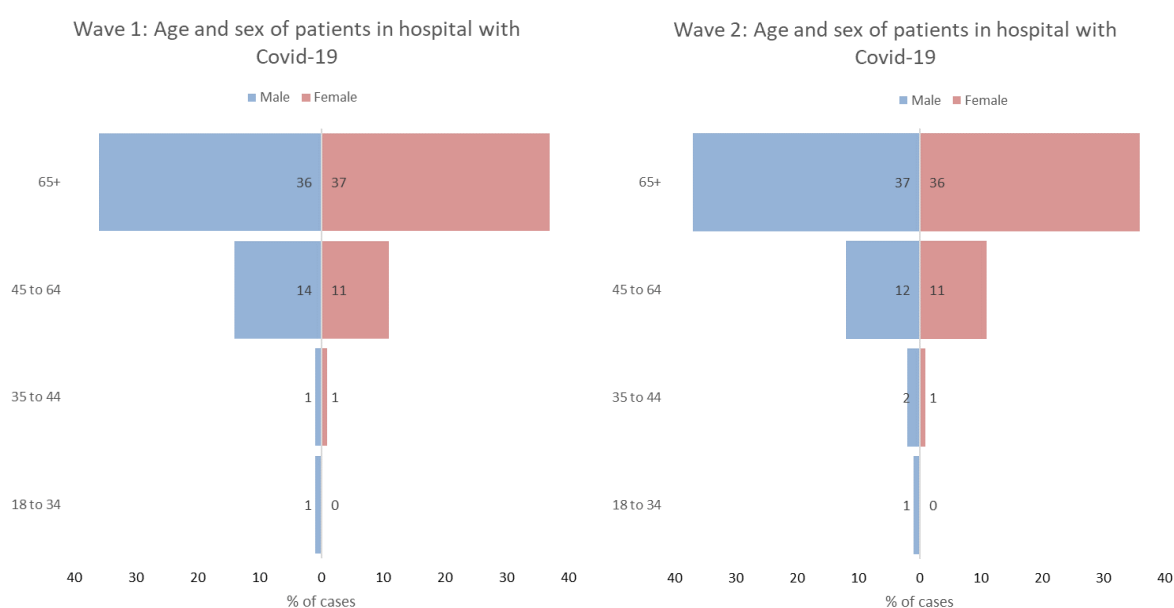
Source: Care and Health Information Exchange (CHIE) extract May 2021

Hospital admissions

Across the course of the pandemic in England, cumulative hospital admission rates were 1.5 times higher for males than females.⁴⁴ Hospital admission and mortality rates increased with age, with the highest rates in those aged 85 and over. At the peak of Wave 1 the admission rate for people in this age group across the pandemic to date was 1.9 times higher than the next oldest group (people aged 75-84) and 3.3 times higher than people aged 65-74. The differences were greater in Wave 2 with admission rates for people aged 85 and over 1.9 times higher than people aged 75-84 and 4.3 times higher than people aged 65-74.

Local data for hospital admissions reflects the patterns shown at national level with older males accounting for 36% of admissions in the first wave and 37% in the second wave which is shown in Figure 20.

Figure 20: Hospital admissions by age group and sex

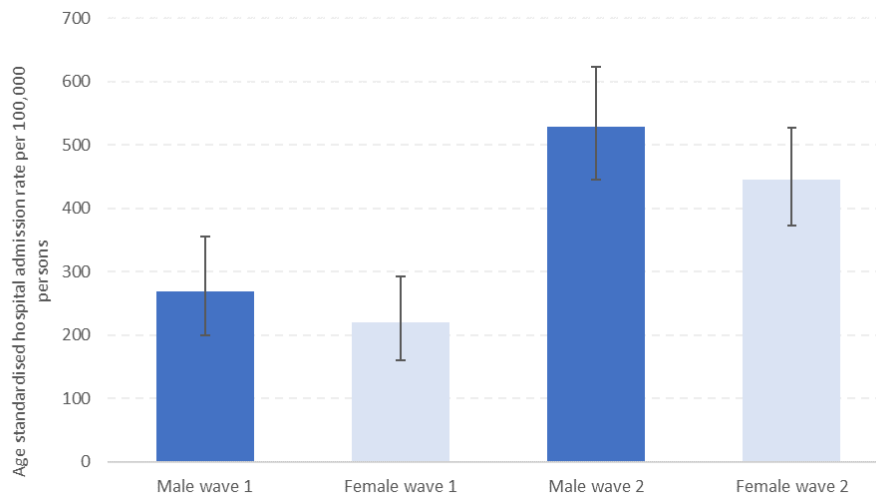


Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021

Figure 21 presents age-standardised hospital admission rate per 100,000 by gender for the two wave periods. During both waves the male admission rate was higher than the female rate although due to small numbers the difference is not statistically significant. Males and females both experienced significantly higher admission rates in Wave 2 compared to Wave 1.

⁴⁴ [CHIME - COVID-19 Health Inequalities \(phe.gov.uk\)](https://phe.gov.uk)

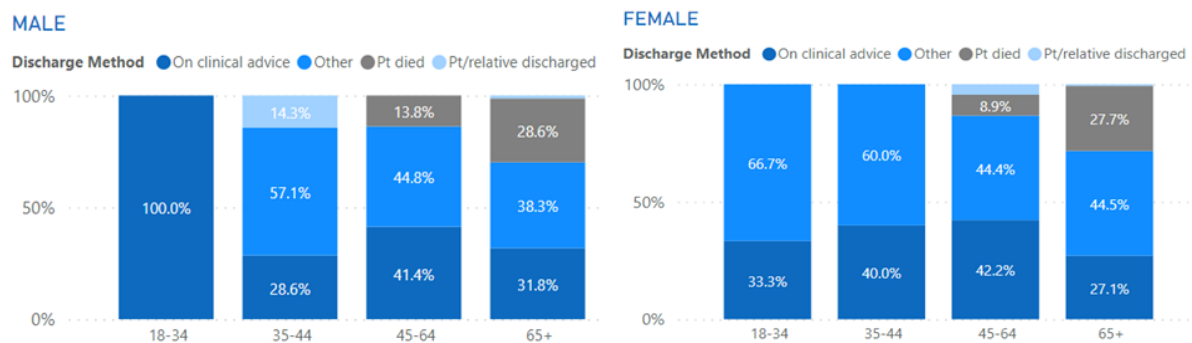
Figure 21: Isle of Wight age-standardised hospital admission rate per 100,000 by gender



Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021

Analysis of where people were discharged to, following an admission for COVID-19, showed that 28% people were discharged to their usual place of residence and 23% of patients died in hospital (Figure 22). However, for patients aged over 65 years, only 23% left hospital to go back to their usual residence, 28% of people aged 65 years and over died following a COVID-19 admission and 5% went to a temporary place of residence. A much higher proportion of older people, aged 65 years and over, died following a COVID-19 admission compared to younger age bands. 29% of males and 28% of females aged 65 years and over died in hospital. It should be noted that a large proportion of Isle of Wight admissions (43%) had a discharge destination of Other. This is a high proportion, and it is unclear if this is correct or due to inaccurate coding. As a result, discharge outcomes by age and gender should be interpreted with the mortality outcomes analysis.

Figure 22: COVID-19 admissions by discharge outcome and gender



Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021

In England as a whole, the Black ethnic group had the highest rate of hospital admissions although at the peak of the second wave the difference was small. At the peak of the first wave the admission rate in the Black group was 3.9 times higher than the White group but was 3.2 times higher at the peak of the second wave.

Among the Asian ethnic group, the Bangladeshi group had a particularly high admission rate at the peak of the second wave which was not the case in the first and may account for this

difference between waves. The admission rate in the Asian group was 2.8 times higher than the White group at the peak of the first wave and increased to 3.3 times higher.

It is not possible to robustly look at Isle of Wight admissions data by ethnic group as 85% of cases had ethnicity missing.

Many of the disparities in health outcomes in ethnic minority communities seem to be in part explained by a number of social determinants of health. The British Medical Journal (BMJ) also reported racism, structural, cultural and discrimination as causes of these ethnic inequalities.⁴⁵ This will be discussed in greater detail in later sections of this report.

Long-term effects and Long COVID

The prevalence of Long COVID varies by age, gender, deprivation, occupation and pre-existing health conditions. Younger people (aged 70 or below) and women are more likely to experience Long COVID. Long COVID may also be more severe for those who had been admitted to hospital or intensive care during their initial infection, including a third who are readmitted to hospital.⁴⁶

A variety of chronic symptoms have been reported including fatigue, dyspnea, myalgia, exercise intolerance, sleep disturbances, difficulty concentrating, anxiety, fever, headache, malaise, and vertigo. These symptoms are similar to those seen in myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).⁴⁷ Although there is currently insufficient evidence to determine if COVID-19 triggers ME or CFS, due to the similarity in presentation of symptoms new diagnoses could be considered as a proxy for Long COVID along with other data.

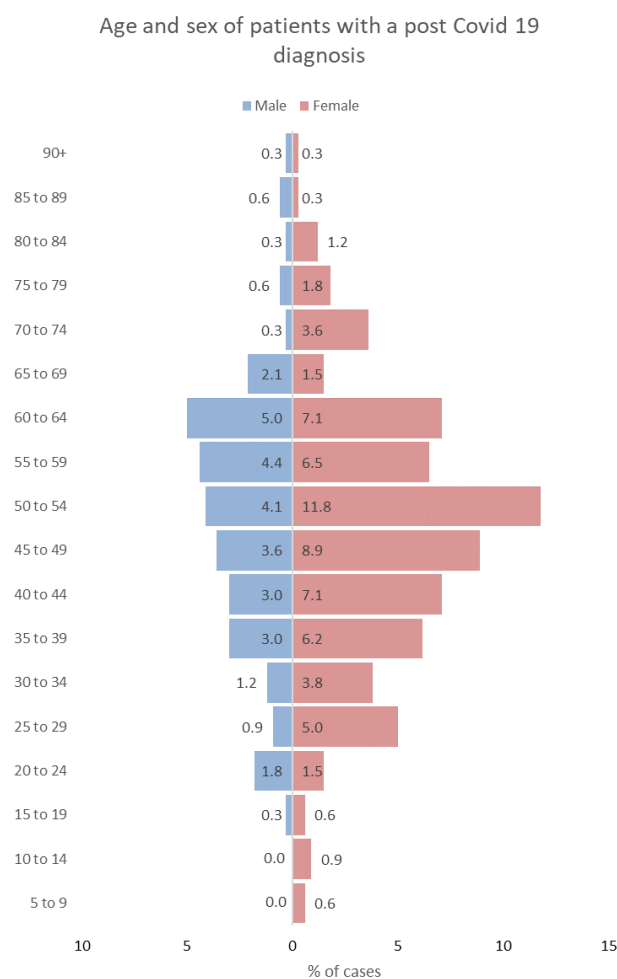
Data for the Isle of Wight supports this national evidence. Figure 23 shows the age and sex breakdown of those patients with a post-COVID-19 diagnosis on their GP record. The chart demonstrates that working-age women, especially those aged 45 to 64, are most likely to require on-going support with their health after contracting COVID-19.

⁴⁵ [Mitigating ethnic disparities in covid-19 and beyond | The BMJ](#)

⁴⁶ <https://www.health.org.uk/news-and-comment/blogs/what-might-long-covid-mean-for-the-nations-health>

⁴⁷ [COVID-19 and post-infectious myalgic encephalomyelitis/chronic fatigue syndrome: a narrative review - Sonia Poenaru, Sara J. Abdallah, Vicente Corrales-Medina, Juthaporn Cowan, 2021 \(sagepub.com\)](#)

Figure 23: Age and sex of patients with a post COVID-19 diagnosis



Source: Care and Health Information Exchange (CHIE) extract May 2021

Mortality – COVID-19

Across the course of the pandemic in England, cumulative mortality rates were higher for males than females. Analysis conducted by Public Health England found that the mortality rate from COVID-19 for males was 1.6 times higher than the rate for females.⁴⁸ Nationally mortality rates increased with age, with the highest rates recorded in those aged 85 and over. The mortality rate for people in this age group across the pandemic to date was 3.2 times higher than the next oldest group (people aged 75-84) and 10.8 times higher than people aged 65-74.

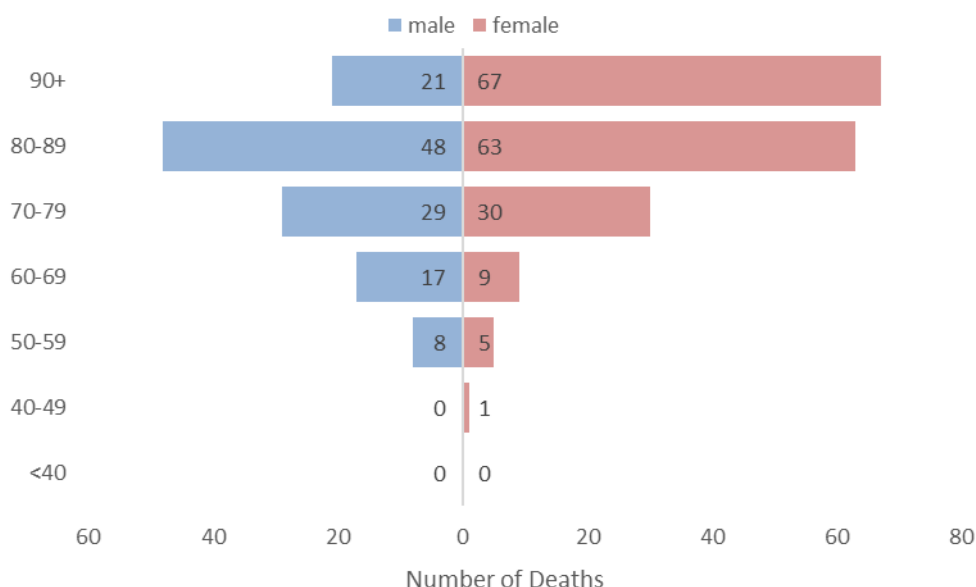
When compared to all-cause mortality in previous years, deaths from COVID-19 have a slightly older age distribution, particularly for males. Between the ages of 40 and 79, the age specific death rates from COVID-19 among males were around double the rates in females compared with 1.5 times for all mortality in previous years.⁴⁹

On the Isle of Wight, there were 298 deaths where COVID-19 was mentioned on the death certificate between March 2020 and April 2021 (week 10 2020 to week 13 2021). This is equivalent to 14% of all deaths over this period. Over 58% of COVID-related deaths were among females and over two thirds were among people aged 80 years and over (66.8%).

⁴⁸ [CHIME - COVID-19 Health Inequalities \(phe.gov.uk\)](https://www.phe.gov.uk)

⁴⁷ Disparities in the risk and outcomes of COVID-19, Public Health England, August 2020

Figure 24: Distribution of deaths where COVID-19 was mentioned on the death certificate, by age group and sex, between March 2020 (week 10) to April 2021 (week 13) – Isle of Wight



Source: Civil Registrations Data, NHS Digital

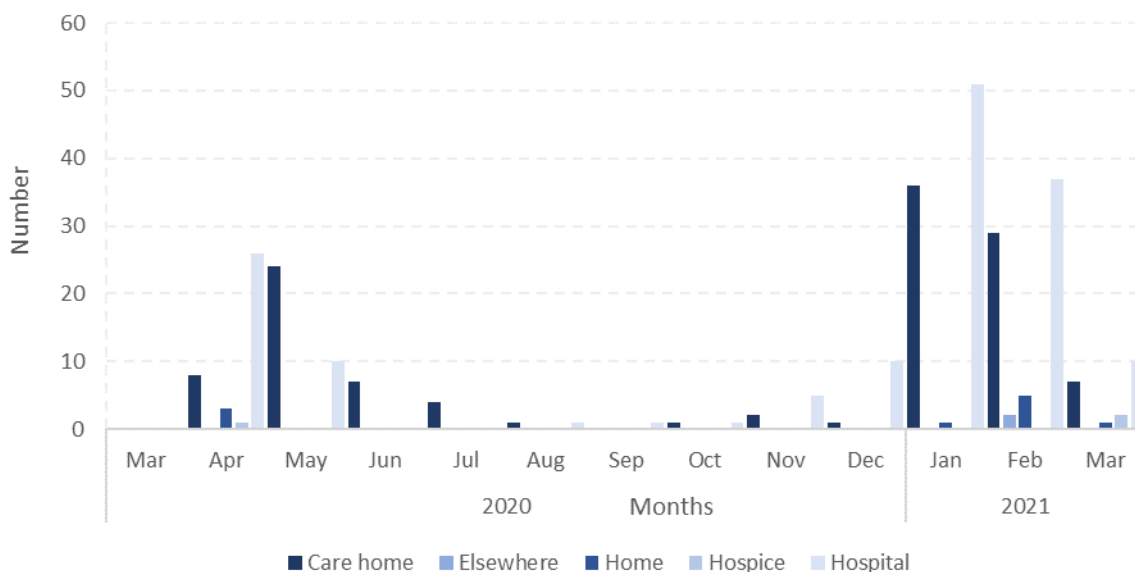
Care homes were disproportionately affected by the COVID-19 outbreak as residents and those working in care homes were more vulnerable to the virus. People living in care homes are often frailer and more likely to have underlying conditions than the population in general. Employees of care homes are working in a higher risk environment where social distancing and infection control may potentially be even more challenging than in hospitals.

Data from the Office for National Statistics (ONS) indicates that 41.8% of all COVID-related deaths on the Isle of Wight occurred in care homes. The number of deaths in care homes peaked in January and February 2021. These figures will not include the deaths of care home residents who died elsewhere.⁵⁰

COVID-related deaths in hospital account for 53% of COVID-related deaths on the Island with a peak seen in February and March 2021.

⁵⁰ Disparities in the risk and outcomes of COVID-19, Public Health England, August 2020

Figure 25: Number of deaths where COVID-19 was mentioned on the death certificate by place of death



Source: Death registrations and occurrences by local authority and health board - Office for National Statistics

People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. These analyses did not account for the effect of occupation, co-morbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying or both.

In England, ethnicity is not recorded on the death certificate. Information on country of birth is collected during the death registration process but this is likely to be a poor proxy for ethnicity. Many people from ethnic minorities are born in the UK and this key group will be missed if this measure is used. Under recommendations from the Race Disparity Unit, the recording of ethnicity data on death certificates is set to become mandatory. This should help to establish the impact of the virus on ethnic minority groups in the future.

Nationally, analysis of COVID-19 mortality by ethnic group has been facilitated by an ONS project to link deaths to the 2011 Census but this has not been possible for local data.

Another group of people who have been shown to have experienced severe health outcomes from contracting COVID-19 were adults with learning disabilities. Adults with Learning Disabilities have been shown to be at increased risk of dying after contracting COVID-19, with a death rate 4.1 times higher than the general population.⁵¹

Mortality – Excess Mortality

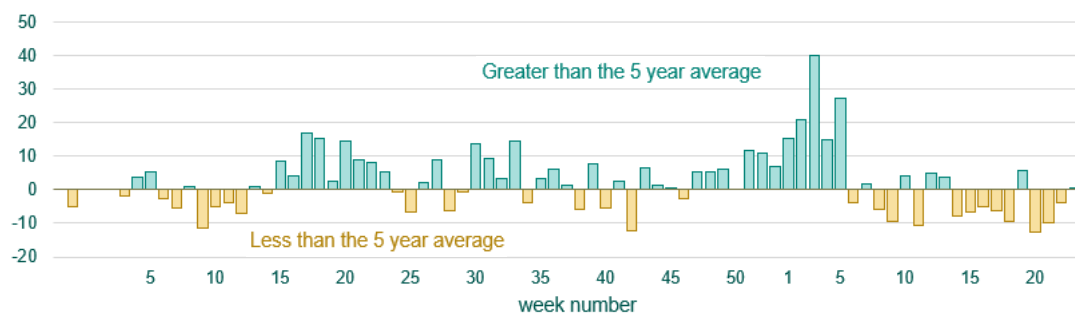
Measuring excess mortality is an attempt to understand the impact of COVID-19 over the course of the pandemic. Public Health England have modelled the expected number of deaths for every week from March 2020 onwards, excess deaths are estimated by comparing the number of observed deaths during the pandemic with the number of deaths would have been expected in its absence. This adjusts for the seasonal mortality observed every year in England, with a higher number of deaths in winter months compared to the

⁵¹ <https://www.gov.uk/government/news/people-with-learning-disabilities-had-higher-death-rate-from-covid-19>

summer. It also mitigates the effects of variations in testing regimes and differential coding of cause of death both between areas and over the course of the pandemic.

Excess mortality on the Isle of Wight hit a peak of 40 above what would normally be expected during Wave 2 of the pandemic, in the week commencing 8 February 2021. This represents more than double the average number of deaths that would normally be expected during this particular week of the year. A total of 77 deaths occurred during that week, 48 of which mentioned COVID-19 on the death certificate. In contrast to the national picture, the level of excess mortality on the Isle of Wight was higher in the second wave of the pandemic.

Figure 26: Weekly excess deaths by date of occurrence 4 January 2020 to 2 July 2021



Source: Excess mortality in England, Public Health England

Nationally, analysis from the first wave of the pandemic conducted by Public Health England found that 98% of excess mortality for White people was attributed on their death certificate to COVID-19. Other ethnic groups had a great deal of non-COVID-19 excess mortality. This may be due to the younger age structure of, or under diagnosis or testing in, ethnic minority groups.⁵²

Indirect impacts

This section of the report discusses the impact of COVID-19 policies on groups within the population rather than direct clinical impacts of contracting the virus. These impacts can be far ranging considering social isolation, closure of workplaces, schools and other non-essential services. The whole population has been impacted by the policies, however particular groups have been impacted in different ways and have experienced different levels of hardship over the course of the pandemic. The full effect of these impacts may be long lasting, and some may not be evident for a number of years.

Older people

Older people have experienced increased risk of serious illness and death from COVID-19 but also large impacts due to the policies put in place to reduce the spread of COVID-19. Older adults who were recommended to shield were more likely to report higher levels of depression, anxiety and loneliness in June and July 2020 than people of a similar age but not recommended to shield⁵³. The impact of restrictions on non-essential services has resulted in decreased social connectiveness and older people are also less likely to use online communications to supplement their interactions.⁵⁴ Anxiety and depression among older people has increased during the pandemic, which can result in self-neglect and loss of

⁵² PHE. Excess mortality in England, week ending October 2020. Published: 9 November 2020. Available from <https://fingertips.phe.org.uk/static-reports/mortality-surveillance/excess-mortality-in-england-latest.html>

⁵³ [2. Important findings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/important-findings)

⁵⁴ https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health-wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf (p.18)

confidence.⁵⁵ New NICE guidelines were issued concerning rising self-harm in the over 60s due to mental health issues during the pandemic, including loneliness, bereavement and access to services.⁵⁶

Social care

Many factors result in increased need for social care services, such as older age, limited existing support, social isolation, long term medical conditions, and reduced mobility.⁵⁷ As the Isle of Wight has an ageing population, an increase in client numbers is expected due to the higher number of people in these older age groups. Assessing the extent that this increase has been impacted by COVID-19 is challenging and may not be apparent for a number of years, especially if people have been delaying accessing social care due to fears for family members contracting COVID-19. Nationally, there has been an increase in unpaid carers during the pandemic as people provide informal help for family members, increasing this number from 9 million to 13.5 million.⁵⁸ Contracting COVID-19 may result in additional people experiencing long term medical conditions and the impact of the social distancing restrictions may also result in increased social isolation and reduced mobility, meaning that people may require social care services earlier than they may otherwise have done.

COVID-19 will also have impacted younger people, especially those with Learning Disabilities who receive support services. Many services, such as day centres, were closed during social distancing restrictions which may have resulted in increased social isolation. Children with disabilities, and their families, have also been impacted accessing medical services. 60% of families report delays in appointments, which can be compounded when disabled children experience multiple diagnoses and therefore require multiple appointments. Carers and families of these children have reported a decline in mental health and isolation.⁵⁹

Working age

The policies put in place to reduce the spread of infection have had large impacts on the working age population, including furlough, redundancy, working from home or changes to the workplace. Whilst some people reported an increase in work flexibility, others have experienced financial strain, longer working hours, poorer work-life balance or increased fear of potential exposure to COVID-19.⁶⁰ Additional caring responsibilities such as home schooling and caring for older relatives have also been experienced by many. Survey data has suggested that one in five adults have experienced some form of depression, double the observed before the pandemic.⁶¹ During the first lockdown age and gender showed the strongest associations with psychological distress, although chronic health conditions, employment status and housing conditions remained important.⁶² Younger adults and

⁵⁵ https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf

⁵⁶ https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

⁵⁷ <https://documents.hants.gov.uk/corprhantsweb/2017-07-04SocialIsolationandLonelinessinHampshireHF000014384094.pdf>

⁵⁸ <https://www.carersuk.org/scotland/policy/policy-library/unseen-and-undervalued-the-value-of-unpaid-care-provided-to-date-during-the-covid-19-pandemic>

⁵⁹ <https://disabledchildrenspartnership.org.uk/wp-content/uploads/2021/05/No-End-in-Sight.pdf>

⁶⁰ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/homeworkinghoursrewardsandopportunitiesintheuk2011to2020/2021-04-19>

⁶¹ <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/januarytomarch2021>

⁶² [2. Important findings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/2-important-findings)

women were more likely to experience some form of depression with over 4 in 10 (43%) women aged 16 to 29 years experiencing symptoms of depression (compared to 26% of men the same age).

Studies examining the links between wellbeing, employment and low income are emerging, but earlier findings suggest low income or loss of income is associated with increasing levels of loneliness during lockdown and higher levels of anxiety and mental distress. Small employers and self-employed people were particularly impacted. Women in lower socio-economic jobs were more likely to be furloughed than any other positions (including key worker roles) and men in general.⁶³ Coronavirus Job Retention Scheme (CJRS) may have alleviated some of the mental distress with research suggesting a smaller psychological impact on those whose income was protected through the policies such as furlough.⁶⁴

Young people

Although children are at low clinical risk of severe health outcomes from contracting COVID-19 they have been impacted by the policies put in place, such as social distancing and the closure of schools. Adolescence is a key period for social cognitive development,⁶⁵ and in July 2020 92% of young people reported missing being face-to-face with people.⁶⁶

In 2020, 16.0% of children aged 5 to 16 were identified as having a probable mental disorder, an increase from 10.8% in 2017.⁶⁷ The likelihood of a probable mental disorder increased with age with a noticeable difference in gender for the older age group (17 to 22 years); 27.2% of young women and 13.3% of young men were identified as having a probable mental disorder in 2020. For those children identified before the pandemic as 'at risk' for mental health problems, these had increased during the pandemic particularly for those experiencing anxiety.⁶⁸

Between 21 January 2020 and 8 April 2020, Childline delivered over 2,200 counselling sessions to children and young people who expressed concerns about coronavirus. Around 1,600 of these counselling sessions were delivered during March, when key events such as school closures and social distancing measures were announced.⁶⁹ Young people have reported experiencing nightmares and trouble sleeping, anxiety about catching and spreading COVID-19, increased feelings of depression and anxiety and feeling lonely or isolated.⁷⁰ Online bullying was also reported by children and during the pandemic 47% of children and teens reported seeing content they wished they had not seen.⁷¹ Some children also reported enjoying time away from school and found online interactions preferable, and

⁶³ [2. Important findings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/important-findings-on-the-impact-of-coronavirus)

⁶⁴ [Full article: Fare differently, feel differently: mental well-being of UK-born and foreign-born working men during the COVID-19 pandemic \(tandfonline.com\)](https://www.tandfonline.com/doi/full/10.1080/13602559.2020.1818181)

⁶⁵

https://www.researchgate.net/publication/256478548_Is_Adolescence_a_Sensitive_Period_for_Sociocultural_Processing

⁶⁶ <https://www.ymca.org.uk/wp-content/uploads/2020/08/ymca-back-on-track.pdf>

⁶⁷ https://files.digital.nhs.uk/AF/AECD6B/mhcyp_2020_rep_v2.pdf

⁶⁸ <https://acamh.onlinelibrary.wiley.com/doi/10.1111/jcv2.12005>

⁶⁹ [What children are saying to Childline about coronavirus \(nspcc.org.uk\)](https://www.nspcc.org.uk/what-children-are-saying-to-childline-about-coronavirus/)

⁷⁰ <https://learning.nspcc.org.uk/media/2195/what-children-are-saying-childline-about-coronavirus.pdf>

⁷¹ <https://www.gov.uk/government/consultations/online-harms-white-paper/outcome/online-harms-white-paper-full-government-response>

many enjoyed gaming as a way to stay in touch with friends.⁷² However, an increase in online gambling was also reported.⁷³

VULNERABILITY INDICES

Mental Health and Wellbeing Index

COVID-19 and the associated restrictions have both had an impact on the population's mental health, with groups who in the past have had robust mental health being affected alongside those with pre-existing experience or diagnosis of mental health conditions.

Using data from a range of sources, a wellbeing vulnerability index has been created to identify and map populations in Hampshire and the Isle of Wight who are more likely to have vulnerable mental health because of the restrictions put in place during COVID-19.⁷⁴ These groups may not have experienced mental health issues before COVID-19, they may not live in areas typically associated with poor mental health and they may not be populations or groups who are typically assumed to have vulnerable mental health. However, these are populations who have been disproportionately affected by the restrictions introduced due to COVID-19 (such as lockdown) and there is evidence that certain aspects of COVID-19 have taken a toll on their mental health. As a result, these groups may have seen a decline in their mental health during COVID-19. Identifying groups who have experienced vulnerable mental health for the first time during COVID-19 is important as they may not recognise that they are experiencing mental ill health and may be unaware of the services which are available and how to access them. These populations need to be supported appropriately, alongside those with long-term mental health conditions who are also at increased risk of worsening mental health and who have seen a change in the support they were able to receive during COVID-19.

Vulnerable groups included in this index can be placed into four domains: Demographic (young people and ethnic minorities), Health (people with two or more long term conditions), Economic (low earners, people working in healthcare and sectors likely to be furloughed, self employed), and Living situation (lone parents, renters, older people living alone and people living in institutions or communal establishments). Mapped results from each domain can be seen in Appendix D.

The index is comprised of all these groups combined and is mapped at the Lower Super Output Area (LSOA), with each LSOA being mapped according to the decile that its score of vulnerability lies in. The lower the decile (e.g., Decile 1) the higher the LSOA's vulnerability. The most vulnerable LSOAs are shown on the map as darker blue areas, with the light-yellow areas being the least likely to have vulnerable mental health as a result of COVID-19 restrictions.

⁷²

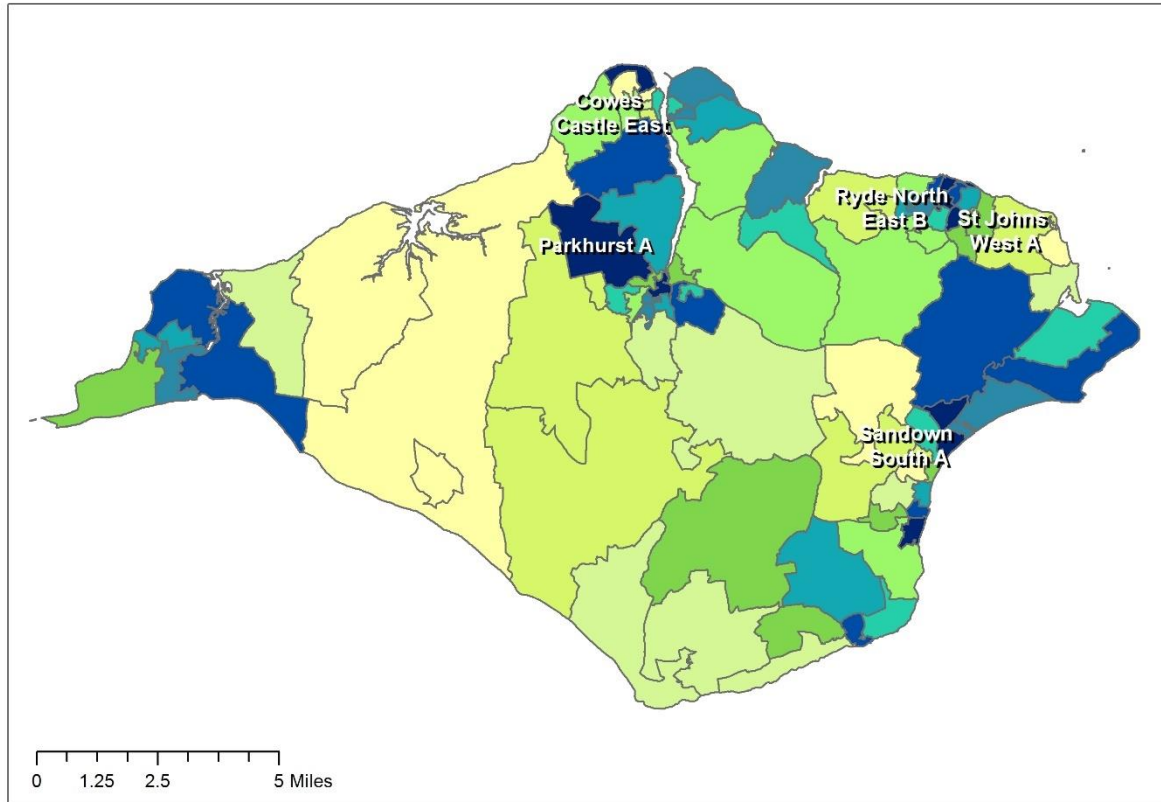
[https://councilfordisabledchildren.org.uk/sites/default/files/field/attachemnt/Lessons%20Learnt%20From%20Lockdown Children%20and%20Young%20People%27s%20Summary.pdf](https://councilfordisabledchildren.org.uk/sites/default/files/field/attachemnt/Lessons%20Learnt%20From%20Lockdown%20Children%20and%20Young%20People%27s%20Summary.pdf)

⁷³ <https://research-information.bris.ac.uk/en/publications/gambling-by-young-adults-in-the-uk-during-covid-19-lockdown>

⁷⁴ A detailed report on the vulnerability indices will be published on the HCC JSNA web pages, and further details of the categories are in Appendix C

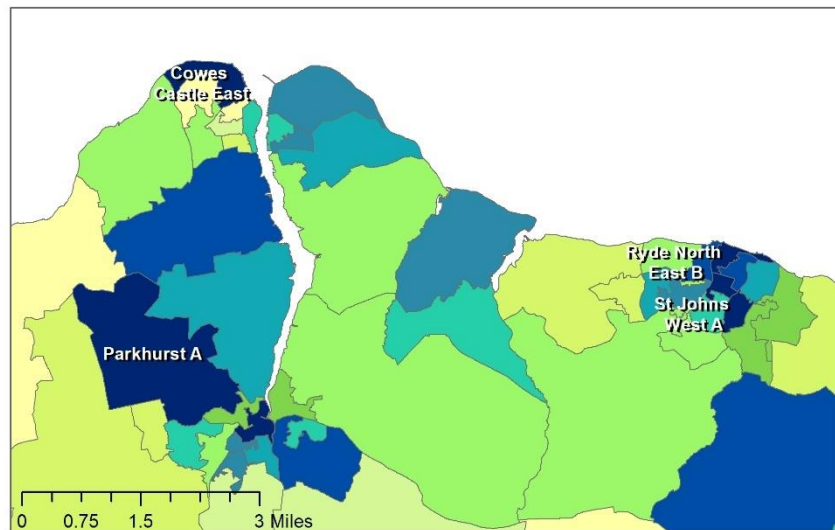
Figure 25: Mental Wellbeing Vulnerability

Isle of Wight Mental Wellbeing Vulnerability by LSOA



Decile

- 1 - Most vulnerable
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 - Least vulnerable



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The LSOAs with the highest level of vulnerability overall as identified in the index are Sandown South A, Parkhurst A, Cowes Castle East, St Johns West A, Ryde North East B, Shanklin South B, Newport North B, Sandown South B, Ryde South East B and Ryde North West A. These LSOAs feature highly for different reasons. Sandown South A, which features in the five most vulnerable LSOAs has experienced high levels of furlough, has higher levels of people working in the care industry, higher numbers of self-employed residents and under 65s with two or more long term health conditions. It also features in the top 10 for other criteria indicating that there is a higher number of care homes located in the area, ethnic minorities, renters and lone parents with dependent children. Parkhurst A is highly impacted due to the location of the Prison as well as those furloughed or working in the care industry and is more ethnically diverse. Cowes Castle East has higher levels of people who are self-employed, those effected by furlough or working in the care industry, renters and ethnic minorities. St Johns West A has higher levels of renters, lone parent families, low earners and ethnic minorities and Ryde North East B has high levels of renters. Both St John's West A and Ryde North East B feature in the top 20% most deprived in the Index of Multiple Deprivation (IMD 2019) and are therefore already facing challenges, Parkhurst A features in previous areas of focus due to the prison and the hospital, but areas such as Sandown South A and Cowes Castle East are more recent areas of concern due to the impacts of COVID-19.

HEALTHY LIVES

This section focuses on how people live healthy lives, including existing long-term conditions which may have resulted in severe health outcomes from COVID-19 or severe impacts from the social restrictions. It also covers lifestyle behaviours which impact on health, such as smoking, diet and exercise, and how these have been impacted by the pandemic.

Direct

Primary care data

Data suggest worse outcomes for those with a history of non-communicable diseases such as obesity, diabetes, heart disease, hypertension and poor outcomes for those living in more deprived areas. In Build Back Fairer: The COVID-19 Marmot Review,⁷⁵ the impact of Covid-19 on those with pre-existing conditions such as dementia, Alzheimer’s disease, diabetes, cardiovascular disease and other chronic diseases such as chronic obstructive pulmonary disease and kidney disease are considered and findings indicate that the relative difference in mortality rates (fully adjusted) in England and Wales between those whose day-to-day activities were limited a lot because of a longstanding health problem or disability and those whose were not was 2.4 times higher for females and 1.9 times higher for males (from 2 March to 15 May 2020).

Information about existing health conditions was not collected for those receiving a positive COVID-19 test. However, for those with a primary care record with a positive COVID-19 test recorded it is possible look at any medical condition diagnoses. As previously discussed, this cohort of those testing positive for COVID-19 is likely to be those who have long-term health conditions requiring ongoing support. However, the data indicates that a greater proportion of these people had long-term conditions than in the general population.

Figure 23: Patients with COVID-19 positive test of GP record, comparison of conditions against population prevalence

| Condition | Proportion with condition testing positive for COVID-19 (%) | HIOW STP Prevalence in population (QOF, 2019/20) (%) |
|---------------------------------------|---|--|
| Chronic Kidney Disease | 5.0 | 3.7 |
| Chronic Obstructive Pulmonary Disease | 3.2 | 2.0 |
| Cardiovascular Disease | 0.7 | 1.2 |
| Dementia | 3.5 | 0.9 |
| Diabetes | 8.7 | 6.6 |
| Hypertension | 18.5 | 14.8 |

Source: Care and Health Information Exchange (CHIE) extracted May 2021. QOF data source: NHS Digital

Figure 24 shows the proportion of lifestyle or behavioural risk factors recorded in the health care record of these who had a positive COVID-19 test recorded, compared to the estimated prevalence in the total population. The most prevalent risk factor was excess weight. Over half of the patients had a BMI which categorised them as overweight or obese. This is reflective of the general adult population prevalence where over 60% of residents are estimated to be overweight or obese. The data suggest that the prevalence of moderately or severely frail patients with COVID-19 is much higher when compared to the overall

⁷⁵ <https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review/build-back-fairer-the-covid-19-marmot-review-executive-summary.pdf>

proportion in the general population, supporting evidence that this population were at high risk of contracting COVID-19.

Figure 24: Physical health or lifestyle risk factors of Hampshire and Isle of Wight residents who had a COVID-19 code recorded on their GP record

| Physical Health or Lifestyle Risk Factor | Proportion with condition testing positive for COVID-19 (%) | Population prevalence estimates (<i>National, Hampshire, IOW</i>) (^{76,77,78}) (%) |
|--|---|--|
| High risk drinkers | 0.3 | 5.0 male, 3.0 female |
| Current smokers | 12.1 | 14.1, 17.5 |
| Overweight or obese | 52.9 | 63.0, 61.9 |
| Moderate or severe frailty | 22.2 | 8.0 |

Source: Care and Health Information Exchange (CHIE) extracted May 2021. QOF data source: NHS Digital

Primary care prescriptions

During the COVID-19 pandemic optimising medicine management has become a priority, both in ensuring appropriate use of medicines and the protection of staff who are administering drugs from contracting the virus.⁷⁹ Between 1 February 2020 and March 2021, 28 million items have been dispensed by community pharmacies in Hampshire and the Isle of Wight. The number of prescribed items was over 268,325 (13%) higher in March 2020 than the same month the previous year. Compared to national data, the proportion of items prescribed in Hampshire and Isle of Wight was higher than in England (7%) in March 2020.⁸⁰ Some of the medicines that showed an increase in prescriptions when compared with the previous year included:

- Inhalers for asthma (salbutamol and terbutaline).
- Anxiolytics and Hypnotics for the short-term treatment of anxiety and sleep problems. Prescriptions increased sharply in March and April 2020 and then declined in the subsequent months.
- Broad spectrum antibiotics (such as co-amoxiclav, cephalosporins and quinolones) also increased sharply at the start of the pandemic.
- Directly acting oral anticoagulant medication for preventing blood clots. Many patients switched from warfarin, as the oral medications did not require regular blood testing.

The finding that poorer health impacts are experienced by those with certain health or lifestyle risk factors is supported by looking at the primary care health records of those admitted to hospital. Figure 25 demonstrates that one of the clearest risk factors is obesity.

⁷⁶ [Health Survey for England 2018 \[NS\] - NHS Digital](#)

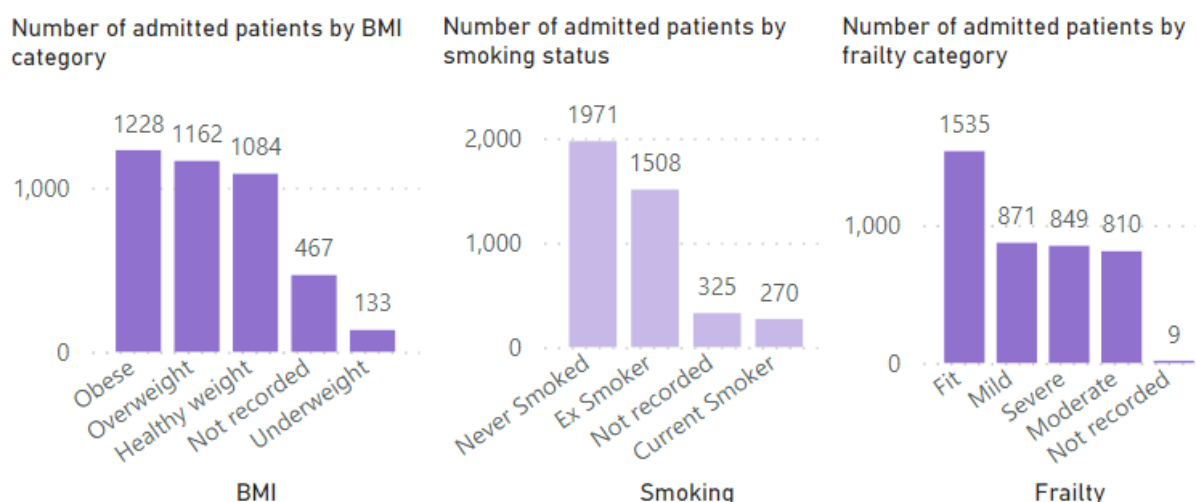
⁷⁷ [Public Health Outcomes Framework - PHE](#)

⁷⁸ South, Central & West CSU: CHIE April 2021 data

⁷⁹ [Optimising medication management during the COVID-19 pandemic \(nih.gov\)](#)

⁸⁰ [Changes in recent prescribing volumes – Nationally, items and costs have changed – Blog \(nhsbsa.net\)](#)

Figure 25: Admissions for COVID-19 by physical health or lifestyle risk factors for Hampshire and Isle of Wight residents



Source: Care and Health Information Exchange (CHIE) extracted May 2021

Other underlying conditions recorded on the death certificate

Public Health England analysis of national data found that among deaths with COVID-19 on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all-cause death certificates and this is likely seen locally on the Isle of Wight. However, due to small numbers the data is less reliable and it is not possible to robustly analyse.

PHE has reported that a study by the OpenSAFELY collaborative found a relationship between deaths from COVID-19 and BMI.⁸¹ The hazard ratio increased as BMI increased, and this persisted even when demographics and other health conditions were controlled for. Local analysis of this relationship was not possible as only a small number of death certificates were coded with information related to obesity.

It should be noted that this analysis only examines information recorded on death certificates. It is likely to be an underestimate of the number of people who die from COVID-19 who have underlying health conditions as not all of these will be recorded.

Occupation

National data has reported a link between occupation and severe outcomes from contracting COVID-19. Men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in health and social care had significantly high rates of death from COVID-19.⁸² Additionally, men from ethnic minority groups are much more likely to work in high-risk occupations. They are overrepresented in eight out of the ten highest death rate occupations; this is particularly true for taxi and cab drivers.⁸³ Long COVID is also more prevalent amongst those working in the health and social care

⁸¹ <https://www.nature.com/articles/s41586-020-2521-4>

⁸² [Disparities in the risk and outcomes of COVID-19 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/91212/disparities-in-the-risk-and-outcomes-of-covid-19.pdf)

⁸³ [COVID-19: Health inequalities and recovery \(local.gov.uk\)](https://www.local.gov.uk/news/2021/03/covid-19-health-inequalities-and-recovery)

sector, and those with long-term health conditions such as obesity.⁸⁴ Care workers and home carers, by the very nature of their occupation, require close contact with others and were unable to work from home. Care homes are known to be particularly vulnerable to the rapid spread of infectious diseases, this has been noted for influenza and other respiratory infections.⁸⁵ Some of this risk may be mitigated by the use of personal protective equipment (PPE) but it has been acknowledged that there was a shortage of PPE inside care home nationally.⁸⁶ Occupation is poorly completed in COVID-19 testing data and therefore local data is not available.

The Isle of Wight has a higher proportion than both the South East and Great Britain for workers in the 'caring, leisure and other service' occupations (13.0% compared to 8.7% for the South East and 8.8% nationally). This is also the case for 'sales and customer service' occupations (7.9% compared to 6.2% for the South East and 6.9% nationally). We have seen above that these sectors were at greater risk of catching COVID-19 with less opportunity for home working. The Isle of Wight also has a higher proportion than the national average and the South East for those working in 'skilled trade' occupations (Isle of Wight 11.4%, South East 8.9%, nationally 9.2%) and 'elementary' occupations⁸⁷ (Isle of Wight 11.7%, South East 7.8% and nationally 9.2%) both also sectors less likely to be able to work from home.

Indirect

This section looks at the indirect impacts of COVID-19 on existing health conditions and lifestyle which can in turn impact on health. For some this impact has been around the management of existing conditions, or quick identification of new conditions, whilst for others the impact of the pandemic may have been focused on behaviour changes during social restrictions.

Access to Primary care including dental

The way primary care was delivered changed significantly in response to the pandemic, remote consultations (e-consults) became the predominant method of consultation for many. Figure 26 shows the recent national trend data up to January 2021, the biggest decrease in consultations was observed during the first lockdown and this was noted across all age bands. Data suggest that recent consultation rates are similar to pre-pandemic times.

Figure 26: National consultation rates per person per year

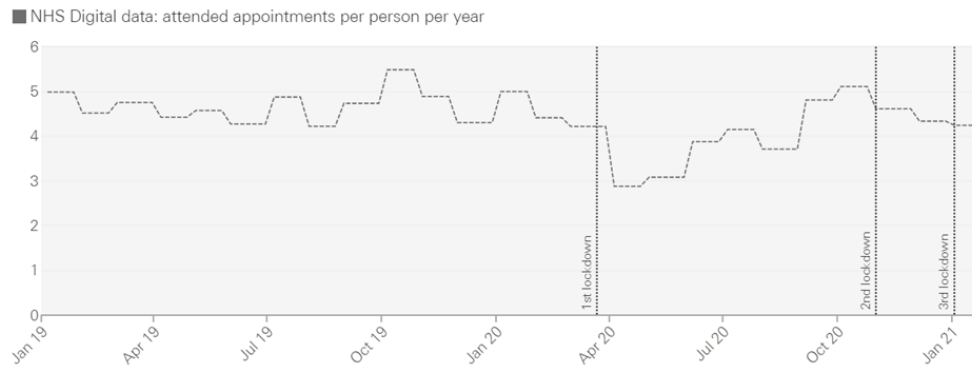
⁸⁴

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1april2021>

⁸⁵ [Characteristics of respiratory outbreaks in care homes during four influenza seasons, 2011–2015 - ScienceDirect](#)

⁸⁶ [Introduction to and spread of COVID-19 in care homes in Norfolk, UK | medRxiv](#)

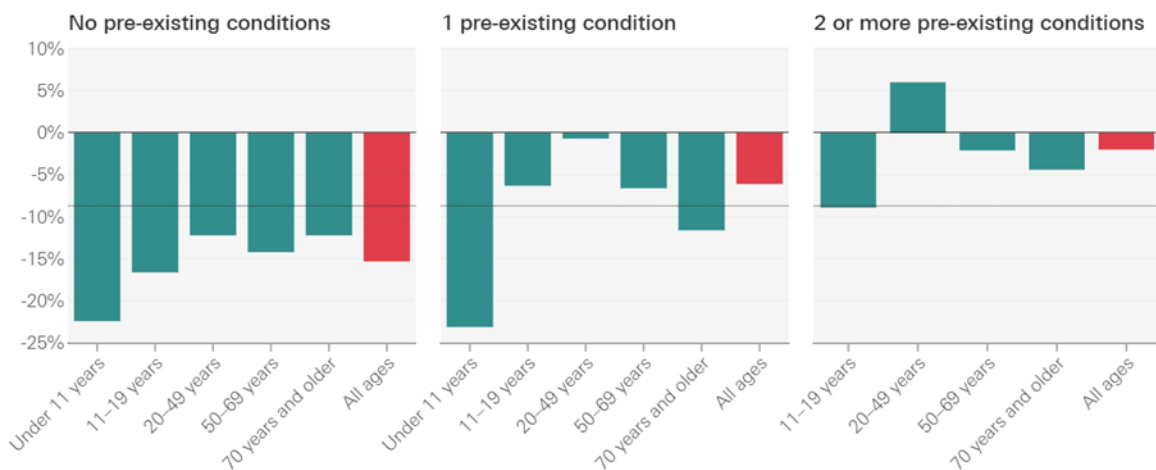
⁸⁷ Elementary Occupations (Group 9 in SOC) include jobs such as security guards, parking and civil enforcement officers, cleaners, postal workers, packers, canners etc [ONS Standard Occupational Classification \(SOC\) Hierarchy \(onsdigital.github.io\)](#)



Source: Health Foundation Use of primary care during the COVID-19 pandemic: May 2021 update⁸⁸

Figure 27 presents changes in the national consultation rates by the number of pre-existing conditions, the biggest decrease was observed in the younger under 11 years age group. In the 70 years and over population, an 11.6% fall was observed in those with one condition and a 4.4% fall in those with two conditions.

Figure 27: Percentage change in national consultation rate in 2020 compared to 2019, by number of pre-existing conditions and age



Source: Health Foundation Use of primary care during the COVID-19 pandemic: May 2021 update⁸⁹

During the pandemic (2020) the proportion of people with Dementia and Alzheimer's disease prescribed anti-psychotic medication in the preceding six weeks (all ages) increased in comparison to 2019. However, those with a care plan or care plan review has significantly decreased. This is of particular concern as the needs of an individual with dementia change with time. The care plan is how an individual's health and care needs are met through the provision of relevant and timely health services. If a care plan is not current, there could be unmet needs that could lead to the deterioration of the dementia condition and/or lead to other health conditions developing.⁹⁰

Figure 28 shows that nationally the estimated diagnosis rate of Dementia and Alzheimer's in those aged 65 years and over and the recorded prevalence rate decreased significantly at the start of the pandemic and has remained at this lower level compared to the baseline.

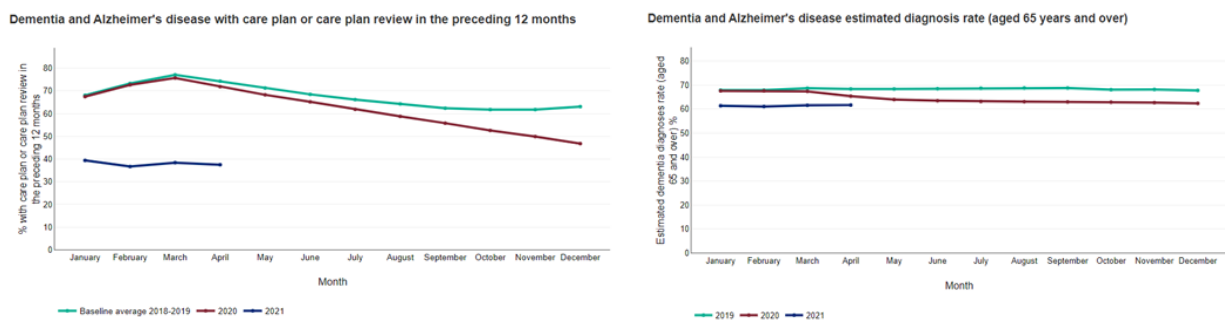
⁸⁸ [Health Foundation Use of primary care during the COVID-19 pandemic: May 2021 update](#)

⁸⁹ [Health Foundation Use of primary care during the COVID-19 pandemic: May 2021 update](#)

⁹⁰ [Wider Impacts of COVID-19 \(phe.gov.uk\)](#)

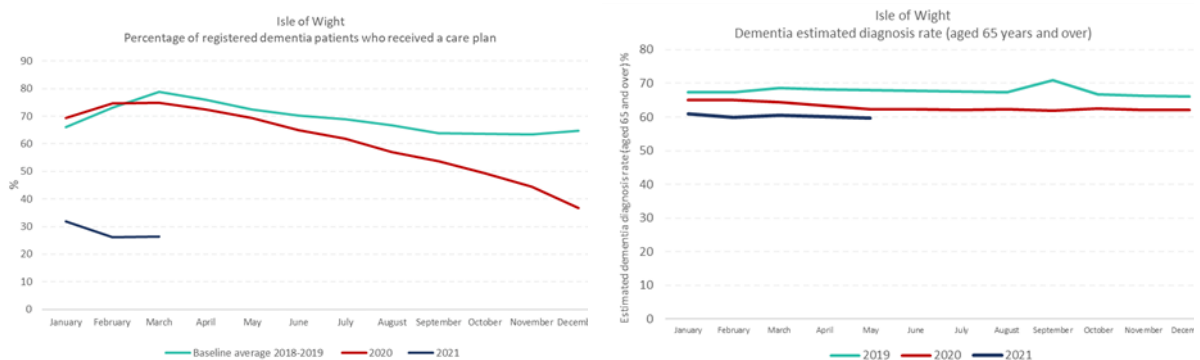
Figure 29 suggest that locally there is a similar decreasing trend in both reviews and diagnosis across the Isle of Wight. These trends are concerning as a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

Figure 28: National Dementia and Alzheimer’s disease management and diagnosis



Source: Public Health England Wider Impacts of COVID-19 on Health (WICH) Monitoring Tool

Figure 29: Isle of Wight Dementia disease management and diagnosis



Source: NHS Digital Recorded Dementia Diagnosis

The British Dental Association indicate that analysis of the government’s last GP Survey indicates over 1.4 million adult patients have tried and failed to access care – with a further 2 million estimated to have not tried in the belief they would be unable to secure an appointment.⁹¹

Access to Secondary care

Social restriction policies and the risk of COVID-19 transmission has impacted greatly on the delivery of all health care. Many services moved to virtual consultations via telephone where possible. All but essential operations and procedures were put on hold.

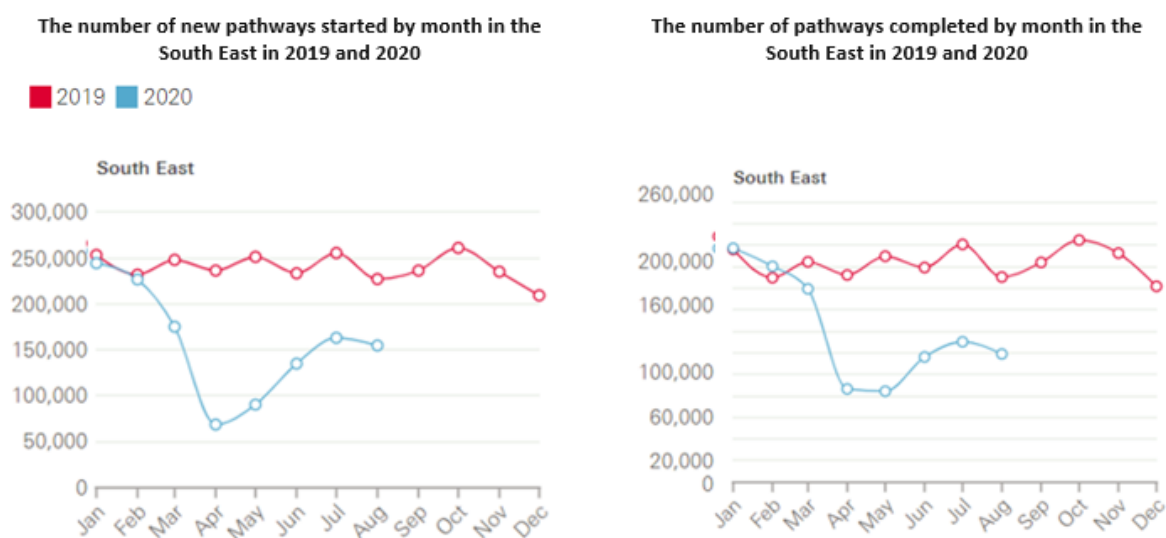
⁹¹ <https://bda.org/news-centre/press-releases/unmet-need-reaches-4-million-as-access-problems-go-england-wide>

Recent findings from the British Medical Association show that the shutdown of most non-COVID-19 services in the first wave, combined with drastic changes in patient behaviour, mean the NHS is facing a large backlog of non-COVID-19 care, storing up greater problems for the future.⁹² For example, between April 2020 and March 2021 there were:

- 3.37 million fewer elective procedures
- 21.4 million fewer outpatient attendances.

Comparing January to August 2020 to the same months in 2019, the South East has observed a reduction in the number of admitted and non-admitted completed and new pathways; this is comparable to other regions across the country.

Figure 30: The number of new pathways started and completed by month in the South East, 2019 and 2020



Source: Health Foundation: Elective Care in England, November 2020⁹³

Throughout the pandemic there have been significantly fewer emergency attendances when compared to 2019 baseline levels. This was particularly evident in the younger population groups aged under ten years. A YouGov Survey asked respondents if they were experiencing worsening health condition in the last seven days and showed a greater proportion of older people aged 55 years and over were affected, and all age groups were most affected during the first lockdown in March 2020.⁹⁴ This supports the concerns that during the pandemic people were not accessing healthcare for non-COVID related health issues and that this may have long-term effects on their health.

There was a national reduction in admissions to hospital from care homes, with 11,800 fewer admissions during March and April 2020 compared with previous years.⁹⁵ This suggests that this vulnerable population may have faced increased barriers to accessing hospital care when COVID-19 became hospitals' focus. Reductions in care home resident hospital activity

⁹² <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs>

⁹³ Health Foundation: Elective Care in England, November 2020

⁹⁴ Public Health England Wider Impacts of COVID-19 on Health (WICH) Monitoring Tool

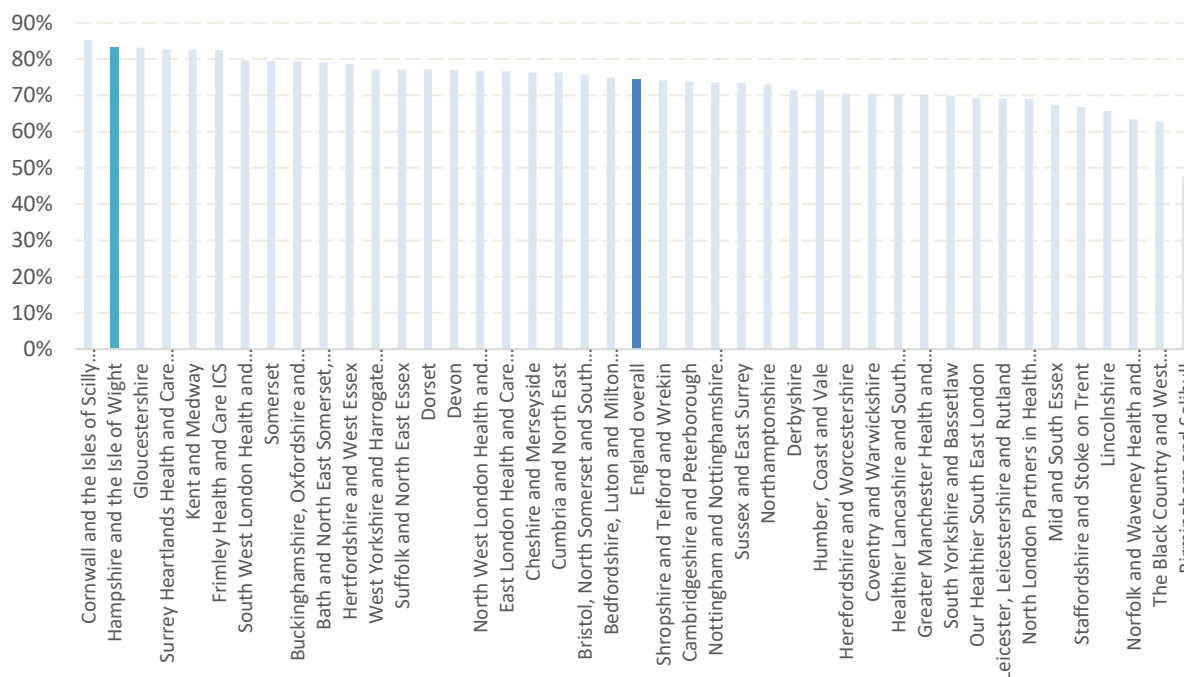
⁹⁵ <https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-policy-response-in-england>

were observed in both emergency admissions including stroke and heart attack and elective admissions such as cataract surgery, some cancer treatment and hip replacements.

Long-term specialist treatment has seen some recent improvements, however numbers waiting are 35 times that of April 2020 and 368 times the number waiting in April 2019. At the beginning of the pandemic, national direction from NHS England and NHS Improvement stipulated that appropriate priority be given to the diagnosis and treatment of cancer.⁹⁶ However, cancer waiting times saw a decline in performance against a number of targets, despite some improvement in recent months. The proportion of patients being seen rapidly still remains lower than what would be expected, with the 93% target for patients to be seen by a specialist consultant within two weeks of an urgent GP referral still unmet since May 2020.

Overall, in England the number of people starting treatment within 62 days of a GP referral dropped from the previous year by 2.8% to 74.3%. However, across the Hampshire and Isle of Wight ICS (which includes Portsmouth and Southampton) the number of people starting treatment within this time increased by 3.9% from the previous year and is now at 83.2%.

Figure 31: 62 day wait for first time treatment following an urgent cancer referral (all tumour types), 2020/21



Source: NHS cancer waiting times 2020/21, as yet unpublished

The impacts of COVID-19 and lockdown has resulted in an increase in remote contact with maternity services. This impact is likely to affect first time mothers more, especially increased social isolation following the birth (particularly for mothers who gave birth at the start of the pandemic).⁹⁷ Two thirds (68%) of parents reported that their ability to cope with their pregnancy or baby has been impacted by COVID-19.

Physical Activity

⁹⁶ [Briefing template \(england.nhs.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/91231/briefing-template-england-nhs-uk)

⁹⁷ <https://www.pmhn.scot.nhs.uk/wp-content/uploads/2020/11/Babies-in-Lockdown-Main-Report-FINAL-VERSION-1.pdf>

A reduction in exercise can result in deconditioning which leads to an increased risk of reduced bone mass and muscle strength, dependence and confusion. The term 'Deconditioning syndrome' is used to describe this effect and includes the physical, functional and psychological decline that can be experienced from reduced mobility.⁹⁸

During social distancing restrictions many people experienced reduced levels of activity.⁹⁹ For those with long term conditions who were shielding, this impact would have been even greater. Those shielding were advised not to leave their homes between 23 March and 1 June 2020. From the 1 June they were advised if they left their homes not to mix with others. From 1 August those shielding were told that they could return to 'COVID-19 secure' workplaces. During the second COVID-19 peak during the winter of 2020/21 those clinically vulnerable to COVID-19 were provided with additional guidance but required to shield.

On the Isle of Wight over the course of the pandemic approximately 7,000 people were shielding. Spending months with reduced activity is suggested to have an impact on the four aspects of physical fitness (strength, stamina, suppleness and skill) and also on cognitive function and emotional wellbeing. This will increase dependency and reduce life expectancy.¹⁰⁰ This is supported from survey evidence which suggests that 25% of older people's ability to do everyday activities has worsened during the pandemic.¹⁰¹ This will increase the need for people to receive health and social care services.

Even for those without long term health conditions, a reduction in physical activity can impact on health. Physical activity for those aged 16 and over declined during the early stages of the pandemic. Around 3 million fewer adults were doing 150 or more minutes per week of physical activity. This increased when the restrictions were lifted but did not recover to pre-pandemic levels.¹⁰²

Children also saw a decrease in overall activity levels.¹⁰³ Sporting activities saw a large decrease whilst walking, cycling and at home fitness activities saw a large increase. Positive attitudes towards sport and physical activity had decreased, with boys seeing the largest drop in activity levels and girls seeing an increase. Those living in less affluent areas had consistently lower levels of activity. Other studies have reported a decline in children's physical fitness and an increase in weight.¹⁰⁴ Additionally 2 million children will have missed out on swimming lessons over the past year.¹⁰⁵ Rates for hospital admissions where obesity was a factor have been steadily increasing from 2013/14 and physical activity is an important aspect of maintaining a healthy weight.¹⁰⁶

Figure 32: Rate per 100,000 population of obesity related admissions, 2013/14 to 2019/20

⁹⁸ <https://www.bmj.com/content/366/bmj.l4185/rr-6#:~:text=We%20define%20'deconditioning%20syndrome'%20as,strength%2C%20commonly%20experienced%20through%20hospitalisation.>

⁹⁹ <https://www.sportengland.org/know-your-audience/demographic-knowledge/coronavirus?section=research>

¹⁰⁰ <https://blogs.bmj.com/bmj/2020/06/15/covid-19-will-be-followed-by-a-deconditioning-pandemic/>

¹⁰¹ <https://www.ageuk.org.uk/latest-press/articles/2021/new-analysis-finds-the-pandemic-has-significantly-increased-older-peoples-need-for-social-care/>

¹⁰² <https://health.org.uk/publications/reports/unequal-pandemic-fairer-recovery>

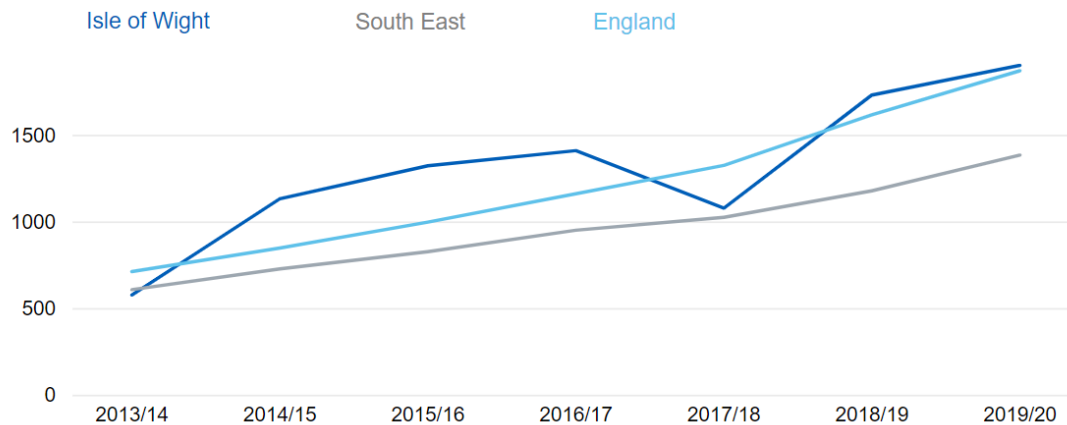
¹⁰³ <https://www.sportengland.org/news/childrens-activity-levels-down-many-embrace-new-opportunities>

¹⁰⁴ <https://activemovementschools.co.uk/>

¹⁰⁵ <https://www.swimming.org/justswim/love-swimming-safe-secure-lessons/>

¹⁰⁶

<https://app.powerbi.com/view?r=eyJrIjoieYzVlMTAxM2ltMzQ1Ni00ZmUxLTg0MzAtYTRjMmM5MjVjZjNhliwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOi9>



Source: Hospital Episode Statistics, NHS Digital

Diet

Diet is another aspect that has been impacted by the pandemic. With hospitality closed more people were cooking from home, however the quality of food has varied across different groups. Unhealthy snacking increased, although families reported eating together more frequently, cooking food from scratch more frequently and food waste decreased. Children from disadvantaged background were most likely to eat more junk food and less likely to be eating more fruit and vegetables.¹⁰⁷

There were large peaks in alcohol purchasing over the periods of social restrictions with increases of alcohol, drinks and tobacco products increasing by 24.7% and 45.4% for March and April 2020 compared with the previous year and increases of 12.6% and 42.9% for January and February 2021 compared with the previous year.¹⁰⁸

Smoking

Rates of smoking have declined over the course of the pandemic, with an estimated one million people stopping smoking since the beginning of the pandemic.¹⁰⁹ This is supported by analysis from PHE shown in the chart below. There is also concern however, that some of those who stopped smoking may have taken up smoking again due to the stress experienced during the pandemic and that existing smokers may be smoking more frequently.¹¹⁰

Figure 33: Current smokers in England by age group, 2019 compared with 4-week period ending 25/04/2021¹¹¹

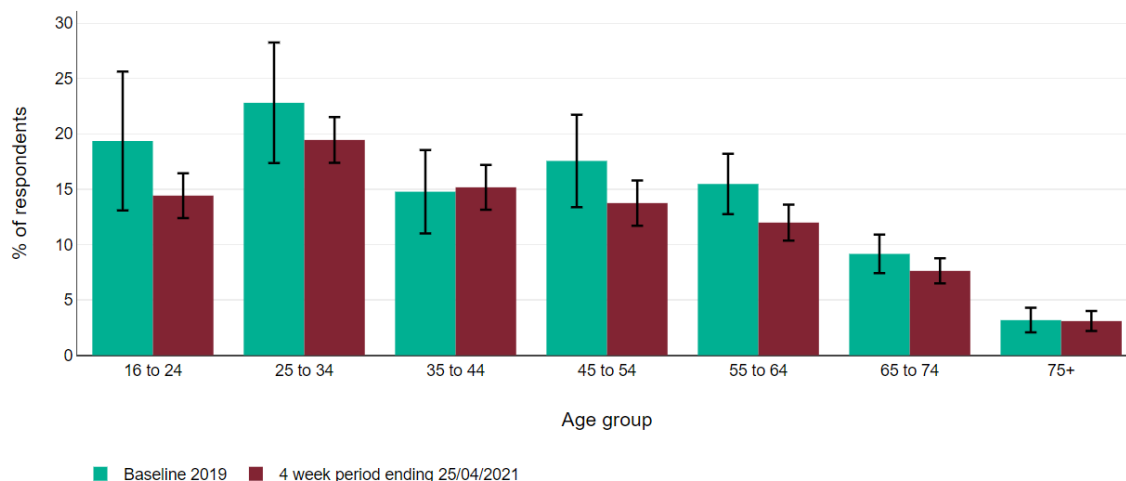
¹⁰⁷ <https://www.nationalfoodstrategy.org/wp-content/uploads/2020/07/NFS-Part-One-SP-CP.pdf>

¹⁰⁸ <https://www.ons.gov.uk/businessindustryandtrade/retailindustry/bulletins/retailsales/february2021>

¹⁰⁹ <https://ash.org.uk/media-and-news/press-releases-media-and-news/pandemicmillion/>

¹¹⁰ <https://www.mintel.com/press-centre/social-and-lifestyle/panic-puffs-half-of-smokers-are-stress-smoking-more-since-the-pandemic-started>

¹¹¹ <https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/>



Source: PHE analysis of Opinions and Lifestyle Survey data from ONS

Work life balance

Working long hours has been shown to be a risk to health, with people working 55 hours or more per week having an increased risk of heart disease or stroke.¹¹² During the pandemic many people’s working arrangements changed with nearly half (46.6%) of people in employment doing some work from home from April 2020.¹¹³ Of these, around one third (30.3%) worked a greater number of hours than usual, with a third stating they worked fewer hours than usual (34.4%). Although some workers completed more hours there may also be benefits from working from home, such as reduced time spent travelling to work, reduced sickness absence rate (0.9% compared with 2.2% who never work from home),¹¹⁴ helping fathers to be more present and to have greater involvement in childcare.¹¹⁵ Many workers have reported that they would like to continue some home working once social distancing restrictions end.¹¹⁶

Health Vulnerability Index

This index was calculated by combining the factors which have been shown to be high risk for severe outcomes from contracting COVID-19. The indicators included are: age (over 75), household overcrowding, proportion of residents with asthma, atrial fibrillation, cancer, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease, coronary heart disease, dementia, diabetes, heart failure, hypertension, learning disabilities, obesity, osteoporosis, palliative care, peripheral arterial disease, rheumatoid arthritis, stroke or transient ischaemic attack, severe or moderate frailty, depression and severe mental health disease. The indicators have been combined to provide an overall estimate of the vulnerability of people living in these areas to severe health outcomes from COVID-19.

The Health Vulnerability Index is presented by Lower Super Output Areas (LSOAs) and can provide more detailed information as to where these vulnerable people live. An LSOA has an

¹¹² <https://www.who.int/news/item/17-05-2021-long-working-hours-increasing-deaths-from-heart-disease-and-stroke-who-ilo>

¹¹³

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/coronavir-usandhomeworkingintheuk/april2020>

¹¹⁴

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/homeworkinghoursrew-ardsandopportunitiesintheuk2011to2020/2021-04-19>

¹¹⁵ <http://www.fatherhoodinstitute.org/wp-content/uploads/2021/05/Lockdown-Fathers-Full-Report.pdf>

¹¹⁶ <https://yougov.co.uk/topics/economy/articles-reports/2020/09/22/most-workers-want-work-home-after-covid-19>

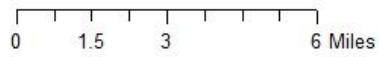
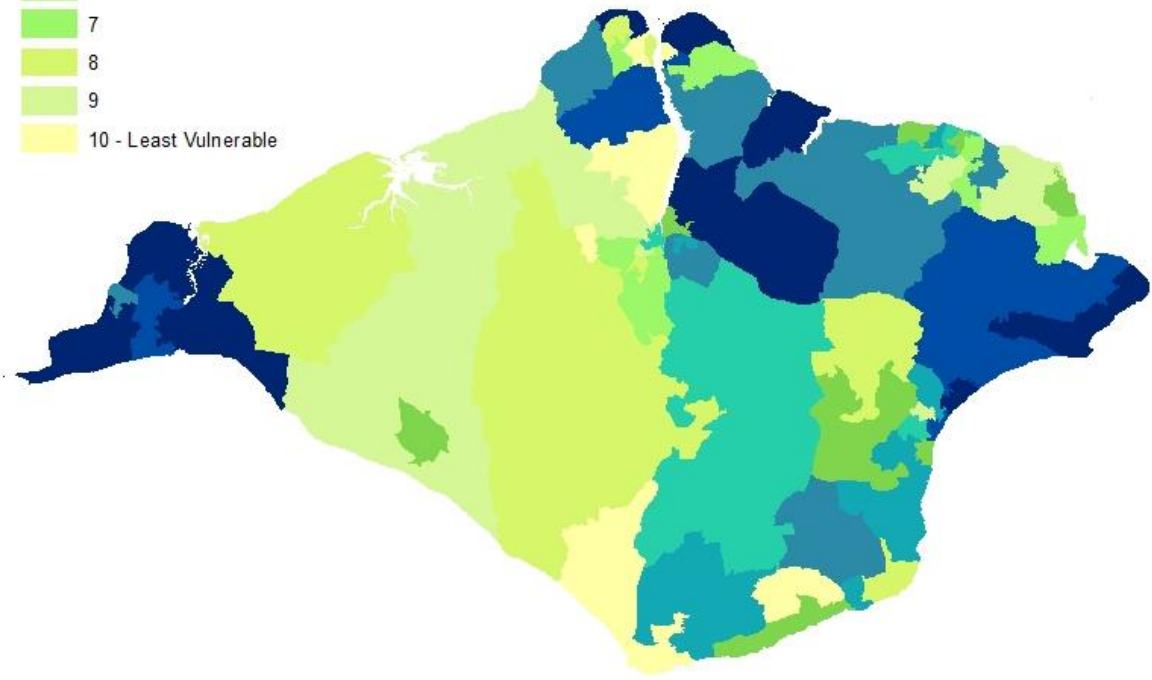
average population of 1,500 to enable better comparisons between areas and this means that LSOAs in more urban areas are small. This map shows the areas where those most vulnerable to severe health outcomes from COVID-19 are living in the darker blue colours.

The health index is not standardised and so does not take into account the age structure of the local population. It is useful to examine this health vulnerability index with the COVID-19 outcomes data.

Overall, the areas with higher vulnerability due to health include parts of Sandown, Freshwater, Cowes, East Cowes, Wootton, Fairlee and Bembridge.

Figure 34: Health Vulnerability Index

Decile



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HEALTHY PLACES

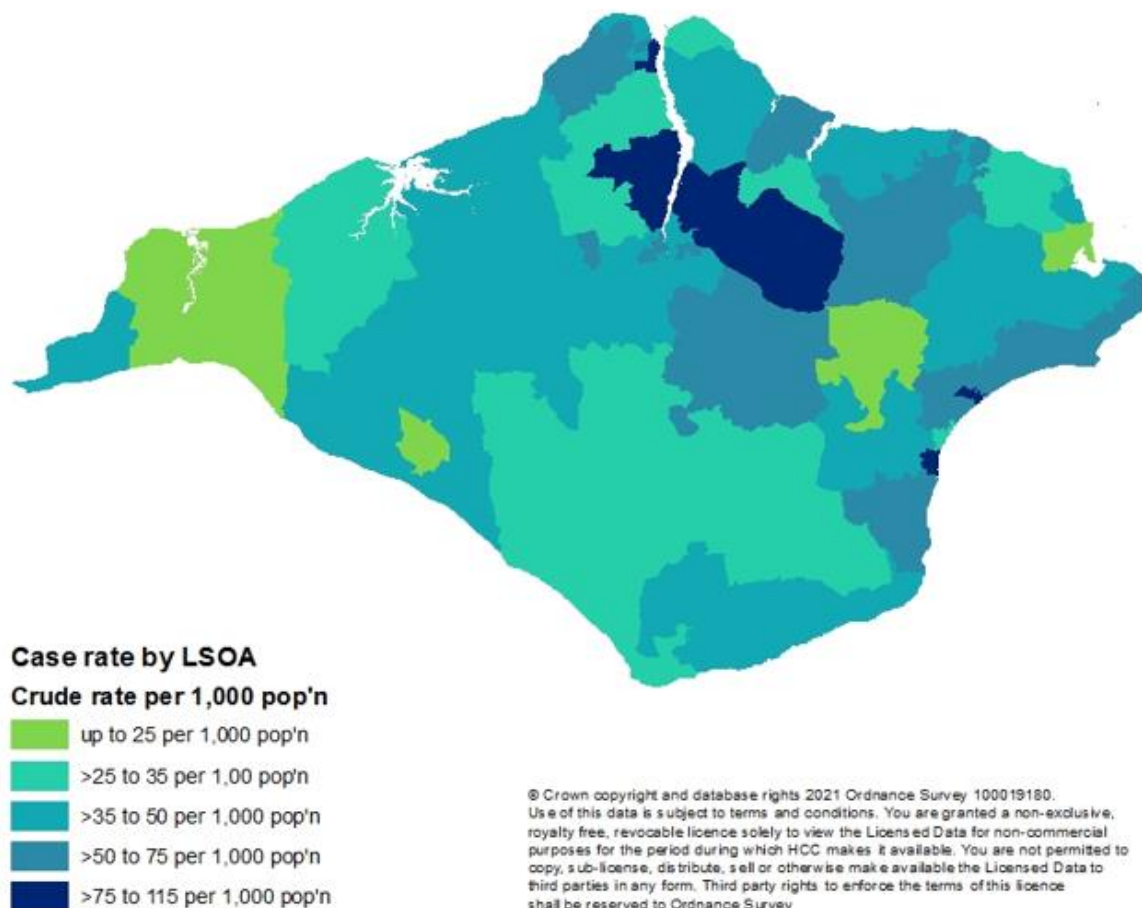
This section of the report looks at how living environment can influence the impact of the COVID-19 pandemic. It includes those factors which increase the risk of contracting COVID-19 and having severe health outcomes from the virus. It also examines how living environment can influence the effect of the social restriction policies during the pandemic.

Direct

Cases

The cases rate of COVID-19 cases has varied across the Isle of Wight with some areas experiencing higher rates of infection. Figure 35 shows the number of cases by LSOA across the island.

Figure 35: Case rates across the Isle of Wight, 4 March 2020 to 31 March 2021. Crude rates per 1,000 population

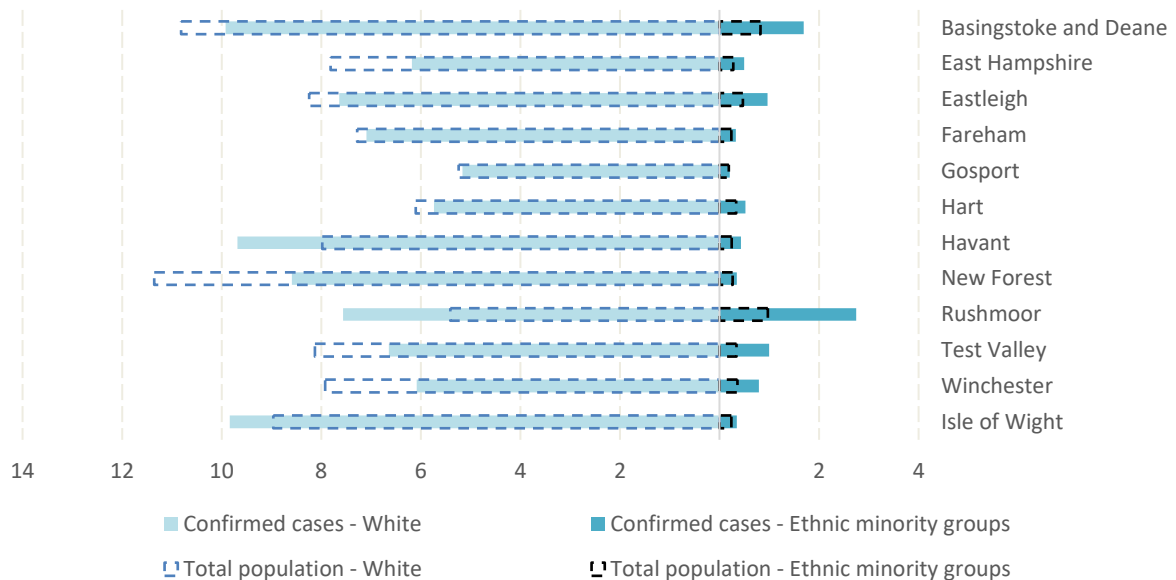


Source: PHE dashboard

In the main, the distribution of cases show concentration around care institutions such as care homes, the hospice and the hospital highlighting those at-risk groups due to age, health or working in a caring profession with increased exposure to COVID-19.

Figure 36 shows the proportion of cases by ethnic group compared with the structure of the population and demonstrates that cases have been higher in ethnic minority backgrounds in almost all areas of Hampshire and the Isle of Wight.

Figure 36: COVID-19 cases compared with population structure by district, February 2020 to March 2021.



Source: PHE dashboard, Census 2011

International data has demonstrated a clear correlation between increased exposure to COVID-19 and physical proximity to others at work, with occupations such as health care, teaching, police and other front-line services with higher risks of infection.¹¹⁷ In the local data, occupation was poorly completed and therefore a breakdown is not included.

Hospitalisations

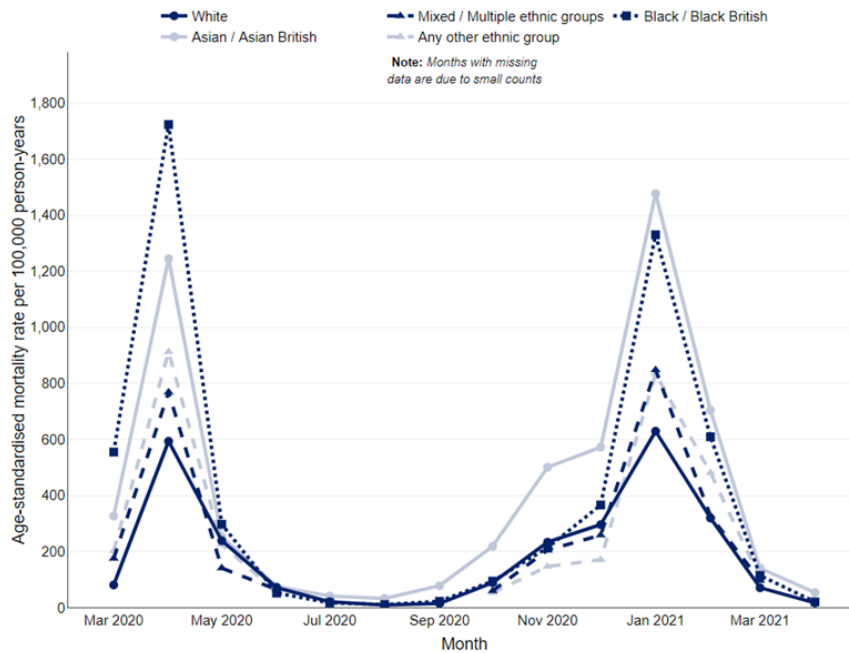
National data show inequalities in COVID-19 related admissions in areas of higher deprivation and ethnic minority groups since the beginning of the pandemic in March 2020. Throughout the pandemic the more deprived areas had higher admissions rates. At the peak of Wave 1, hospital admission rates in the more deprived areas were 2.3 times higher than those in the less deprived areas and 1.8 times higher at the peak of Wave 2. Rates were higher in males than females across all deprivation deciles.

Figure 37 shows that during Wave 1 the Black/Black British population had the highest admission rates which at peak was 2.9 times higher than the admission rates in the White population group. During Wave 2 the Asian/Asian British population had the highest admission rate which at peak was 2.3 times higher than the admission rates in the White population group. Rates were higher in males than females across all ethnic groups.

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<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11>

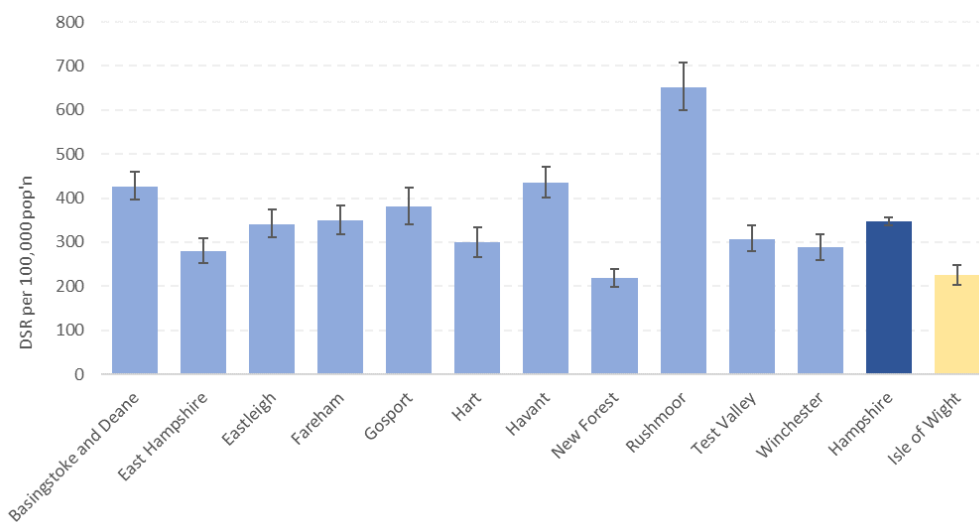
Figure 37: Monthly age-standardised mortality rate per 100,000 person-years, for deaths involving COVID-19 in England by ethnic group, March 2020 to April 2021



Data source: Source: COVID-19 Health Inequalities Monitoring for England (CHIME) tool¹¹⁸

Locally, hospital admission rates varied widely across Hampshire and the Isle of Wight. Figure 38 shows that Rushmoor had a significantly higher COVID-19 admission rate of 651 per 100,000 population, this rate is over three times higher than New Forest which had the lowest COVID-19 admission rate across Hampshire and the Isle of Wight of 217.6 per 100,000 population.

Figure 38: COVID-19 hospital admission rates by local authority Directly Age Standardised Rates (DSR) per 100,000 population: All Persons



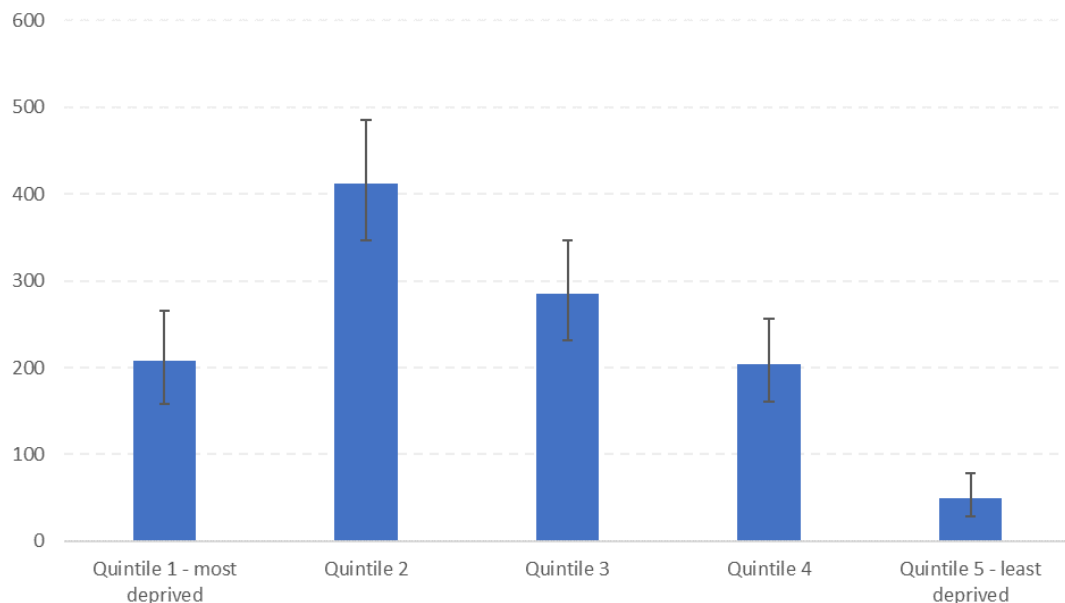
Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021

At a local level admission numbers by ethnic group are too small to calculate robust age standardised hospital admissions rates for the Isle of Wight. However, Figure 39 explores

¹¹⁸ [COVID-19 Health Inequalities Monitoring for England \(CHIME\) tool](#)

the local correlation between deprivation and COVID-19 admission rates. Similar to the national picture, a gradient in the overall COVID-19 admission rates by deprivation is evident. However, the highest rates are seen in Quintile 2 where rates were eight times higher than those in the least deprived areas. When analysing data at a lower level, smaller numbers can make the rates less robust. Not all differences between the quintile rates are statistically significant so care should be taken when interpreting these results.

Figure 39: COVID-19 hospital admission rates by national deprivation quintile. Directly Age Standardised Rates (DSR) per 100,000 population.



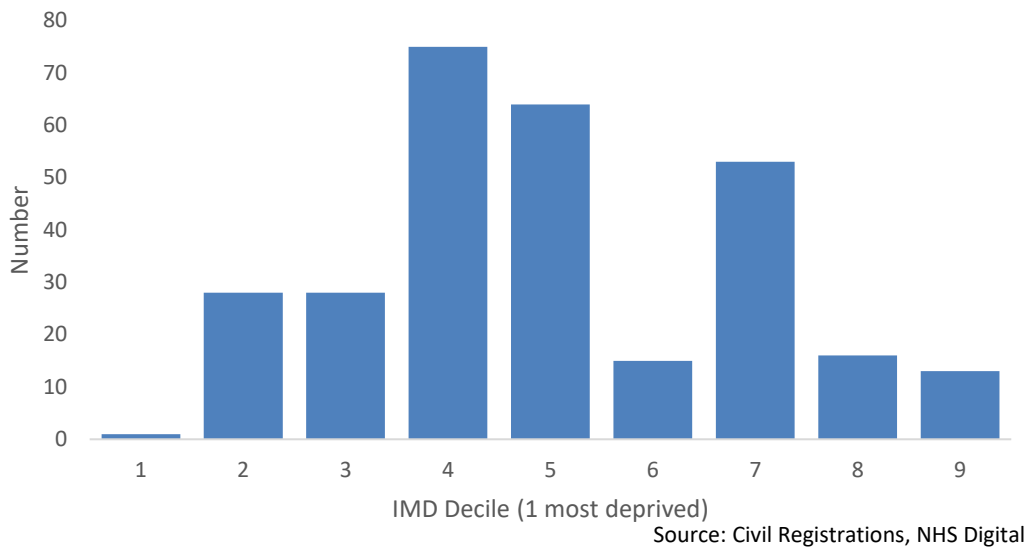
Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021

Mortality

There was a gradient in mortality rates by level of deprivation: the impact of the pandemic increased with each increase in the level of deprivation. Across the pandemic to date, the cumulative mortality rate was 2.4 times higher for the most deprived than for the least deprived across England. This is greater than the inequality seen in mortality rates in previous years, indicating greater inequality in death rates from COVID-19. These patterns may be attributable to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed.

On the Isle of Wight, the pattern is less pronounced and is likely to be due to the small numbers involved.

Figure 40: Count of COVID-19 deaths by national deprivation quintile March 2020 to April 2021 - Isle of Wight

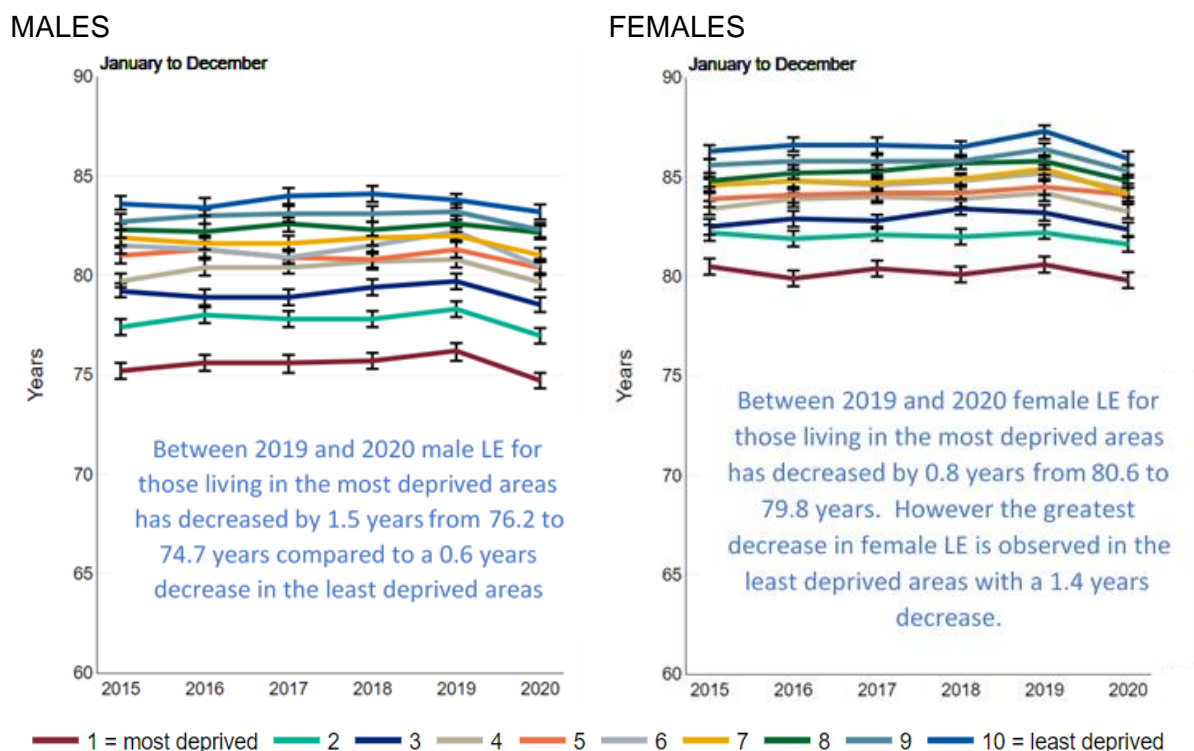


A model developed by Public Health England (PHE) has been used to estimate levels of all cause excess mortality in the population by comparing the number of deaths that would have been expected for corresponding dates in the five-year period prior to the pandemic. Analysis produced by PHE suggests that there were a little over 78,000 excess deaths nationally over the course of the pandemic to date, from the beginning of 2020 to the 18 of June 2021. There were an estimated 159 excess deaths on the Isle of Wight over the same time period.¹¹⁹

Early analysis presenting life expectancy trends from 2015 to 2020 suggest that inequalities have widened significantly, disproportionately impacting on those living in the more deprived areas. Trends in life expectancy at birth across the South East region by deprivation decile are presented in Figure 41. Life expectancy has reduced in all deprivation deciles. These data suggest that COVID-19 has had a disproportionate impact on the life expectancy of males living in deprived areas. However, females living in the least deprived areas have also experienced a significant impact on the life expectancy estimates for 2020

¹¹⁹ Excess deaths data summary for week 24 2021, LKIS South East, Public Health England.

Figure 41: Trend in life expectancy (LE) at birth across South East Region & deprivation decile



Source: Public Health England: Wider Impacts of COVID-19 on Health (WICH) monitoring tool

Indirect

Education

Children and young people population group have been described as ‘the COVID generation’.¹²⁰ Clinically this population group were the least at risk of becoming severely ill from COVID-19 but the impact of school closure will have been significant for all children.

Time spent learning declined during lockdown for secondary school pupils, from 6.6 hours per day before the pandemic to 4.5 hours during the pandemic.¹²¹ This varied by area, for example, those schools in higher areas of deprivation had lost 2.2 months of learning by September 2020 compared with 1.5 months in areas of lower deprivation.¹²² There was also variation by school type with 51% of teachers in private schools reporting being fully open to Year 11 in November 2020, compared with only 33% in state schools.¹²³

There are many reasons why those children from deprived background had reduced participation in learning. For example, reduced access to digital resources and support required for distance learning may have been a barrier.¹²⁴ Home schooling may also have been especially challenging in households with overcrowding, where parents have lower

¹²⁰ [Living-Safely-with-Covid-ADPH-Guidance-1.pdf](#)

¹²¹ <https://ifs.org.uk/uploads/R178-Family-time-use-and-home-learning-during-the-COVID-19-lockdown-1.pdf>

¹²²

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962330/Learning_Loss_Report_1A_-_FINAL.pdf

¹²³ <https://www.suttontrust.com/wp-content/uploads/2021/01/Learning-in-Lockdown.pdf>

¹²⁴ National Foundation for Educational Research: The challenges facing schools and pupils in September 2020

educational attainment or reduced language skills.¹²⁵ This may have resulted in some pupils disengaging from school and increased the educational divide.¹²⁶ In the summer term when schools invited certain year groups to return to school only 56% of pupils returned, and this was lower for pupils from ethnic minority groups (49%).¹²⁷ There are also growing concerns for vulnerable children who in lockdown became a ‘hidden population’ due to reduced contact and social interaction with educational and health professionals.

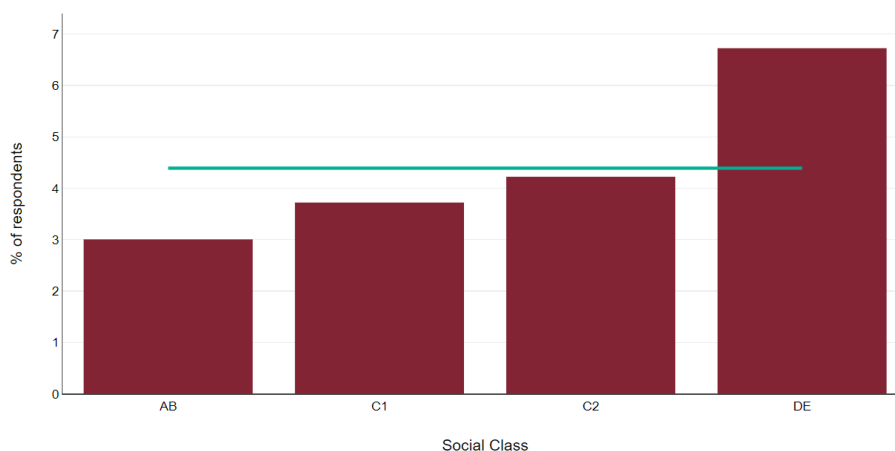
It is challenging to estimate the long-term impacts of the disruption to education however it has been estimated that the learning loss equivalent of one third of a school year can reduce a young person’s income in their working life by 3%.¹²⁸

Those children from deprived areas who were entitled to free school meals may also have experienced food insecurity. It has been reported that one month into the social distancing restrictions in 2020, 2 million children had experienced food insecurity, with one third of children eligible for free school meals not receiving any alternative provision.¹²⁹

Green space

The social distancing restrictions and stay at home measures impacted people very differently depending on where they lived and their type of accommodation. Data from PHE indicate that access to a private garden space varies by social class and by ethnicity.¹³⁰ Those people living in smaller, more crowded homes with less access to private garden space would have experienced greater stress during social distancing restrictions than those with a garden and additional living space.

Figure 42: Access to private garden space by class and ethnicity (2014-19)



¹²⁵ <https://youngminds.org.uk/media/3808/youngminds-submission-to-education-committee-the-impact-of-covid-19-on-education-and-childrens-services.pdf>

¹²⁶ [Education and COVID-19: Focusing on the long-term impact of school closures \(oecd.org\)](https://www.oecd.org/education/COVID-19-Focusing-on-the-long-term-impact-of-school-closures)

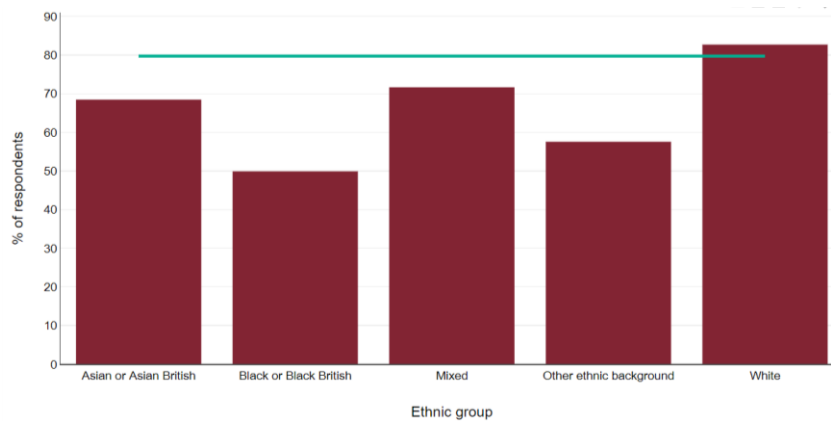
¹²⁷

https://www.nfer.ac.uk/media/4119/schools_responses_to_covid_19_the_challenges_facing_schools_and_pupils_in_september_2020.pdf

¹²⁸ <https://www.oecd.org/education/The-economic-impacts-of-coronavirus-covid-19-learning-losses.pdf>

¹²⁹ <https://health.org.uk/publications/reports/unequal-pandemic-fairer-recovery>

¹³⁰ <https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/>



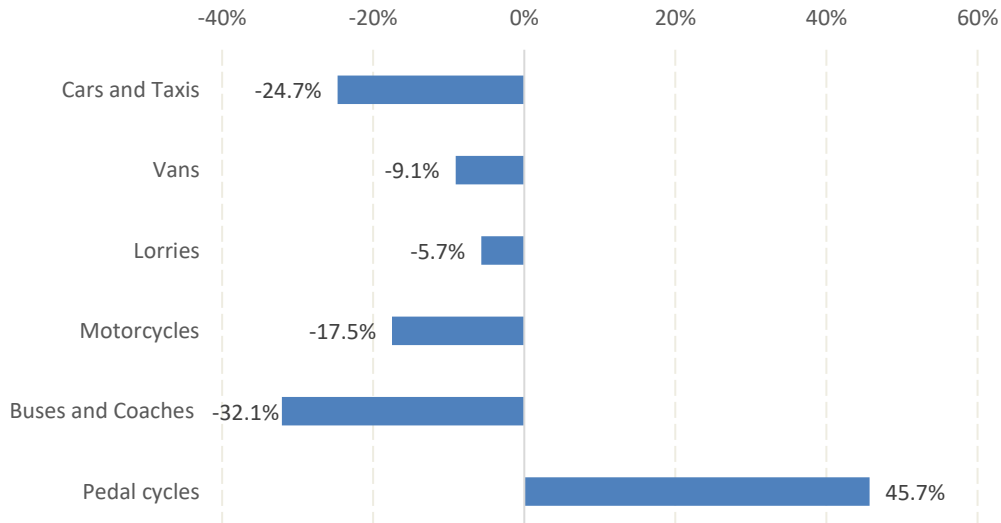
Source: PHE Wider Impacts of COVID-19 on Health monitoring tool

Air Quality

Air quality is considered a health risk in the UK. It can contribute to chronic disease and reduced life expectancy. Health can be affected both by short- and long-term exposure to pollution. Transport has an important impact on local air quality due to vehicle emissions, including nitrogen oxide and particulate matter.¹³¹

In April 2020, during the ‘Stay at Home’ restrictions motor vehicle travel was 63% lower than in the same month in 2019. Overall, motor vehicle travel reduced by 21.3% in 2020 compared with 2019.¹³² The largest decrease was shown for buses and coaches, followed by cars (Figure 43), whilst the use of pedal cycles increased.

Figure 43: Change in miles driven by type of vehicle, Great Britain, 2019 to 2020



Source: Department for Transport

The social distancing measures and lockdown restrictions reduced the amount of nitrogen oxide (NOx) generated by motor vehicle transport in the UK.¹³³ The same pattern was identified in Hampshire and the Isle of Wight. The data reported by the UK Department for Transport shows that the concentration of NOx was lower during the pandemic compared to

¹³¹ [Clean Air Strategy 2019 \(publishing.service.gov.uk\)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981967/road-traffic-estimates-in-great-britain-2020.pdf)

¹³² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981967/road-traffic-estimates-in-great-britain-2020.pdf

¹³³ [2007010844 Estimation of Changes in Air Pollution During COVID-19 outbreak in the UK.pdf \(defra.gov.uk\)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981967/road-traffic-estimates-in-great-britain-2020.pdf)

previous years in Hampshire.¹³⁴ PHE says that a reduction in NOx, sulphur dioxide, particulate matter and volatile organic compounds presents potential benefits to human health.

Emerging evidence suggests that there is a link between air pollution and COVID-19 infection rates. Studies have demonstrated that both short-term and long-term exposure to air pollution, especially PM_{2.5} and nitrogen dioxide (NO₂), may contribute significantly to higher rates of COVID-19 infections and mortalities.^{135,136} The health burden of air pollution is not equal. Deprived communities are more likely to be exposed to air pollution, contributing to a greater risk of becoming ill or severely ill from COVID-19 infections.¹³⁷

As we move forward, promoting air quality is a crucial part of an integrated approach toward healthy places and healthy lives. Transport has a key role to play in reducing emissions and meeting the local goals on the environment and public health. Encouraging active travel, alternative transport, promoting healthy places, and effective communication about air pollution particularly across vulnerable communities, can save and improve people's lives.

Crime

Police data indicates that crime has also been impacted by the pandemic and associated policies.¹³⁸ In the year to September 2020, police-recorded crime had the biggest annual decrease since 2010 (with some variations by specific offence). Robbery and theft dropped dramatically during 2020 as there were fewer people out and about. Reports of stolen dogs have soared as the lockdown has generated a demand for dogs. Anecdotally, many communities have experienced more fly-tipping and fraud. Some very serious offences have increased, such as recorded drug crime.

The National Youth Agency found that young people have been at increased risk from county lines as criminal groups find new online ways and social media platforms to coerce young people into drug running.¹³⁹

Domestic abuse has also seen an increase during the pandemic with many people not feeling safe in their own home. There has also been an increase in domestic abuse interventions and the National domestic abuse helpline reported a 66% rise in calls and a 950% increase for visits to the website compared with pre-COVID-19.¹⁴⁰

¹³⁴ [Data Selector - Defra, UK](#)

¹³⁵ [Frontiers | The Effects of Air Pollution on COVID-19 Infection and Mortality—A Review on Recent Evidence | Public Health \(frontiersin.org\)](#)

¹³⁶ [2007010844 Estimation of Changes in Air Pollution During COVID-19 outbreak in the UK.pdf \(defra.gov.uk\)](#)

¹³⁷ [Frontiers | The Effects of Air Pollution on COVID-19 Infection and Mortality—A Review on Recent Evidence | Public Health \(frontiersin.org\)](#)

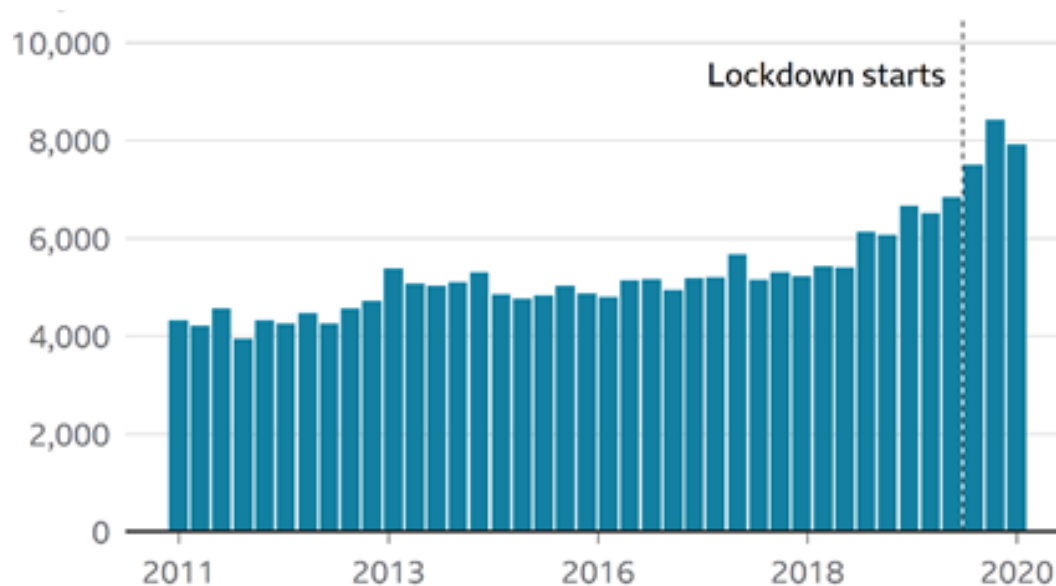
¹³⁸

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2020>

¹³⁹ <https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2021/february/briefing-policing-county-lines-during-covid-19.pdf>

¹⁴⁰ <https://www.refuge.org.uk/refuge-reports-further-increase-in-demand-for-its-national-domestic-abuse-helpline-services-during-lockdown/>

Figure 44: Domestic abuse interventions, 2011 to 2020



Source: Ministry of Justice

Economic

A number of economic policies were introduced which were designed to mitigate the negative impact of the public health interventions on businesses and employees. Employees will have been impacted by the lockdown policy in different ways depending on the sector they work in. This was particularly evident during Wave 1 where all non-essential businesses were instructed to close. Around 80% of hospitality and food businesses ceased trading during lockdown.¹⁴¹ Consequently, those working in food service, accommodation, arts and entertainment were the workforce most affected.

The Coronavirus Job Retention Scheme (CJRS) provided economic support enabling workers to be furloughed. National data suggest that the young working age population had the highest rates of furlough, the most likely age to be furloughed during the first half of the pandemic was 17 years old.¹⁴² This age group was also less likely to be able to work from home due to their roles. Occupations requiring higher qualifications and more experience were more likely to provide homeworking opportunities than elementary and manual occupations.¹⁴³

Despite economic support available, experimental weekly Labour Force Survey (LFS) estimates suggested approximately half a million employees received no pay while their job was on hold and/or affected by the COVID-19 pandemic in April and May 2020. This decreased and remained flat from July but then increased in the first two months of 2021.¹⁴⁴ Workers on precarious contracts such as zero hours or some self-employed were at high risk of adverse effects from loss of work and no income.¹⁴⁵

Employees in the worst affected sectors who remained in work saw their hours decline sharply. The Office for National Statistics reported the largest annual decrease in hours

¹⁴¹ [Furloughing of workers across UK businesses - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

¹⁴² [Coronavirus Job Retention Scheme statistics: July 2020 - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

¹⁴³ [Coronavirus and homeworking in the UK - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

¹⁴⁴ [X07: Labour Force Survey weekly estimates - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

¹⁴⁵ [Mitigating the wider health effects of covid-19 pandemic response | The BMJ](https://www.bmj.com)

worked in the UK in the first part of 2020.¹⁴⁶ Fewer job vacancies were available, resulting in fewer job opportunities, with lockdown restrictions continuing to affect jobs and vacancies in two industry sectors more than others: arts and entertainment, and recreation and hospitality.¹⁴⁷

Employment rate for all people decreased by 1.4% from the start of lockdown. People aged 16 to 24 years and those aged 65 years and over were the main drivers for the annual decrease in the number of people in employment, whilst people aged 50 years and over were most affected by redundancy. In these times of economic uncertainty, there was a sharp and large increase in the number of people who claimed for universal credit during 2020.¹⁴⁸ Across the UK, claimant count has increased by 114.3% since March 2020.¹⁴⁹

The unemployment rate for people from a minority ethnic background increased by a larger proportion than those from a White background from October to December 2020.¹⁵⁰ This inequality maybe in part driven by the types of occupation and industry sector that ethnic communities work in. The service and hospitality industries were most affected and national reports suggest that around a third of taxi drivers and chauffeurs are Bangladeshi or Pakistani men¹⁵¹ and almost one third (29%) Asian / Asian British workers are employed in the service sector.¹⁵²

Social deprivation is a risk factor for poorer outcomes, evident in higher mortality and hospital admission rates for those living in the most deprived areas.¹⁵³ People in these areas are also more likely to be employed in insecure work without financial reserves. The economic impact on this population could be severe, potentially widening existing inequalities with families losing the benefits of free school meals and having to meet increasing home costs.

On the Isle of Wight, the impacts of the COVID-19 pandemic on employments have been slightly higher when compared to England and the South East. The proportion of working aged adults claiming out of work benefits increased to 6.94% in March 2021 compared to 6.58% and 5.37% in England and the South East, respectively.

The COVID-19 pandemic had a major impact on employment, with the number of adults claiming out of work benefits doubling from 2,575 in February 2020 to 5,490 in March 2021. Figure 45 shows how the number of people claiming out of work benefits changed during the COVID-19 pandemic and shows very clearly the increasing numbers of people claiming out of work benefits over the pandemic compared to the February 2020 data.

¹⁴⁶ [Labour market overview, UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/labourmarketandproductivity/articles/labourmarketandproductivity/labourmarket/2020-02-20)

¹⁴⁷ [Vacancies and jobs in the UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/labourmarketandproductivity/articles/labourmarketandproductivity/labourmarket/2020-02-20)

¹⁴⁸ [Employment in the UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/labourmarketandproductivity/articles/labourmarketandproductivity/labourmarket/2020-02-20)

¹⁴⁹ [Labour market overview, UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/labourmarketandproductivity/articles/labourmarketandproductivity/labourmarket/2020-02-20)

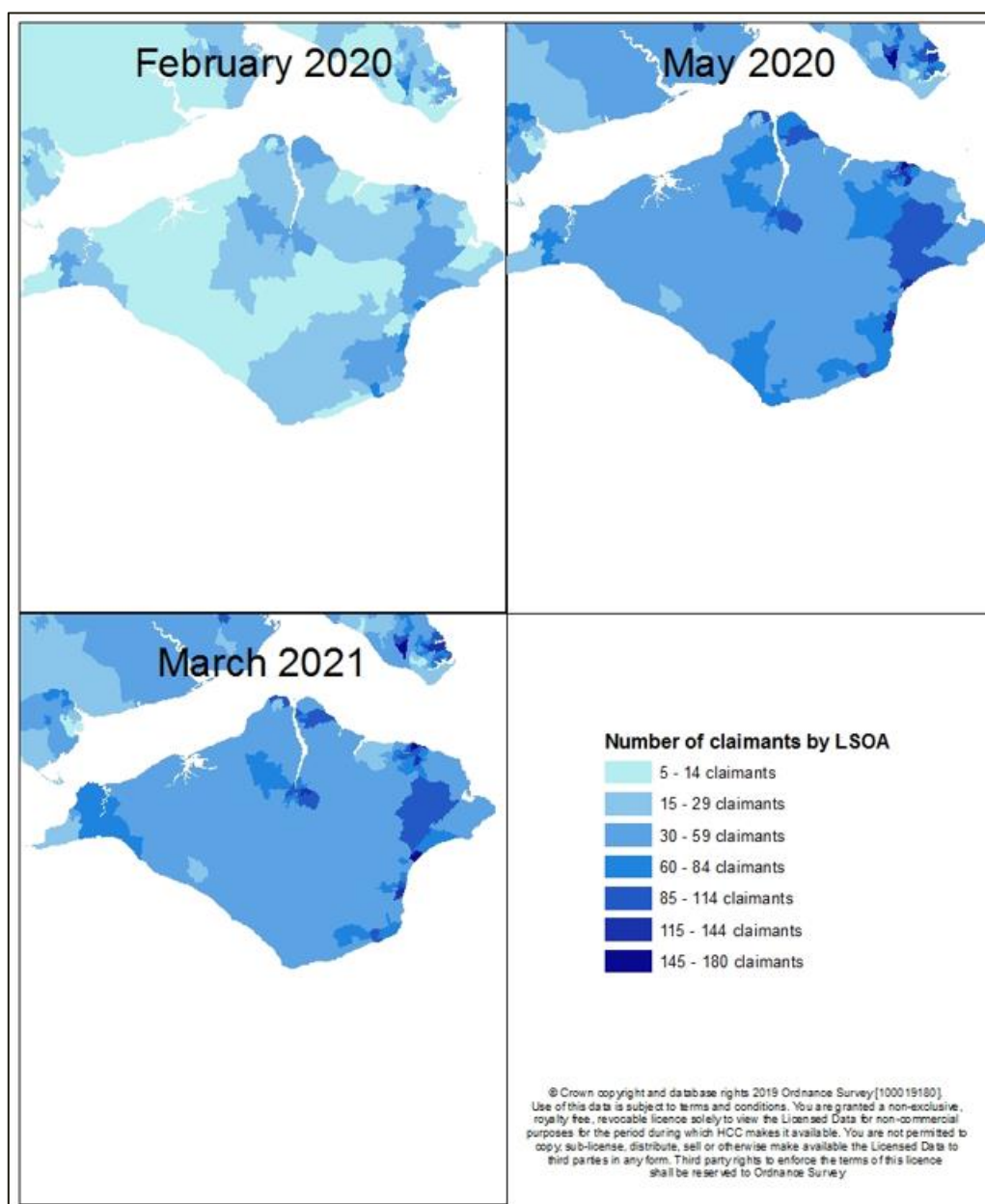
¹⁵⁰ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/december2020>

¹⁵¹ [Why have Black and South Asian people been hit hardest by COVID-19? - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/labourmarketandproductivity/articles/labourmarketandproductivity/labourmarket/2020-02-20)

¹⁵² Census 2011

¹⁵³ [Disparities in the risk and outcomes of COVID-19 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/531111/disparities-in-the-risk-and-outcomes-of-covid-19.pdf)

Figure 45: Number of people claiming out of work benefits changed during the COVID pandemic

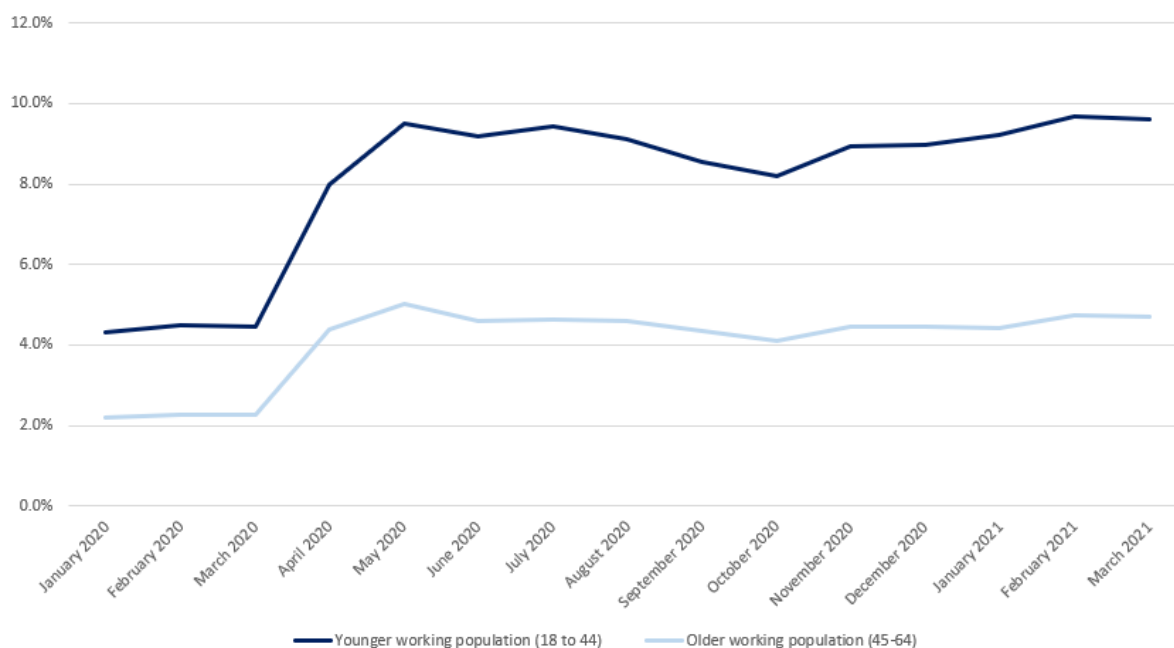


Source: NOMIS

There was a large variation in the proportion of working aged adults claiming out of work benefits across the Isle of Wight. Areas with the highest number of claimants were parts of Ryde, Shanklin, Sandown and Newport. LSOAs as Ryde North East B, Shanklin South B, Sandown South B, St Johns West A, Shanklin Central B and Pan B are amongst the highest and have also been identified in the Wellbeing Index as having low earners, affected by furlough or working in the care industry, self-employed, renters, lone parent families and under 65s with two or more long term conditions.

Claimant count was higher and increased significantly more in the younger working age population, age 18-44 years, peaking at 9.7% in February 2021.

Figure 46: Claimant count percentage uptake by working age group



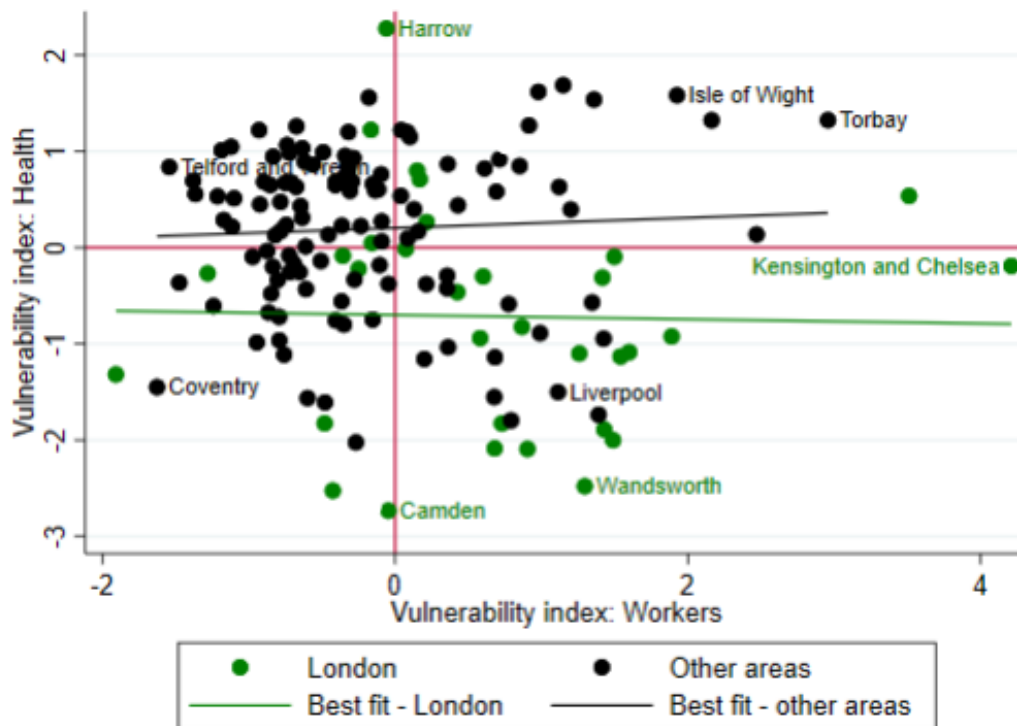
Source: NOMIS

As of February 2021, 10,460 jobs were furloughed on the Isle of Wight, with 45% of businesses having one or more employees on furlough. Around 5,000 of the furloughed jobs were from the accommodation and food services, wholesale, retail and repair of motor vehicles sectors.

In 2020 the Institute for Fiscal Studies (IFS) reported on the varying impact of COVID-19 and COVID-related policy on parts of England.¹⁵⁴ The findings included that there was no single measure of vulnerability that could summarise which areas of the country would be hardest hit. However, some areas are more vulnerable than average on health, economic and social lines. The IFS identified nine local authorities within this particularly vulnerable group, these were spread around the country and included both urban and rural areas. Even within this group, Torbay and the Isle of Wight stood out; their elderly populations, economic reliance on tourism and hospitality, and pockets of socio-economic deprivation driving high levels of vulnerability along all three dimensions. This contrasts with 17 local authorities identified by the IFS as relatively unaffected by the pandemic, these areas are concentrated in the South East and East of England.

¹⁵⁴ <https://ifs.org.uk/uploads/The-Geography-of-the-COVID19-crisis-in-England-final.pdf>

Figure 47: Relationship between dimensions of vulnerability: health and workers



Source: Institute for Fiscal Studies

Business Vulnerability Index

The Business Vulnerability Index was created to assess the variations in how vulnerable businesses are to the impacts of the COVID-19 pandemic restrictions across the Isle of Wight.¹⁵⁵ This tool provides an assessment of the relative impacts during the COVID-19 pandemic of across the area. The Index is constructed from a range of indicators. These aim to capture the employee and business aspects of the impacts which arose from the COVID-19 pandemic restrictions.

Based on a review of the evidence, four main factors were identified in determining how vulnerable a business is to the impacts of the COVID-19 pandemic restrictions. The identified factors were:

- The sector that the business operates in
- Mobility of consumers
- Business Size (based on the number of employees)
- Location and type of business

Evidence was used to identify what businesses, in terms of sector and size, would be the most vulnerable to the impacts of the COVID-19 pandemic restrictions. The most vulnerable sectors were identified as Accommodation and Food Service Activities, Arts, Entertainment and Recreation and Other Service Activities, as these sectors had the highest furlough uptake rate and the biggest decline in GVA (Gross Value Added) between February 2020 and February 2021.¹⁵⁶ Businesses with fewer than ten employees were identified as more vulnerable, as businesses of this size were the most likely to pause or permanently cease

¹⁵⁵ A detailed report on the vulnerability indices will be published on the JSNA web pages

¹⁵⁶ ONS (2021) Available at: [Monthly gross domestic product by gross value added - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/economy/grossvalueadded/articles/monthlygrossdomesticproductbygrossvalueadded)

trading during the COVID-19 lockdown restrictions.¹⁵⁷ No indicator was used for the type of business, as the data currently available does not capture this characteristic. Due to the lack of available data on business income and sales over the COVID-19 pandemic, Coronavirus Job Retention Scheme (Furlough), Self-Employment Income Support Scheme (SEISS) and Claimant Count data were used as proxy indicators.

This tool uses various datasets and sources to determine the overall vulnerability of businesses on the Isle of Wight and highlight variations across the island:

- Claimant Count (via NOMIS)
- Google Mobility data
- HMRC – Coronavirus Job Retention Scheme and Self-Employment Income Support Scheme
- Inter Departmental Business Register (via NOMIS) – Business enterprises counts by industry and size

Figure 47: Isle of Wight Business Vulnerability Index Tartan Rug

| District | Furlough (Average take up rate per month) | Mobility - Retail and Recreation (difference from baseline) | Self-Employment Income Support Scheme (Average take up rate by grant) | Vulnerable Industry (Rate per 1,000 business) | Vulnerable business size (Rate per 1,000 business) | Claimant Count Rate (Increase between Feb 2020 and Feb 2021 - proportion of residents aged 16-64) |
|---------------|---|---|---|---|--|---|
| Isle of Wight | 13.95% | -35.82 | 68.22% | 205.72 | 863.59 | 3.75% |

■ Less vulnerable compared to the South East average
■ Similar vulnerability compared to the South East average
■ More vulnerable compared to South East average

The Isle of Wight experienced a higher furlough uptake and claimant count rate per month than the South East average. This was due to the large number of businesses on the Isle of Wight which operate in the identified vulnerable sectors, with 20.6% of businesses on the Isle of Wight operating within these sectors compared to only 11% of businesses in the South East.

Businesses which operate in the vulnerable sectors are likely to gradually rebound with the Isle of Wight likely to be a popular destination for holiday trips as restrictions ease. A partial rebound was observed in the summer of 2020 after the first lockdown with population movement for retail and recreation reasons during August and September being above the levels observed pre-lockdown.

Based on data from previous lockdown periods, it is expected that businesses which operate in the food and beverage serving activities sector will be the quickest to rebound as restrictions ease. Businesses in this sector had turnover levels in August 2020 just below what was experienced in February 2020. Other sectors such as the Accommodation sector are expected to recover more gradually as the restrictions ease.

A correlation was found between areas with a higher proportion of businesses operating in vulnerable sectors and those which experienced the largest increases in people claiming out of work benefits between February 2020 and March 2021. This correlation was typically seen on the East coast around the towns of Ryde, Sandown and Shanklin, with these areas having a large presence of businesses who operate in the identified vulnerable sectors and a large increase of people claiming out of work benefits.

¹⁵⁷ ONS (2021) Available at: [Business insights and impact on the UK economy - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/business-insights-and-impact-on-the-uk-economy)

KEY AREAS OF FOCUS

The burden of illness and death due to coronavirus as well as the indirect impacts of COVID-19 have not been shouldered equally, disproportionately affecting different population groups.¹⁵⁸ It is very clear that the importance of health inequalities has been brought to everyone's attention, existing health and social care vulnerabilities exacerbated and vulnerabilities are evident in population groups not traditionally considered. The Living Safely with COVID report¹⁵⁹ stated that "health outcomes are driven by a wide range of factors. If we are truly going to 'build back fairer' we need a comprehensive recovery strategy that incorporates preventative action at every level".

Areas of focus are presented which emulate the sentiment of The Health Foundation COVID-19 impact inquiry report¹⁶⁰ and look to focus our work on those main drivers of inequalities which have been contributors to the direct and indirect impacts of COVID-19 on our population.

Key areas of focus 1: Many of the underlying health risk factors for COVID-19 are the result of poor conditions associated with the social determinants of health. The rate of improvement of the health of the Isle of Wight population has slowed and is unequal with the proportion of time spent in good health decreasing.

- Provide Public Health leadership to the population health management programme – provide evidence and support to enable focus on modifiable behaviours and the wider determinants of health alongside clinical data.
- Focus on lifestyle interventions at person and place level importantly smoking, obesity and physical activity. Public Health should explore conducting a lifestyle survey to provide greater insight and understanding into lifestyle behaviours within local communities, working with relevant stakeholders including Districts and Healthwatch.
- Whilst the present report examines some of the impacts of the pandemic on mental and physical wellbeing, there are longer-term impacts that remain unknown. Public health will continue to monitor trends in the general population for instance the mental wellbeing of our young, working age and older populations, obesity and alcohol consumption.
- Capitalise on good joint working between councils, the voluntary sector and the NHS to focus on tackling the wider determinants of health, focusing on health inequalities.

Key areas of focus 2: Older people, ethnic minority groups & those living in deprived areas were disproportionately affected by the severe outcomes of COVID-19.

- Commissioned services should ensure disadvantaged population groups have equity of access. Recommendations from the Hampshire and Isle of Wight (HIOW) Ethnic Minority and COVID-19 Needs Assessment need to be addressed as a system.
- Providers of commissioned services should be outcomes focused. Health equity impacts should be conducted to look at the impacts and health outcomes of the service provision across different population groups. This requires good data collection to identify population groups and measure outcomes which should form part of the key performance indicator data collection.

¹⁵⁸ [Inequalities and deaths involving COVID-19](#)

¹⁵⁹ [Living Safely with Covid](#)

¹⁶⁰ [Unequal pandemic, fairer recovery](#)

- Providers of commissioned services should analyse their service activity data to help understand what impact COVID has had on accessing services and subsequent delays in treatments or service provision. Has this disproportionately impacted certain populations?
- Work with the HIOW COVID-19 Vaccination Programme to maximise uptake of the primary and booster dose in populations most affected by the severe outcomes of COVID-19.

Key area of focus 3: Women of working age have been disproportionately affected by Long COVID

- Public health departments have an important role in continuing to monitor long term outcomes for those populations recovering from COVID.
- Reform workplace occupational health policy to recognise and anticipate Long Covid as a debilitating condition and plan support for employees physically and mentally.
- Primary Care Network health and wellbeing coaches could provide a supportive role providing practical lifestyle advice.

Key areas of focus 4: Children and young people have experienced disrupted education and have been significantly impacted by economic policies. The pandemic has affected their education, health and wellbeing. Evidence has shown that these impacts are greater for those living in deprived areas driving concerns that health inequalities will have widened for an already vulnerable population.

- Public Health needs to work with partners to better understand what the impacts of the pandemic have been on our children and young people especially those children already identified as vulnerable. Disseminate findings and recommendations from the Hampshire and Isle of Wight 0-25 Mental Health Needs Assessment and Impact of COVID-19 Review
- Share HIA report with our corporate, education and children's services colleagues as well as other public sector partners to identify possible actions (e.g. digital and remote learning experiences – lessons learnt).
- Work with the business sector to encourage more opportunities for young people such as apprenticeships and work experience to provide economic and educational certainty.

Key area of focus 5: Build on and consolidate relationships established during the pandemic to work more creatively and capitalise on the positives COVID has created.

- Public Health should capitalise on the general increase in community groups and mutual support in the wake of the pandemic. Continue to utilise and strengthen initiatives like the community researchers and insight work that has been conducted.
- Public Health should drive changes in information governance, data dissemination, sharing to improve data completeness and enable better local analysis of local inequalities.
- The Health Foundation report refers to groups who currently lie 'below the data line' such as some ethnicity minority communities. People belonging to inclusion health groups have extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities¹⁶¹. This includes homelessness, drug and alcohol dependence,

¹⁶¹ [Inclusion health: applying All Our Health](#)

vulnerable migrants, Gypsy, Roma and Traveler communities, sex workers, people in contact with the justice system and victims of modern slavery. The Public Health Joint Strategic Needs Assessment needs to better understand these Inclusion Health Groups at a local level; who they are, where they live, and what are their challenges?

Key area of focus 6: Focus on staff health and wellbeing – in particular we need to recognise and support those who have worked in the pandemic response who may be suffering stress, feeling burnt out or experiencing trauma

- Reform workplace occupational health policy to recognise the impact and potential trauma the pandemic has caused for those working in the pandemic response

Key area of focus 7: Identify and build on the positive impacts of COVID-19 for example:

- COVID-19 lockdown events have led to declines in air pollution and put a big focus on air quality.
- Maintain the gains made in the environment, sustain the momentum in home fitness activities in the post COVID-19 era.
- Greater community support and resilience.
- Greater awareness of infection prevention, control and vaccination.

APPENDICES

Appendix A - Summary of Impacts

| Direct impact of contracting COVID-19 | Impact of COVID-19 related policies |
|--|--|
| Children and young people | |
| Low clinical risk | Lost learning from school closures, varying between groups, e.g., high deprivation reduced home learning resources Home learning may have been positive for some children to escape bullying or where extra support available for those with disabilities |
| | Social isolation, missing of key social events and concerns for mental health |
| | Online bullying, increase in gambling, however also opportunities to connect online |
| | Reduced physical activity and poorer diet |
| | Highest rate of furlough / unemployment in young adults |
| Working age adults | |
| Higher risk of severe health outcomes from COVID-19 linked to specific groups such as health and social care staff, security guards, taxi and bus drivers, retail workers, construction, and processing plants | Specific groups more at risk of furlough and redundancy: retail, hospitality, entertainment Those aged 50 and over at greatest risk of redundancy |
| | Increased caring responsibilities for older family or home-schooling children |
| | Decline in mental health, increase rate of depression and anxiety |
| | Increase in junk food intake and alcohol intake but reduction in the number of people smoking |
| | Home working increased working hours for a third of people, but also decreased for a third Reduction in commuting |
| Older adults | |
| Highest risk of severe health outcomes from contracting COVID-19. Those aged 80+ are 70 times more likely to die compared with those aged under 40 | Increased social isolation, especially for those in care homes, and lower use of online services may also impact on isolation |
| | Reduced physical activity leading to deconditioning |
| Gender | |
| Males more likely to die from COVID-19, 55% of deaths | Increase in domestic abuse, especially against women |
| Females, aged 45 to 64, more likely to experience Long COVID | Women more likely to be carers and shoulder more of the home schooling / childcare |
| Ethnic minority groups | |
| Increased risk of contracting COVID-19 | Greater proportion of lone parent households in Black, mixed and Pakistani ethnic groups compared with White. Lone parent families |

| | |
|---|--|
| | experienced increased stress and financial pressure. |
| | Black ethnic groups have lower levels of access to gardens |
| Higher mortality rate in those from minority ethnic groups linked to: <ul style="list-style-type: none"> - Higher proportion with existing conditions such as diabetes, hypertension, obesity - Over-representation in high-risk occupations such as caring roles, retail, hospitality and transport - Living in deprived areas and in overcrowded housing | Higher increase in unemployment rate for those from a minority ethnic background compared with White ethnic groups |
| | Lower school attendance for pupils from ethnic minority groups in summer term |
| Those with disabilities | |
| Increased mortality and severe health outcomes from COVID-19 for those with numerous health conditions including diabetes, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, dementia, obesity, asthma | Reduction in access to healthcare appointments, poorer management of existing health conditions |
| Increased risk of severe health outcomes for those with Learning Disabilities | Reduced physical activity exacerbating existing conditions |
| | Severe social isolation for those 'shielding' or from the closure of services, e.g., learning disability day centres |

Appendix B – Table of Timeline

Detailed timeline of key COVID-19 policy decisions

| Month | Event |
|--------------|--|
| January 2020 | 12 - WHO confirms Wuhan cluster caused by novel coronavirus |
| | 30 - WHO declares Public Health Emergency of International Concern (PHEIC) |
| | 31- First two COVID-19 cases in UK |
| February | 27 – First Hampshire COVID-19 case |
| March | 4 - First Isle of Wight COVID-19 case UK Government unveils Coronavirus Action Plan. UK in 'Contain and Research' phase (testing and contact tracing) |
| | 5 - First UK COVID-19 related death |
| | 11 - WHO declares pandemic |
| | 12- UK Government announces moving out of contain phase and into 'Delay'. Community testing and contact tracing ceases. |
| | 16 - UK Government advises on 'Social Distancing' measures as Imperial modelling study published. |
| | 23 - UK Government imposes 'Stay at Home' lockdown regulations and shielding for vulnerable people begins |
| April | 4 - Testing expanded to NHS, healthcare and social care workers |
| | 15- NHS postpones all non-urgent operations to make additional beds available |
| | 23 - Key workers and their households now eligible for tests in drive through centres ONS prevalence study begins |
| May | 7 - Isle of Wight pilot of app begins |
| | 10 - New COVID-19 alert levels introduced. UK at Level 4 |
| | 13 - Lockdown measures eased to allow garden centres and recycling centres to open and mixing outdoors with one other person. "Stay alert" messaging introduced. |
| | 18 - Testing extended to all people displaying symptoms, excluding under 5-year-olds |
| | 28 - NHS Test and Trace scheme begins |
| June | 1 - Further easing of lockdown measures: those shielding can go outside (but not mix), 'rule of 6' outdoors, primary schools reopen for years R, 1 and 6 |
| | 8 - Increased availability of testing in care homes, dental practices reopen, 14-day quarantine for UK entrants |
| | 13 - Social bubbles for those living alone (excludes those shielding) |
| | 15 - Non-essential shops reopen, masks on public transport, secondary schools reopen for years 10 and 12 |
| | 19 – UK alert level reduced to 3 |
| | 25 - Heatwave and major incident declared in Dorset |
| | 29 - First local lockdown in England – Leicester, other areas follow |
| July | 4 - Further easing of lockdown measures: Social distance reduced to 1 metre, pubs, restaurants, hotels and hairdressers reopen, 2 households can meet indoors |
| | 10 - Travellers from 75 countries no longer need to quarantine on entry to UK |
| | 13 - Further easing of lockdown measures: Nail bars, tattoo parlours reopen |
| | 18 - Local authorities now able to close shops, outdoor spaces and cancel events to control COVID-19 |
| | 24 - Face coverings mandatory in shops and on public transport in England |

| | |
|--------------|--|
| | 25 - Further easing of lockdown measures: gyms and indoor sports reopen |
| August | 1 - Further easing of lockdown measures: Shielding comes to an end (aside from some of the areas in local lockdown), reduced working from home, 'Eat out to help out' scheme begins. |
| | 8 th - Face coverings required in additional public spaces |
| | 15- Further easing of lockdown measures: bowling alleys and soft-play reopen, indoors gigs, and wedding parties allowed up to 30 guests |
| | 28 - Guidance outlining bubbles for schools published |
| September | 1 - Schools reopen |
| | 14 - 'Rule of 6' for social gatherings introduced |
| | 21 – UK alert level increased to 4 |
| | 24- Pubs to close at 10pm, table service only, working from home advised. The new App becomes available to download, |
| | 28 - Wedding parties reduced to 15. |
| October | 14 - New tier system comes into place (medium, high, and very high). Hampshire and Isle of Wight in medium tier (Tier 1) |
| | 30– SAGE publishes papers outlining the increase in cases is faster than the worst-case scenario |
| November | 5 - New national restrictions: schools remain open, however non-essential shops, leisure facilities and restaurants closed. No mixing of households |
| December | 2 - National restrictions end, Hampshire enters Tier 2: gyms, hairdressers reopen, hospitality as long as it involves a meal, no indoor mixing of households, rule of 6 outdoors. Isle of Wight remains at Tier 1. |
| | 3 to 9 - Student travel window |
| | 15 - Reduction in quarantine time when private test completed at 5 days |
| | 17 - Gosport and Havant (and Portsmouth) move into Tier 3 |
| | 20 - Gosport and Havant (and Portsmouth) move into Tier 4 |
| | 25 - Christmas mixing of three households indoors (excluding areas in Tier 4) |
| | 26 - All other districts aside from New Forest and Isle of Wight move into Tier 4 |
| | 31 - New Forest and Isle of Wight move into Tier 4 |
| January 2021 | 4 - UK alert level increased to 5. Primary schools reopened after Christmas break |
| | 5- New national lockdown announced: schools and non-essential shops closed, mix with only one person outside household outdoors. Vaccine rollout begins |
| February | 15 - Quarantine hotels at airports open for those arriving from "red list" countries |
| | 22 – UK Government announces 'Roadmap' for COVID-19 restrictions easing |
| | 25- UK alert level reduced to 4 |
| March | 8- Easing of lockdown measures: schools and colleges to reopen. Additional testing available for children and those providing childcare, limited travel overseas permitted |
| | 25 - UK alert level reduced to 3 |
| | 29 - Further easing of lockdown measures: rule of 6 outdoors, grassroots sport reopens |
| April | 6- Rapid home testing offered to employees of firms with more than 10 employees |
| | 9– All residents to be permitted access to two LFTs per week in England |
| | 12- Further easing of lockdown measures: gyms, non-essential shops reopen, and outdoor hospitality |
| May | 17- Further easing of lockdown measures: two households meeting indoors, rule of 6 applying to pub settings |
| June | 21 - Further easing of lockdown measures: all social distance restrictions lifted |

Appendix C – Data details

Primary care data

The following data have been extracted from the Care and Health Information Exchange (CHIE) primary care system. This contains information from GP surgeries across Hampshire and Isle of Wight, not all GP practices are represented in CHIE however the data cover approximately 95% of our population and are presented for the time period 1 February 2020 to 31 March 2021.

It should be noted that these data will not provide a complete picture of all residents who have had COVID-19 however they can be used for indicative purpose to help better understand the scale of ill health from COVID-19 in our population.

Data were extracted based on the following criteria:

- Patients (including those who have died) have a confirmed, suspected, probable or positive COVID-19 test recorded
- Hospital admissions were identified using hospital requested pathology test results
- Resident in the Hampshire County area or Isle of Wight

Hospital data

Hospital admissions data were extracted from SUS PbR Inpatients dataset by South, Central and West Commissioning Support Unit. An admission was extracted using the following case definition:

- Admissions date was between January 2020 and May 2021
- Emergency admissions only
- A diagnosis code of U071 - COVID-19 virus identified or U072 - COVID-19 virus not-identified was recorded in any diagnosis field for that admissions
- Patient was an Isle of Wight resident

Mortality data

Mortality data were extracted from the Civil Registration of Deaths dataset supplied by NHS Digital. Registrations were extracted using the following case definition:

- Date of death was between January 2020 and April 2021 – it should be noted that there may be deaths which occurred during this time period which were not registered at the time of extraction and the numbers in this report may be subject to change, particularly more recent figures.
- A diagnosis code of U071 - COVID-19 virus identified or U072 - COVID-19 virus not-identified was recorded in any position on the death
- Usual place of residence as recorded on the death certificate was the Isle of Wight

Medicine management

The following information shows prescribing data within primary care practices and NHS trusts. It has been extracted from three sources: OpenPrescribing, ePACT2 and PHE Fingertip. OpenPrescribing and ePACT2 contains national information about drugs prescribed by GP practices which is published by the NHS E/I. PHE Fingertip utilises a combination of sources from NHS trusts across the UK in order to deliver Antimicrobial Resistance local indicators.

Health Index

The indicators included were counts of those aged 75 and over, IMD measure for overcrowded housing, and those with any of the following on their primary care record: asthma, atrial fibrillation, cancer, cardiovascular disease, chronic kidney disease, COPD, dementia, diabetes, heart failure, hypertension, learning disability, obesity, osteoporosis, palliative care, peripheral arterial disease, rheumatoid arthritis, stroke (or TIA), or moderate / severe frailty.

Mental Wellbeing Index

Vulnerable groups included in this index can be placed into four categories:

Demographic

- Young people aged 16-24 years - Most likely age group to work in furloughed industries, have experienced disrupted education.
- Ethnic minorities - Overrepresented in health care roles, experienced specific discrimination during COVID-19 and tend to live in deprived areas.

Health

- People aged below 65 years with two or more long term conditions (LTCs)
- People aged 65 years or above with two or more long term conditions (LTCs)
 - Both may have been shielding due to increased clinical vulnerability.

Economic

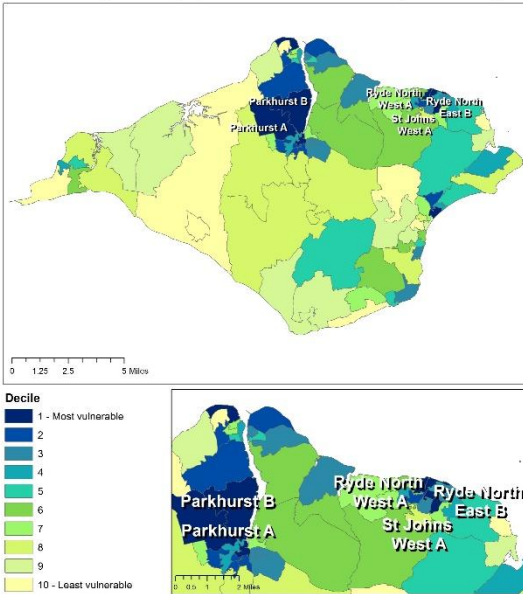
- Low earners - Experiencing financial stress.
- People employed in healthcare and sectors most heavily affected by furlough - Reduced income and job security stress.
- People who are self-employed - Affected by the Self-Employment Income Support Scheme (SEISS) if eligible, job security stress.

Living situation

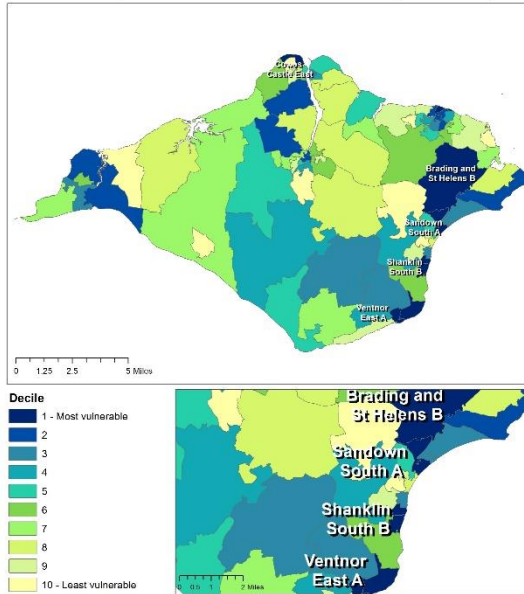
- Lone parent households with dependent children - Financial stress, adapting to home schooling.
- Renters - Financial stress.
- Single member households aged 65 years or above - Difficulty staying connected with family and friends.
- People living in institutions and communal establishments- Difficulty staying connected with family and friends, inadequate living conditions to cope with COVID-19.

Appendix D - Isle of Wight Mental Wellbeing Vulnerability Domains

Isle of Wight Demographic based Mental Wellbeing Vulnerability



Isle of Wight Economic based Mental Wellbeing Vulnerability



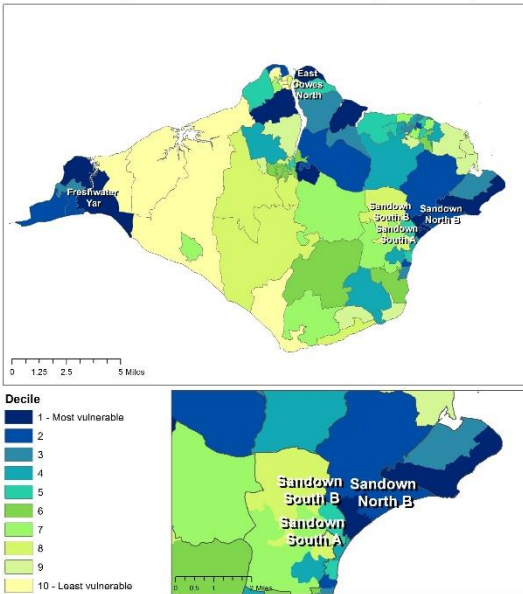
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 10 - Least vulnerable

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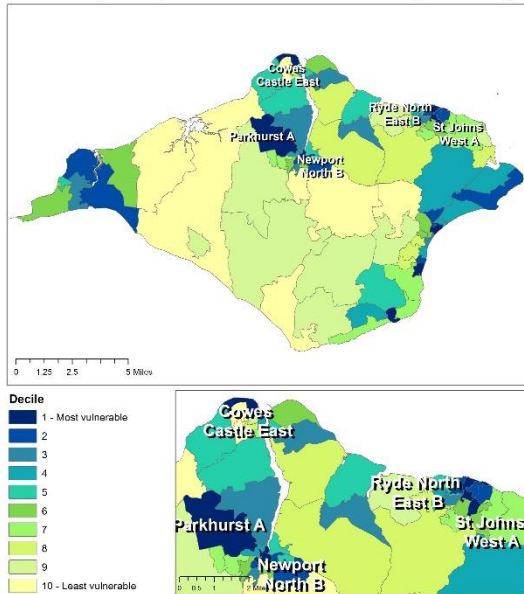
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Isle of Wight Health based Mental Wellbeing Vulnerability



Isle of Wight Living Situation based Mental Wellbeing Vulnerability



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