Hampshire and IOW JSNA
Work programme update

Hampshire and Isle of Wight COVID-19 Health Impact Assessment: Late spring 2021

On the 11th March 2021 the World Health Organisation declared COVID-19 a pandemic, 15 months on this report aims to look at the impact COVID-19 has had on the residents of Hampshire & IOW.

COVID-19 has exposed, exacerbated, and created new inequalities. People across the UK, and indeed the world, have been harmed by the virus in very different ways. What has COVID-19 meant for our local population groups and their future population health and social care needs.

JSNA Core Documents: Late summer 2021

- Demographics including protective characteristics, deprivation and life expectancy/health life expectancy
- Inclusion health groups – homelessness, drug and alcohol dependence, travellers, sex workers, vulnerable migrants, victims of modern slavery, people in contact with CJS
- Vital Statistics – mortality and birth data

JSNA Main Chapters: Autumn /Winter 2021 linked to the social determinants of health model

Detailed JSNA Topic reports informed by HIA

Strategic context – key policy decisions and timeline– NPIs, economic policy, medicines management

Assessment of impact – evidence of population groups and policy categories themed by impact (health/clinical, Mental well being/economic, education, social care, living conditions)

Population profile – socio demographic data
COVID-19 data – infections, social care, primary care, secondary care, long COVID, medicines management, mortality
Vulnerabilities Indices

Population health impacts discussion by JSNA chapters

Healthy People

This chapter focuses on the age structure of our population and future projections and the socio demographic characteristics of our population.

Healthy Living

This chapter focuses on risk factors including behavioural risk factors and the wider determinants of health.

Healthy Places

This chapter focuses on place, the area assets and the social and commercial drivers for health

Inequalities: age, ethnicity, religion, learning or physical disability, sex, sexual orientation,

Demography & Vital Statistics JSNA Chapter

This chapter focuses on the age structure of our population and future projections and the socio demographic characteristics of our population.

To include

- Current population – resident and registered
- Challenges of an ageing population
- Protective characteristics
  - Age
  - Disability
  - Gender reassignment
  - Marriage and civil partnerships
  - Pregnancy and maternity
  - Race
  - Religion or belief
  - Sex
- Population density
- Urban Rural communities
- Population forecasts including Old Age Dependency Ratio projections
- Vital statistics
  - Births – general fertility rate
  - Deaths inc. excess deaths
  - Migration
- Socio economic factors – some paused for Census 2021 results
  - Employment / Unemployment
  - Housing
  - Lone parents
  - Lone 65+ households
- Deprivation
- Housing developments

Paused for Census 2021 data

Healthy People

This chapter focuses on the health outcomes of our population and the health inequalities which are evident.

To include;

- Life expectancy/Healthy Life expectancy
- Mortality/avoidable deaths
- Physical Health conditions
  - Long Term Conditions/multimorbidity
- Mental wellbeing
- Population groups
  - Older people – falls ,frailty, sensory impairment
  - Carers
  - Ethnic minority groups
  - Learning Disabilities
  - Homeless
  - Veterans
  - Alcohol and drug dependence
  - Travellers

Healthy Living

This chapter focuses on risk factors including behavioural risk factors and the wider determinants of health.

To include

- GBD 2019 findings- burden of ill health
- Physiological risk factors – diabetes, excess weight, hypertension, high blood sugars
- Behavioural risk factors – alcohol misuse, drug misuse, smoking, physical activity, healthy diet
- CYP – education, training employment
- Employment/economy
- Protective measures, cancer screening, sexual health, vaccination coverage
- Maternity
  - Smoking and alcohol in pregnancy
  - Teenage pregnancy
  - Low birth weight
  - Breastfeeding
- Risk factors for children
- infant mortality
  - children's social, emotional and MH
  - child poverty
  - LAC
  - SEND
  - Autism – use Stef's report
  - overweight and obesity in children

Healthy places

This chapter focuses on the social and commercial drivers for health

- Access to green space
- Influencing planning
  - Including green space planning
- Local environment
  - Air pollution
  - Road safety
- Food insecurity
- Access to housing
  - Healthy homes inc. fuel poverty
  - Affordability
  - Access to accommodation
  - Overcrowding
  - Homelessness/temporary accommodation
- Access to services
  - Distance to GP
  - Distance to Pharmacy
  - Distance to community facilities – sports/leisure
- Mental wellbeing vulnerabilities and strengths
- Social connectiveness/isolation
- Digital
  - Access to broadband – mosaic data
- Crime

Inclusion Health Groups

People who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. 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 inequalities. Includes homelessness, children in care, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery

Hampshire COVID-19 HIA Summary

Hampshire & Isle of Wight Public Health Intelligence Team

July 2021

Contents

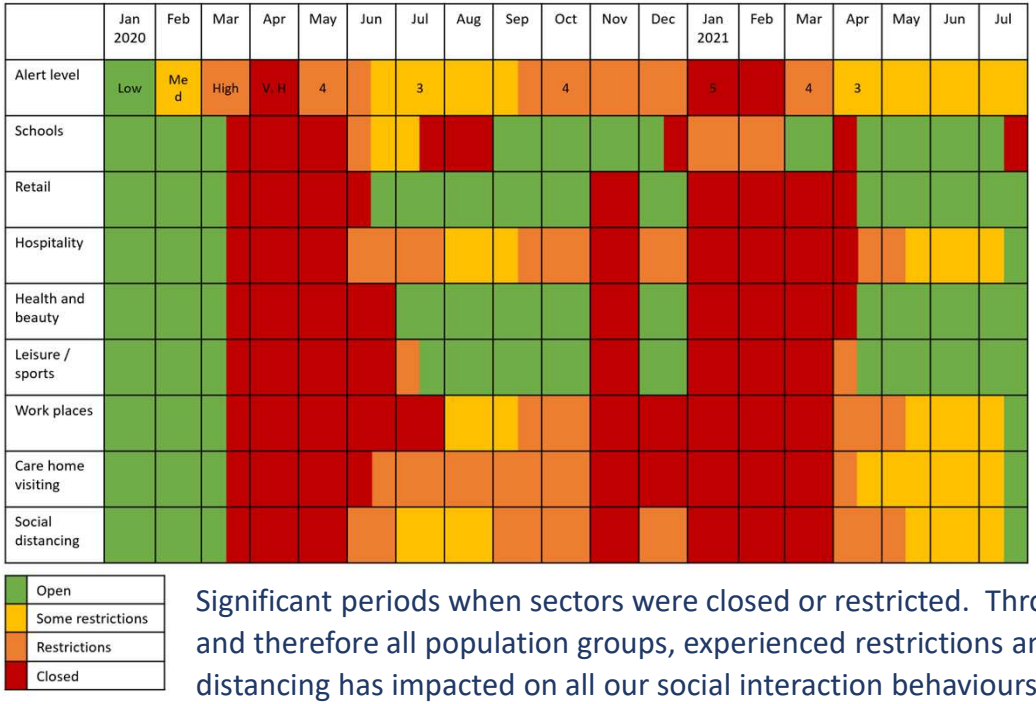
Hampshire & IOW Public Health Intelligence

1. Strategic context

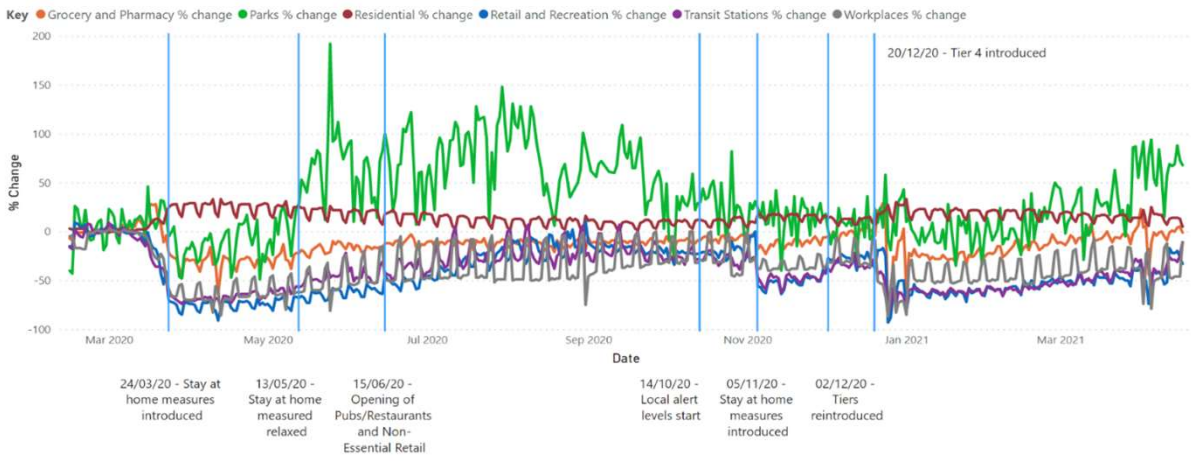
How have COVID-19 policies impacted on population movements, work patterns, socialisation and connectiveness?

- The direct health and clinical impacts of these policies are evident - suppressed infection rates resulting in fewer people being hospitalised and dying.
- 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. Policies addressing businesses and employment, such as the Coronavirus Job Retention Scheme, have been significant. Economic indicators suggest wide reaching, and perhaps long term, impacts on the current and future working age populations.

Timeline of key policy decisions



Population movement trends over time by category of place

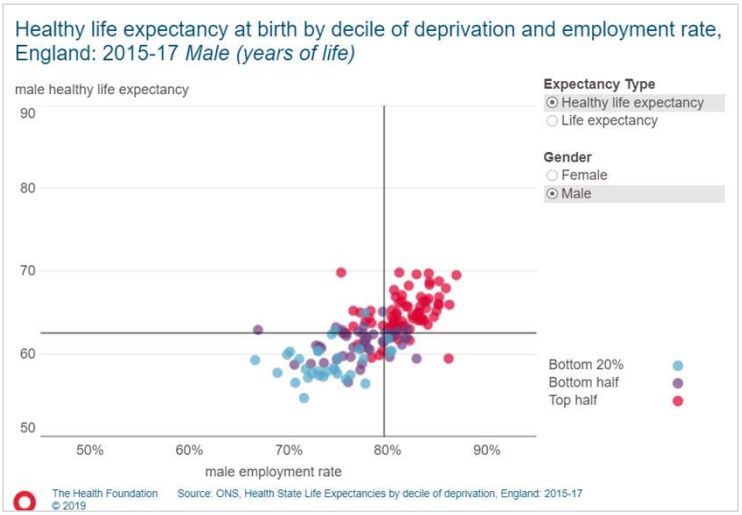


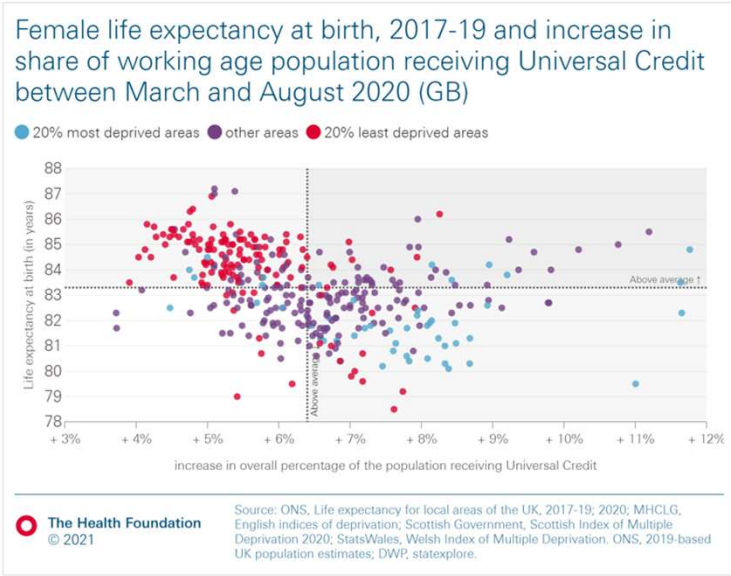
Source: Google COVID-19 Community Mobility Reports

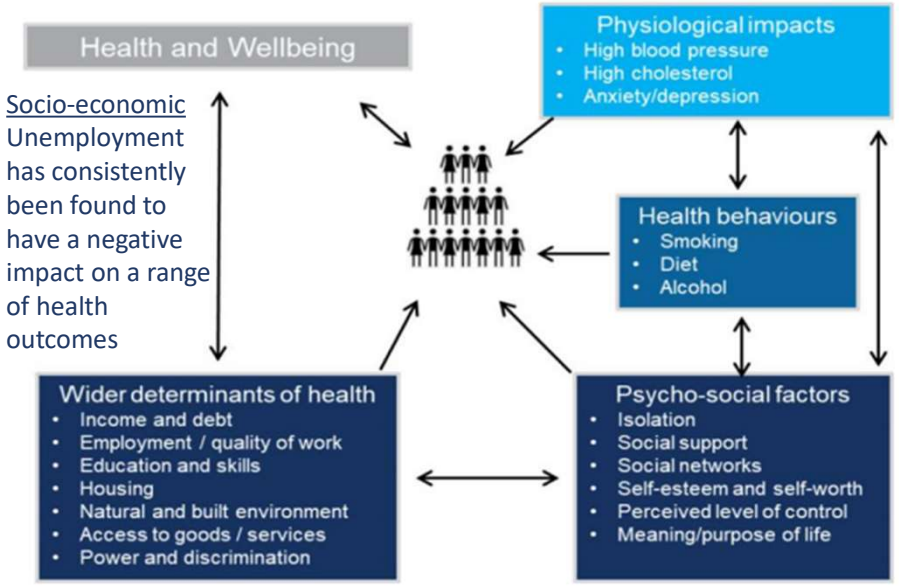
Significant periods when sectors were closed or restricted. Throughout 2020 all sectors, and therefore all population groups, experienced restrictions and closures. Social distancing has impacted on all our social interaction behaviours and movements since the start of the pandemic in March 2020.

Mobility data show significant population compliance with non pharmaceutical intervention policies. Adapting behaviours accordingly for example working from home, shopping online and staying local.

Health and mental wellbeing outcomes are driven by a wide range of factors. We must consider and understand the impacts of the wider determinants, physical and health behaviours which drive these.







Socio-economic
Unemployment has consistently been found to have a negative impact on a range of health outcomes

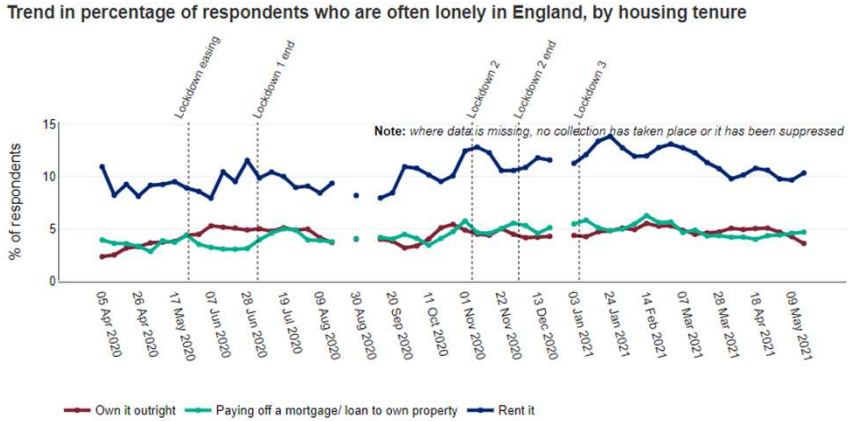
Socio-economic
Greater increases in the share of the population receiving Universal Credit have tended to be in more deprived areas and those with lower life expectancy.

Long term conditions
Around 30 per cent of all people with a long-term physical health condition also have a mental health problem with a higher proportion reporting high levels of anxiety

Health behaviours
Adults with depression are twice as likely to smoke as adults without depression.

People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily.

Social connectiveness
Those with an underlying health condition more likely to feel lonely often – especially in the younger 16–24-year-old population groups



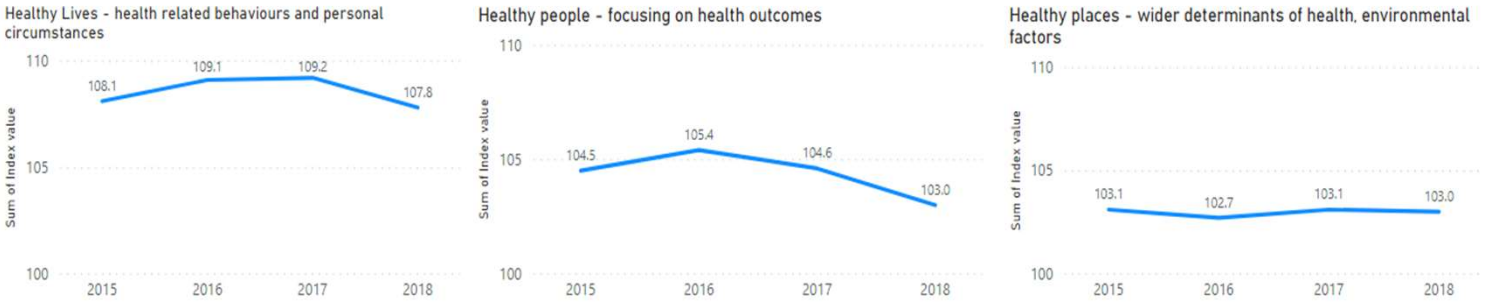
Housing
Those in rented accommodation more likely to feel lonely often – especially in the younger 16–24-year-old population groups

2. Hampshire demographics and health index baseline

How healthy were the population of Hampshire before the pandemic?

- Older population ageing at a faster rate than England overall
- Less ethnically diverse population compared to England but growing diversity. Basingstoke & Deane and Rushmoor districts with higher ethnic group diversity.
- Demographic structure of the population who are from an ethnic minority group is younger compared to the white population.
- Overall an affluent county but masks marked inequalities, with areas of significant deprivation affecting children and older people, including rural deprivation
- Before the pandemic improvements in our population's health had stagnated and in some areas deteriorated. Mental health and physical health such as musculoskeletal conditions are all worse in Hampshire than England and have deteriorated further. These areas will have been significantly impacted upon further due to COVID-19.
- Population density and inter-connectedness varies across Hampshire and only partly explaining the distribution of infection and deaths
- Provisional data indicate there was no baby boom as a result of the first lockdown restrictions.

ONS Health Index data uses a broad definition of health, including health outcomes, health-related behaviours and personal circumstances, and wider determinants of health and suggests that although better than England, population health has worsened between 2015 and 2018



Data source: ONS Health Index

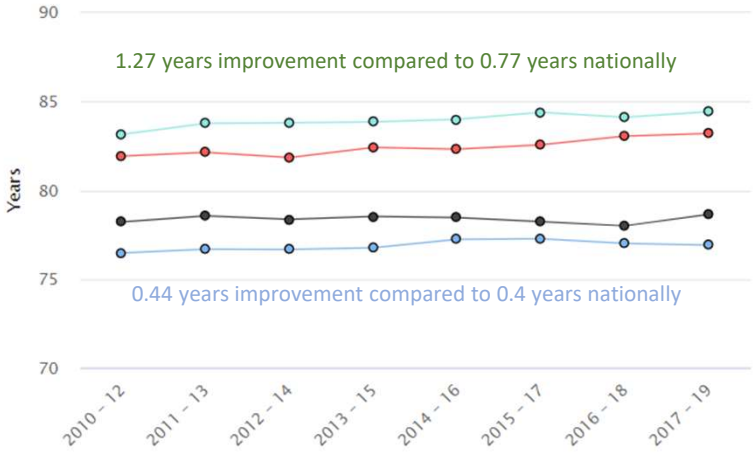
'Inequalities in social and economic conditions before the pandemic contributed to the high and unequal death toll from COVID-19'

Build back fairer: The COVID-19 Marmot Review

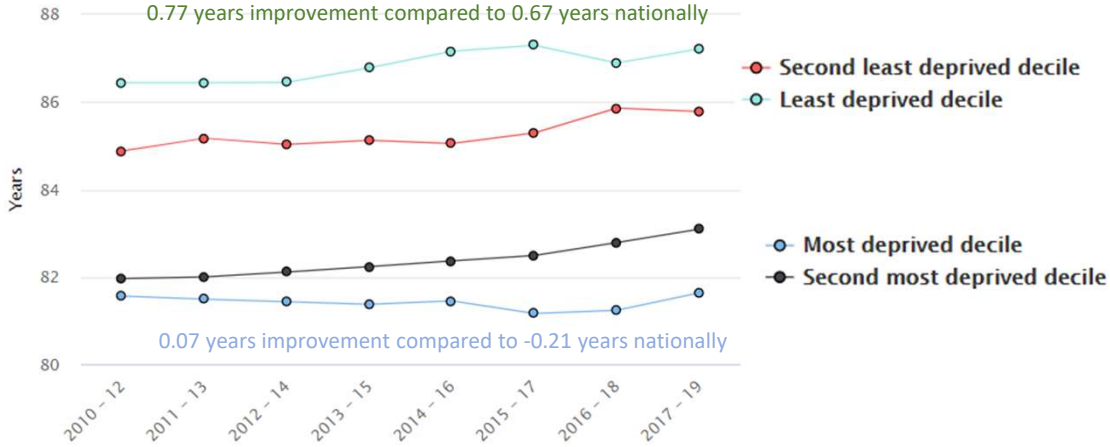
How healthy were the population of Hampshire before the pandemic?

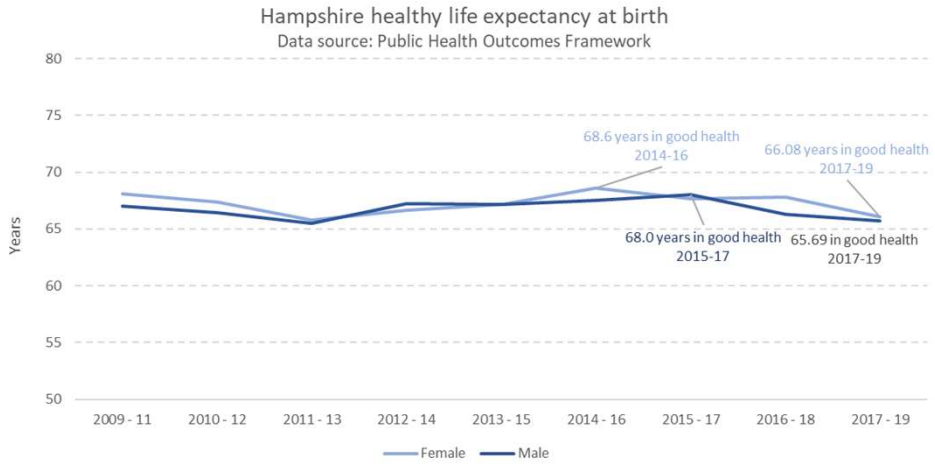
Hampshire & IOW Public Health Intelligence

Hampshire life expectancy at birth (males): inequalities



Hampshire life expectancy at birth (females): inequalities





Life expectancy improvements have been stagnating particularly in the more deprived areas, this is most evident in female life expectancy

The time spent in good health for both Hampshire males and females has decreased over the past five to six years, by 2.5 years for females and 2.3 years for males

Data source: Public Health Outcomes Framework

3. COVID-19 Outcomes in Hampshire

Data Summary: How many people in Hampshire were infected, hospitalised and died due to COVID-19 during the first and second wave?

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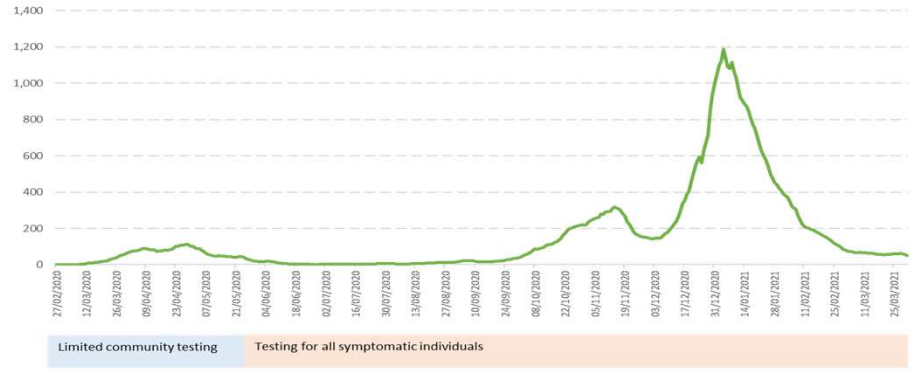
COVID-19 cases (7 day average) from 27/02/2020 to 31/03/2021

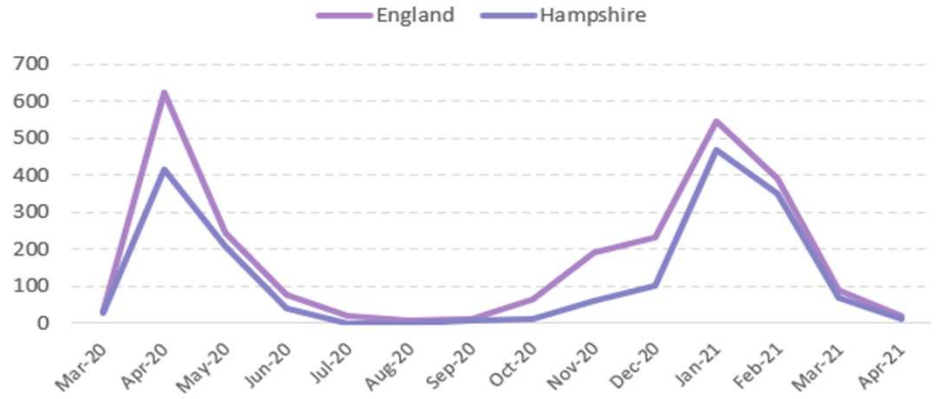


Source: PHE COVID-19 Dashboard

62,872 confirmed COVID-19 cases in Hampshire, this a rate of 4,457.7 per 100,000 of the population.

Over 15,000 people in Hampshire were experiencing Long COVID for 12 weeks or longer

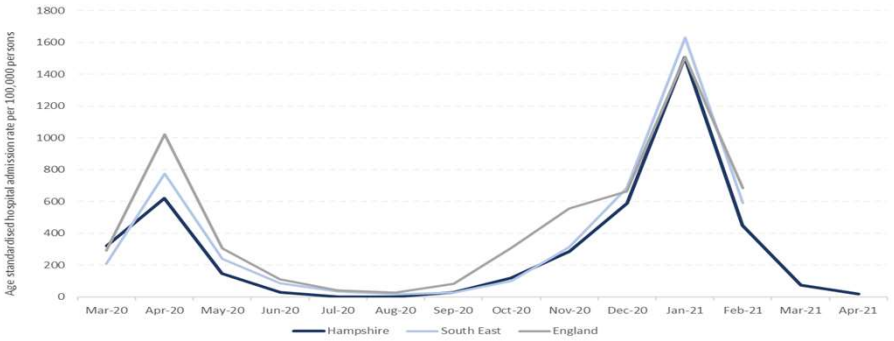
Age standardised mortality rates due to COVID-19



Source: Deaths due to COVID-19 by local area and deprivation, 20th May 2021 release, ONS

2,465 deaths due to COVID-19. Mortality due to COVID-19 was at its highest during the second wave of the pandemic.

Hampshire monthly age-standardised hospital admission rate per 100,000 person-years, for COVID-19 in England, South East March 2020 to February 2021 and Hampshire to May 2021



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

5,209 emergency admissions for Hampshire residents where COVID-19 was recorded

Hampshire rates suggest a greater burden from COVID-19 was evident in our population during Wave 2.

Note: How the waves are defined varies depending on the data being presented, for local analysis the cases, hospital admissions and mortality wave time periods have been driven by the peak month. When interpreting data it is important to consider the policy context between Wave 1 and Wave 2, such as the change in testing strategies and clinical treatment

4. Healthy people

The impact of the pandemic on different groups

What demographic factors drove the direct impacts of COVID -19 on our population?

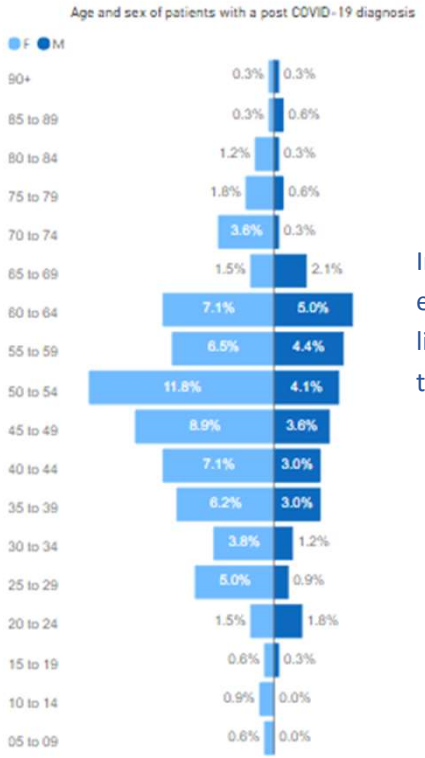
AGE

Advancing age (>60 years) was a strong predictor of poor outcomes - increasing hospital admission rates and deaths.

Older people were disproportionately affected by severe COVID-19 outcomes

Younger people (aged 70 or below) and women are more likely to experience Long COVID.

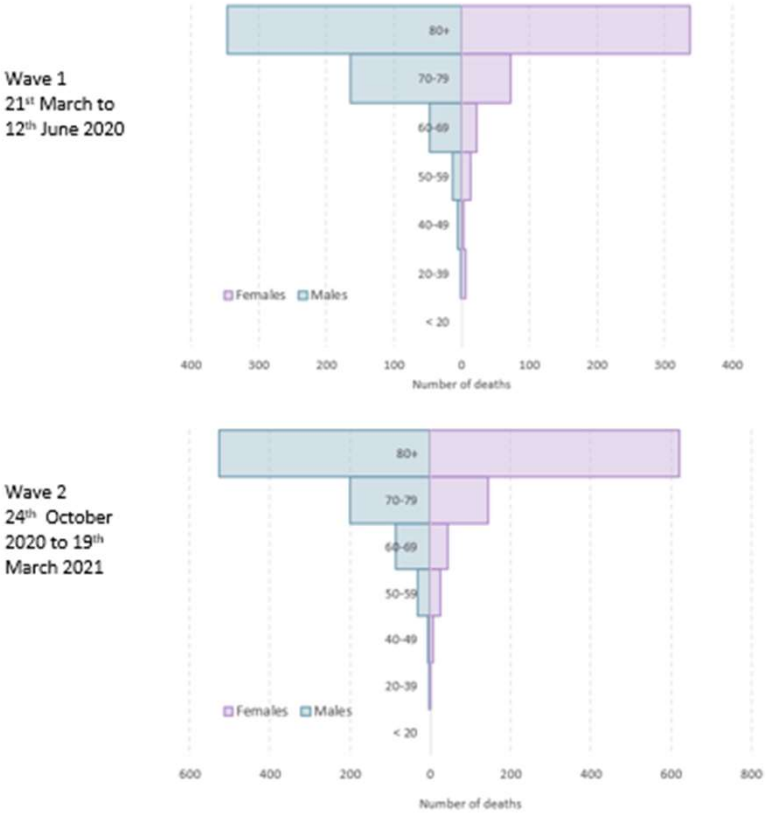
Age and sex of patients with a post COVID-19 diagnosis



In Hampshire working age women, especially those aged 45 to 64, are most likely to require on-going support with their health after contracting COVID-19.

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

Distribution of deaths by age group and sex, for Waves 1 and 2



In Hampshire cases of COVID-19 were higher in older people in the first wave, mainly due to limited testing and that older people were most likely to be admitted to hospital.

Males aged 65 years and over accounted for 36% of admissions in the first wave and 31% in the second wave

Mortality rates were highest amongst the older population, 66.2% and 63.9% of deaths were among people 80 years and older during wave 1 and wave 2 respectively.

Source: Civil Registrations, NHS Digital

What demographic factors drove the direct impacts of COVID -19 on our population?

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GENDER

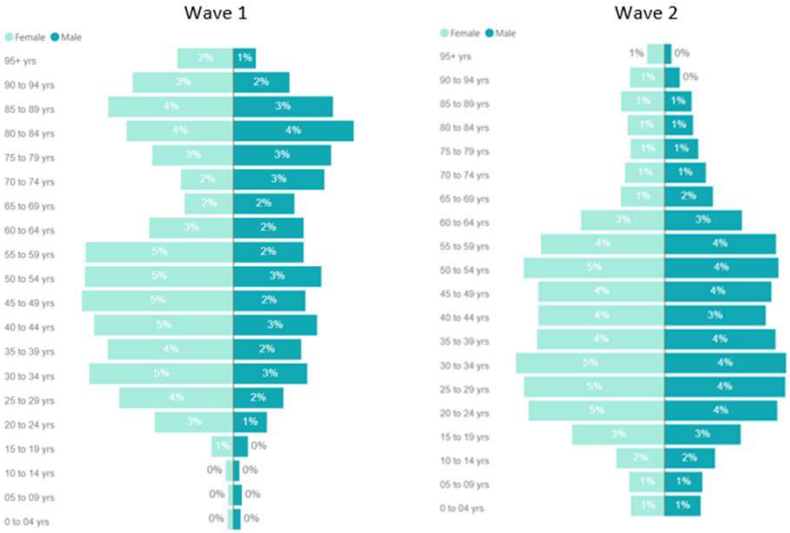
Higher numbers of cases were reported in females when compared to males.

- This is possibly linked to occupation for example, a higher proportion of females work in caring occupations with regular testing
- Women are more likely to experience Long COVID and so most likely to require on-going support with their health after contracting COVID-19.

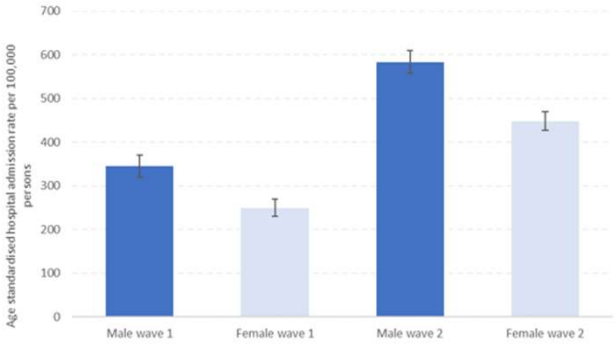
Males were disproportionately affected by the severe health outcomes due to COVID-19

- During both waves the male admission rate was significantly higher than female rate. Males and females both experienced significantly higher admission rates in Wave 2 compared to Wave 1.
- Overall, the mortality rates for deaths where COVID-19 was mentioned on the death certificate were significantly higher for males in older age bands than in females, this pattern occurred among all age bands aged 60 years and over.
- The annualised age standardised mortality rate in males (361.7 per 100,000) was over fifty per cent higher than that observed in females (204.0 per 1000,000) over the first wave of the pandemic.

Demographics of COVID-19 cases in Wave 1 (27th February 2020 to 31st May 2020) compared with Wave 2 (1st October 2020 to 31st March 2021)

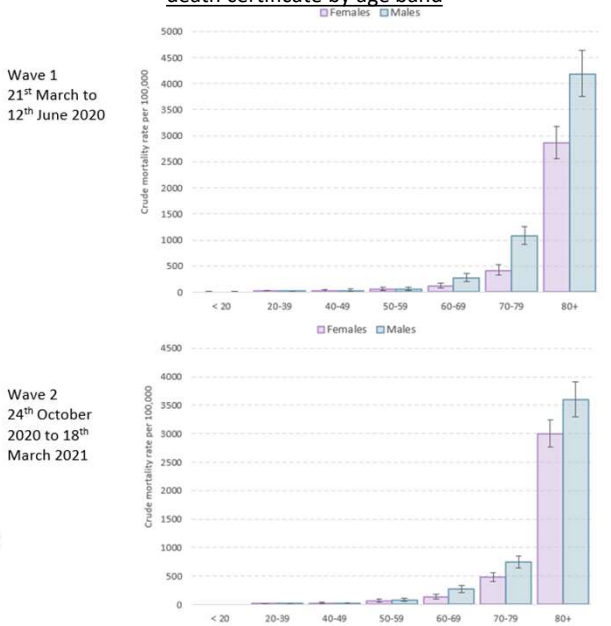


Age-standardised hospital admission rate per 100,000 by gender



Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 202

Crude mortality rate for deaths with COVID-19 mentioned on the death certificate by age band



What demographic factors drove the direct impacts of COVID -19 on our population?

Ethnic group

People from ethnic minority groups were more likely to be diagnosed with COVID-19

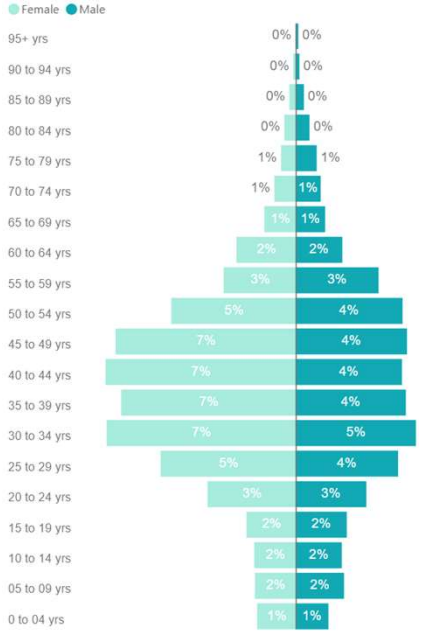
- Nationally people from Black ethnic groups were most likely to be diagnosed with COVID-19

People from ethnic minority were disproportionately affected by the severe health outcomes due to COVID-19

- 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 is 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
- 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.

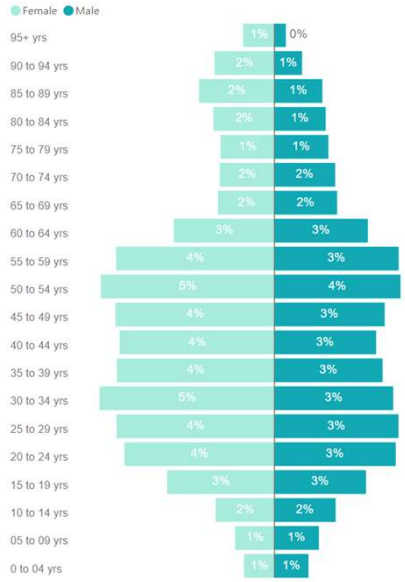
Demographics of COVID-19 cases in Wave 1 (27th February 2020 to 31st May 2020) compared with Wave 2 (1st October 2020 to 31st March 2021) .

A – Ethnic Minority Populations



A greater proportion of the working age population in ethnic minorities groups tested positive for COVID-19 compared to the White population. This is reflective of the younger population structure evident in Hampshire's ethnic population groups

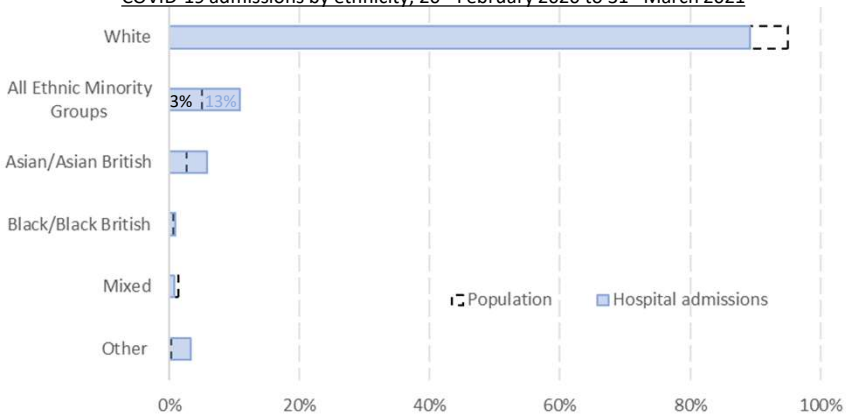
B – White Population



Hampshire admission data suggest there was a greater proportion of admissions of people from minority ethnic groups when compared with the population

Death rates from COVID-19 were highest among people of Black and Asian ethnic groups.

COVID-19 admissions by ethnicity, 20th February 2020 to 31st March 2021

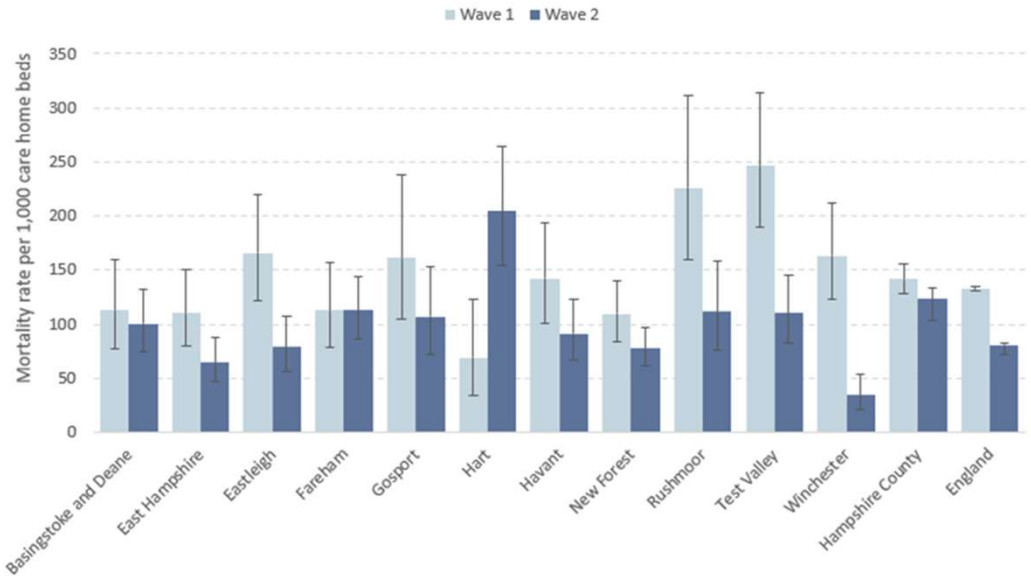


What demographic factors drove the direct impacts of COVID -19 on our population?

Care home settings

Care homes were disproportionately affected by the COVID-19 outbreak as residents and those working in care homes were more vulnerable to the virus.

Annualised mortality rate per 1,000 care home beds by district



In Hampshire, deaths in care homes comprised 44% of all deaths where COVID-19 was mentioned on the death certificate in Wave 1 and just under one third during wave 2.

Rushmoor and Test Valley experienced the highest rates of care home mortality in Wave 1. Hart and New Forest, the lowest rates.

Hart was disproportionately affected in Wave 2 of the pandemic. Rates in Winchester were significantly lower than the national and county average.

What were the indirect impacts of COVID -19 on our population ?

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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. Variation is mainly accounted for by the broad stages of life.

The full effect of these impacts may be long lasting and some may not be evident for a number of years.

Older people were more vulnerable to serious illness and deaths from COVID-19 and more likely to shield. Decreased social connectiveness for older people who were also less likely to use online communications to supplement their interactions. Impacted on mental health with increased anxiety and depression reported as well as increases in cases of self neglect and self harm including self neglect.

Carers and Social Care nationally, there has been an increase in unpaid carers during the pandemic as people provide inform help for family member . Carers and families of these children have reported a decline in mental health and isolation. The impact of social distancing restrictions has also compounded social isolation and reduced mobility, so people may require social care services earlier than they may otherwise have done Service closures such as day centres will have impacted those with Learning Disabilities who receive support service. Children with disabilities, and their families, have also been impacted accessing medical services and experienced delays in appointments

Working age over the pandemic, some people have experienced financial strain, longer working hours, poorer work life balance or increased fear of potential exposure to COVID-19. One in five adults have experienced some form of depression, double the observed before the pandemic. Younger adults and women were more likely to experience some form of depression with women in in lower socio-economic jobs were more likely to be furloughed than any other positions (including key worker roles) and men in general. Low income or loss of income is associated with increasing levels of loneliness during lockdown and higher levels of anxiety and mental distress.

Children - evidence shows that number of children living in relative poverty has been steadily increasing prior to COVID, the economic impact of COVID has disproportionately impacted low-income families potentially further driving and widening the inequalities for these children

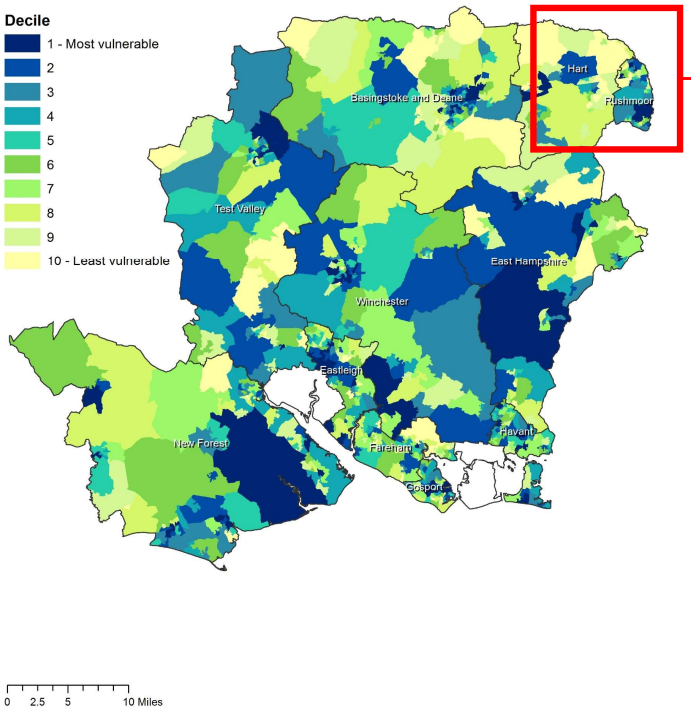
Young people – although at low clinical risk of severe health outcomes from contracting COVID-19 adolescence is a key period for CYP social cognitive development and the policies will have impacted on this development for some. The main pressures reported by CYP during the pandemic were; increased feelings of loneliness and isolation, concerns about school, college or university work., trouble sleeping ,anxiety about catching and spreading COVID-19 and a breakdown in routine. Many young people also expressed fears about the future. Online bullying and an increase in online gambling has also been reported in young adults.

Who in our population may have vulnerable mental wellbeing?

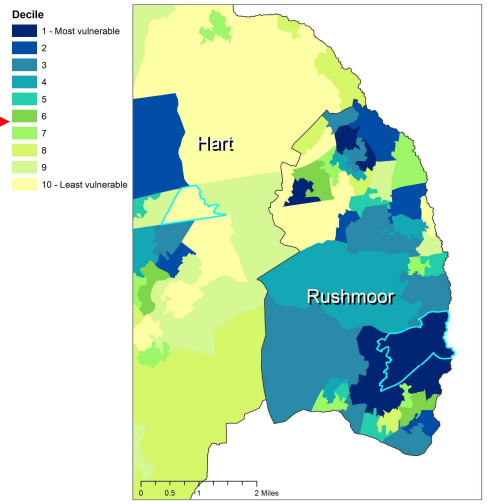
COVID-19 and the associated restrictions have both had an impact on the population's mental health, with groups who in the past have had robust mental health being affected alongside those with pre-existing experience or diagnosis of mental health conditions.

Using data from a range of sources, a wellbeing vulnerability index has been created to identify and map populations in Hampshire who are more likely to have vulnerable mental health because of the restrictions put in place during COVID-19

Hampshire Mental Wellbeing Vulnerability by LSOA



Hampshire's most and least vulnerable areas



Generally, Hampshire's urban populations are more likely than rural populations to have vulnerable mental health as a result of COVID-19 restrictions. Basingstoke town centre, Andover town centre, Eastleigh town centre and Winchester City Centre all follow this pattern

In Hart, East Hampshire and the New Forest more complex patterns of vulnerability exist. There are both urban and rural populations which are more vulnerable to mental ill health as a result of COVID-19 restrictions.

LSOA's most likely to have vulnerable mental wellbeing have the following characteristics in common

- Close to the centre of the major town in their respective district
- Most have new housing developments, or unusual types of accommodation (e.g., university halls or army barracks)

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5. Healthy lives.

How different lifestyle behaviours which effect health have in turn been impacted by the pandemic

How have our lifestyles, behaviours and existing health conditions directly impacted our population's health through the pandemic?

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Existing Health Conditions

Comorbidities predicted worse outcomes, especially evident for those with a history of non-communicable diseases such as obesity, diabetes, heart disease, hypertension and poorer for those living in more deprived areas.

- Exploring primary care data found that across Hampshire and Isle of Wight 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
- The prevalence of moderately or severely frail Hampshire and Isle of Wight patients with COVID-19 is much higher when compared to the overall proportion in the general population, supporting evidence that this population were at high risk of contracting COVID-19.
- Admissions data for COVID-19 by physical health or lifestyle risk factors for Hampshire and Isle of Wight residents suggested that obesity was the most prevalent risk factor

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.

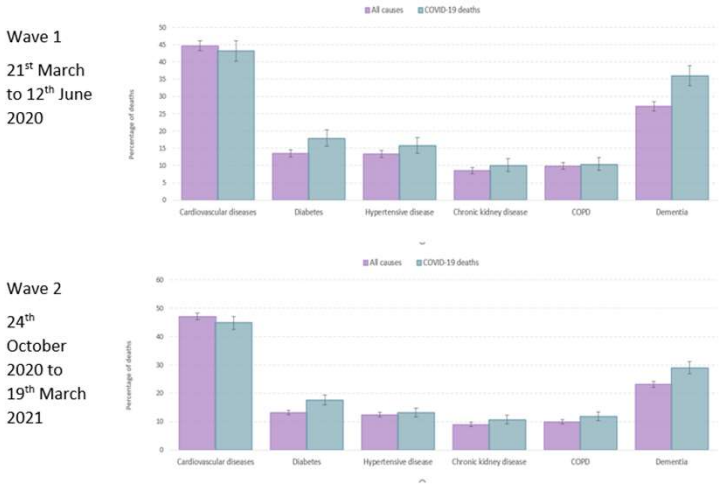
- Locally, similar patterns were found with the exception of cardiovascular diseases overall. The largest difference was for dementia. Dementia was mentioned on 27% of all death certificates over Wave 1 and 23% over wave 2.
- Diabetes was mentioned on 18% of death certificates which also had a record of COVID-19, significantly higher than the proportion of all deaths

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

Percentage of COVID-19 deaths and all cause deaths where other conditions were mentioned on the death certificate



Source: Civil Registrations, NHS Digital

How have our lifestyles, behaviours and existing health conditions directly impacted our population's health through the pandemic?

Occupation. National data has reported a link between occupation and severe outcomes from contacting 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.

Long COVID is also more prevalent amongst those working in the health and social care sector

Men from ethnic minority groups are much more likely to work in high risk occupations such as taxi or cab drivers

In wave 1 deaths in people aged 20 to 64 in 2020 were 1.22 times higher than average.

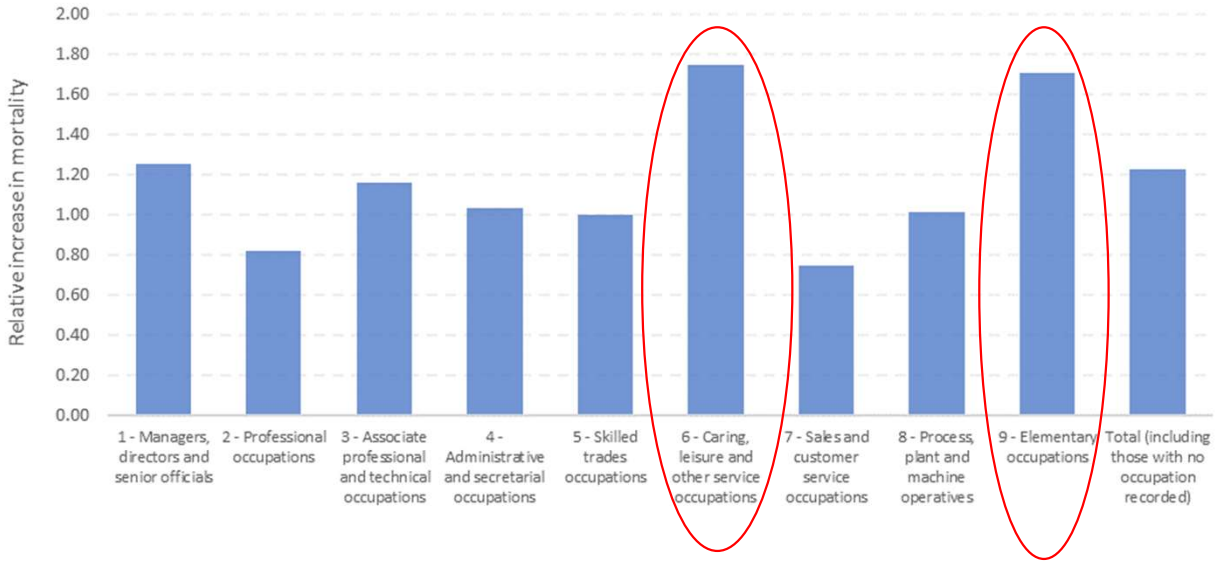
The biggest increase was in caring, leisure and other service occupations where death rates were 1.75 times higher than average.

The second highest rates were in deaths rates were in elementary occupations these were 1.70 times higher than the 2015-19 average.

Both occupation groups are traditionally poorly paid

Additionally, low income levels may be associated with factors likely to increase the risk of death from COVID-19 such as living in a more deprived area.

Hampshire relative increase in deaths occurring in Hampshire across Wave 1 compared to the average for 2015 to 2019 by occupation, residents aged 20 to 64 years of age



Source: Civil Registrations, NHS Digital

How have our lifestyles, behaviours and existing health conditions indirectly impacted our population's health through the pandemic?

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Lifestyles and behaviours

In Hampshire over the course of the pandemic approximately 53,000 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.

Physical activity levels have impacted by the pandemic, for those aged 16 and over physical activity declined during the early stages of the pandemic. Children also saw a decrease in activity levels further affected by school closures as children could not engage in PE and swimming lessons. A reduction in exercise can result in deconditioning which leads to an increased risk of reduced bone mass and muscle strength, increased dependence and confusion. During social distancing restrictions many people experienced reduced levels of activity, however, for those with long term conditions who were shielding, this impact would have been even greater.

Diet 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. Children from disadvantaged background were most likely to eat more junk food and less likely to be eating more fruit and vegetables and these children, who were entitled to free school meals, may also have experienced food insecurity. There were also large peaks in alcohol purchasing over the two periods of social restrictions with increases of alcohol, drinks and tobacco products.

Smoking rates have declined over the course of the pandemic, with an estimated million people stopping smoking since the beginning of the pandemic. However contrary to this there is a concern 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

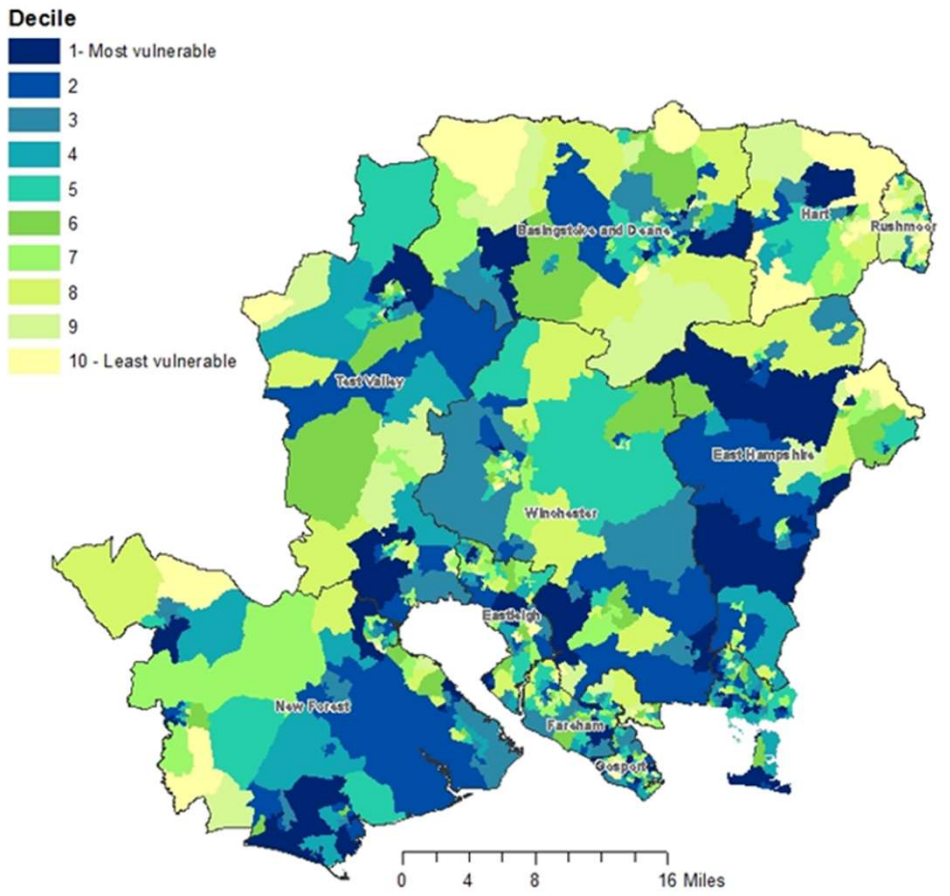
Work-life balance. During the pandemic many people's working arrangements changed with nearly half (46.6%) of people in employment doing some work from home from April 2020. Of these around one third (30.3%) worked a greater number of hours than usual. Working long hours has been shown to be an risk to health, with people working 55 hours or more per week having an increased risk of heart disease or stroke. Reported benefits of working from home include; reduced time spent travelling to work, reduced sickness absence rate, helping fathers to be more present and have greater involvement in childcare. Many workers have reported that they would like to continue some home working once social distancing restrictions end

Who in our population may be more at risk of health vulnerabilities?

The Health Vulnerability index has been produced calculated by combining the factors, such as long term condition prevalence, age ,overcrowding, which have been shown to be high risk for severe outcomes from contracting COVID-19 and provides an overall estimate of the vulnerability of people living in these areas to severe health outcomes from COVID-19.

Rural areas across East Hampshire, Test Valley, the New Forest and Basingstoke and Deane are the areas which show as most vulnerable on the map. More urban areas such as Rushmoor, Fareham and Gosport, have lower vulnerability to severe health outcomes from COVID-19 overall but vulnerable populations are still evident in these districts.

Health Vulnerability index



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6. Healthy places.

How COVID-19 has impacted populations differently depending on where they live and circumstances

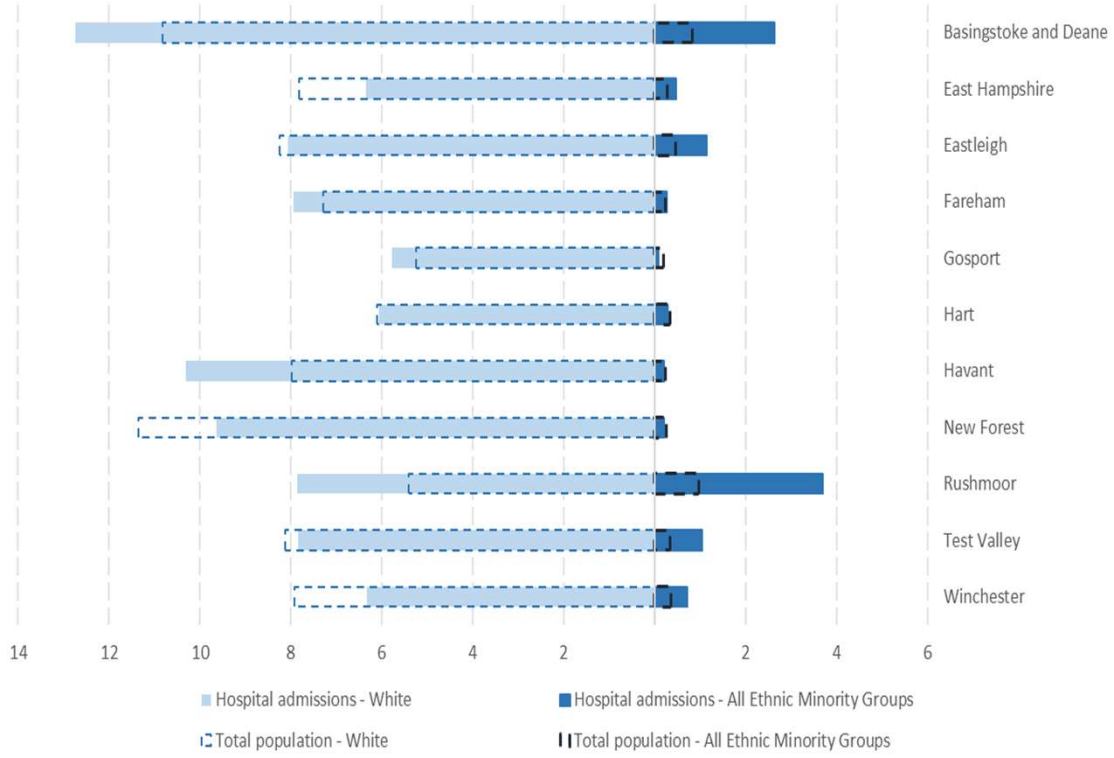
Place: Where has been directly impacted upon by COVID-19?

Place

Basingstoke and Deane & Rushmoor had significantly higher COVID-19 rates of cases, admissions and deaths compared to other districts

Admissions rates in the more deprived areas were 2.1 times higher for males and 1.8 times higher for females than those in the least deprived areas.

COVID-19 admissions compared with population structure by district, 18th February 2020 to 31st May 2021



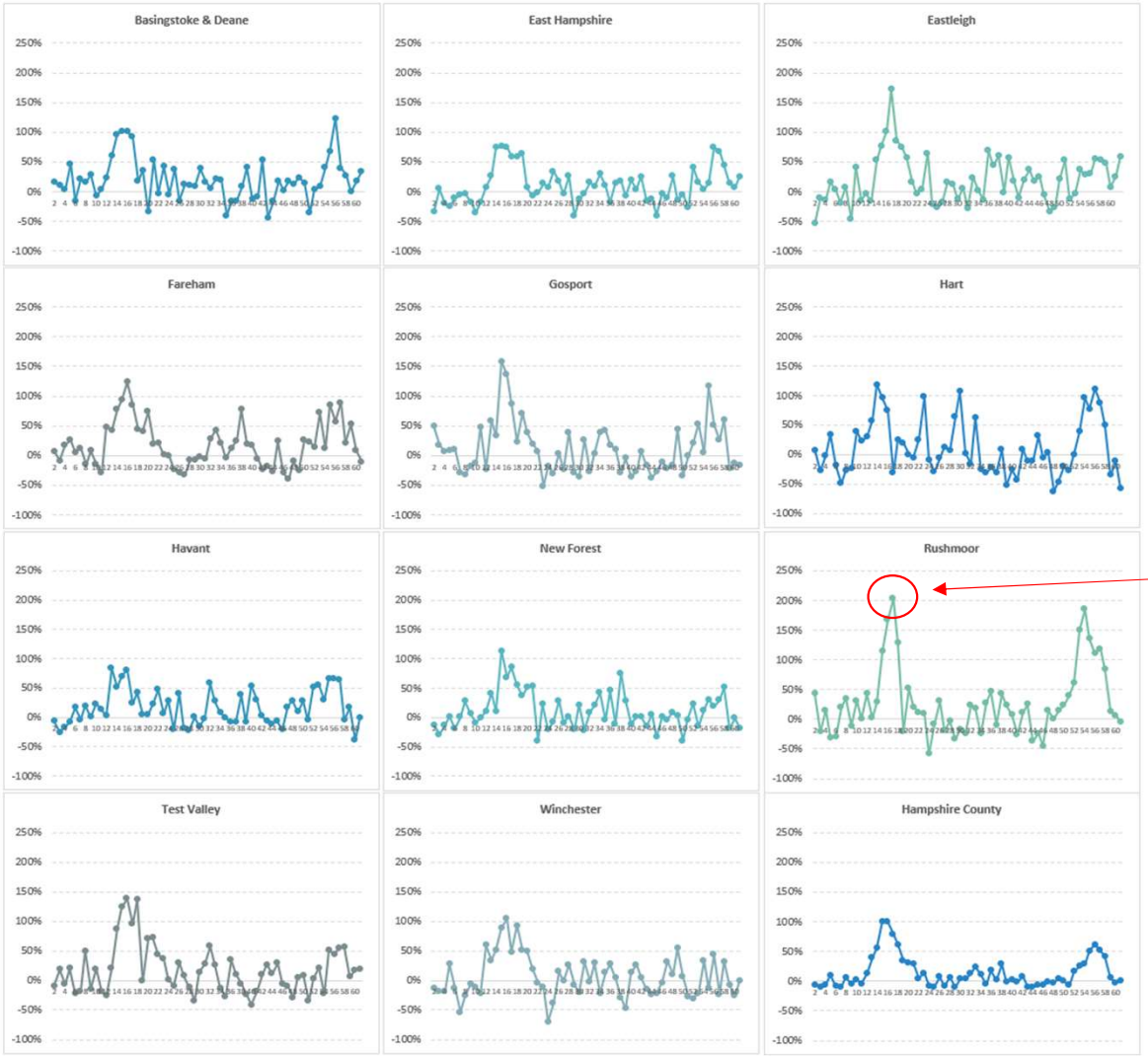
Rushmoor and Basingstoke & Deane districts have specific vulnerabilities

- urban
- densely populated areas
- areas considered most deprived
- high proportion of people working in front line roles such as health care and the service industry.
- greatest ethnic diversity with a larger population of people from an Asian background.
- more likely to be living in multigenerational housing are more likely to be living in overcrowded housing

However district level still masks variation e.g. Andover area in Test Valley

Place: Where has been directly impacted upon by COVID-19?

Excess deaths as a share of usual deaths in Hampshire districts, Week ending 10th Jan 20 to week ending 26th Feb 21



Source: Excess deaths data summary for week 24 2021, LKIS South East, Public Health England

Life expectancy trends from 2015 to 2020 suggest that inequalities have widened significantly, disproportionately impacting on those living in the more deprived areas.

Levels of excess mortality varied across the districts of Hampshire during the COVID-19 pandemic. When excess deaths are examined as a proportion of usual deaths, the highest peaks are noted in Rushmoor district

Rushmoor experienced over 200% more deaths than would usually be expected

Place: What has been indirectly impacted upon by COVID-19?

Education has been significantly impacted on due to school closures. Time spent learning declined for secondary pupils with the greatest loss evident in areas of higher deprivation. There are many reasons why those children from deprived background had reduced participation in learning. For example reduced access to digital resources, parental educational attainment, language barriers and challenges for home schooling in overcrowded households. Concerns for vulnerable children who in lockdown became a 'hidden population' due to reduced contact and social interaction with educational and health professionals

Access to green space will have impacted people very differently during lockdown depending on where they lived and their type of accommodation. 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 garden and additional living space.

Air quality has been positively impacted on. During the 'Stay at Home' restrictions motor vehicle travel was 63% lower than in the same month in 2019. Overall in 2020 motor vehicle travel reduced by 21.3% compared with 2019. The largest decrease was shown for buses and coaches, followed by cars, whilst the use of pedal cycles increased by almost 50%

Crime data present a mixed picture depending on the type of crime. Robbery and theft dropped dramatically during 2020, however there are reports of young people being at increased risk from county lines as criminal groups find new online ways and social media platforms to coerce young people into drug running. Domestic abuse has also seen an increase during the pandemic, national domestic abuse helpline reported a 66% rise in calls and a 950% increase for visits to the website compared with pre-COVID-19. With the increase in domestic abuse the number of Children in care is also increasing.

Economic policy has been introduced throughout the pandemic designed to mitigate the negative impact of the public health interventions on businesses and employees**.** Around 80% of hospitality and food businesses creased trading during lockdown. Consequently, those working in food service, accommodation, arts and entertainment were the workforce most affected. Young working age population had the highest rates of furlough. 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. The unemployment rate for people from a minority ethnic background increased by a larger proportion than those from a White background.

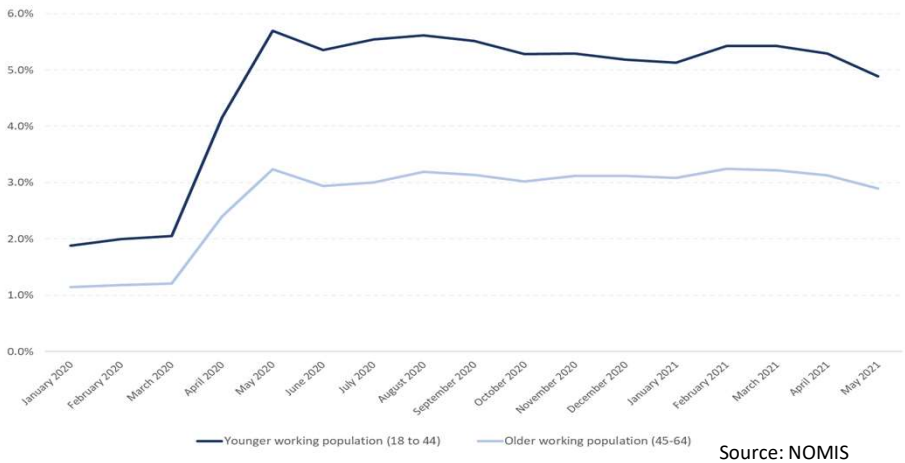
Which businesses were more vulnerable due to economic policy?

The index aims to assess the variations in how vulnerable businesses are to the impacts of the COVID-19 pandemic restrictions across Hampshire.

Based on a review of evidence, four key vulnerability factors were identified:

- Business Size - businesses with under 10 employees most vulnerable [NOMIS]. Business income used SEIS and CJRS as proxy [HMRC]
- Sector that the business operates in - Sectors most vulnerable – Accommodation and Food Service Activities, Arts, Entertainment and Recreation and Other Service Activities [NOMIS]
- Mobility of consumers [Google Mobility data]
- The type of business (e.g. operating online or in-store) – data not available

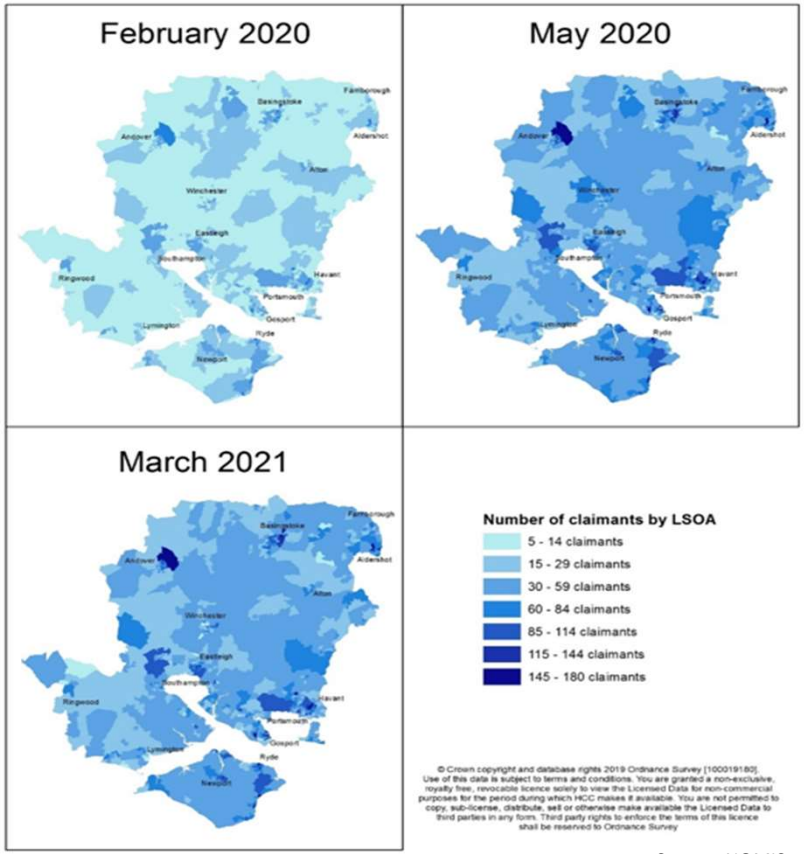
Claimant count percentage uptake by working age group



Source: NOMIS

Claimant count was higher and increased significantly more in the younger working age, 18-44 years

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



Source: NOMIS

Which businesses and districts across Hampshire and Isle of Wight were more vulnerable due to economic policy?

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Business Vulnerability Index: Sum of Ranks

District	Furlough (Average take up rate per month)	Mobility - Retail and Recreation (difference from baseline)	Self-Employment Income Support Scheme (Average takeup 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	Sum of Ranks
South East	**12.15%**	**N/A**	**68.70%**	**110.31**	**902.50**	**3.22%**	
Hampshire (not including IOW)	**11.24%**	**-44.04**	**67.55%**	**98.56**	**893.27**	**2.72%**	
Basingstoke and Deane	10.26%	-46.28	66.26%	82.65	908.58	2.68%	33
East Hampshire	11.71%	-43.74	65.35%	95.38	906.15	2.66%	37
Eastleigh	11.38%	-45.20	70.37%	83.27	909.92	2.37%	36
Fareham	11.71%	-44.99	69.23%	100.66	884.03	2.49%	38
Gosport	10.22%	-36.08	71.30%	170.16	897.91	3.43%	39
Hart	11.47%	-51.57	66.67%	94.26	912.91	2.46%	43
Havant	11.45%	-44.16	74.07%	106.90	905.64	3.61%	50
New Forest	12.88%	-37.39	67.36%	120.45	890.84	2.59%	39
Rushmoor	11.30%	-46.89	70.21%	100.73	871.72	3.20%	40
Test Valley	9.93%	-42.48	65.22%	89.97	899.71	2.35%	16
Winchester	11.34%	-52.89	62.71%	93.96	845.68	2.41%	25
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

For each indicator, every district was compared to the South East average and the colours of the tartan rug were calculated based on statistically difference to the South East

Businesses in Hart and Havant were identified to be most likely to be vulnerable to the impacts of the COVID-19 pandemic restrictions, with businesses in Test Valley and Winchester being the least likely to be vulnerable.

7. Key areas of focus

"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"

Living Safely with Covid. Moving toward a Strategy for Sustainable Exit from the Pandemic.

Hampshire & IOW Public Health Intelligence

Key areas of focus

- 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 Hampshire population has slowed and is unequal with the proportion of time spent in good health decreasing.
  - PHM workstream – focus on modifiable behaviours
  - Focus on lifestyle interventions at person and place level – smoking, obesity, physical activity

"Early intervention to prevent health inequalities"

- Older people, ethnic minority groups & those living in deprived areas were disproportionately affected by the severe outcomes of COVID-19.
  - Commissioned services - proportionate universalism approach

"Ensure proportionate universal allocation of resources and implementation of policies".

  - Provider outcomes focused- health equity impacts– requires good data collection to identify population groups and measure outcomes

"Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy"

- Women of working age have been disproportionately affected by Long COVID
  - Reform workplace occupational health policy to recognise the debilitating condition and support employees physically and mentally
  - PCN health and wellbeing coaches – could provide a supportive role providing practical lifestyle advise - NICE guideline [NG188] published December 2020

Health Equity in England: The Marmot Review 10 Years On | The Health Foundationuidance-1.pdf

"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"

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Key areas of focus

- Children and young people – limited social development in the very young, missing key life experiences, mental health, educational and economic long term impacts uncertain but clearly has had a huge impact – how do we help this cohort of our population increase resilience for the future?
    - Share HIA report with our ETE , education and children's services colleagues to identify possible actions (e.g., digital and remote learning experiences – lessons learnt)
    - Work with the business sector (maybe through the district links) to encourage more opportunities for young people such as apprenticeships and work experience to provide economic and educational certainty

"Increase the number of post-school apprenticeships and support in-work training throughout the life course"

- Build on and consolidate relationships established during the pandemic to work more creatively' e.g., NHS, Social care, CSU, Public health, community researchers and community organisations

- 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

Health Equity in England: The Marmot Review 10 Years On | The Health Foundationuidance-1.pdf