

Health Impact Assessment of COVID-19 in East Riding of Yorkshire

Public Health Intelligence Team
Joint Strategic Needs Assessment (JSNA)
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2 Introduction

2.1 Background

The World Health Organisation (WHO) named the novel virus which we now know as 'COVID-19' on 11 February 2020, having been first aware of its existence from a cluster of cases from an unknown source since 31 December 2019. On 11 March 2020, WHO declared the outbreak as a global pandemic. Internationally, the COVID-19 pandemic of 2020, 2021 and 2022 has had a devastating impact on morbidity and mortality, and with no current indication of it abating it is likely it will continue to be a worldwide concern throughout subsequent years. As of 29 April 2022, there have been almost 106,000 confirmed cases of COVID-19 in the East Riding, hundreds of hospitalisations and over 1,100 deaths registered with COVID-19 on the death certificate.

It is fair to say that little in the lives of the East Riding population has not been affected by the pandemic since March 2020, this document aims to set out a range of affected conditions and factors impacting on the East Riding Population's Health and Wellbeing.

2.2 COVID-19 against the backdrop of the social determinants of health

The COVID-19 pandemic is occurring against a backdrop of pre-existing social and economic inequalities that have existed for generations. Campos-Matos et al (2020) suggested inequality has been a key feature of past pandemics and are unsurprised that "it is the disadvantaged poor that have been hardest hit by COVID-19 in the UK, as they have all over the world". These broad social and economic circumstances that together determine the quality of the health of the population are known as the 'social determinants of health'.

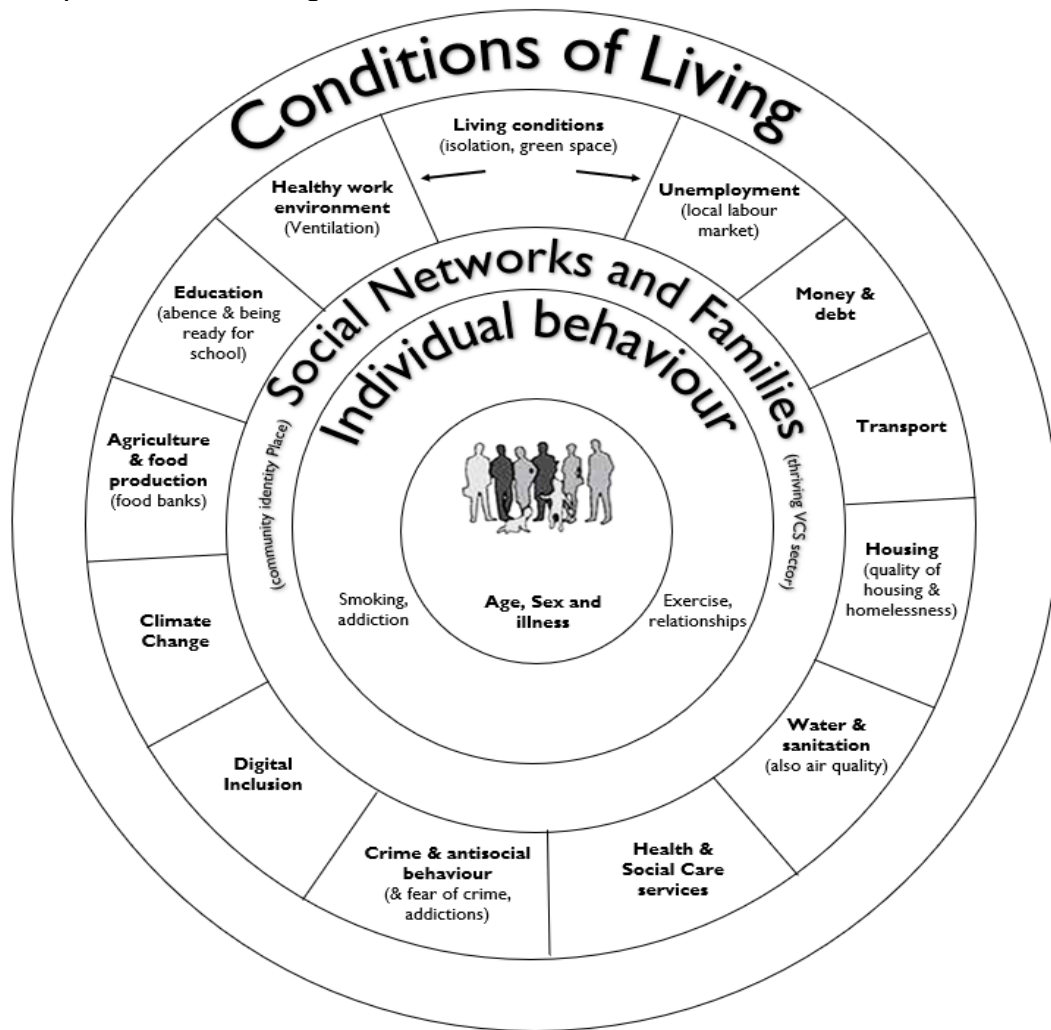
Image Figure 1 is the 'Conditions of Living' model created by East Riding Public Health (initially based on the Dahlgren and Whitehead model of health determinants). The model maps the relationship between the individual, their environment and health; demonstrating that health and wellbeing is influenced much more than access to health and wellbeing services. In the model, individuals are placed at the centre and surrounding them are the various layers of influences on health – such as individual behaviour, community influences, living and working conditions, and more general social conditions. Medical care is estimated to account for only 10-20% of the modifiable contributors to healthy outcomes for a population (Magnan, 2017), the rest is related to conditions of living. These conditions of living are highlighted within the model, which are influenced by the Council, NHS and system partners at a local level. Many of the of the conditions are directly influenced by national government policy and agencies, locally partners have the power to mitigate against the affects and lobby for change to national mandates. If as a system we can improve these aspects then we give people the protective factors to live longer and healthier lives and we remove the risk factors that create the burden of illness and disease.

To gain insights from East Riding of Yorkshire Council colleagues and partners around the East Riding area, it was decided that a qualitative survey would be the most appropriate method to elicit and extract key themes around the impact of COVID-19. Survey templates were issued to a wide range of commissioning leads, key members of staff and partners and 22 were completed and returned. In addition to the typical qualitative analysis performed by the public health intelligence team around diseases, documents from partners including ERVAS, HealthWatch and others were drawn upon for insight gathered during the pandemic.



The remainder of the document will be structured around the conditions of living model, attempting to highlight in each segment what we know about the impact of COVID in that area. As with all needs assessment, iterative understanding is built from a partnership of wisdom. This document is a snapshot of what was available at the moment in time of writing from available partners. Inline with the new dynamic system for Joint Strategic Needs Assessment, gaps found here in time will be filled by system partners most qualified to speak to their topic area.

Figure 1. Conditions of living model, East Riding Public Health, 2022
(initially based on the Dahlgren and Whitehead model of the main determinants of health)



2.3 Headline issues for the East Riding – “Right ‘Round the Wheel”

In the East Riding system the pandemic has had both indirect and direct effects on health and wellbeing for the population. It's clear this is spanned physical, mental and social factors that determine health and wellbeing state at any point in time. Delays in diagnosis and subsequent treatment due to the NHS having to respond to the pandemic, has created a growing burden of ill health and poorer wellbeing for our population. Disease burden is causing physical and mental wellbeing to deteriorate across groups of people often who are most vulnerable in society. The distribution of where this growing burden is felt is not equal across the East Riding, those in our poorest communities are experiencing greater levels of ill health, poorer mental health and deteriorating social connectedness.

People's resilience to manage the conditions they suffer with has been eroded during the pandemic. We can see this translating in the growing demand on mental health services across the county. Common mental ill health disorders such as depression and anxiety prevalence's' are growing in the county and whilst at often lower than national levels it's clear the trajectory is growth for our population. This compounds the physical conditions that people are suffering as resilience fails, they're unable to manage with the physical conditions they are experiencing, raising the risk of needing statutory services to intervene. This further compounds pressure on our health and care system locally, which is already clamouring to catch up with the backlog brought about by the interruption to services.

As shown in multiple sources within this document and in nationally available reports, children have been significantly impacted during the pandemic. The disruption due to the periods of school closure and having to isolate from school due to being a case or a contact, have significantly impacted children's academic attainment. Groups of children have missed key health and wellbeing checks during 2020 which are only now beginning to be caught up. Resilience, relationships and mental wellbeing has been negatively affected in children of all ages in the period.

Economic hardship faced by many in our county because of the pandemic is having lasting effects on communities. As this grows the poorest in society are finding it harder to access services, who are often the most in need of these, further compounding the late presentation/need for more acute support. Over the winter of 2021/22 people were struggling with meeting food and energy costs, as of April 2022 with the increase in energy cap this over one in four household were pushed into fuel poverty. Inflation rising at near 10% driving the price of food higher, is doubling the impact on poorer households. Given the nation is entering its warmest months, this problem is set to manifest with greatest impact in the winter months of 2022/23

Unemployment during the 2020/21 period had risen, with sectors such as hospitality and tourism being badly effected due to the restrictions. During late 2021- into 2022 this had changed as restrictions eased unemployment fell. All of this was set in the longer-term issue of under employment and low paid work, it remains a fact that over 35% of the claimants if universal credit are in full time employment. This issue is persisting in the face of the lowest level of unemployment and highest number of vacancies for a generation, low skilled low pay jobs are still widespread.



2.4 Key Findings

2.4.1 Age, Sex and Illness

- Premature death (those <75 years old) in the last 3 years has increased
- Premature death has occurred more in our poorest communities.
- Cardiovascular diseases in the last 3 years has killed more people than COVID for those under 75
- disease specific entries:

2.4.2 Health and Social Care Services

- The cessation of NHS screening appointments, the redeployment of staff to Covid-19 related duties and the reluctance of the public to leave their homes and enter usually crowded hospital buildings for emergency and planned care has led to late presentations of serious conditions such as cancer and strokes. This will impact upon all stages of the life course.

2.4.3 Digital Inclusion

- The migration of many services online has exacerbated the digital divide, increased health inequalities and has intensified the sense of isolation and detachment for our most rural and most deprived individuals and communities.

2.4.4 Social Networks and Families

- The Covid-19 restrictions on social and community life have resulted in the suspension of social activities for children, young people, adults and the elderly and the intensification of the sense of isolation, anxiety and mental ill health amongst our most deprived urban and rural populations.
- Children's mental health has deteriorated.

2.4.5 Individual behaviour

- Children like adults have seen an average increase in excess weight gain. (lifestyle factors)
- Mental ill health has increased, with anxiety, depressions and many conditions rising. (lifestyle factors)

2.4.6 Education

- The disruption to schools is causing attainment to decrease, running the risk of children within this cohort having more limited life chances.

2.4.7 Living Conditions

- The impact of loneliness was referred to on several occasions for children, adults and the elderly. The requirement of some residents having to isolate alone due to the lockdowns or due to having an infection meant there was an absence of contact with friends, family and colleagues.
- Partners raised the concern over the threat of deconditioning and increased frailty in the East Ridings older population.



3 COVID19 epidemiological summary

The COVID-19 pandemic of 2020 continues to have a devastating impact on morbidity and mortality both nationally and internationally. The East Riding, as with most other areas within England, has endured high infection rates within residents which in turn has led to hospitalisation and unfortunately death. The Public Health Intelligence team have worked throughout the pandemic reporting numbers and rates relating to COVID-19 to try to inform the picture locally. This has been communicated through dashboards and daily situation reports, examples of which are presented within this section.

3.1 Infections

Since the start of the pandemic in March 2020 through to 20 June 2023, there have been almost 21 million positive cases of COVID-19 in England, almost 121,000 of these cases have involved East Riding residents. Figure 2 displays the daily number and the 7 day rolling average of cases between February 2020 and April 2022. The various peaks of cases would usually correspond with the emergence of new variants that had started to circulate in the weeks before. The maximum number of East Riding cases recorded in a single day was 1,715 on 4th January 2022. The end of free testing for the general public on April 1st 2022, effectively ended the usefulness of tracking community wide infections as testing levels plummeted.

Figure 2. Daily number and the 7 day rolling average of new positive cases of East Riding residents between 2020 and 2022. Source: coronavirus.data.gov.uk

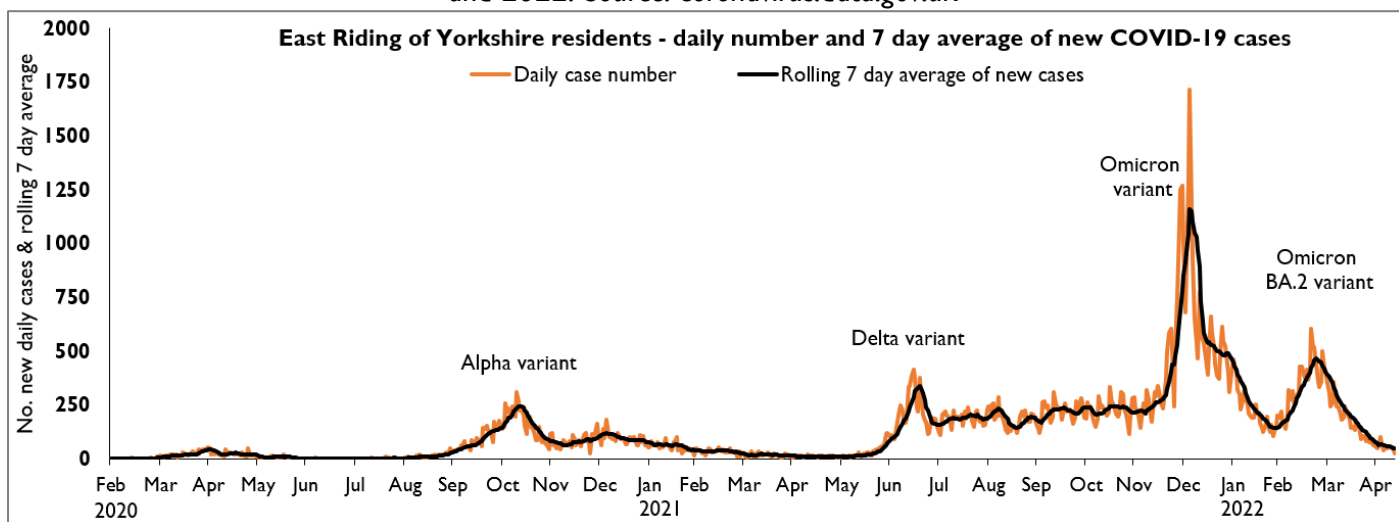
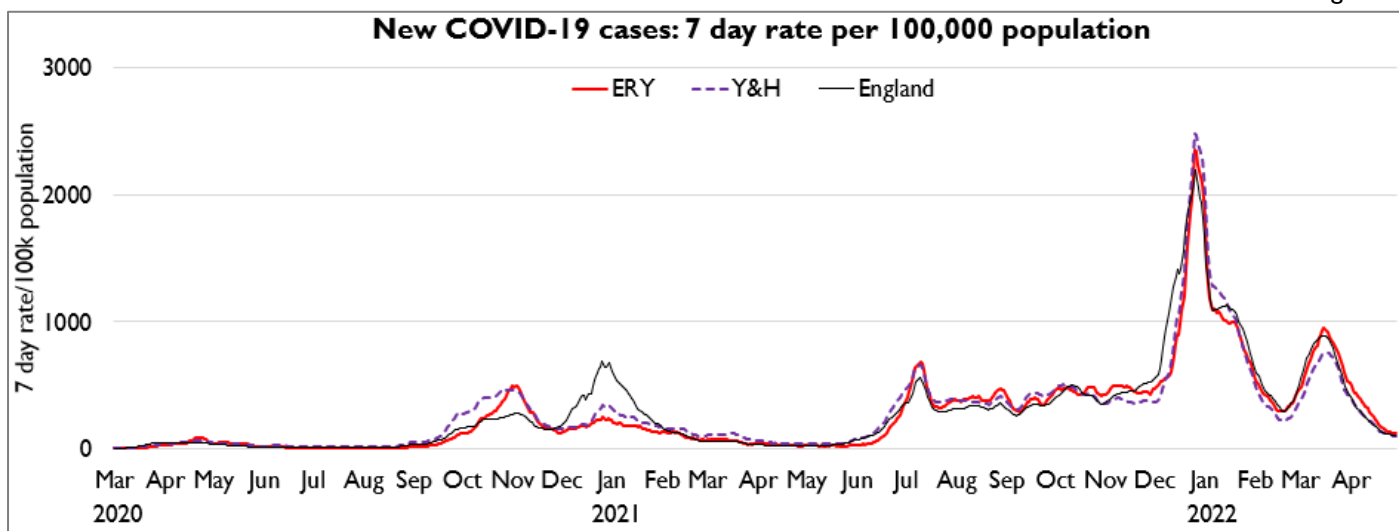


Figure 3. East Riding compared to region and England. 7 day crude rate per 100,000 population. New positive cases of COVID-19 between 2020 and 2022. Source: coronavirus.data.gov.uk



Rates of infection compared to other areas.

The main method of comparing the infection levels in the East Riding with England and other local authorities was the use of the 7 day rate per 100,000 population. Figure 3 is an example of this, which plots the East Riding 7 day rate against those of the Yorkshire and Humber region and England. The red line of the East Riding can usually be seen coinciding with the peaks and troughs of the areas it is compared against, although it is clear that in certain periods the East Riding infection rate was much higher than other parts of the country (equally it was much lower at other times). Throughout the pandemic, the consensus has often been that the East Riding was at the ‘tail end’ of increasing infection rates occurring elsewhere in the region, with our area increasing at a similar rate some week later. An example of this can be seen between September and December 2020. The highest rate of infections for the East Riding was for the 7 day period to the 4th January 2022 (the peak of the chart in figure 3) with a rate of 2,359 per 100,000 population, in contrast the region and England overall were reporting rates of 2,488 and 2,203 per 100,000 respectively for the same period.

Local community rates

Local infection rates were usually monitored at middle super output area (MSOA), which are areas containing approximately 8,000 residents. Naturally, there have been different infection rates within the local communities of the East Riding at different times throughout the pandemic, although there was no one single local area which dominated for a prolonged period of time. The monitoring of areas with the highest rates would see changes extremely quickly, for example local communities in the west of the local authority area (such as Pocklington or Stamford Bridge) might report the highest rates at a particular point in time, but within a week the highest rates would be reported in areas on the east coast.

Age of residents

Crude rates were also utilised to allow for analysis by age group, this was particularly pertinent when tracking case rates in elderly residents who are amongst our most vulnerable residents. An infection is more likely to translate into a period of hospitalisation and then potentially death, compared to younger age groups. As well as age, having certain underlying medical conditions could also make residents more likely to get severely ill with COVID-19, although this cohort of residents was more difficult to monitor from the information that was available to local authority staff.

3.2 COVID-19 related hospital admissions

Information related to COVID hospital admissions information is most readily available at hospital trust level and has been updated daily on the GOV.UK website start of the pandemic. Locally, COVID hospital admission reporting has focussed on standalone Hull University Trust Teaching Hospital (HUTH) admissions numbers and then also monitoring them combined with numbers at York Teaching Hospital (York) and Northern Lincolnshire and Goole NHS Foundation Trusts (NLAG). Please note that the patient number reported are not solely East Riding residents, the patients counted in each trust could potentially reside anywhere in the country but are being treated within that specific hospital trust.

Figure 4 shows the daily numbers and 7 day rolling average of COVID-19 patients admitted to HUTH between March 2020 and May 2021. In the early phase of the pandemic (March to June 2020) there was a maximum number of 20 admissions in a single day, whereas between October 2020 and April 2021 numbers rose to a maximum of 31 admissions per day. More recently between January and May 2022, numbers have reached 22 per day, however, as shown in figure 5 the numbers of extremely ill patients requiring invasive mechanical ventilation has reduced over the course of the pandemic, largely in part due to the impact of the vaccine.



The numbers of COVID patients in beds on mechanical ventilation reached a maximum of 17 in the early phase of the pandemic and increased to as high as 21 in November 2020, but reduced to a maximum of 5 patients in beds during May 2022. The lower proportion of mechanical ventilation patients in comparison to the overall numbers being admitted, suggests less patients being admitted are more severely ill with the virus in contrast to earlier stages of the pandemic.

Figure 4. Daily and cumulative numbers of COVID-19 patients admitted to hospital (not just ERY residents), Hull University Teaching Hospitals NHS Trust. Source: coronavirus.data.gov.uk

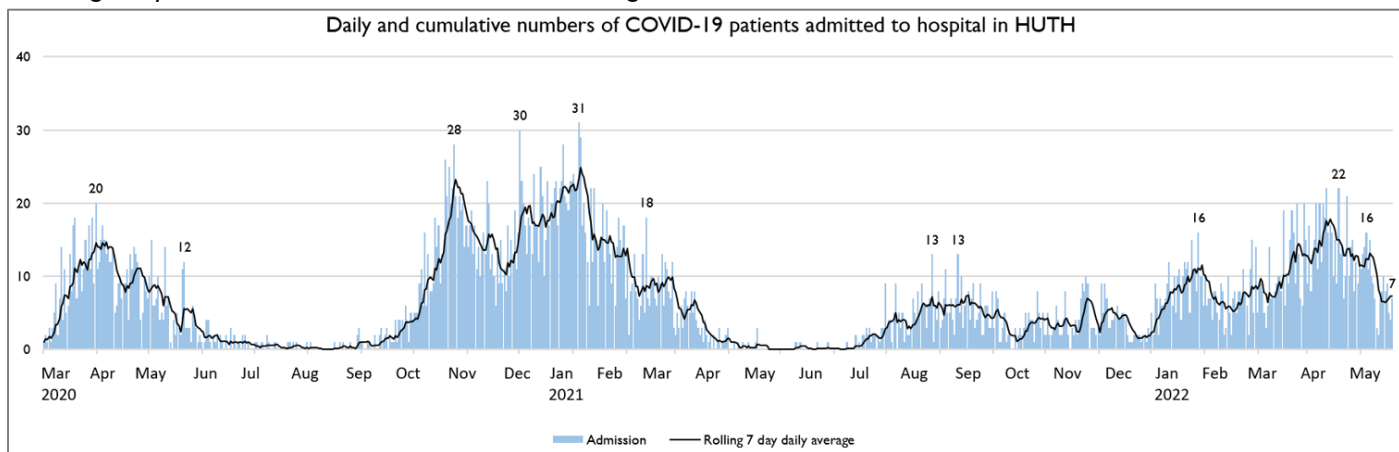
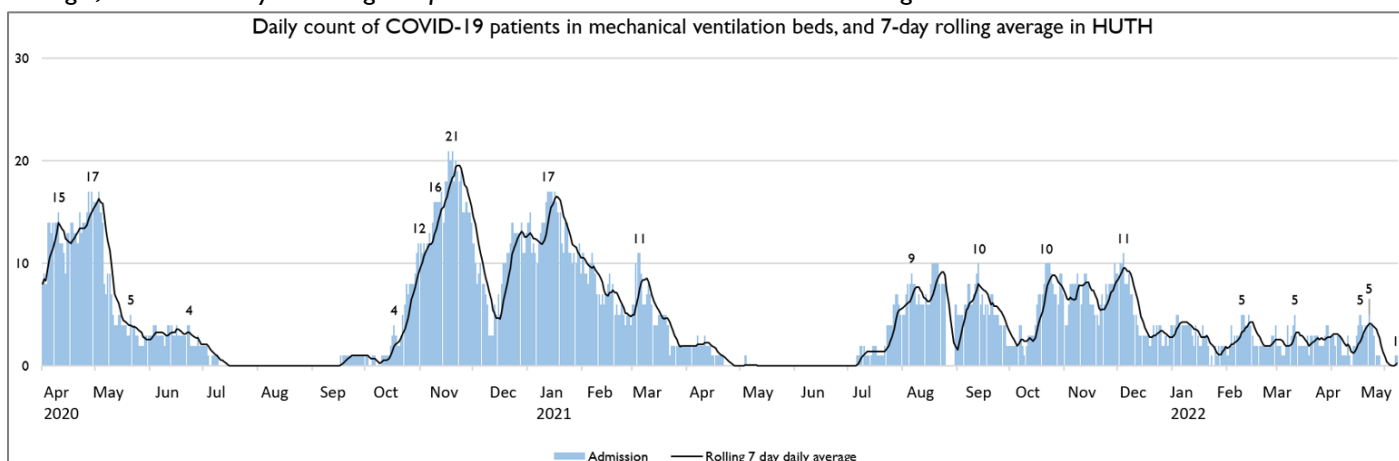


Figure 5. Daily count of COVID-19 patients (not just East Riding residents) in mechanical ventilation beds, and 7-day rolling average, Hull University Teaching Hospitals NHS Trust. Source: coronavirus.data.gov.uk



Charts for the NLAG and York can be viewed in the appendix. Note that these charts related to admissions do not show the true impact of COVID on the hospital system, as the patients admitted may remain in hospital occupying beds for many days and in some cases weeks. The charts also fail to reflect the pressure created from the measures that needed to be put in place to isolate patients, particularly those severely immunocompromised.

3.3 COVID related deaths (ONS method)

As of the 29 April 2022 there have been 1,154 East Riding resident deaths which have occurred since the start of the pandemic, whose death certificate mentioned COVID-19 as one of the causes (this is also known as the ONS method). Figure 6 shows the weekly number of East Riding COVID deaths between March 2020 and April 2022, a selection of weeks have been labelled to show the count of deaths during that week. The higher count of deaths in a single week occurred during the 1st and 2nd waves clearly defined on the chart (starting March 2020 and then October 2020 respectively). Deaths picked up again in July 2021 after a wave of new infections brought on by the Delta variant but remained lower than 2020 mainly due to the impact of the COVID vaccination programme. East Riding COVID deaths are still occurring to the present day at, on average, 7 per week since January 2022.



Figure 6. East Riding residents: weekly deaths whose death certificate mentioned COVID-19 as one of the causes.

Source: coronavirus.data.gov.uk

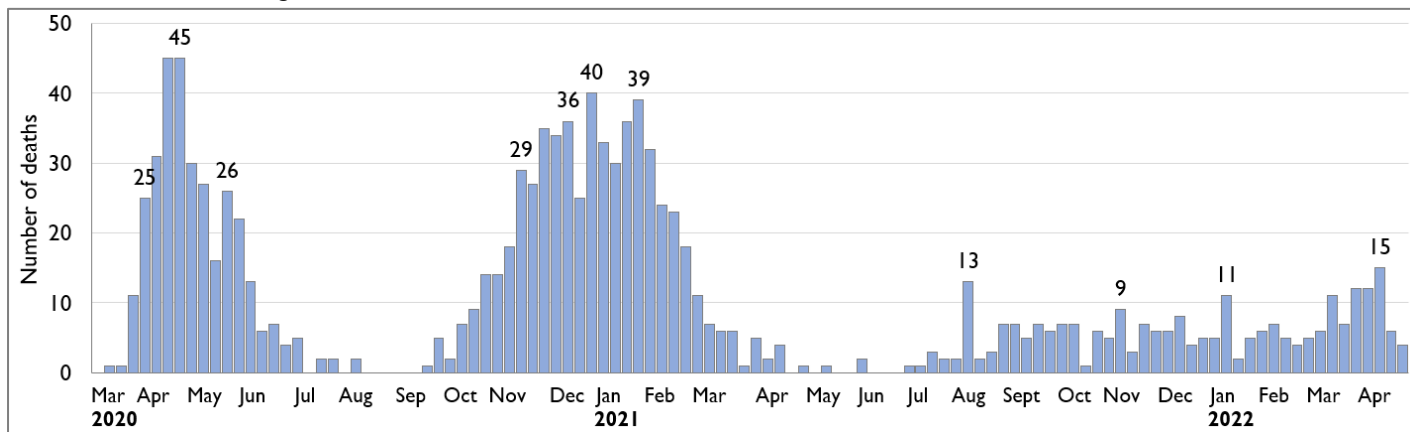


Figure 7 shows the location of the East Riding COVID deaths, where the death actually occurred (note that a care home resident who died in hospital would be classified as hospital death in this instance). Most deaths, at almost 60% (n=688), occurred in a hospital setting whilst care homes accounted for the 2nd highest count (31%, n=358).

Figure 7. East Riding residents: weekly deaths whose death certificate mentioned COVID-19 as one of the causes

Source: coronavirus.data.gov.uk

Location	Number of deaths	Deaths
Hospital	688	59.6%
Care home	358	31.0%
Home	76	6.6%
Hospice	19	1.6%
Elsewhere	7	0.6%
Other communal establishment	6	0.5%
Grand Total	1,154	100%

Figure 8. East Riding count of deaths by age group where death certificate mentioned COVID-19 as one of the causes

Source: coronavirus.data.gov.uk

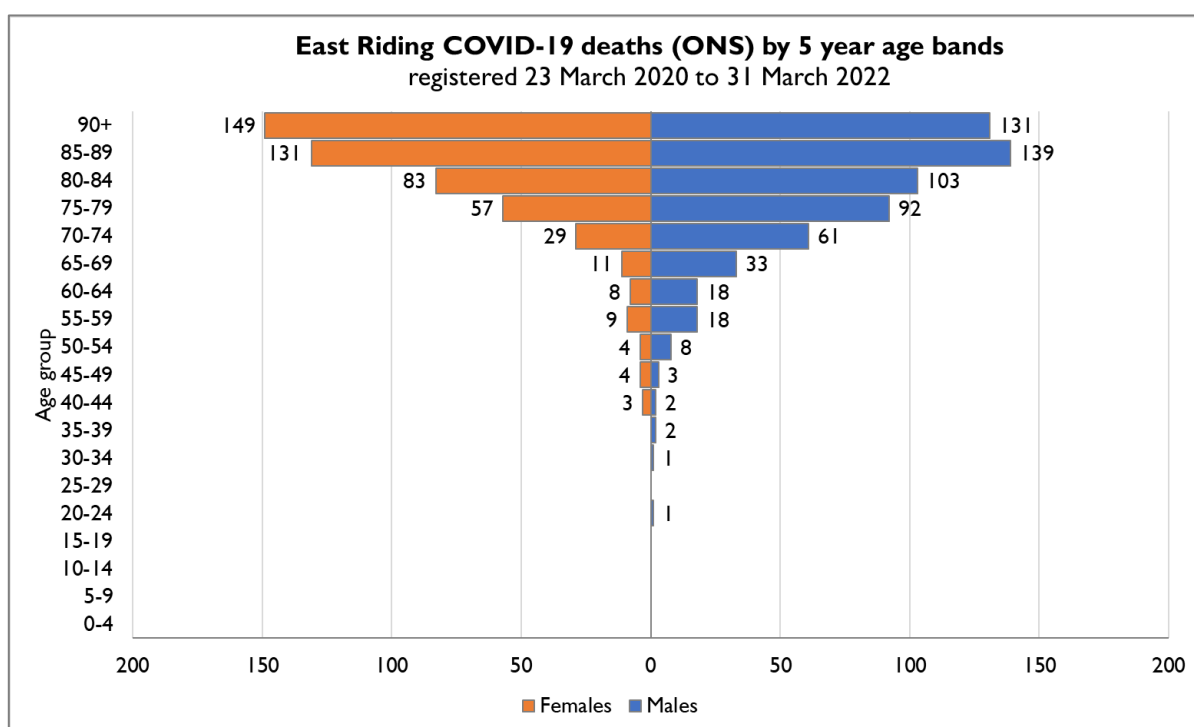
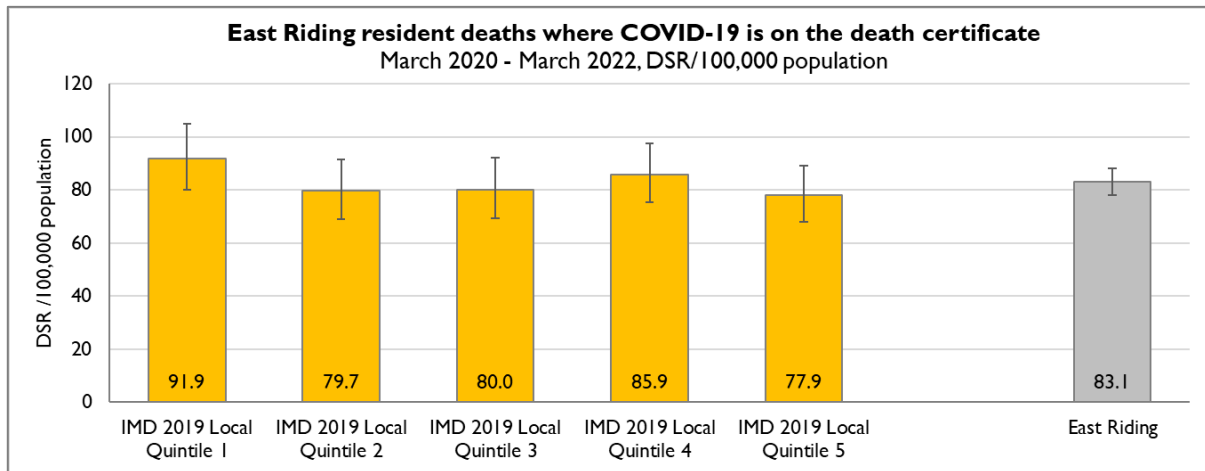


Figure 9. East Riding residents directly standardised rate per 100,000 population by local IMD 2019 deprivation quintile whose death certificate mentioned COVID-19 as one of the causes. Source: ERY PHI / NHS Digital



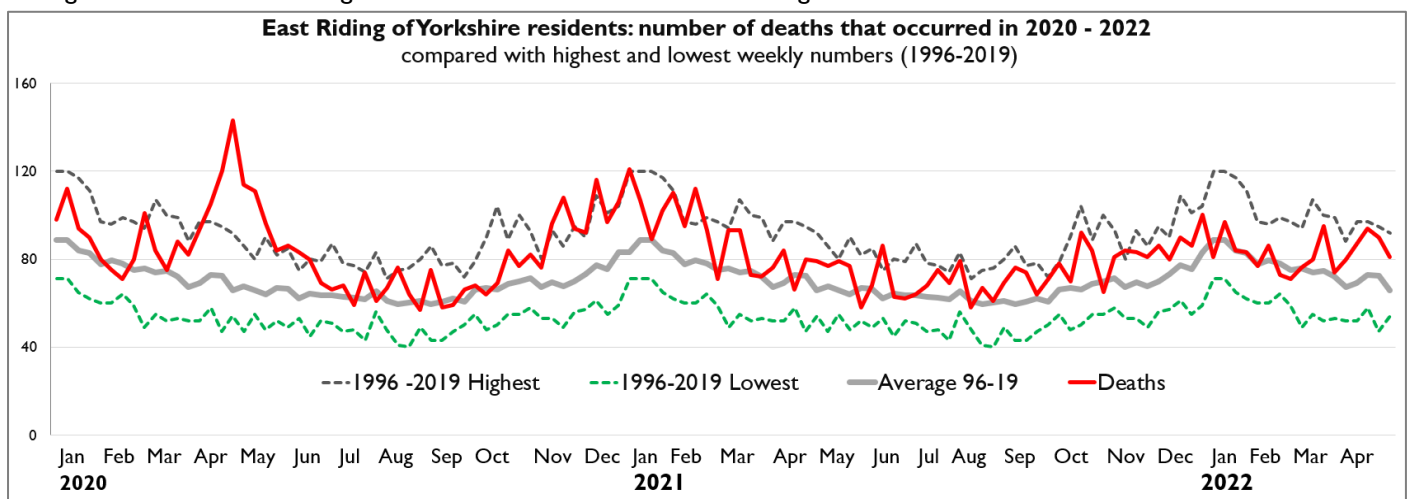
3.4 Excess deaths (ONS method)

Excess deaths refers to the number of deaths from ‘all causes’ (not just COVID-19) during the pandemic, that were above and beyond what was reported pre-pandemic. In other words, this tells us how deaths during the COVID-19 pandemic compare to the average number of deaths over the same period in previous years. Monitoring excess deaths (as opposed to just confirmed COVID specific deaths) captures those COVID-19 deaths that were not correctly diagnosed or reported as such and will include deaths from other causes attributable to the overall pandemic. It is considered a more comprehensive measure of the total impact of the pandemic on mortality.

Figure 9 illustrates how the weekly deaths (red line) in 2020 through to 2022, compare with the average, minimum and maximum number of deaths for the same period between 1996 and 2019. Throughout the pandemic the weekly death count of 2020-22 has largely been higher than the 1996-19 average but remained within the maximum weekly count. There were obvious exceptions, however, most notably the 2 month period of April and May 2020 when deaths in that period exceeded the maximum deaths previously experienced between 1996 and 2019 for those specific weeks.

The peak of deaths in the pandemic occurred in week 17 (week ending Friday 24 April 2020) with a total of 143 East riding resident deaths during the 7 day period, 77 more deaths than the average number for that week between 1996-19. Other notable periods of excess deaths occurred during November 2020 through to January 2021.

Figure 10. East Riding resident number of weekly excess deaths that ‘occurred’ in 2020-2022 compared to weekly average/min/max deaths during 1996-2019. Source: ERY PHI / NHS Digital/ONS



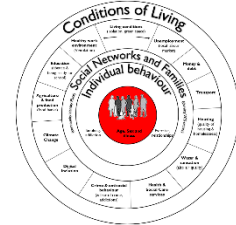
3.5 Long-term effects of COVID-19 (long COVID)

The ongoing effects of the virus on individuals after the end of the acute infection stage has been widely reported and has been termed 'long COVID'. These prolonged symptoms and complications affect individuals in different ways and for different lengths of time. The symptoms that have been reported include fatigue (the most common symptom according to the ONS), headaches, breathlessness, coughing and 'brain fog' (a cognitive impairment). There has also been emerging evidence of organ damage.

ONS (2022) estimate that as of 2nd January 2022, "1.3 million people living in private households in the UK (2.1% of the population) were experiencing self-reported long COVID (symptoms persisting for more than four weeks after the first suspected coronavirus (COVID-19) infection that were not explained by something else)".

Nationally, models have been produced attempting to estimate the prevalence of long COVID within smaller geographies such as local authority areas, however the different models have produced extremely varying results were difficult to report with any degree of confidence. In March 2022 OHID paused/ceased development of its own 'Post Acute COVID-19' model (made available to local authority analytical teams) due to the reduction of population wide testing and the lack of quality research data that has been published that might inform the model. We would envisage that as the detection and categorisation of long COVID improves over time, then it's prevalence will be more consistently reported in the future.





4 Age, sex and illness

4.1 Impact of COVID-19 on length of life

Put simply, life expectancy is an estimate of the average number of years a newborn baby would expect to live, based on the age-specific mortality rates of a particular place (e.g. country, local authority or ward) at a particular point in time. It is always produced separately for males and females, as opposed to one overall 'person' estimate. Whilst there are many ways to examine and quantify health and health inequalities (see later in this section for a spotlight on the latter), the key measure of the status of a population's health most often used is 'life expectancy'. The Kings Fund (2020) state it is one of the foremost measures of inequality and is closely related to people's socio-economic circumstances.

4.1.1 Impact of COVID-19 on life expectancy (East Riding overall)

To date, there have been numerous studies and papers on the impact of COVID-19 on life expectancy, one of which (Aburto et al, 2021) found that life expectancy decreased between 2019 and 2020 in 27 out of 29 countries analysed and they went on to state:

“The COVID-19 pandemic triggered significant mortality increases in 2020 of a magnitude not witnessed since World War II in Western Europe or the breakup of the Soviet Union in Eastern Europe.”

Normally life expectancy is shown in 3-year pooled periods, however recently OHID has released single year life expectancy figures on their Fingertips website for England overall and local authorities. Single year figures enable us to see more clearly the impact of COVID-19 on life expectancy. A summary of the key points comparing life expectancy in 2019 and 2020 can be found below in table 4.2.1. Life expectancy has fallen for males and females in both the East Riding and England overall. In 2020, East Riding life expectancy remains higher (i.e. better) than England, but not significantly, for both males and females.

Figure 11. Life expectancy at birth, comparing 2019 and 2020

Area and gender	Year		+/-	Comment
	2019	2020		
ERY males	80.7 yrs	79.2 yrs	-1.5 yrs	Statistically significant difference
ERY females	83.8 yrs	83.1 yrs	-0.7 yrs	Not significantly different
England males	80.0 yrs	78.7 yrs	-1.3 yrs	
England females	83.6 yrs	82.6 yrs	-1.0 yrs	

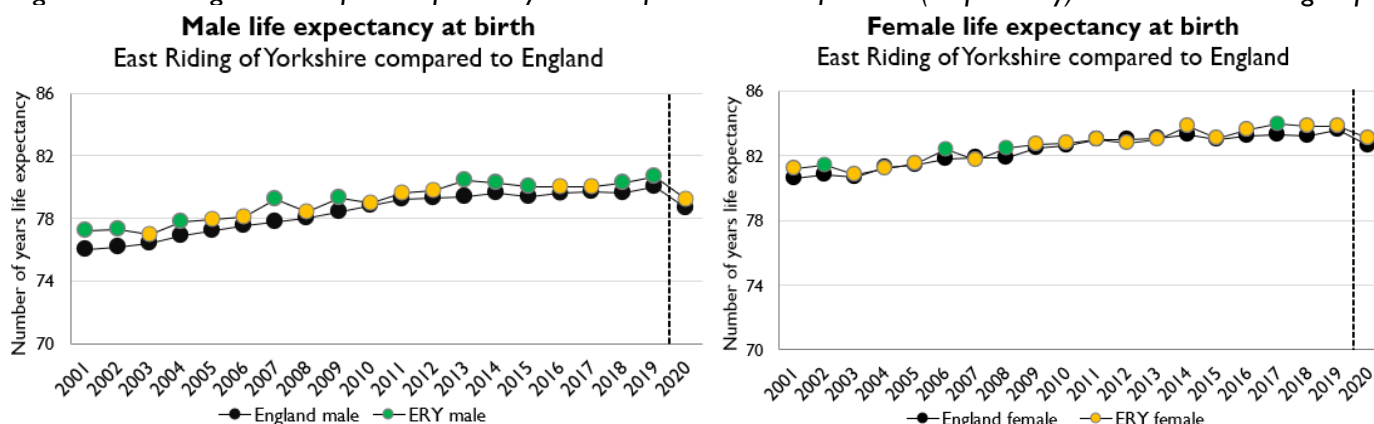
On the next page there are 2 charts relating to life expectancy at birth (1 each for male and female) comparing the East Riding to England overall, between 2001 and 2020.

- Chart markers that are coloured green indicate that East Riding life expectancy for that year is significantly higher (i.e. better) than England;
- Chart markers that are amber coloured indicate no significant statistical difference.



The reduction in life expectancy between 2019 and 2020 (separated by the vertical black dotted line) is clearly visible with the downward direction of the line between those 2 years.

Figure 12 and Figure 13. Life at expectancy at birth for males and females (respectively). Source: OHID Fingertips



4.1.2 COVID and inequalities in life expectancy

The previous section considered the impact of COVID-19 on the East Riding overall, but as is often found, an impact on a populations health and wellbeing is more acutely affected in certain communities as opposed to others. Life expectancy analysis was conducted on the local deprivation quintiles of the East Riding for both males and females, comparing life expectancy in 2016-18 (the 3 year period prior to COVID-19) and 2019-21 (which largely covers the period during the pandemic). The results are shown in chart/table 4.3.1 for males and chart/table 4.3.2 for females.

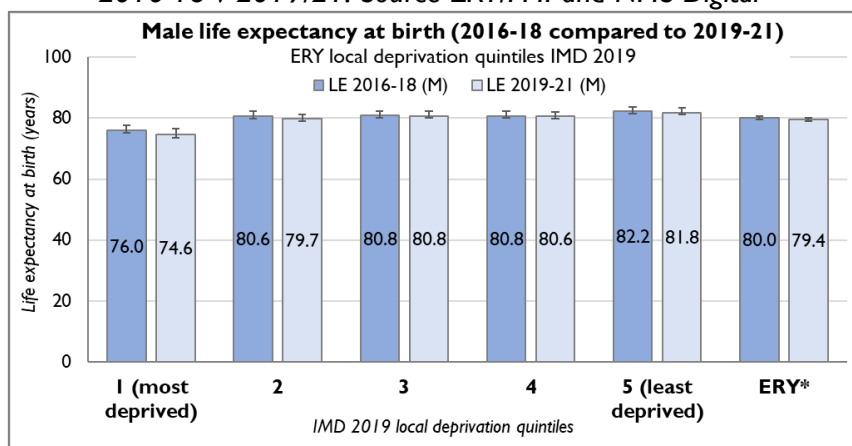
Across all quintiles, life expectancy largely fell between the 2 periods (there were 2 quintiles in which it remained the same), however the biggest drop in life expectancy was felt within the more deprived quintiles. A summary can be found below:

- Males: the biggest drop in life expectancy occurred within the most deprived quintile with a drop of 1.4 years (from 76.0 years to 74.6), compared to the least deprived quintile which reduced by 0.4 years
- Females: life expectancy reduced most in the 2nd most deprived quintile, falling by 1.3 years (from 84.8 years to 83.6 years), by comparison the least deprived quintile fell by 0.1 years.

Analysis was also conducted at an East Riding ward level, highlighting the difference between 2016-18 and 2019-21, this can be viewed in table A.1 in Appendix I.



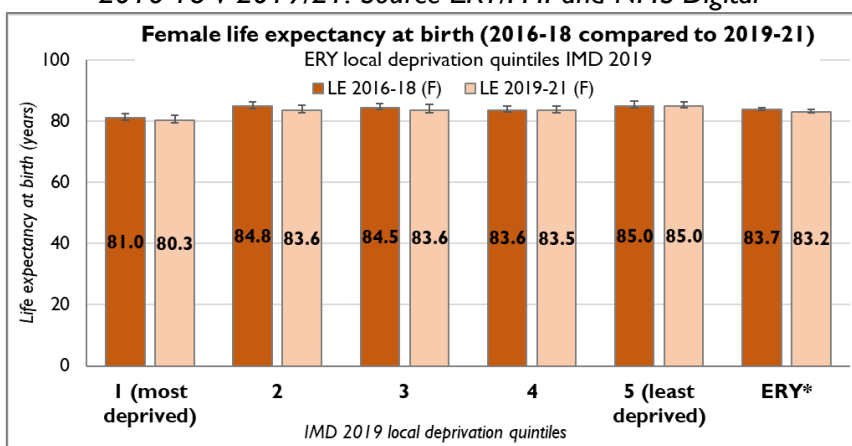
Figure 14. Male life expectancy at birth by ERY local deprivation quintile. 2016-18 v 2019/21. Source ERY/PHI and NHS Digital*



Local Quintile	Male life expectancy at birth (years)		
	2016-18	2019-21	Difference
1 (most deprived)	76.0	74.6	-1.4
2	80.6	79.7	-0.9
3	80.8	80.8	-0.1
4	80.8	80.6	-0.1
5 (least deprived)	82.2	81.8	-0.4
ERY*	80	79.4	-0.6

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Figure 15. Female life expectancy at birth by ERY local deprivation quintile. 2016-18 v 2019/21. Source ERY/PHI and NHS Digital*



Local Quintile	Female life expectancy at birth (years)		
	2016-18	2019-21	Difference
1 (most deprived)	81.0	80.3	-0.7
2	84.8	83.6	-1.3
3	84.5	83.6	-0.9
4	83.6	83.5	-0.1
5 (least deprived)	85.0	85.0	-0.1
ERY*	83.7	83.2	-0.6

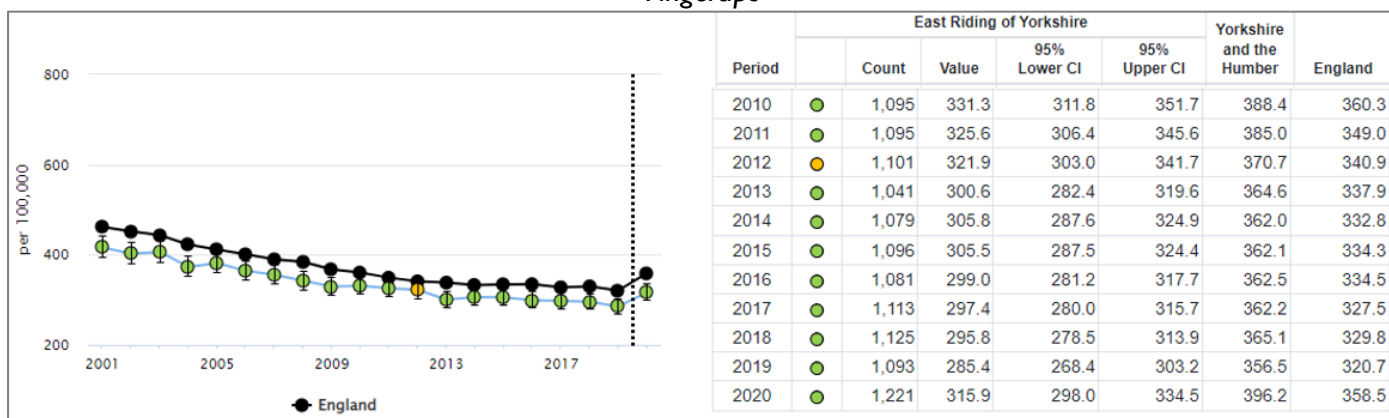
* Copyright © 2022, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.



4.2 Premature death from all causes

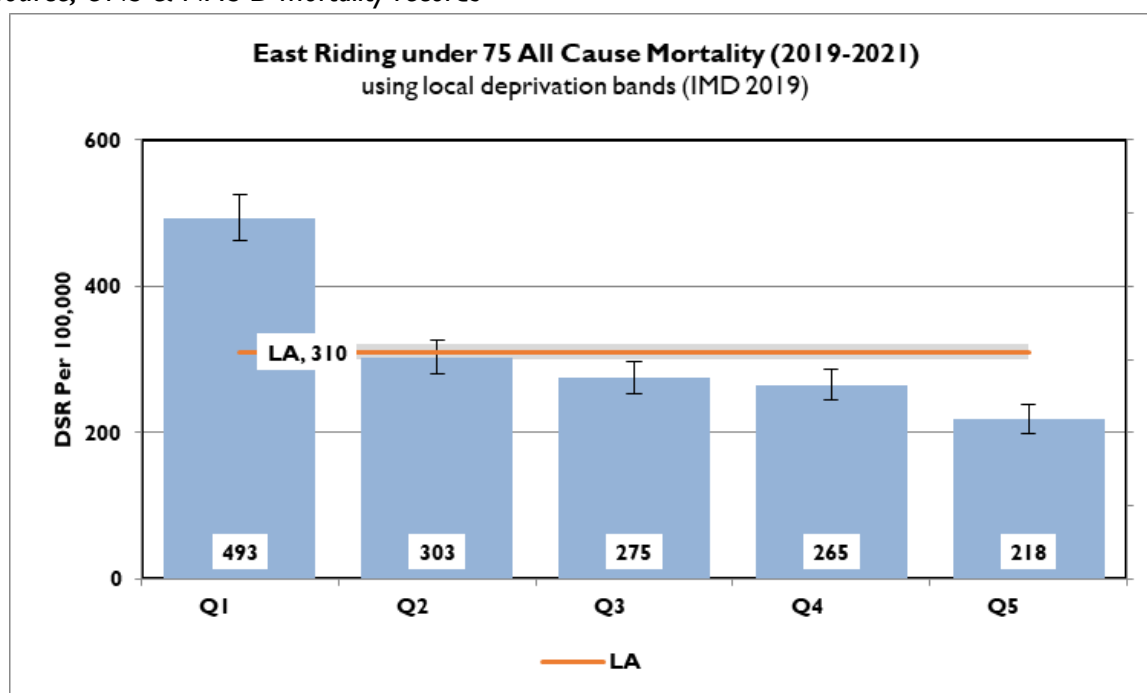
Premature mortality (those dying before the age of 75 years of age), has increased since the start of the pandemic, in contrast to the historic trend of premature death which had been decreasing. Chart 4.4.1 below displays the East Riding and England premature mortality rate before the pandemic in 2019 (left of the black dotted line) and the rate in 2020 (right of the dotted line). Between the 2 periods, the East Riding rate rose from 285.4 per 100,000 population to 315.9 (based on an increase from 1,093 East Riding premature deaths to 1,221). The mortality rate for England overall also increased (shown by the black line) and remains significantly higher (i.e. worse) than the East Riding.

Figure 16 Premature mortality (all cause/all person) directly standardised rate per 100,000 population. Source: Fingertips



However, the burden of premature deaths has not been felt evenly in society. Those residing in the most deprived quintile (Q1) have seen the far highest rate of premature death, indeed more than double the standardise rate of the least deprived quintile. Quintiles 4 and 5 both have significantly lower than the East Riding average premature mortality rate as shown in chart 4.4.2.

Figure 17 Premature mortality DSR per 100,00 from all causes pooled between 2019-2021 by deprivation local quintile. Source; ONS & NHS D mortality records



4.3 Cancer

With the interruption of many mainstream health care services in the wake of the pandemic. Screening service for cancer programmes including breast, cervical and bowel were affected. The impacts across programmes was not consistent with breast and cervical being more determinately effective due to the screening methods when compared with bowel for example. Access to mammography machines was stopped for several months in 2020 similarly sexual health clinics and General Practice were not accessible to the population for cervical smears. This undoubtedly will have been felt unequally in society, areas covered by slower responding sexual health clinics and practices will have great burden of consequences for access to this service.

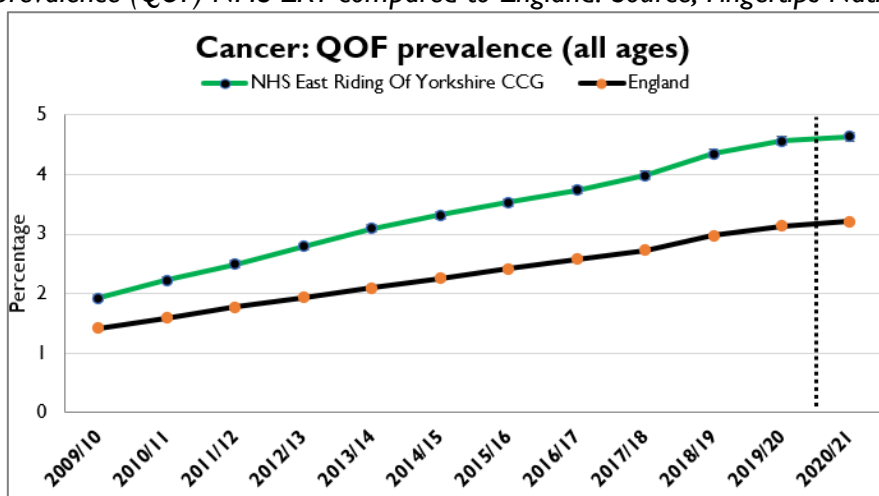
Pre-pandemic the area was wrestling with increasing levels of cancer found via the two week wait pathway as well as increase emergency presentations. Whilst these will include the breath of cancer the subset that are covered by a screening programme due to the pandemic will add to this later presentation of cancer, given the restricted access to screening programmes. The consequence for the lower access to services is a cohort of missed patients, an increased waiting list and a likely increase 2 week referral pathways and emergency presentations at a later stage of cancer, this sadly will undoubtedly lead to deteriorated in 5-10 year survival levels from cancer and an increase in mortality from cancer in the coming years

4.4 Cancer prevalence

Pre-pandemic Cancer prevalence was rising in the county, this pattern follows national trajectory though the county has long maintained a greater prevalence of cancer than the national average. The East Riding in normal years follows a growing trajectory of around 0.5% per year. In the most recent periods this has slightly flattened which is suspect to be a direct consequence of the pandemic and the access and closure of screening programmes and restricted access to primary care for a period 2020.

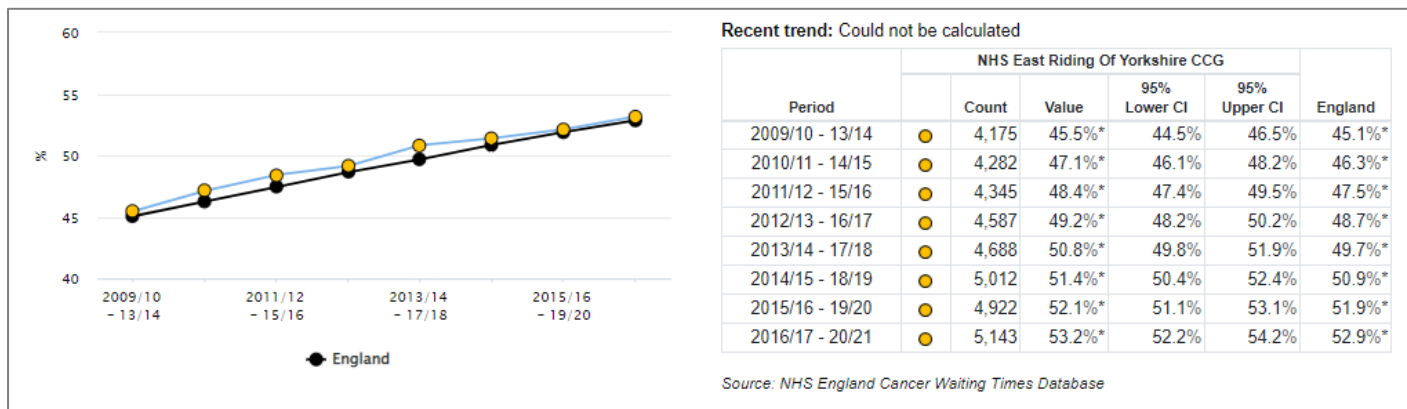
The black dotted line in the chart shows the approximate period of when COVID-19 appeared. The NHS ERY CCG prevalence of cancer in 2019/20 was 4.6% (England was 3.1% in the same year) and in 2020/21 it was 4.6% (England = 3.2%).

Figure 18. Cancer prevalence (QOF) NHS ERY compared to England. Source; Fingertips National Practice Profiles



Over time the rate of diagnosis of new cancer has increased across the area, the area has similarly followed the national pattern of increase. The two-week pathway is more likely to be in response to symptoms, discussed with a health practitioner. This can often result in disease presenting later than picked up via screening programme. Please note, that the 5-year pooled periods used in figure 28 make it difficult to place a ‘before and after start of COVID’ marker within the chart.

Figure 19 New Diagnoses of Cancer as a result of a Two Week Wait pooled 5-year proportions to 2015/16-2019/20 for NHS East Riding CCG patients. Source: Fingertips



Pre-pandemic the East riding was seeing a rise in emergency presentations from a consistently higher than national average place. Indeed pre-pandemic the national trajectory was a decreasing pattern year on year for emergency presentation, East Riding was not following this, conversely the area is seeing a rising trajectory, indicating that there are barriers in people seeking an early point of cancer diagnosis. Figure 29 presents the rate of emergency presentations by NHS ERY CCG practice.

Figure 20 Emergency presentations for Cancer. Source: Fingertips National Practice Profiles

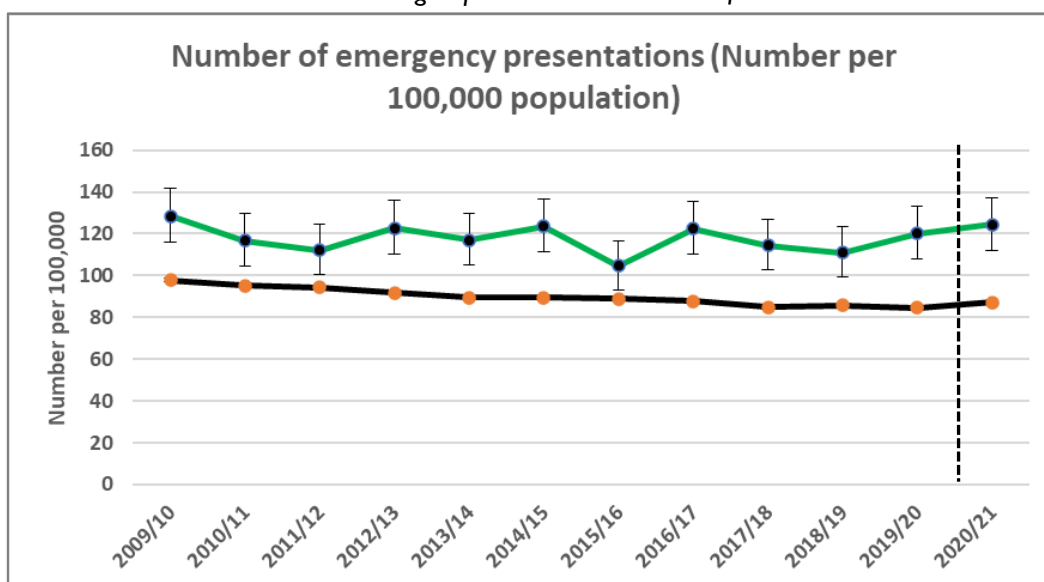
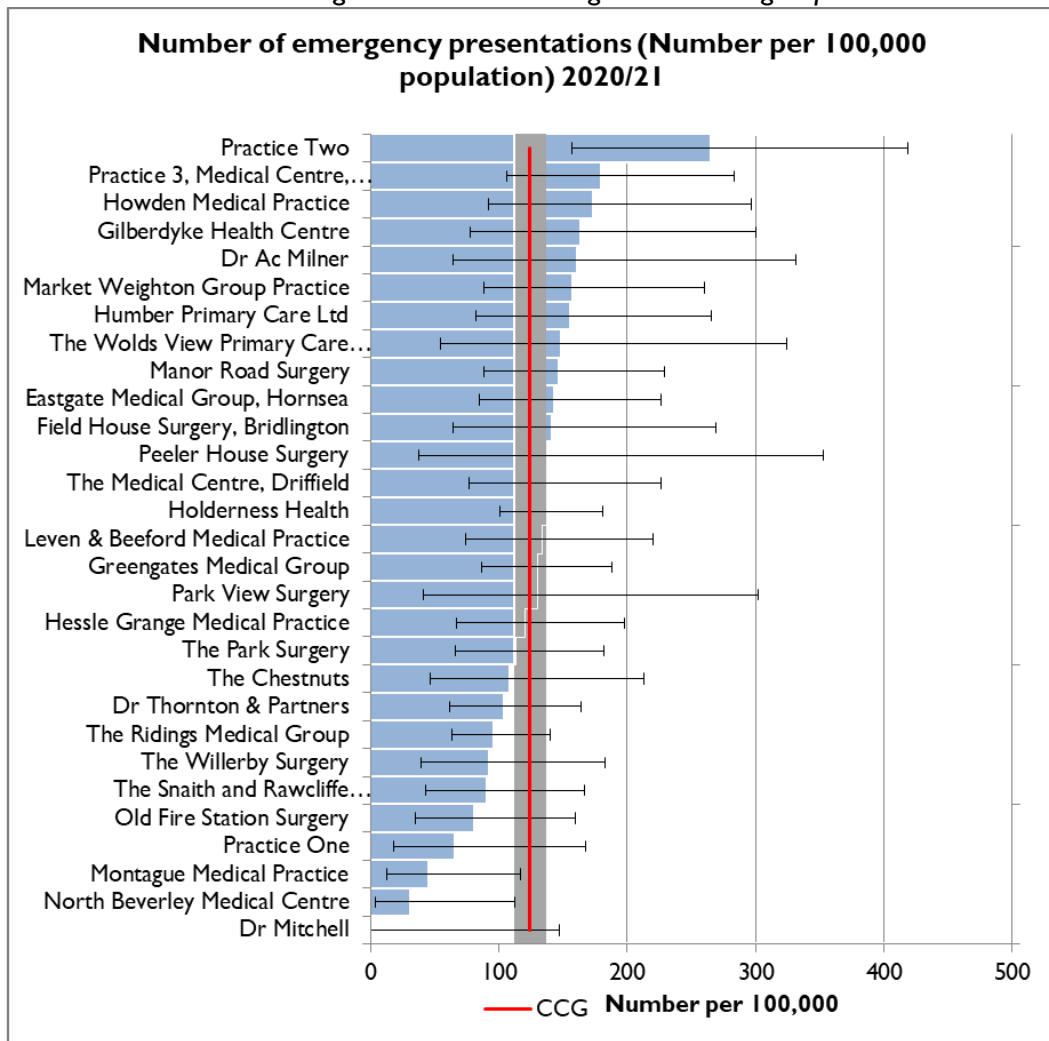
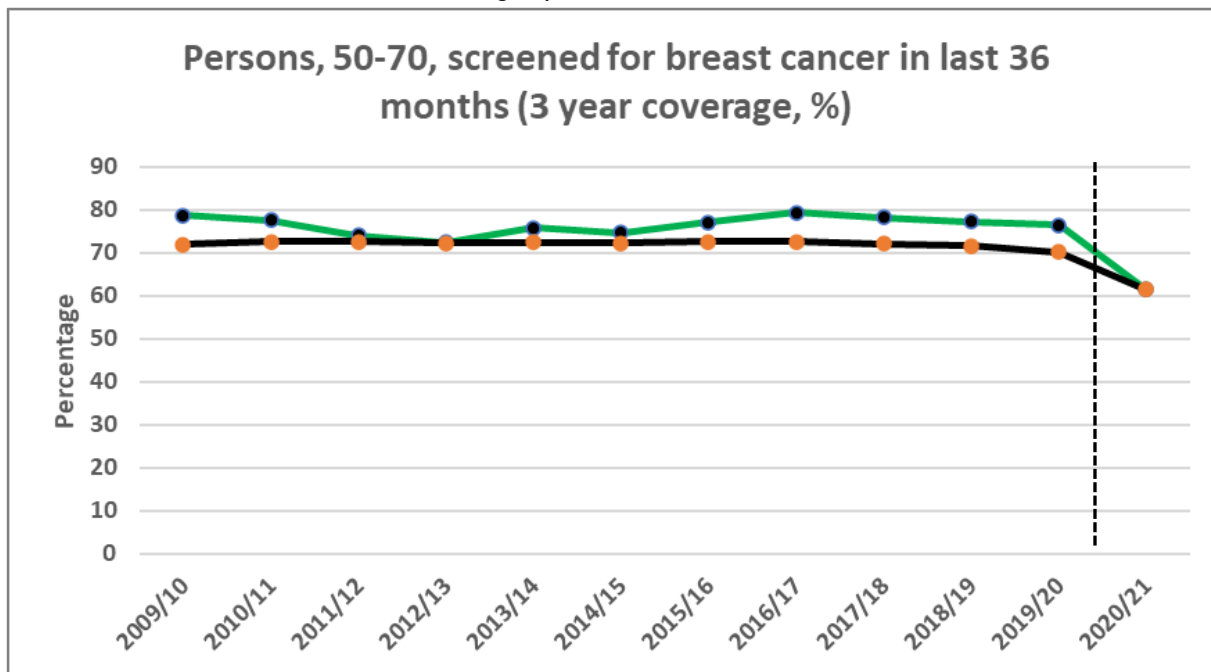


Figure 21 Emergency presentations for Cancer in 2020/21 by General Practice shown against the CCG average. Source: Fingertips



As mentioned in the previous paragraph, as by way of demonstrating the pandemic’s impact on screening, figure 31 below, shows the depression in coverage of females attending breast screening. This pattern is mirrored across bowel and cervical cancer screening programmes.

Figure 22 Screening coverage for Breast Cancer 3 year pooled to 2020/21.
Source: Fingertips National Practice Profiles



4.5 Cancer Staging Diagnosis Changes

The following analysis contains the HUTH an NLaG trust data. For the time period pre COVID has been defined as Apr 2017 – March 2020, the post COVID period is Apr 2020 – May 2022 .

Table 1 Showing the change in pre and post COVID % of Cancer by stages 1&2 and 3&4

Site	Stage 3&4 PreCOVID	Stage 3&4 PostCOVID	All Stages - PreCOVID	All Stages PostCOVID	% Diagnosed at stage PreCOVID	% Diagnosed at stage PostCOVID	Change
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	3	1	22	5	13.6%	20.0%	6.4%
brain/central nervous system tumours	2	2	2	3	100.0%	66.7%	-33.3%
breast cancer	20	61	419	380	4.8%	16.1%	11.3%
gynaecological cancers	5	1	8	1	62.5%	100.0%	37.5%
haematological malignancies (excluding acute leukaemia)	3		3	0	100.0%	0.0%	-100.0%
head & neck cancers	73	70	175	147	41.7%	47.6%	5.9%



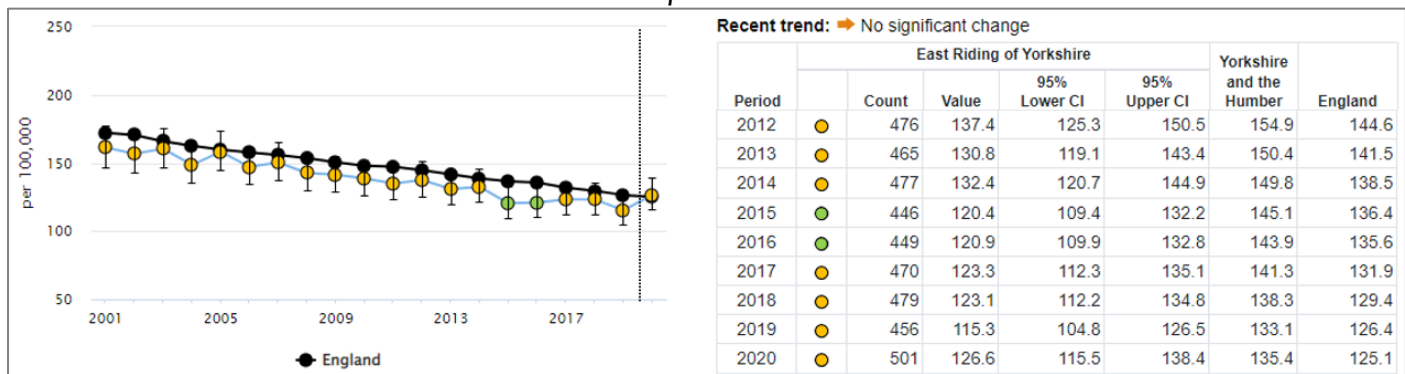
lower gastrointestinal cancers	349	270	526	413	66.3%	65.4%	-1.0%
lung cancer	207	194	435	355	47.6%	54.6%	7.1%
skin cancers	92	106	1045	601	8.8%	17.6%	8.8%
testicular cancers	1		11	8	9.1%	0.0%	-9.1%
upper gastrointestinal cancers	168	88	219	118	76.7%	74.6%	-2.1%
urological cancers (excluding testicular)	222	165	673	445	33.0%	37.1%	4.1%

Looking at the above table it can be seen that various cancer sites have seen an increase in the proportion of the population being diagnosed at the latest stages of three and four. Large cancer areas such as breast and gynaecology along with head neck long and urological cancers have seen an increase when comparing the proportion of people diagnosed at later stages pre pandemic and against those post pandemic.

4.6 Premature cancer mortality

The generally declining trend of premature cancer mortality in the East Riding, was halted in 2020 with the biggest increase in rate between 2 individual years since 2001, as shown in figure 9. The rate increase between 2019 (115.3 per 100,000 population) and 2020 (126.6 per 100,000) moved the East Riding rate above the national rate for the first time within the period of data shown on the chart. Whilst the rate was higher than England, it was not significantly higher. The dotted line on the chart separates the years 2019 and 2020

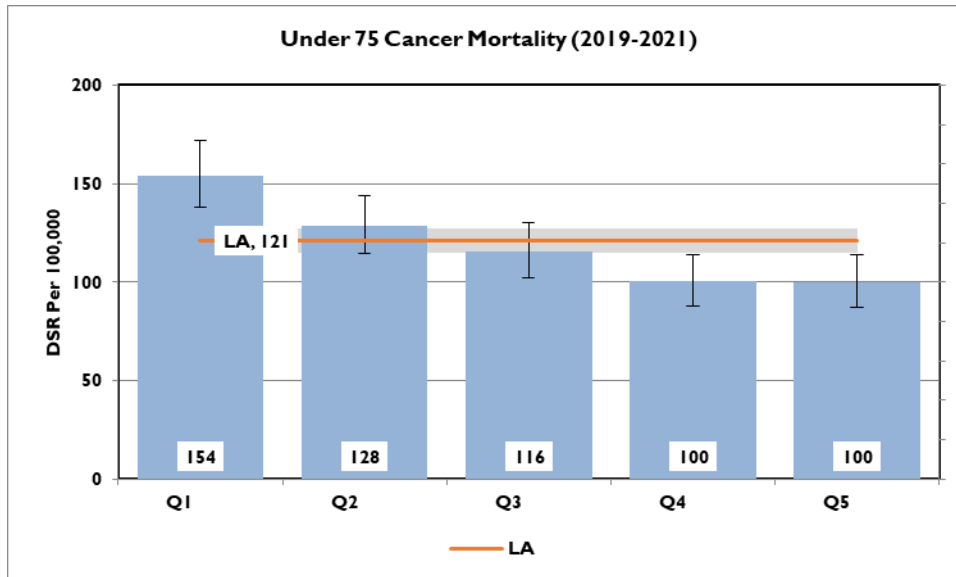
Figure 23. Premature mortality DSR per 100,00 from Cancer pooled between 2019-2021 by deprivation local quintile



As highlighted the premature all-cause mortality section, the burden of premature deaths from cancer has not been felt evenly in society. Figure 10 shows premature cancer mortality for the 3 year period 2019-21. The gradient is not as steep as that seen in all-cause mortality highest and least deprived, however there is still significant variation. Those residing in the most deprived quintile (Q1) have seen the far highest rate premature deaths, significantly higher than the East Riding average. Conversely both quintile 4 & 5 have seen significantly lower levels.

Figure 24. Premature mortality DSR per 100,00 from Cancer pooled between 2019-2021 by deprivation local quintile. Source; ONS & NHS D mortality records



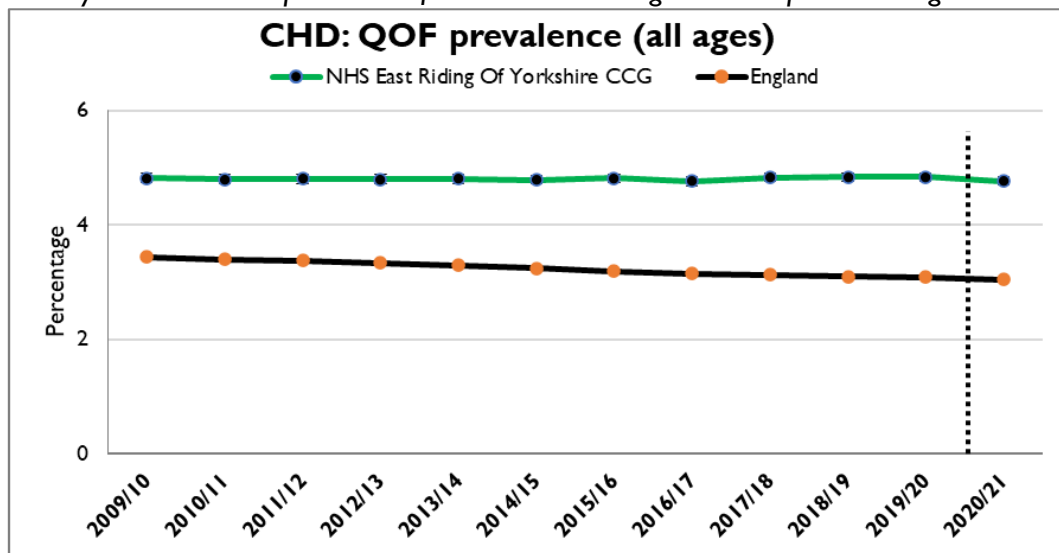


4.7 Cardiovascular Disease (CVD)

4.8 Cardiovascular Disease Prevalence

Cardiovascular disease (CVD), encompassing, hypertension, stroke, and heart diseases as proportions of the population are growing nationally and locally year on year. Stroke, Hypertension and Atrial Fibrillation registers are increasing, Coronary Heart Disease (CHD) remains flat at just under 5%. Nationally the prevalence has decreased over time. The East Riding as a whole has higher level of cardiovascular disease when compared to the national levels. For the most part this pattern has been growing at a faster rate within the East Riding than national levels, demonstrating a growing burden of ill health in the East Riding and demand on the health and care system from the basket of conditions that make up cardiovascular disease. Figures 10 shows the prevalence of CHD for NHS East Riding CCG compared to England.

Figure 25 Coronary Heart Disease prevalence for NHS East Riding CCG compared to England. Source: Fingertips

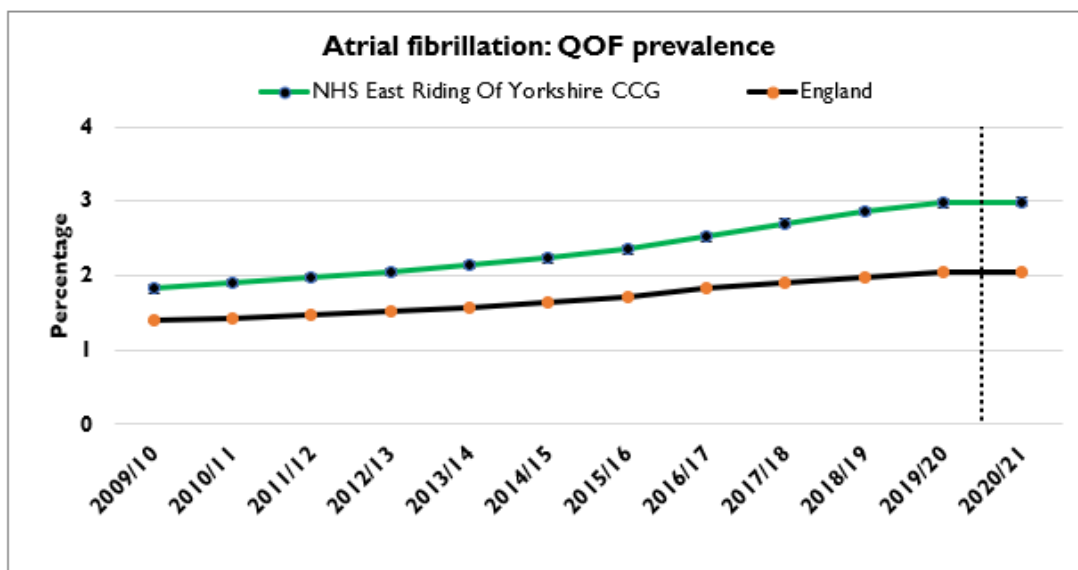


The East Riding for many years has had a higher prevalence of the CHD in the population, holding at just under 5% of the 18+ population being on the CHD register. In the years displayed in figure 11, the national trend has been a slowly decreasing one, from just over 3.5% to just above 3%. The prevalence trend for both the East Riding and England have continued uninterrupted between 2019/20 and 2020/21 (shown by black dotted line).



Atrial fibrillation nationally and locally has been rising over the last decade. East Riding in the most recent years has risen faster than the national prevalence levels but in both 2019/20 and 2020/21 (split by the black line) the prevalence has remained the same at around 3%.

Figure 26 Atrial fibrillation prevalence for NHS East Riding CCG compared to England. Source: Fingertips



On the next page, figure 12 is the practice distribution of patients registered with heart failure in 2020/21 against the East Riding CCG average. Practice 3 in Bridlington has significantly higher than ERY average prevalence of heart failure at over 2.5%. Park view surgery has significantly lower prevalence at less than 0.5% prevalence of heart failure. Given this is simple prevalence practices with older populations are more likely to have greater proportions. The prevalence is those on the heart failure register as a proportion of the total practice population.

Also on the next page is the practice distribution of patients registered with stroke in 2020/21 against the East Riding CCG average, shown in figure 13. Humber Primary Care has significantly higher than ERY average prevalence of stroke at near 3.5%. Park view surgery has significantly lower prevalence at near 1.5% prevalence of heart failure. Give this is simple prevalence practices with older populations are more likely to have greater proportions. The prevalence is those on the heart failure register as a proportion of the total practice population.



Figure 27 Heart Failure prevalence by practice 2020/21. Source; Fingertips National Practice Profiles

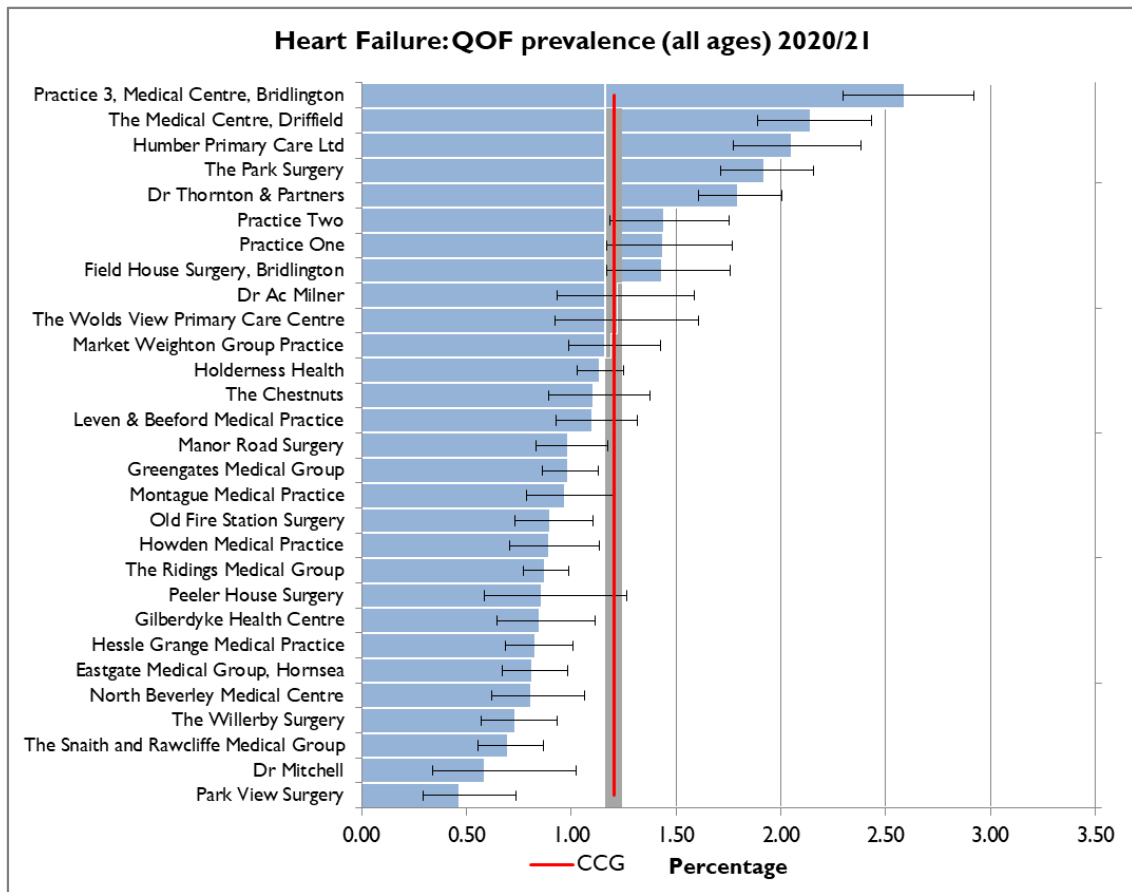
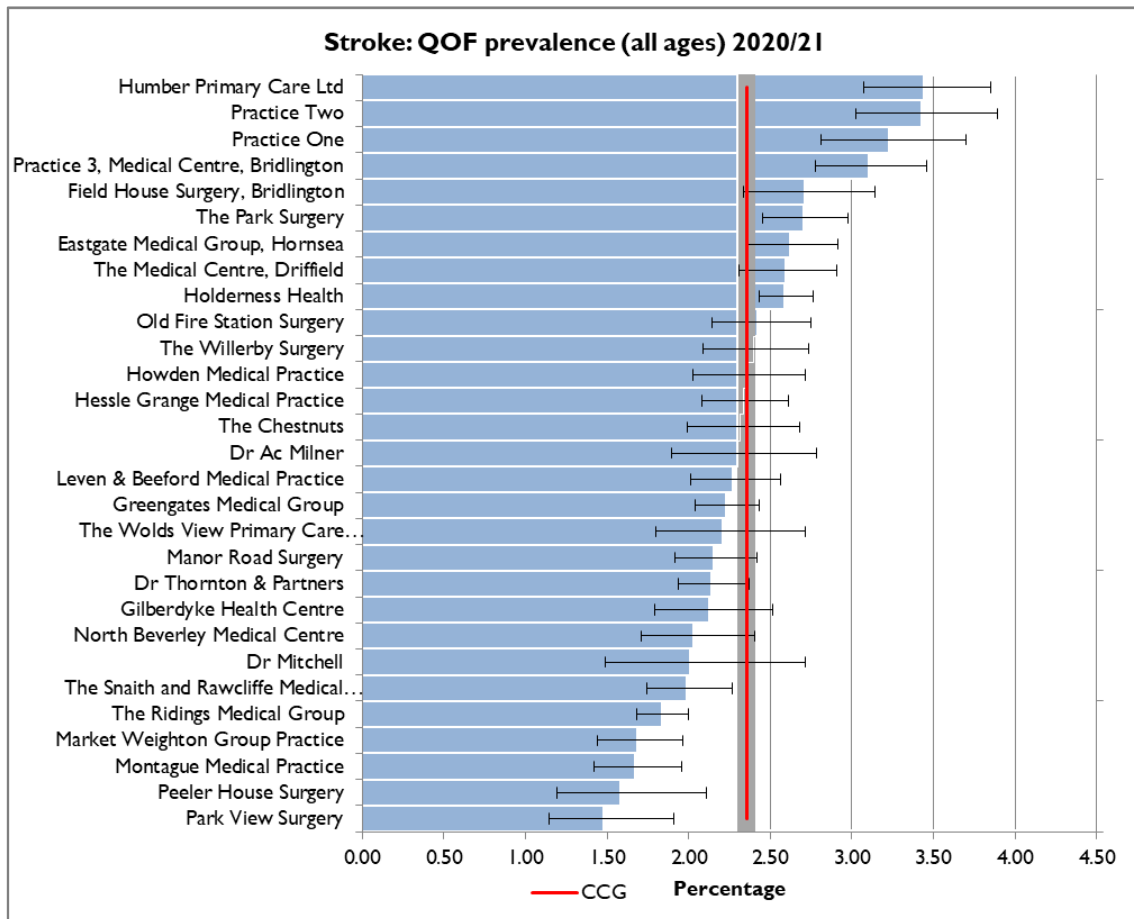


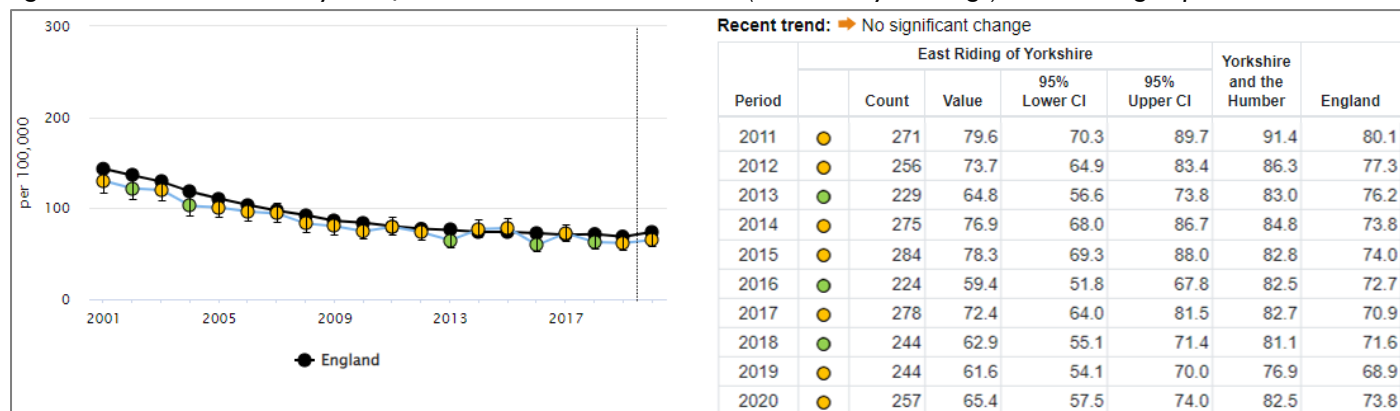
Figure 28 Stroke prevalence by practice 2020/21. Source; Fingertips National Practice Profiles



4.9 Cardiovascular Disease Premature Mortality

Premature mortality from CVD has been on a downward trend both national and locally for the past 20 years, although this has more recently flattened out. The East Riding has followed a similar rate of change over time as the national average and both encountered an increase between 2019 and 2020 (as shown in figure 14).

Figure 29 Under 75 mortality rate from all cardiovascular diseases (Persons, 1 year range). Source: Fingertips



However, this rate of change is not equal over the county, the following show the electoral ward and Indices of Multiple Deprivation (IMD) 2019 Quintiles for the East Riding. Figure 15 below, shows the IMD 2019 standardised rates of premature mortality from CVD, the disease is unfairly disturbed with those in the most deprived quintile have significantly higher rates than the county average.

Figure 30. Under 75 mortality rate from all cardiovascular diseases. All persons. Source: Source; ONS & NHS D mortality records

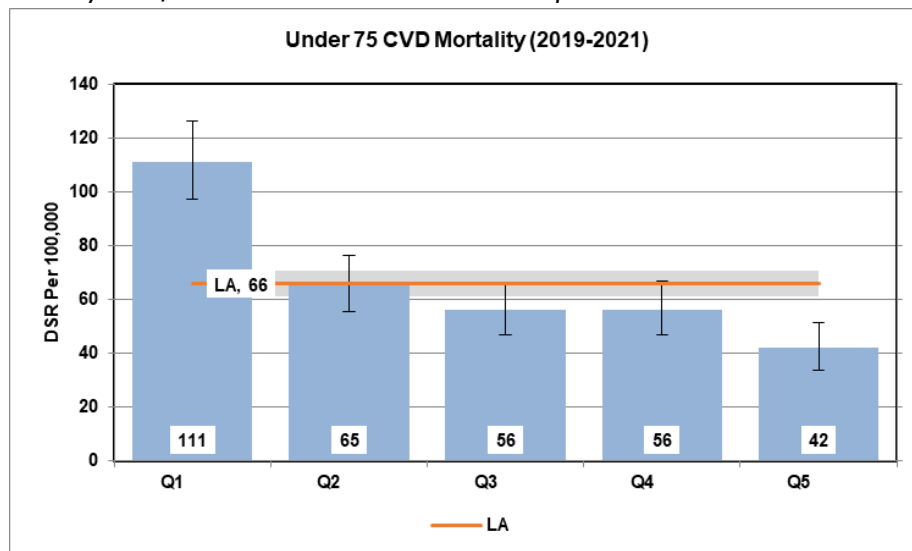


Figure 32 in Appendix 2, shows the premature CVD rates by East Riding ward. Bridlington Central, Bridlington South and South East Holderness all have significantly higher rates of deaths from CVD than the East Riding average. Beverley Rural, Dale and Driffield/Rural wards have significantly lower rates of premature death from CVD. The remaining wards are not significantly different from the East Riding average.

Similar premature CVD mortality analysis was conducted for each NHS ERY CCG Primary Care Network (PCN) and can be viewed in Figure 33 within Appendix 2. It is generally acknowledged that an area with a greater burden of CVD disease will experience a higher rate of mortality from this set of conditions at a younger age. Bridlington PCN is reported to have the highest rate of premature CVD mortality and given that the Bridlington practices feature highly in the prevalence tables of this section of the document, then this higher rate of premature mortality might be expected.



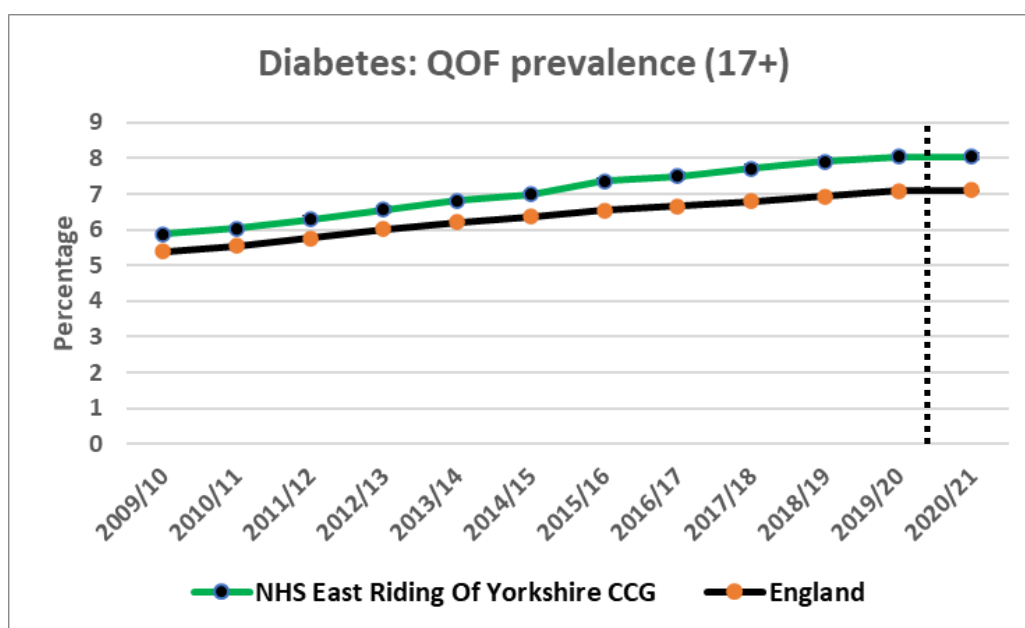
4.10 Diabetes

Diabetes in parallel to the obesity rates in adults have long been on the increase in the nation and our East Riding population. It is estimated by the Office for Health Improvement and Disparities (OHID, formerly Public Health England) that over two thirds of the adult population have excess weight a Body Mass index of over 25. The consequence seen for this increase is the growing prevalence of type II diabetes. The disease is starting sooner in people lives with prevalence in young people in greater numbers than ever before.

The Coronavirus pandemic has further compounded this issue in the last 2 years. Convenience food and home alcohol consumption rocketed during the lockdowns experience by our nation. Simultaneously our access to gyms and other active pursuits were limited to prevent the transmission of the virus. Well pharmacy who polled thousands of people estimated that on average adults in England gained 10 pounds or just over 4.5 kilograms in weight.

Nationally and locally the prevalence of diabetes has been rising with now over 6% of the adult population in England having diabetes. The East Riding has broadly followed this rate of growth in the same timeline, however the county has remained consistently higher than the national average. In the most recent years the rate of increase in the East Riding has slightly accelerated, the gap to the national average has grown resulting in the East Riding having a 1% greater prevalence than the nation for the latest period.

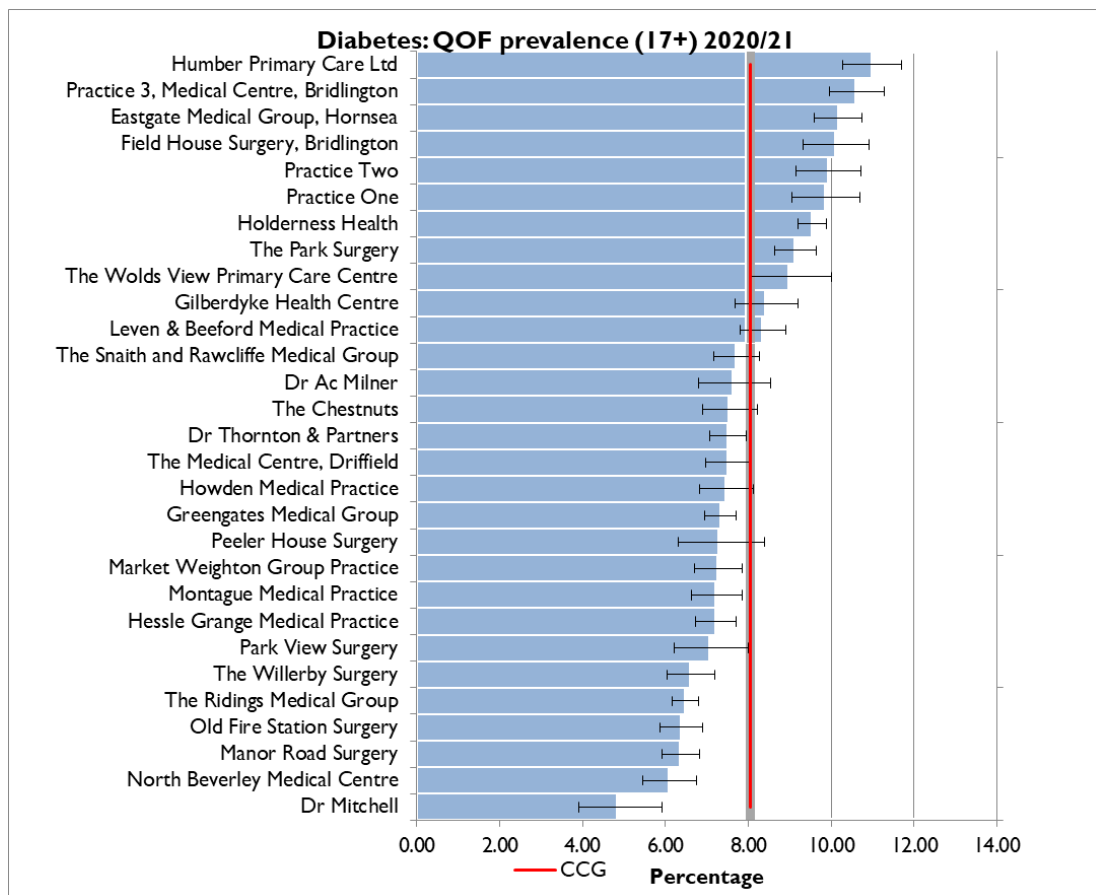
Figure 31 Diabetes prevalence for the East Riding. Source; Fingertips National Practice Profiles



Diabetes prevalence by NHS ERY CCG practice is shown on the next page in figure 17. The prevalence of diabetes is variable across the practices of the East Riding, ranging from the lowest at around 5% to the highest which is in excess of 10% of the practice population.



Figure 32 Diabetes prevalence for the East Riding by practices in 2020/21. Source; Fingertips National Practice Profiles



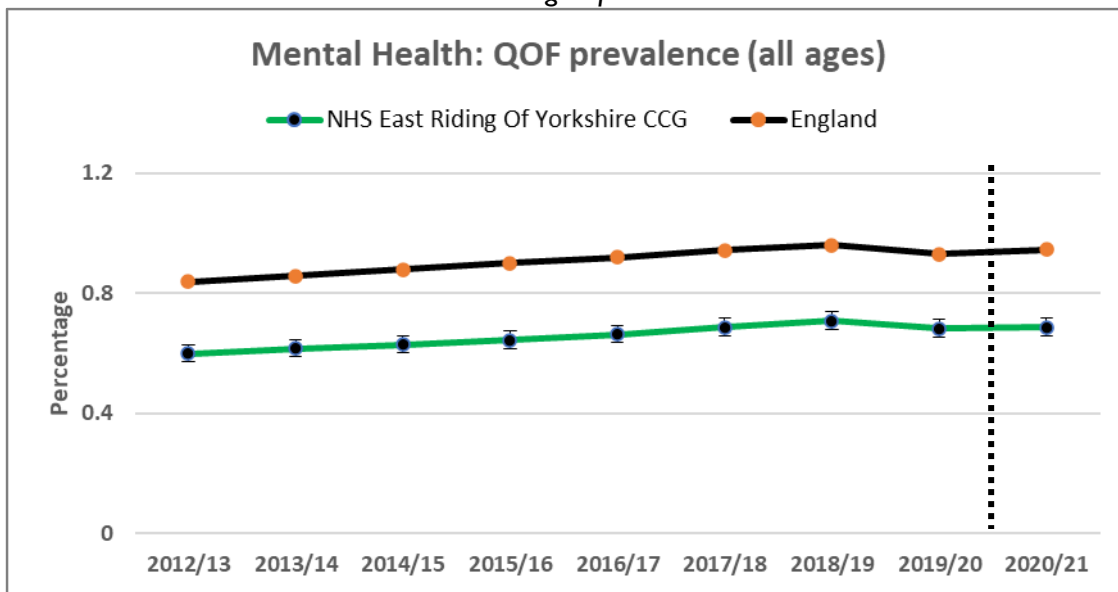
4.11 Mental Health

4.12 Prevalence of severe mental health conditions

This indicator shows the prevalence of all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses, to avoid a generic ‘mental health’ phrase that is open to variations in interpretation. The prevalence of severe mental health conditions had already been slowly rising within both the East Riding and England overall. In the East Riding, between 2012/13 and 2019/20 the prevalence rose from 0.6% to 0.68%. A year later, the post ‘start of COVID’ prevalence of 2020/21 (0.69%) was not significantly different from the previous 6 years on the chart.

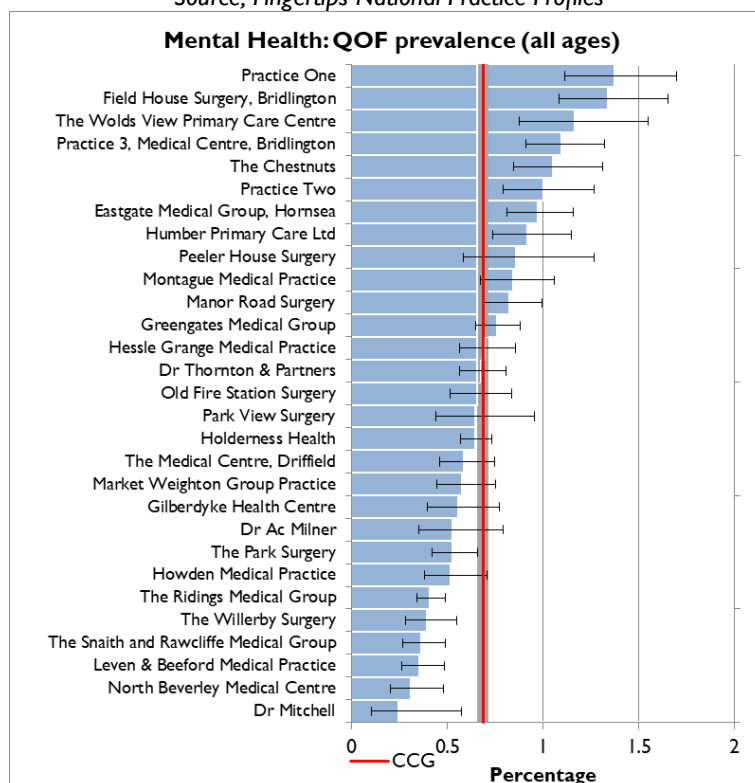


Figure 33 Severe mental health prevalence, incl. schizophrenia, bipolar affective disorder & other psychoses. Source: Fingertips



The variation in severe mental health prevalence is quite stark across our county. Practices can range from having nearly 1.5% of the population who are registered with a mental health condition, down to less than a 0.25% of the population.

Figure 34 Mental Health conditions prevalence incl. schizophrenia, bipolar affective disorder, and other psychoses. Source; Fingertips National Practice Profiles

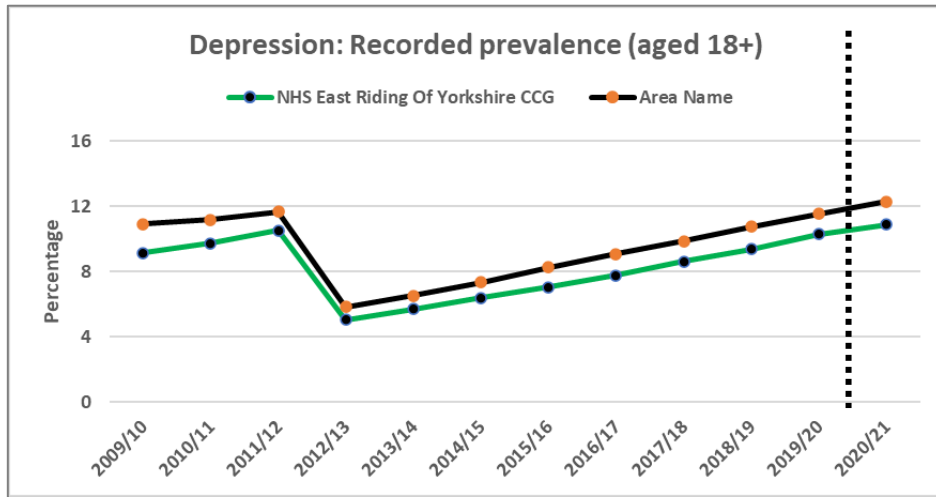


4.13 Prevalence of depression

Mental health conditions on the whole have been on the rise across the nation, as well as locally across the East Riding for many years. These is starkly illustrated in figure 20, with depression in East Riding adults increasing in parallel with the England average years before the appearance of COVID-19. Depression in East Riding adults increased from 10.1% to 10.8% between 2019/20 and 2020/21.

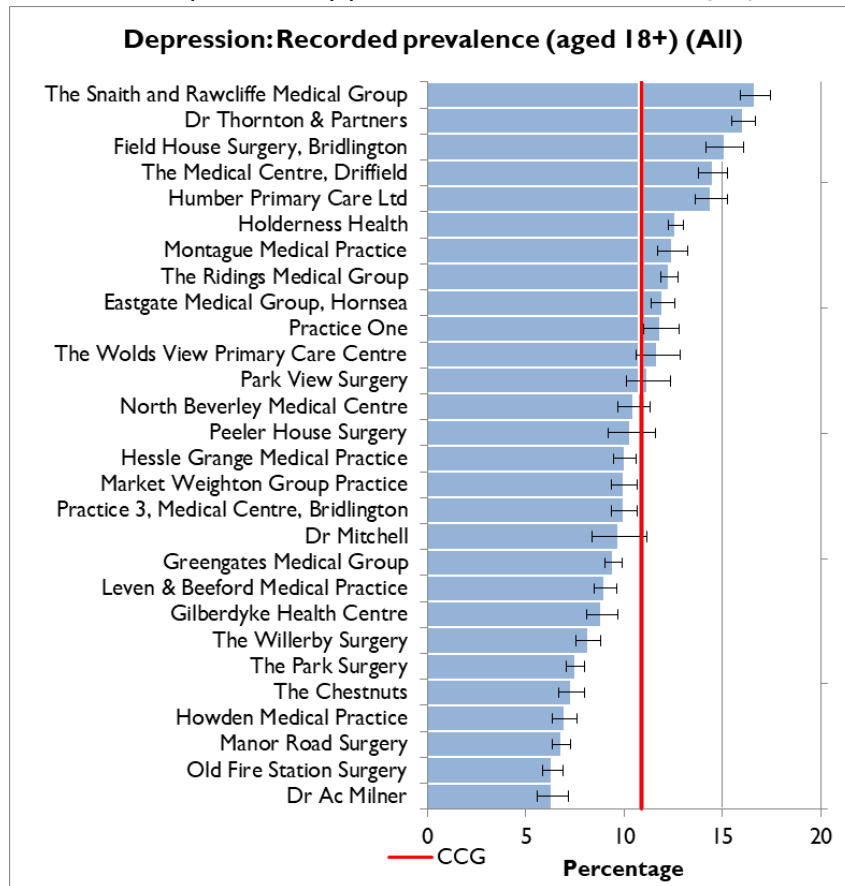


Figure 35 Depression Prevalence in those 18 and over. Source: Fingertips National Practice Profiles



Similarly to severe mental health conditions, depression has variability across the county however the proportion of the population suffering from depression is far greater. The NHS East Riding CCG average is around 11% as a whole, practices across the area can range from in excess of 16% down to 6%.

Figure 36. Depression recorded prevalence by practice for 2020/21, Source; Fingertips National Practice Profiles

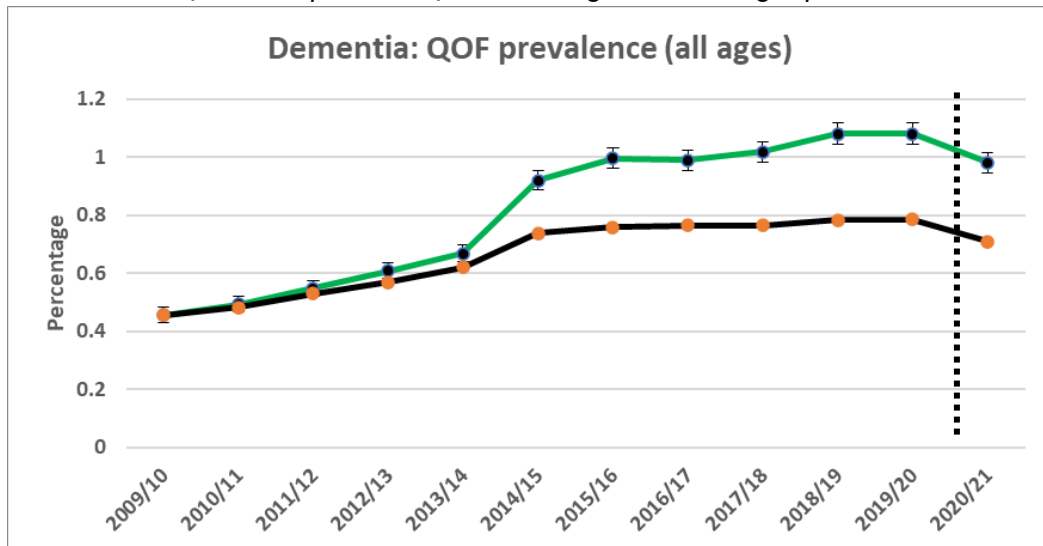


4.14 Prevalence of dementia

The prevalence of dementia in the East Riding has for many years been higher than the national average, reflecting in part the demographic of the county, having proportionally more older people. National drives within the NHS have increased energies in primary care to find those with dementia particularly in early onset. Between 2019/20 and 2020/21 the East Riding prevalence of dementia reduced from 1.1% to just under 1%, as shown in figure 22.



Figure 37 Dementia of recorded prevalence for those all ages. Source: Fingertips National Practice Profiles



Given where the greatest impact of deaths being felt in our care homes of the pandemic's first and second waves, and the reduced access to primary care likely explains the most recent decline in prevalence.



4.15 Hospital Admissions due to self-harm (a proxy for prevalence)

4.15.1 Hospital Admissions due to self-harm (all ages)

This indicator counts self-harm events that are severe enough to warrant hospital admission, which is frequently used as a proxy of the prevalence of severe self-harm. However, hospital admissions are only the tip of the iceberg in relation to the health and well-being burden of self-harm, as many people who self-harm are not admitted to hospital. Self-harm results in approximately 110,000 inpatient admissions to hospital each year in England, 99% are emergency admissions. Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. With the negative impact that COVID is so far understood to have had on some of the population's mental health, there have been concerns raised that this may reveal itself through increased acts of self-harm.

Figure 18 displays the all age rate of admissions due to self-harm, between 2010/11 and 2020/21. The East Riding has generally remained significantly lower than the England average (as shown by the green dots) throughout this period. Between 2019/20 and 2020/21 (as shown by the line on the chart) the rate of admissions decreased for both the East Riding and England overall. The drop in rate from 177.5 per 100,000 population to 145.8 per 100,000 between 2019/20 and 2020/21 was the largest year on year reduction in East Riding within the 11 year period shown on the chart.

Figure 38. Emergency Hospital Admissions for self-harm (Persons, All ages). ERY residents & England. Source: Fingertips

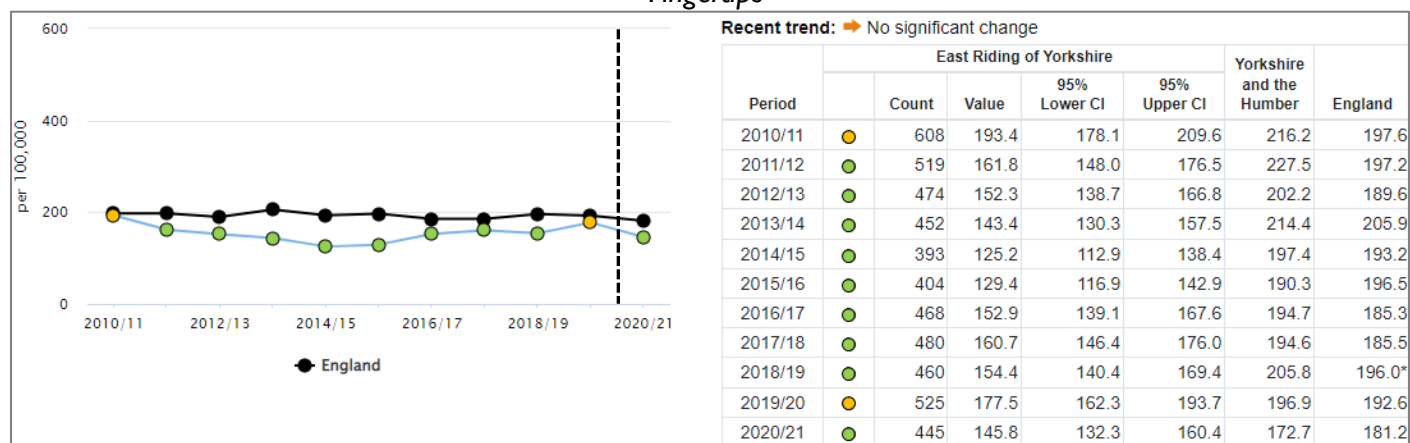
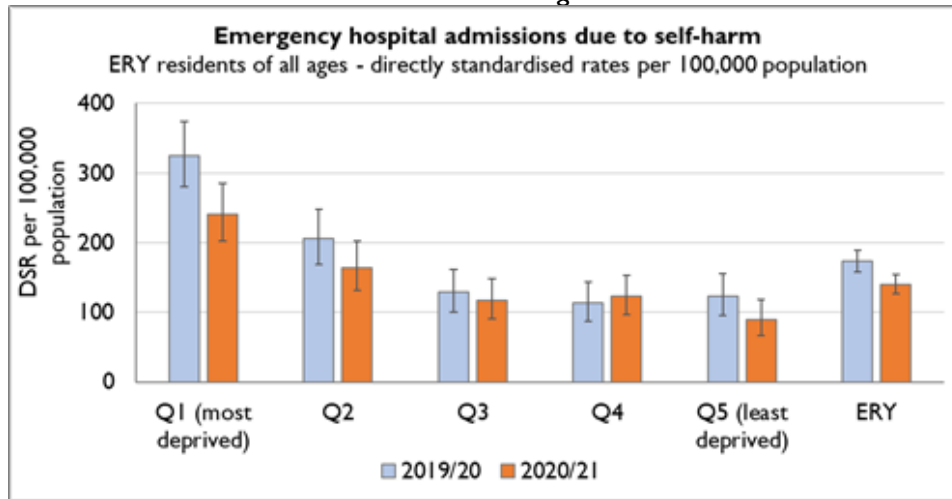


Figure 24 shows the rate of all age hospital admissions due to self-harm, divided by East Riding local deprivation quintiles. All quintiles experienced a reduction in rate, but none were a statistically significant reduction. The most deprived quintile is shown to have had the largest reduction in hospital admission rate between 2019/20 and 2020/21.



Figure 39. Emergency admissions due to self-harm by IMD 2019 Quintile. Comparing 2019/20 and 2020/21. Source: NHS Digital



4.15.2 Hospital Admissions due to self-harm (children and young people)

With national and local intelligence informing us of the negative impact that COVID has had on the mental health of children and young people, it was only logical to analyse the self-harm admissions using a single, younger cohort.

Figure 26 illustrates the rate of admissions due to self-harm involving those aged between 10 and 24 years of age, in the years from 2010/11 to 2020/21. As with the rates for all ages, the East Riding has largely remained significantly lower than the England average throughout this period. Between 2019/20 and 2020/21 the rate of admissions decreased for both the East Riding and England overall. Between 2019/20 and 2020/21, the rate of hospital admissions reduced from 369.7 per 100,000 population (based on a count of 175 admissions during that financial year) to 344.9 per 100,000.

Figure 40. Emergency Hospital Admissions for self-harm (Persons, 10-24yrs). ERY residents & England. Source: Fingertips

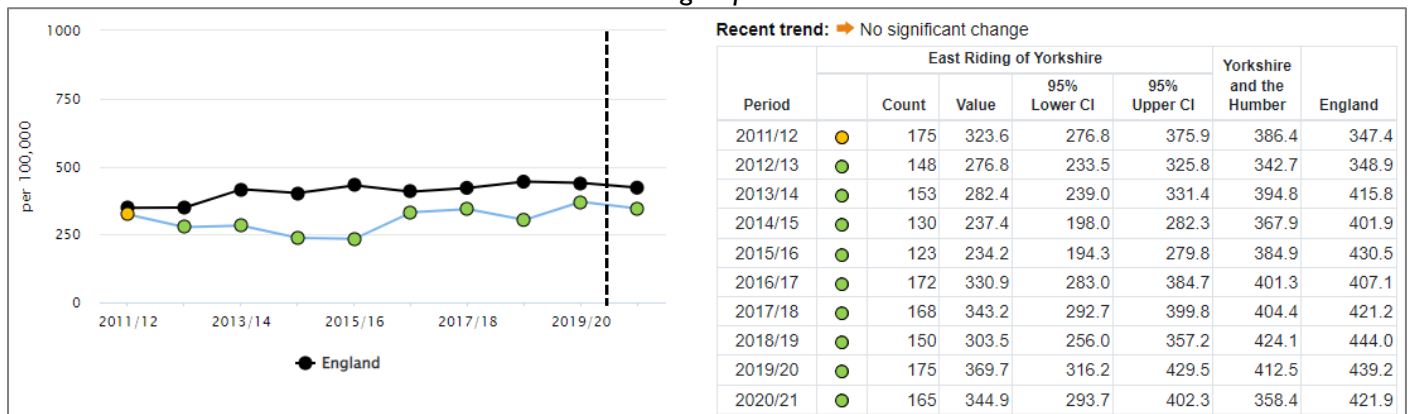
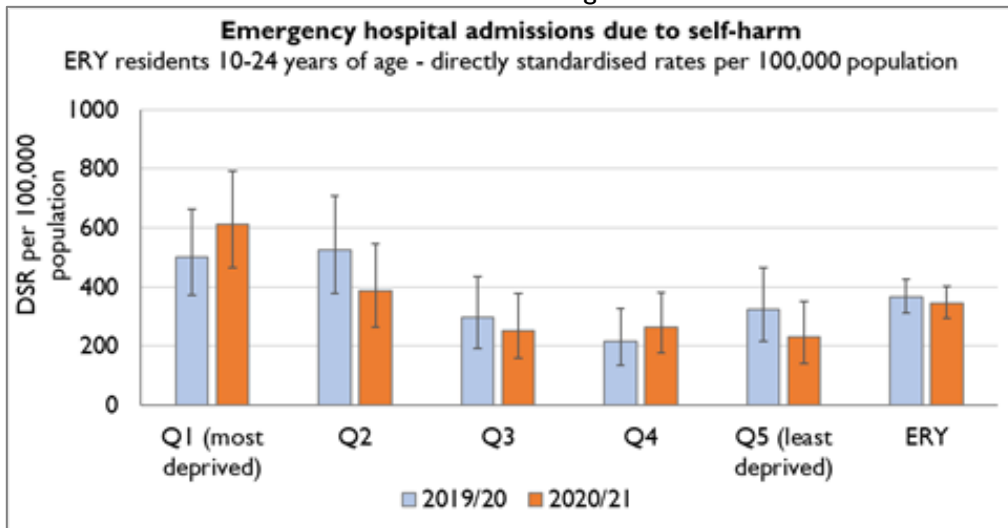
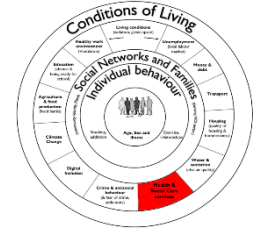


Figure 27 presents hospital admissions due to self-harm by East Riding local deprivation quintile, for the 10-24 age group. There were no statistically significant differences in any of the quintiles between the 2 periods and all but 2 quintiles experienced a reduction in rate. However, it was the most deprived quintile that was shown to have had the largest increase in the self-harm hospital admission rate between 2019/20 and 2020/21, increasing from around 500 admissions per 100,000 population to just over 600 admissions per 100,000 population.



Figure 41. Emergency admissions due to self-harm by IMD 2019 Quintile. Comparing 2019/20 and 2020/21.
Source: NHS Digital





5 Health and Social Care Services

5.1 Impact of COVID-19 on drug and alcohol treatment

Like other services, drug and alcohol treatment services were affected by the need to protect their service users and staff in the pandemic, especially in the early stages. Most services had to restrict face-to-face contacts which affected the types of interventions that service users received. Fewer service users were able to access community and inpatient detoxification for alcohol. Beyond drug and alcohol treatment itself, testing and treatment for blood-borne viruses and liver disease were also greatly reduced. These, and other changes to service provision, will have impacted on many of the indicators included in this report.

In 2020-21 there was an 44% increase at a national level in the number of people recorded as having died while in treatment for alcohol alone. There is wide local variation in this increase in deaths in treatment. These deaths are not likely to be predominantly attributable to COVID-19 infection and occurred within the context of an increase in alcohol-specific deaths in the wider population.

It is likely that changes to alcohol and drug treatment, reduced access to broader healthcare services, changes to lifestyle and social circumstances during lockdowns, as well as COVID-19 itself, will have contributed to an increase in the number of service users who died while in treatment during 2020-21. Commissioners and providers are encouraged to consider any actions they can take towards reducing deaths in treatment.

5.2 Oral health

The global pandemic has impacted adversely upon every aspect of dentistry, oral health and oral health promotion. As the General Dental Council noted in June 2021, it has exacerbated oral health inequalities and limited access to dental services; which will take time to recover as some sections of the population are either unwilling or unable to access oral healthcare services.

The pandemic has impacted adversely upon every aspect of dentistry, oral health and oral health promotion. Firstly, following the national lockdown in England, the Chief Dental Officer (CDO 2020) advised that all routine, non-urgent dental care should be stopped and deferred. Practices were advised to provide a virtual emergency assessment service, mainly using a telephone triage system and tele-dentistry and only refer patients to urgent emergency care hubs for essential clinical treatment. Although patients were satisfied by the service provided by the urgent care hubs (Paipani et al 2021), dental practice was further restricted by the requirement to adhere to additional personal protective equipment and fallow time requirements, particularly for all aerosol-generating procedures, such as fillings (General Dental Council 2020).

The suspension, cancellation or deferment of routine dental services, such as 6 monthly check-ups, recalls and root canal treatments led some to be concerned about the long term impacts of the pandemic on caries, cavities, cancer and general oral health (Daly and Black 2020). A debate ensued and a number of articles, systematic reviews and reports explored the issues (Fee et al 2020). Although many developed countries adopted and operated the 6 month recall system, there was found to be no evidence that longer recall periods of 12 to 24 months, for example, resulted in worse dental and oral health (Fee et al 2021).

Secondly, the CDO recommended that all community outreach activities such as oral health improvement programmes and dental surveys should be suspended (CDO 2020). Simultaneously, many health visitor and school nursing duties were halted or migrated online and in many parts of the UK these workers played a key role in previously providing oral health advice to vulnerable and high-risk children, parents and families.



Although, initially, school and community based oral health promotion and education was suspended during the lockdowns, following the easing of restrictions, teams either migrated online or adapted their activities to be COVID safe.

For example, Barts Community Smiles student oral health education volunteering project in Tower Hamlets, would, normally, hold interactive events using games, posters and quizzes in schools, community centres and libraries but, due to the pandemic, has migrated online or through YouTube (Liu & Onudiwe 2020). In the East Riding of Yorkshire, the City Health Care Partnership (CHCP) relaunched its oral health education resource materials, such as a crocodile and a brush bus, to ensure that they adhere to COVID restrictions (CHCP 2021).

Thirdly, despite the easing of restrictions, many families remained anxious about returning to perceived 'high-risk' environments for non-urgent assessments and check-ups (Community Research 2020). The effects of the ebbs and flows of lockdown, the easing of restrictions and furlough on oral health behaviours has led to increased snacking, infrequent or non-existent toothbrushing regimes, especially in the more deprived areas (Campagnaro 2020), and a dramatic 90% fall in oral cancer surgery referrals (Sandhu P 2020 & Westgarth D 2020).

Poor oral health is almost entirely preventable and, despite good progress over the last few decades, oral health inequalities remain a significant public health problem in England (PHE). The pandemic has exacerbated these health inequalities. Access to the Urgent Care Centres in, for example, Blackpool and Sidcup, via taxis or public transport, was difficult for those on furlough, those on low incomes and those with disabilities. The lockdowns and the subsequent cyclical easing of restrictions engendered uncertainty, disrupted oral health behaviors, such as regular and routine toothbrushing and encouraged snacking, alcohol consumption and poor dietary choices (Watton 2021).

5.3 Qualitative feedback from system partners about impact of COVID on Health and Social Care Services

5.3.1 Limited or compromised access to services

Some pregnant and 'pre-pregnant' women not accessing services

There was also a concern that where face to face appointments were possible, some women would not attend due to the fear of catching COVID-19 leaving themselves potentially vulnerable as they were not receiving the care that they needed. Equally it was reported that some women were in fear of the vaccine whilst trying to conceive due to the uncertainty of the effects of vaccine. It was remarked that some services have reduced, such as access to postnatal contraception and EHC (emergency hormonal contraception, aka the morning after pill). Waiting times for LARC (long-acting reversible contraception) had also increased. The paucity of antenatal and postnatal appointments was causing a perceived lack of support and "anxiety" for both parents.

Sexual health services reduced

The suspension of sexual health outreach and school nursing services under lockdown and the subsequent migration away from walk in clinics to telephone triage, appointments and digital online platforms, led to reduced access to postnatal contraception, Emergency Hormonal Contraception and Long Acting Reversible Contraception during the Covid pandemic. Whilst the lifting of restrictions has restored walk in



clinics, such as that at Leconfield barracks, and improved sexual health services across the East Riding, there remains a backlog of LARC capacity and women are being advised to “retain their LARC devices for an additional year”

Children and young people

It was suggested that the limited access to routine face to face health care provision could potentially mean a lack of early diagnosis of emotional and behavioural disorders. There was also concern that safeguarding issues could be missed. Increases in mental health issues within children were frequently mentioned by partners in the questionnaire, with an acknowledgement that there were already long waits for mental health services before the pandemic started. The “long waits” for treatments during COVID had exacerbated mental health conditions for children and young people. Walk in centres (e.g. for sexual health) have not been restored to what they were before, potentially creating risks. School immunisation programmes also face a challenge in catching up. There are concerns that children with education, health and care (EHC) plans are not getting access to face to face session (particularly if parents don’t want them exposed to others) and that overnight short break provision has been reduced, increasing pressure on families. A CCG respondent noted that Covid-19 had increased and escalated family breakdowns leading to the urgent requests for respite care.

Care Sector and unpaid carers

Examples were given of people living in care with COVID-19, who were denied the chance to go to hospital and therefore did not have access to some of the medication and treatment made available for those living at home. One partner stated that the cessation of podiatry appointments had led to more falls in the care homes. There was particular concern on the impact of reduced services for people like unpaid carers who could no longer access physiotherapy or counselling.

5.3.2 Delay in treatment and potential for missed diagnosis

Back logs and delays reducing quality of life

As widely reported nationally, there is a back log of operations, services and treatments due to COVID, particularly in secondary care. A CCG respondent noted that the “Inability to access appointments in a timely fashion in both primary and secondary care, fear of accessing health care services has resulted in people presenting to health care services with an advanced diagnosis or poorly controlled health conditions”. Non-mandated services have often been cancelled or postponed, leading to long waiting times. Whilst appointments were often made, they were a long way off into the future, causing patients to return to primary care and put pressure on to resolve it by finding earlier dates. Whilst some health conditions are not life threatening, a lack of treatment does reduce quality of life and risk the conditions deteriorating, for example delays in minor surgery would have an impact on the management of long-term condition. There was the potential for missing early diagnosis of a developing condition as residents are not coming forward nor attending routine health checks or medications review, as there was anxiety about catching COVID.

COVID took priority over everything

In some primary care settings there was a feeling that vaccinations for COVID took priority over chronic disease management potentially leading symptoms and conditions to become exacerbated. Some services within primary care stopped during the pandemic, e.g. related to sexual health, which might lead to the potential for gaps in the East Riding geographically. It is reported that there are still issues with LARC



capacity within Integrated Sexual Health (ISH) clinics. Oral health was remarked as being an area that has particularly declined.

Missing early diagnosis in the elderly

With elderly residents in mind, partners in their responses communicated the concern that there was a risk of missing an early diagnosis of developing conditions, e.g. dementia, and a delay in receiving treatment as residents were reluctant to go to primary care services. There was also concern that those with 1 or more existing long-term conditions (who have been shielding) potentially would not have their conditions monitored and that their outcomes were likely to be worse. A reluctance to report conditions getting worse might mean presenting at A&E when health issues become more acute and more difficult to treat. There was also concerns that this could cause delays for referral to social care, which in turn put pressure on wider family. Those in already receipt of social care were requesting more home care due to the perception, in the press, that care homes were not safe.

5.3.3 Requirement for the development of services

Tyler D & Lawer D (2021) stated that there was requirement for “increased access to a range of support services to help children and young people with their mental health and emotional well-being”. Sexual health services had also “seen a massive increase in sexually transmitted infections, unplanned pregnancy, young people accessing contraception, particularly young boys wanting condoms”.

5.3.4 Potential for health inequalities to increase

Services centralised not a solution for those with transport issues

Following the cessation of screening programmes under lockdown, the subsequent easing of restrictions led to a centralisation of, for example, oral cancer screening activities which, the CCG respondent noted, had led to an increase in health inequalities for those vulnerable patients without cars or the means to travel to screening appointments.

Digital inequalities

Furthermore, the migration of many services onto digital platforms further intensified health inequalities for those who were poor, those who were isolated, those who lived in the depths of the countryside and those who did not or could not wish to learn new IT skills. For example, The Lead for Children and Young People noted that “families with fewer resources report more problems in their children. Young people in low income families/areas have had less access to technology to communicate with school & friends & are most likely to have lost routines & sleep & have seen an increase in children & young people’s mental health problems. However, rather than going totally digital, our CHCP partners reported that “Community Services, including district nursing, end of life care, treatment rooms, specialist nursing, therapy and rehab, including ICT have maintained all services”

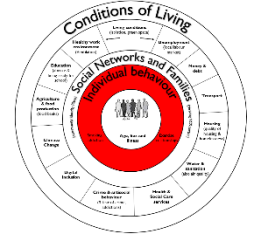
5.3.5 A focus on children and young people with special educational needs or disability (SEND)

Findings from this specific section are a summary of the research conducted Tyler D & Lawer D (2021).



Children with Special Educational Needs and/or Disabilities (SEND) saw a disruption to their routines and often the social activities which helped give them independence halted. Official guidance around COVID-19 was usually unclear and often changed on a daily basis, leading to anxiety about the correct course of action to follow with daily routines. Family members were often put under additional stress in having to look after children when educational settings were closed. It was felt that there was not enough advice or support overall. Children were also reported to prefer face to face appointments, as opposed to virtual appointments but the latter were hard to arrange with the restrictions in place. Short activity breaks which children would normally attend and give parents respite were generally unavailable. East Riding Community Hubs struggled to fully support families with children with SEND, partly due to issues related to shielding and there was a fear that 'food poverty' had started to creep in over the pandemic for these families. There were also instances of concern recorded about parental abuse during the pandemic. The East Yorkshire Parent and Carer Forum (EYPCF) stated that "there is even more need now and in the future for mental health and emotional wellbeing support for children and young people with SEND, and their parents and carers".





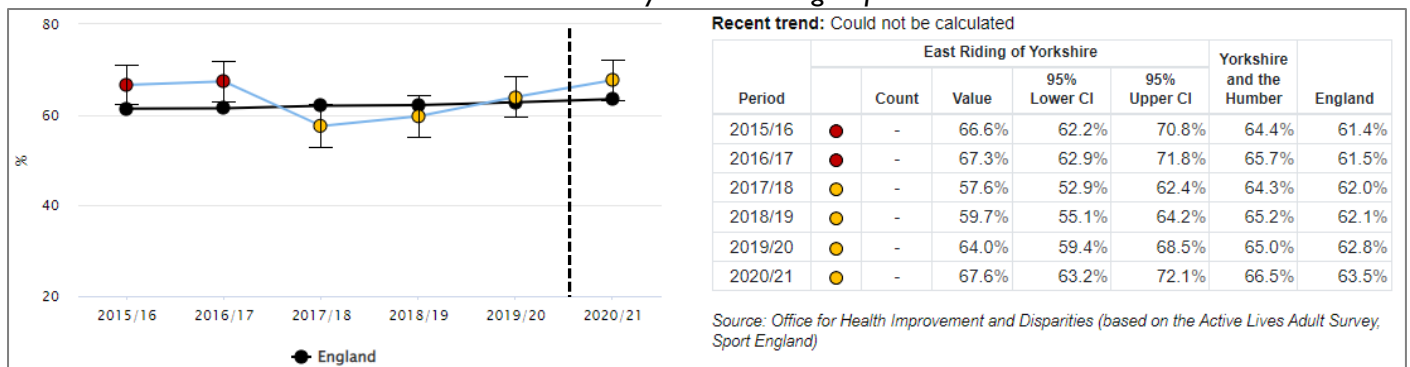
6 Individual behaviour

6.1 Excess weight in adults (18+ years)

Globally, the pandemic has been reported to have had a negative impact on the healthy weight of the population, caused by decreased movement during lockdowns to coping with the added stress of the crisis. There have also been suggestions from the media that a downturn in economic circumstances can also push people towards cheaper but healthier food choices, exacerbating the problem. The 2020 Ipsos Mori report (Bailey et al, 2021) found that more than a third of respondents across the world reported that they had gained weight during the pandemic.

Sport England conduct an 'Active Lives Adult Survey' each year and from that produce an 'excess weight' indicator which is derived from the number of adults aged 18+ with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Figure 38 below compares the East Riding excess weight prevalence to that of the England average between the financial years 2015/16 and 2020/21. An increase was recorded for the East Riding between 2019/20 and 2020/21 from 64.0% to 67.6%, but this was not a statistically significant increase, nor was the East Riding significantly different from England in the latest year (63.5%). The East Riding prevalence of excess weight had already been increasing year on year from 2017/18 to the latest period.

Figure 42 Percentage of adults (aged 18+) classified as overweight or obese ERY LA compared to England. Active Lives Survey. Source: Fingertips



6.2 Child obesity

Results from the National Child Measurement Programme (NCMP) found that nationally, there has been a substantial rise in the number of obese children in England during the pandemic. Obesity rates in in reception year (children aged 5-6) rose from 9.9% to 14.4%, whilst rates in year 6 children (aged 10-11 years) it rose from 21% in 2019/20 to 25.5% in 2020/21. Figures 52 and 53 in the Appendix display these increases on chart for each respective school year cohort.

For both school year cohorts, the obesity rates were found to be twice as high within the most deprived areas of the country recording a prevalence of 20.3% and 33.8% (reception year and year 6 respectively) compared to 7.8% and 14.3% in the least deprived decile. The differences were even more stark when the prevalence of the most acute category 'severely obese' was analysed; 7.6% and 10.6% (reception year and year 6 respectively) were severely obese within the most deprived decile, compared to 1.9% and 1.8% with the least deprived decile. Figures 54 and 55 illustrate the disparities gap between most and least deprived over time and show how the potential impact of COVID has increased this gap further for 2020/21.



In the East Riding the prevalence of obesity also saw significant increases, rising from 8% and 18.2% (reception year and year 6 respectively) in 2019/20 to 16.7% and 23.2% in 2020/21. Caution must be taken with the 2020/21 results as the number of children weighed and measured was much lower than in the past. In a standard year around 6,500 East Riding reception year and year 6 children are measured, in 2020/21 this number was reduced to around 1,250.

Figure 43. Prevalence of obesity within ERY reception year children (left) and year 6 (right) compared to England.
Source: NCMP and Fingertips



Analysis was conducted on the East Riding 2020/21 dataset to analyse obesity prevalence by local deprivation quintile, the results are presented for both school year cohorts in figures 44 and 45 below. In both cohorts the most deprived quintile was reported to have the highest prevalence of obesity: 23.1% in reception year (compared to 7.1% in the least deprived) and 29% in year 6 (compared to 18.5% in the least deprived). In both cohorts there was no significant difference in prevalence between the different quintiles. However historically, when the data has been pooled together into 3 year periods providing a more robust dataset, the most deprived quintile in year 6 has usually been significantly higher than other quintiles and the East Riding average.

Figure 44. % Reception year obese by local deprivation quintile (IMD 2019)

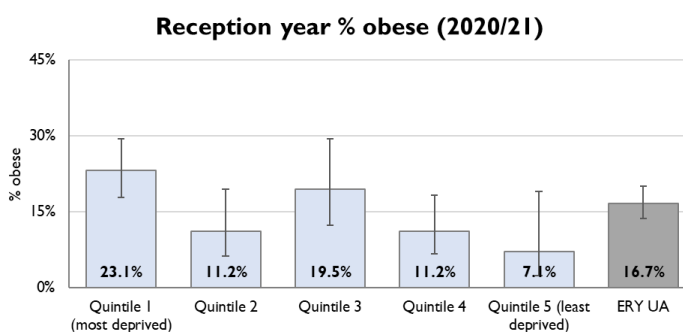
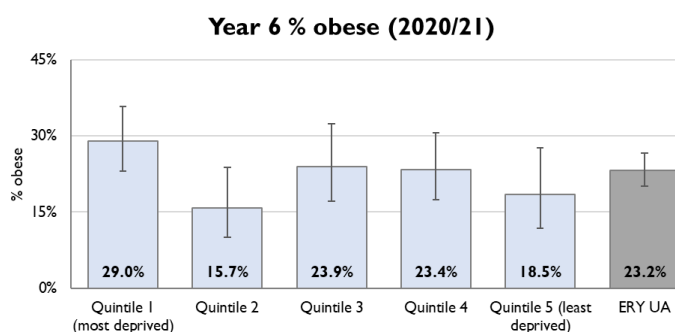


Figure 45. Year 6 % obese by local deprivation quintile (IMD 2019)



6.3 Alcohol misuse

6.3.1 COVID impact on admissions and mortality (summary)

Public Health England (PHE) wrote in their 2021 report (PHE 2021) that nationally there was a reduction in the rate of unplanned admissions to hospital for alcohol-specific causes in 2020, down by 3.2% compared to 2019. This drop was largely driven by reduced admissions for mental and behavioural disorders due to alcohol use. Unplanned admissions for alcoholic liver disease were the only alcohol-specific unplanned admissions to increase between 2019 and 2020, with significant increases showing from June 2020 onwards. There were rapid decreases in the rate of alcohol-specific admissions that coincided with the start of the pandemic and the first national lockdown. It is important to note that this pattern was not unique to alcohol. All unplanned admissions, irrespective of cause, sharply decreased as the pandemic took hold. This 'lockdown effect' likely relates to psychological factors where people reported avoiding hospitals to ease the pressure on the NHS and because they were perceived as high-risk settings for catching COVID.

6.3.2 Alcohol specific admissions

Alcohol specific admissions count the number of times that a person has been admitted to hospital in a year with an alcohol specific condition, and not the person themselves. Figure 33 shows the trend of the directly standardised admissions rates (DSR) for East Riding and England from 2008/09 to 2020/21, rates for both areas decreased between 2019/20 and 2020/21 as shown on the chart.

Figure 46. Alcohol-specific admissions (Persons, 1 year range). ERY compared to England. DSR per 100,000 population. Source: Fingertips

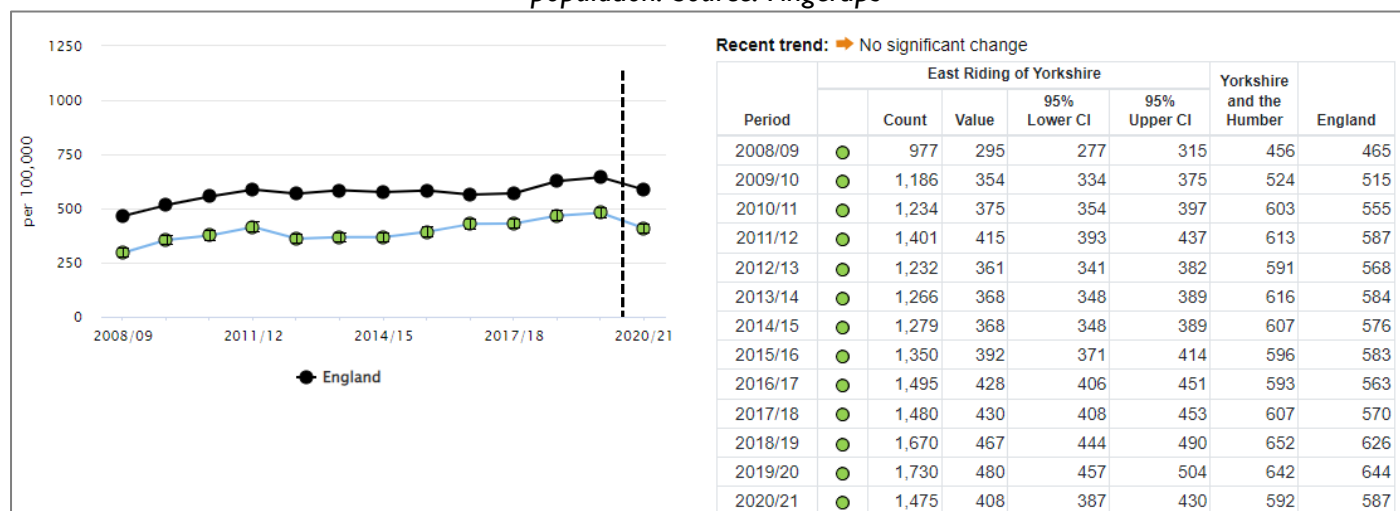
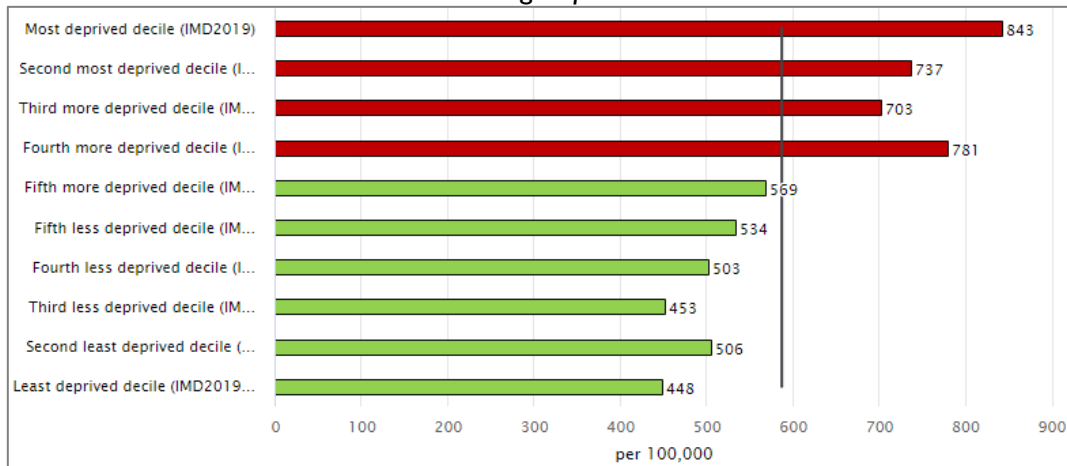


Figure 34 divides the admissions for England overall in 2020/21, by deprivation deciles. The highest rates of alcohol specific admissions are clearly shown to be from some of the most deprived communities within England. The red colour indicates that these reds are significantly higher (i.e. worse) than the England average.



Figure 47. Alcohol-specific admissions in England, for 2020/21. Deprivation quintiles. DSR/100,000. Source: Fingertips



6.3.3 Alcohol specific mortality

Alcohol-specific mortality relates to deaths from conditions wholly caused by alcohol. Data reported on the Wider Impacts for COVID-19 on Health (WICH) dashboard showed an increase in total alcohol-specific disease deaths, driven by an unprecedented annual increase in alcoholic liver disease deaths above levels seen pre-pandemic. Between 2019 and 2020, death from alcoholic liver disease increased by 20.8% compared to an increase of 2.9% between 2018 and 2019. Between 2019 and 2020, deaths from mental and behavioural disorders due to alcohol use and alcohol poisonings increased by 10.8% and 15.4% respectively, compared to a respective 1.1% increase and 4.5% decrease between 2018 and 2019.

Figure 34 compares the DSR of alcohol specific mortality for the East Riding to those of England overall, between 2006 and 2020. Historically the East Riding mortality rate has been lower than England. Between 2019 and 2020 the East Ridings mortality rate remained similar, however for England overall the rate rose significantly from 10.9 deaths per 100,000 population to 13.0. This is clearly illustrated in the final time point within the chart.

Figure 48. Alcohol-specific mortality (Persons, single years). ERY compared to England. DSR/100,000 pop. Source: Fingertips

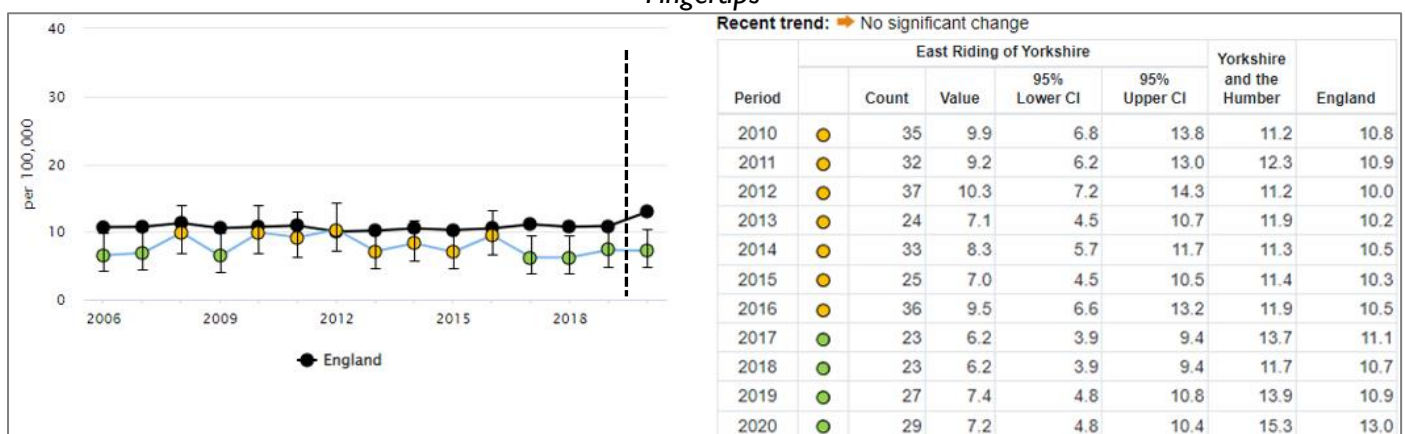
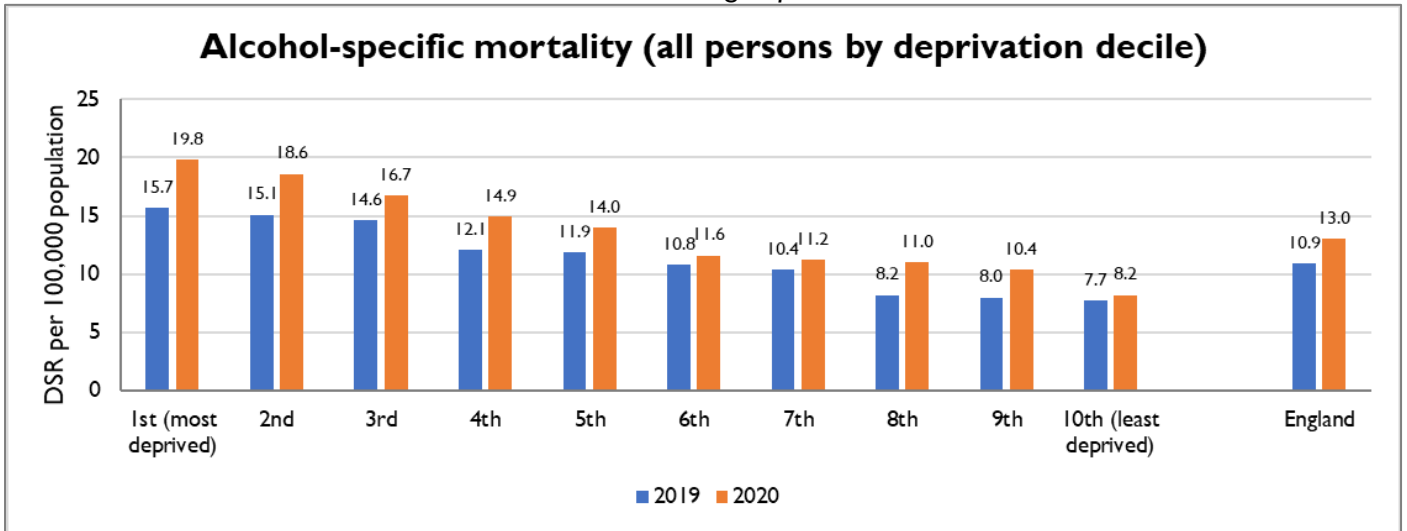
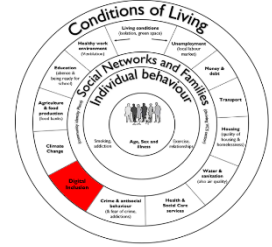


Figure 36 divides the mortality rates for England in 2020/21, by deprivation deciles. As shown with admissions in the previous section, the highest rates of alcohol specific mortality are also from the most deprived communities within England. All deprivation deciles increased in mortality rate between 2019/20 and 2020/21 but it was the 2 most deprived deciles which had the greatest increase.



Figure 49. Alcohol-specific mortality inn England (Persons, single years) by deprivation decile. DSR/100,000 pop.
Source: Fingertips





7 Digital Inclusion

This section contains information obtained from partners via a questionnaire type template. We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.

7.1 Replacement of face to face services with digital is not always ideal

Whilst many services have continued through telephone appointments or digital means, partners voiced that this level of support might not be enough compared to what the more traditional face to face appointments would bring. An example of a specific groups that this affected included pregnant or pre-pregnant women. Online and telephone services were particularly problematic if English was not the first language of the person accessing services. It was noted that not everyone has access to IT equipment nor was the quality of the online service provision necessarily always very good. Vaccination appointments were relatively easy to access and book online but people not familiar with the technology could miss out. Telephone consultations were singled out as not being suitable for those with hearing issues and not being a suitable medium to assess how much a condition has deteriorated.

Tyler D & Lawer D (2021) found that Youth Providers weren't always able to effectively utilise digital means to engage with young people and that it was not always suitable to use it. The authors also stated that some online sessions were held by the East Riding Pathway Team but nobody ended up attending.

However, there were also reports that generally the move to digital services was popular with some people and that IT and online interaction yielded extremely positive results.

7.2 Over-reliance on digital connectivity creates inequalities

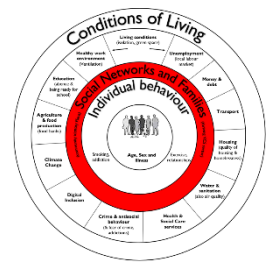
Partners remarked that there was a potential risk of inequalities developing across the life-course, by the shift in providing education, services and social interaction more through digital means rather than through traditional face to face methods. For children, education was frequently delivered through digital means, but not all families could afford the hardware (computers/laptops) and/or the fast broadband required to have an effective and reliable online connection to receive the lessons. This was equally applicable to non-school hours where some children would encounter problems in keeping in touch with their friends and peers remotely.

Many of these reasons equally applied to adults and the elderly. Those who could not afford to buy digital technology, nor were able to use it, were potentially left behind by not being able to book or interact with medical appointments nor keep in touch with family or peers.

7.3 Digital connectivity became tiresome for children and drained confidence

Tyler D & Lawer D (2021) discovered that many young people had grown tired of being online for many aspects of their life (e.g. education, socialising) and some lost confidence for fear of how they would appear online.





8 Social Network and Families

This section contains information obtained from partners via a questionnaire type template. We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.

8.1 Social isolation and limited social interaction

Pregnancy and early years

There has been an impact on the emotional wellbeing of expectant and new mums who have felt socially isolated as support groups have disappeared which has meant less social interaction. Partners have also not always been allowed to attend appointments which left some expectant or new mums feeling vulnerable. There was also a concern that babies and young children were missing out on social interaction with each other, potentially stifling their natural development in this area.

Children and young people

It was felt that many children were already often in challenging circumstance due to academic or peer pressures, but COVID has made this much worse. The absence of contact with friends and fear of catching Covid-19 have had an impact on low level mental health. It was remarked that isolation and withdrawal from wider society left some children anxious and unsure in how to interact with peers again.

Tyler D & Lawer D (2021) raised the same issue, that the consequence of the national lockdowns meant that children were not permitted to see their friends, peers or some family groups in person, increasing boredom, sadness, loneliness and isolation. Locations that have traditionally offered much social interaction, including schools, other people's homes and the abundance of youth and sports clubs were now inaccessible. Teachers, parents and carers all noticed a deterioration of mental health and emotional well-being in children. Some pupils are no longer comfortable being around other people. An increase in the waiting list for students wanting to access counselling support was also reported. Young people who were people who are not in education, employment or training (NEET) were singled out as another group who had become more socially isolated. The Youth Offending Service reported in their clients a decline in confidence, self-presentation, confidence and social skills. The report specifies a need for the development of youth activities and services, for example more community youth clubs and outdoor activities; and increased access to support for mental health and well-being.

Older people

It was mentioned on several occasions by partners that our elderly population felt anxiety from catching Covid-19 from within the own community and were reluctant to leave their homes to avoid unnecessary contact or exposure. This meant residents would not go out socially and avoided contact with family and friends, resulting in depression and a lack of confidence. There was concern that this developed lack of confidence in elderly residents would mean they would not return to the activities they had previously enjoyed post pandemic



8.2 Lack of youth provision

Tyler D & Lawer D (2021) noted that there was a “significant shortage of youth provision for young people to access, in what was an already sparse landscape in some areas of East Riding” (page 28). The report noted that the reduction of activities “reduced young people’s wider support network, affecting their skill set and confidence, and preventing them getting involved in positive activities that increase their aspirations and improve their behaviour” (page 33). Many youth providers also found themselves losing out on funding during the pandemic but were still incurring the costs associated with day to day running. The governments furlough scheme, whilst supporting many businesses and their employees, was less applicable to the majority of the voluntary and community youth sector in East Riding, as it is heavily reliant on volunteers.

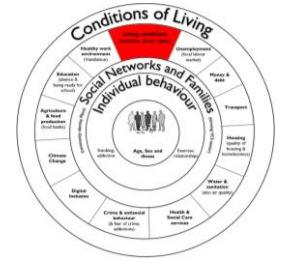
8.3 Negative impact on family life

Tyler D & Lawer D (2021) wrote that whilst some respondents reported that the pandemic had brought their family closer together, others felt that there was more stress, more arguments and more tensions during the lockdowns and restrictions. A third of respondents noted that Covid-19 had had a negative impact upon their parenting, making them more anxious, intense and quick to lose their tempers, but the majority said there had been no impact on family life. Child carers were less likely to be able to access any kind of respite, if caring for family members and were limited were also less likely to have any kind of social interaction if family members were clinically extremely vulnerable and shielding. Job losses and a reduction of income due to furlough meant an increase in poverty and a long-term negative impact on households.

8.4 Negative behaviour by children and young people

It was noted several times that many community and sport clubs had not reopened since the start of the pandemic. This has contributed to an absence of things to do, meaning in many cases children have resorted to negative behaviour in the community and at school. The ERYC Health and Well Being team noted that “A lot of support groups and social, physical groups have ceased during lockdown and have not restarted. There is a lack of groups for young people to access”. The Sport & Active Communities Health & Wellbeing Team Cottingham observed that “Sports clubs, group and activities paused within the locality...and local businesses who provide activity provision were closed”. Again, the ERYC Lead for Behaviour Change commented that “there are very few after school groups and activities for young people in Withernsea; Covid reduced access to even the few that were in place which compromised their wellbeing”.





9 Living Conditions

This section contains information obtained from partners via a questionnaire type template. We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.

9.1 Loneliness and anxiety

The impact of loneliness was referred to on several occasions for children, adults and the elderly. The requirement of some residents having to isolate alone due to the lockdowns or due to having an infection meant there was an absence of contact with friends, family and colleagues. Once lockdowns were lifted there were high levels of anxiety reported where people had to get out to access services. This was particularly noticeable with learning disability services, as people returned to day services but didn't want to exposure to the wider community, instead preferring to remain in small bubbles. Many adults suffering from low confidence, a lack of motivation and not re-engaging with society. Large numbers of social places such as pubs and gyms had closed for part of the pandemic. For some there was the stress of having to go to work either with Covid or the fear of catching Covid as the nature of their jobs did not allow them to work from home. To compound this issue, the full impact may never be fully appreciated as people are not readily willing to communicate it.

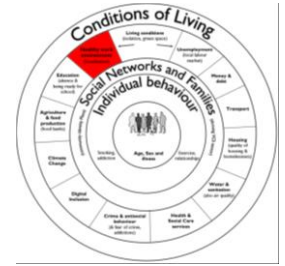
9.2 Deconditioning and increased frailty in older people

The threat of deconditioning and increased frailty in the East Ridings older population was mentioned in numerous responses by partners. The requirement to isolate had had a negative effect on both mental and physical health, reducing independence and an increase in the risk of falls. Residents with dementia were highlighted as having a more rapid increase in cognitive decline due to reduced social activity and a loss of routine in their daily lives. Falls were reported to be an issue due lack of podiatry and some people living in residential care still making up ground in terms of foot care.

9.3 Low level mental health issues in adults increasing in severity

There were reports of issues relating to low level mental health (depression and anxiety) increasing due to financial hardships brought on by pandemic (including unemployment) and bereavement. Some mental health services reported that whilst they hadn't seen an increase in mental health referrals, the severity of issues was worse.





10 Healthy Work Environment

This section contains information obtained from partners via a questionnaire type template. We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.

10.1 The Care Sector

Less of a 'home', more of a clinical setting

COVID-19 has had both positive and negative impacts upon care homes; their staff, their residents and their relatives. A vicious circle of loneliness, isolation and anxiety driven by restrictions, guidance and the wearing of full PPE has meant that staff felt unable to provide a homely environment for residents, instead it is more clinical.

Recruitment and retention issues

Moreover, difficulties in recruiting and retaining staff were exacerbated by the compulsory vaccination plans (driving many workers out based upon principle), the psychological trauma of deaths and infections and the physical impacts of lockdowns, long hours and split shifts.

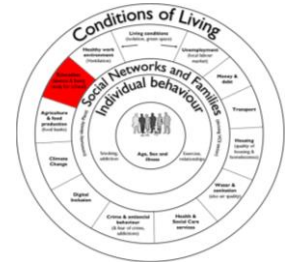
Negative perception of the care sector

The long-term perception of the care sector and the economic impact of a shortage of workforce (and some sectors paying more for "unskilled" workforce) is having an impact on both quality of care and the sustainability of care services. The perception of residential care has been badly damaged, and people are opting for no services at all, in preference to residential care, which has a massive impact on health and wellbeing as well as safety and quality of life.

Positive aspects: partnerships and infection control

Despite the adverse impacts of the pandemic, one senior manager reported that the ongoing situation was conducive to 'enhanced partnership working'; bolstered and underpinned by flexible working and the use of new technology; such as MS Teams. Again, improved infection control across the board had become the norm with compulsory and 'routine' face covering.





11 Education

This section contains information obtained from partners via a questionnaire type template. We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.

11.1 Education interrupted

Tyler D & Lawer D (2021) stated that having to conduct schooling at home and join lessons online was often demotivating for many children and sometimes difficult to participate in as not all children are fully competent in using computers nor have the equipment needed to participate (such as a reasonably fast broadband connection) or simply may not have the space to set it all up within the home environment. Whilst many young people who responded to surveys that supported the research said they were happy not having to go into school or college during the pandemic, this was not the case for all young people. The research found that young people felt de-motivated and worried about their futures with regard to their education,

11.2 Home Education continued for a period after lockdown ended

The Council’s Principal Education Welfare Officer stated that the number of pupils electively home educated rose dramatically as schools reopened in September 2020 and parents were still cautious and anxious about children returning to school. As of May 2022, this has now levelled off, with the vaccine programme having an effect meaning some pupils have now returned to school and the Education Welfare team are no longer seeing Covid being given as a reason by parents who are removing their children to home educate.

During the national lockdowns the legislation around school attendance was paused so no fines were issued between March 2020 and September 2020. As schools reopened more widely, the schools and the local authority took a supportive approach in encouraging parents to return their children to school, so although referrals are now once again from schools to issue penalty notices, far fewer are being issued pre-pandemic.

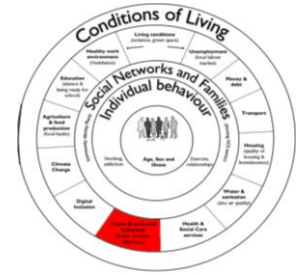
11.3 Readiness for work suffered

Tyler D & Lawer D (2021) also found that whilst some young people are ready to enter the job market, assistance in preparing them has been hindered as interviewing skills and CV development is harder to do remotely over media such as MS Teams. There was concern also of the actual availability of work for young people. Year 10 work experience in schools simply didn’t happen due to the pandemic.

11.4 Lack of routine

Partners in their feedback noted the disruption of children ‘having a routine’ by not attending school including. This included poor sleep, which was noted as disproportionately hitting the most deprived communities worse. The impact of catching up with academic studies also means less time for social and physical activities.





12 Crime and Antisocial behaviour

12.1 Police reported crime (national perspective – a summary)

The Criminal Justice Joint Inspection (CJJI, 2022) stated that there were 5.8 million overall crimes recorded by police within England and Wales in the 12 months to September 2021, which was a 2% increase on what was reported the previous year. However once fraud and computer misuse were removed from the figures, the numbers reduced down to 4.9 million, a 1% increase over the previous year. It was noted that the lowest levels of crime occurred during reintroduction of the national lockdown between January and March 2021, after which crime levels began to rise once again to levels witnessed in July to September 2019

The BBC (2021) theft and robbery reduced dramatically, partly owing to less opportunity for burglary due to more people being at home. The article reported that different communities (inevitably) reported different problems relating to crime, from an increase in fly-tipping and fraud to the theft of family pets (notably dogs). Domestic abuse was reported to have increased during lockdown, with victims often finding themselves locked in their properties along with the perpetrators of the crimes, for longer periods of time.

12.2 Police reported crime (Humberside specific)

Humberside police recorded that total crime between 2019/20 and 2020/21 reduced by 14%. Figure 50 illustrates the percent difference between 2019/20 and 2020/21 of victim based crime recorded by the Police, comparing Humberside with the region and England. These victim based crimes had largely decreased between the 2 periods (including sexual offences, although another source, CJJI 2022, stated that this had increased). Whilst many crimes decreased between the two periods, there were increases in drug offences (27.2% in Humberside), public order offences (12.7%) and miscellaneous crimes (3.9%). Stalking and harassment (not shown on the chart) increased by 26%.

Antisocial behaviour crimes are highlighted in figure 51, after 2 consecutive years of declining numbers in 2018/19 and 2019/20, numbers rose again in 2020/21 by over 2,000 incidents in the Humberside area. As a rate per 1,000 population the numbers of anti-social incidents in Humberside were lower than both region and England.

The number of domestic abuse related crimes are displayed in figure 52 and had been increasing year on year since 2015/16, but in 2020/21 the number decreased (by almost 300 crimes) for the 1st time in almost 5 years. However as a proportion of all crime, domestic abuse-related crimes increased from 16.5% pre-pandemic (in 2019/20) to 18.7% in 2020/21.



Figure 50. Victim based crime & other crimes: % difference between 2019/20 and 2020/21. Source: ONS

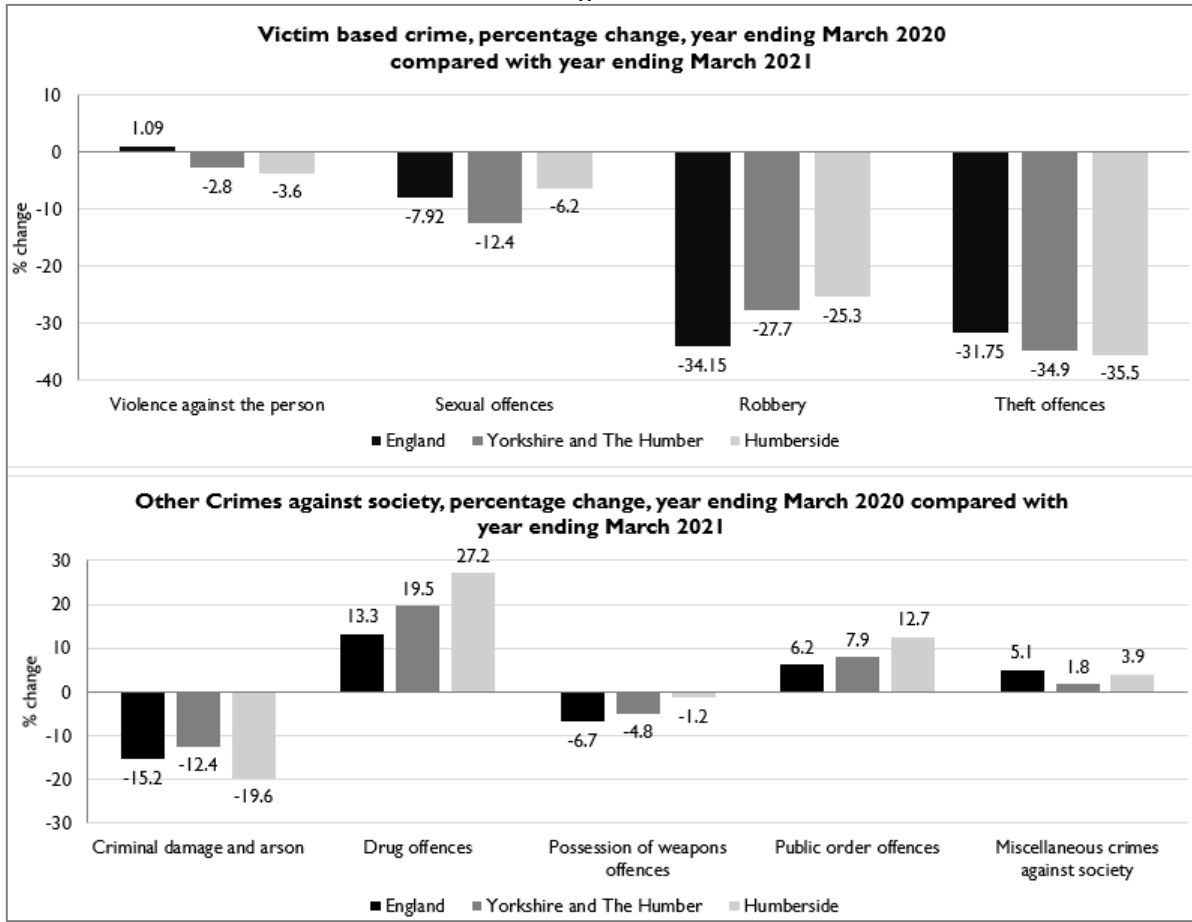


Figure 51. Anti-social behaviour incidents: count and rate 2015/16 to 2020/21. Source: ONS

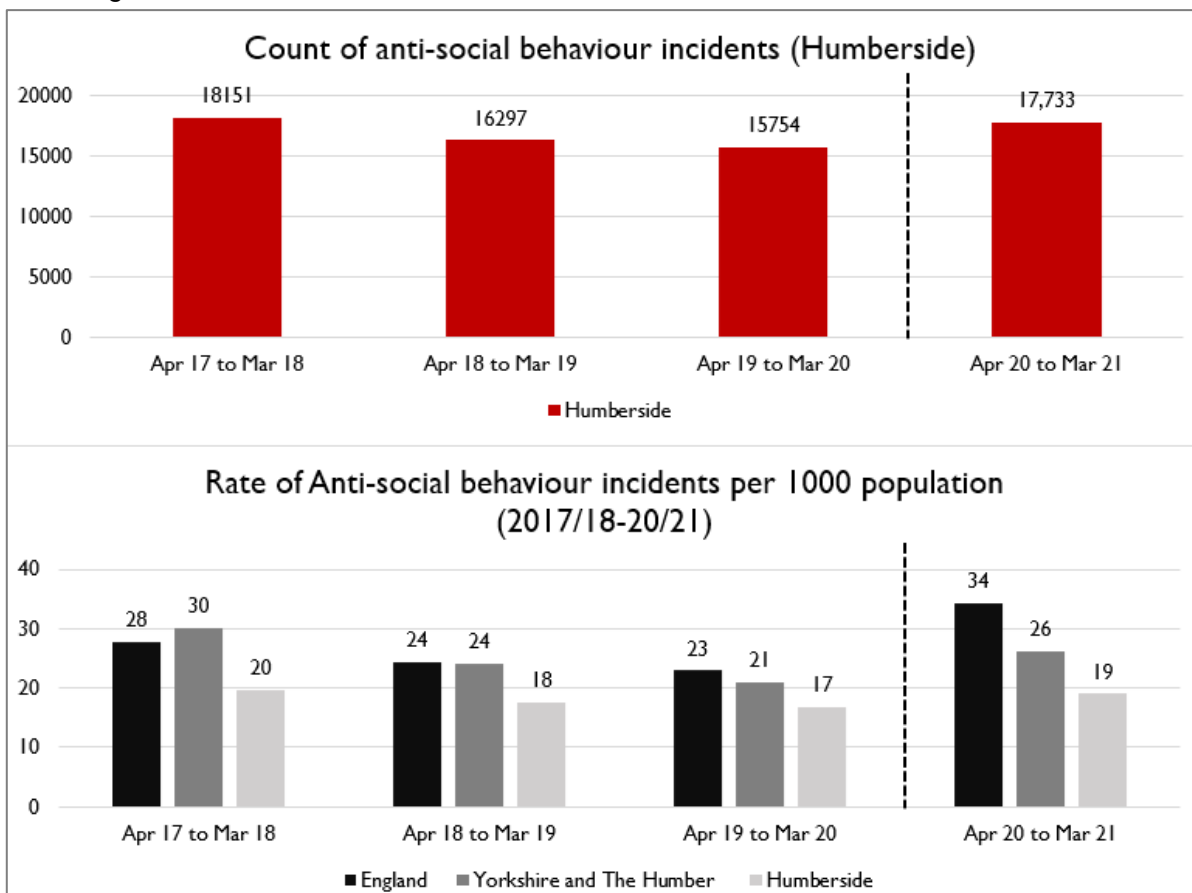
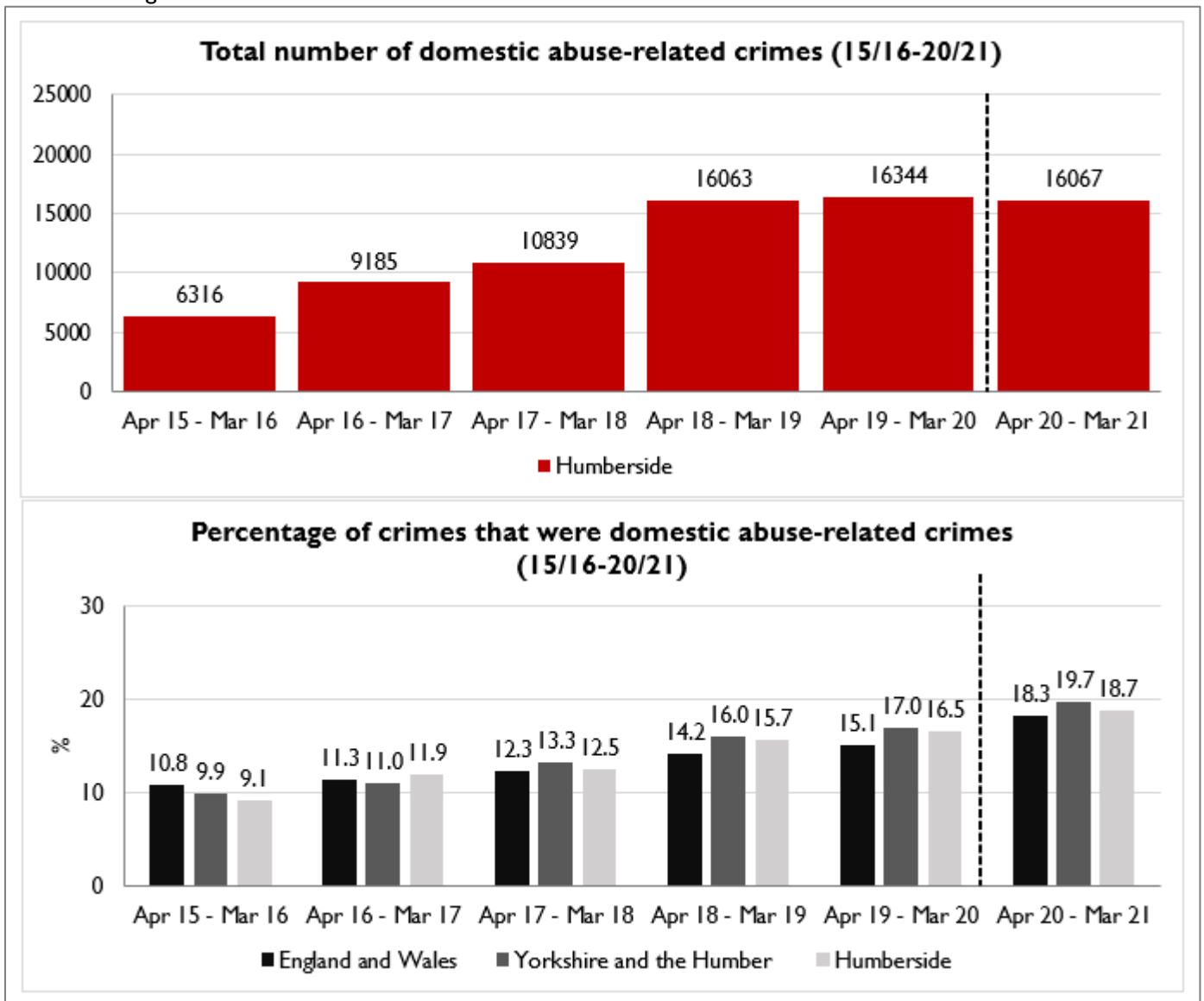


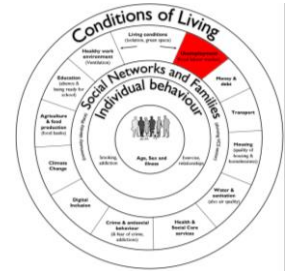
Figure 52. Domestic abuse related crimes: count and % 2015/16 to 2020/21. Source: ONS



12.3 Negative behaviour in children and young people (ERY partner feedback)

System partners within the East Riding reported back to us, via the template sent out, the importance of the traditional school day structure and influence of positive youth activities. Without these, the daily routine of their lives inevitably became unstructured and in some instances individuals turned to crime (e.g. criminal damage) to alleviate boredom as they had nowhere to go. Some children and young people would ‘sneak out’ and leave the family home when they shouldn’t, potentially creating situations that posed a welfare risk.





13 Unemployment

The disruption caused by the pandemic over the past 2 years has been extremely challenging for businesses in the UK. Many were put into an impossible situation of employees not being able to attend work nor could customers buy their products. Many employees were put onto the furlough via the governments Coronavirus Job Retention Scheme, losing at least part of their income, whilst others lost their jobs completely. Those companies hit hardest included restaurants, theatres and construction companies. Even as lockdown measures ease and consumer demand recovers, surging inflation, labour shortages and uncertainty about future sales present several obstacles ahead.

Figures 51 and 52 display the count and proportion of East Riding residents aged 16-64 claiming unemployment benefits* between January 2012 and March 2022. The dotted line on the charts shows the approximate start of the pandemic in March 2020 and labels the contrasting numbers between March 2020 and May 2020. Between these months the number of residents claiming unemployment benefits doubled from over 4,500 to almost 9,500 (an increase of 4,900 persons), increasing from 2.3% of the population to 4.8%. Numbers remained high for approximately a year until May 2021 and then appeared to gradually reduce each month onward. Numbers recorded for March 2022 (5,505 claimants, 2.8% of the population) remain higher than any other recent period since June/July 2013.

Figure 53. Number of East Riding residents claiming unemployment benefits (aged 16-64). Source: NOMIS

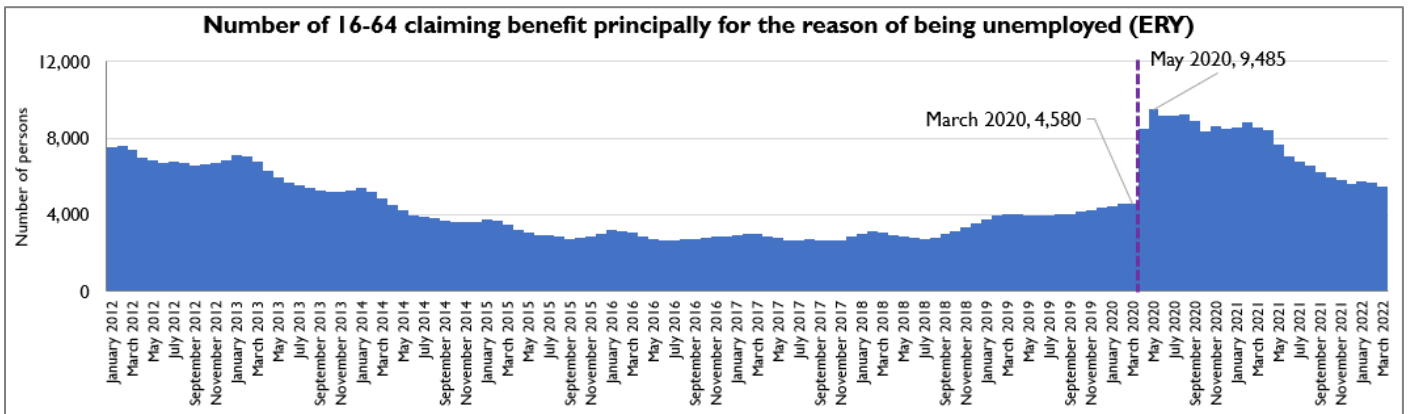
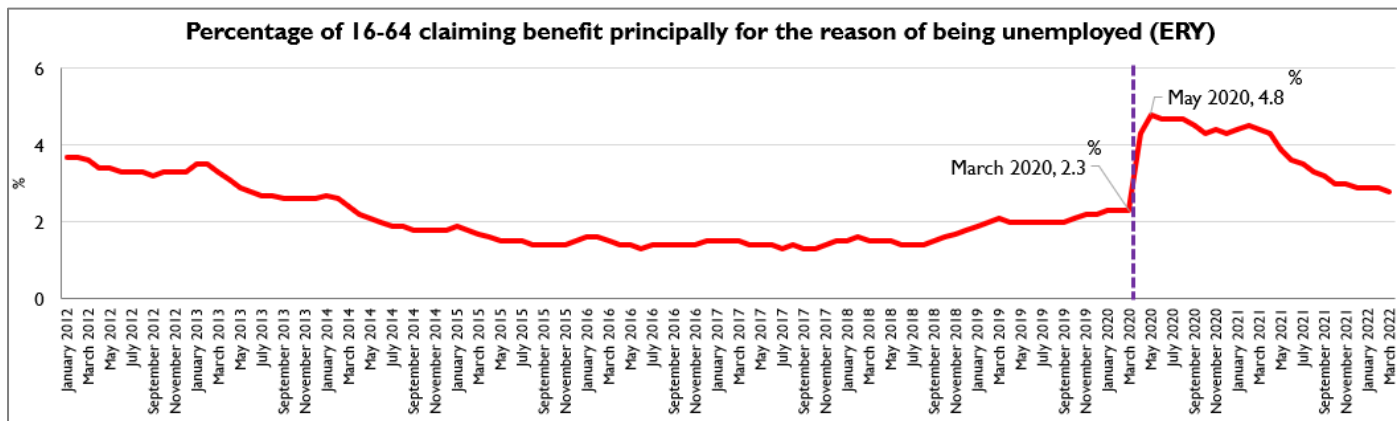


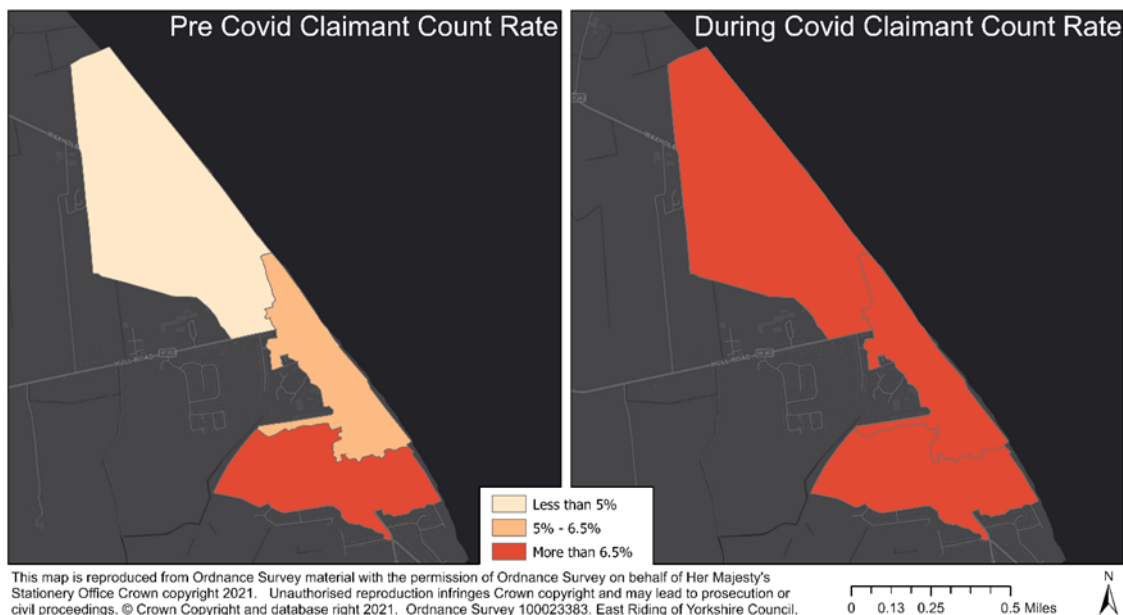
Figure 54. Percent of East Riding residents claiming unemployment benefits (aged 16-64). Source: NOMIS





The ERYC OSC report on ‘Health Inequality in the East Riding of Yorkshire Covid-19’ (January 2022) stated coastal areas were significantly impacted by the pandemic, with regard to unemployment rates. The reliance on tourism and hospitality was contributed to this, but it was also noted that the existing geographic barriers and limited alternative employment options played a role. Figure 53 below demonstrates the impact of COVID-19 on unemployment within Withernsea.

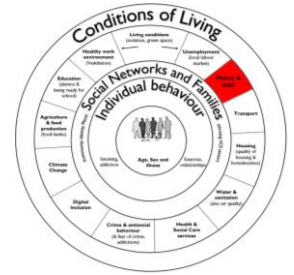
Figure 55. Percent of Withernsea residents unemployed. Source: ERYC OSC report Jan 2022



* Notes:

- from April 2015, the Claimant Count includes all Universal Credit claimants who are required to seek work and be available for work, as well as all JSA claimants;
- between May 2013 and March 2015, the Claimant Count includes all out of work Universal Credit claimants as well as all JSA claimants;
- between October 1996 and April 2013, the Claimant Count is a count of the number of people claiming Jobseeker's Allowance (JSA).





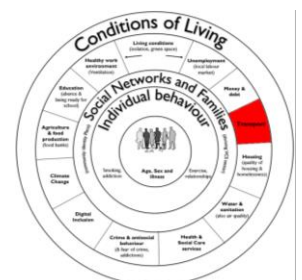
14 Money and Debt

14.1 Financial pressures

The House of Commons (2021) reported that overall household savings had increased and household debt had largely gone unchanged due to the reduction in spending on non-essential items. However, whilst this might present the picture overall, there was evidence suggesting that there many households on low incomes who had needed to borrow or use savings to make ends meet (Beynon and Vassilev, 2021). By December 2020, almost 9 million people had to borrow more money than usual due to the pandemic. ONS identified that there were specific groups more negatively affected by the pandemic including the self-employed, parents, young people and those living on the lowest household incomes.

The self-employed were three times more likely to report a reduced income and twice as likely to eat into savings, compared with employees working for companies (Beynon and Vassilev, 2021). From our own local questionnaire templates, partners frequently made reference to adults (particularly the self-employed) facing financial pressures due to enforced isolation requirements, being off work on long term sick leave due to COVID-19 or due to others in their households having the virus, which then limited their movements.

We would welcome partner input into this section to help us strengthen the evidence about what is known about these issues in the East Riding area and what impact COVID-19 has had on it.



15 Transport

15.1 Public transport concerns

From our survey questionnaires, issues relating to transport weren't broadly mentioned. Those comments that were raised mentioned that as greater deconditioning occurred (particularly in the elderly) there was more reliance on public transport to go to social activities. Limited access to public transport in rural areas has been well documented in the past.

We would welcome partner input into this section to help us strengthen the evidence about what is known about the issues of transport in the East Riding area and what impact COVID-19 has had on it.



16 Summary

From the findings outlined within this document (summarised in section 2.4) it is clear that the COVID-19 pandemic has negatively impacted the East Riding population across a wide range of domains.

Some elements are more immediately tangible, for example the increase in mental health issues in children and for many people inequality to an access to services as they moved online services. Whereas the impact of the disruption of key health services (such as screening) and occurrence of premature deaths may not appear until some years into the future. In essence, the culmination of all these factors (both present and future) places the East Riding at greater risk and increases the fragility of individuals, communities and our services.

However, whilst the impact of the pandemic has been widespread, it is not being felt fairly across our society. Those suffering greater deprivation (with less resources) have fared far worse than those least deprived who have better resources to tackle the adversity of COVID-19. Since the pandemic, inequality is continuing to grow across the East Riding and the consequences of this is poor health and wellbeing outcomes for our most deprived and some of our most vulnerable in society.

Going forward the system and its partners (including the Council, NHS and voluntary sector organisations) need to maximise the support to communities. This can entail assessing where our communities are lacking, in some of the key assets that neighbouring communities may have and supporting those communities in growing their community assets.

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18 Appendices

18.1 COVID related hospital admissions

Figure 56. Daily count of confirmed COVID-19 patients (not just ERY residents) in hospital at 8am, York Teaching Hospitals NHS Foundation Trust. Source: coronavirus.data.gov.uk

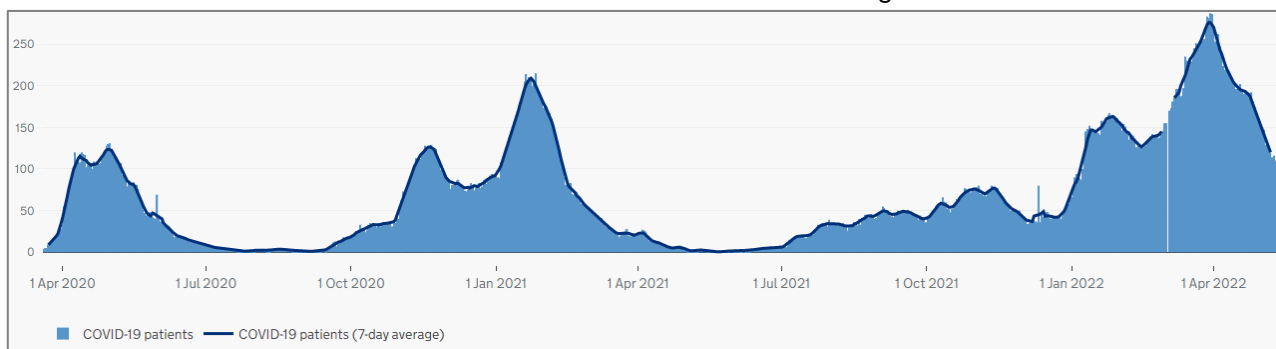


Figure 57. Daily count of COVID-19 patients (not just East Riding residents) in mechanical ventilation beds, and 7-day rolling average, York Teaching Hospitals NHS Foundation Trust. Source: coronavirus.data.gov.uk

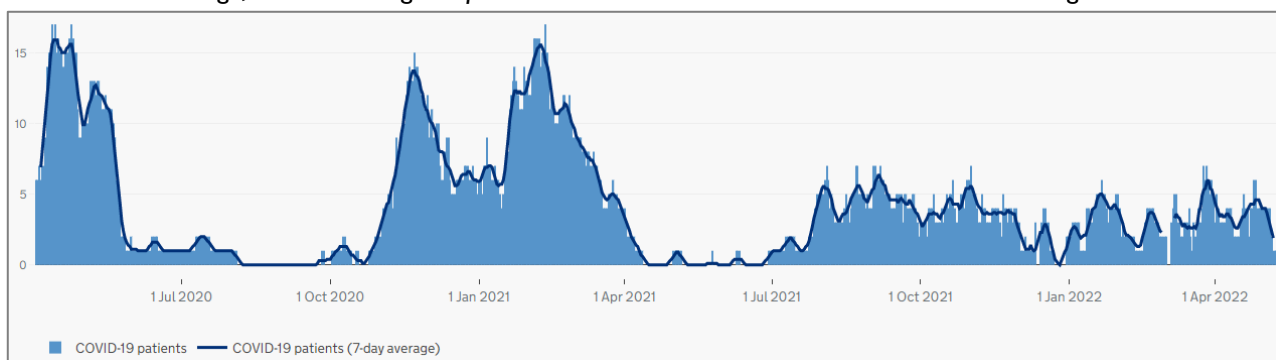


Figure 58. Daily count of confirmed COVID-19 patients (not just ERY residents) in hospital at 8am, Northern Lincolnshire and Goole NHS Foundation Trust. Source: coronavirus.data.gov.uk

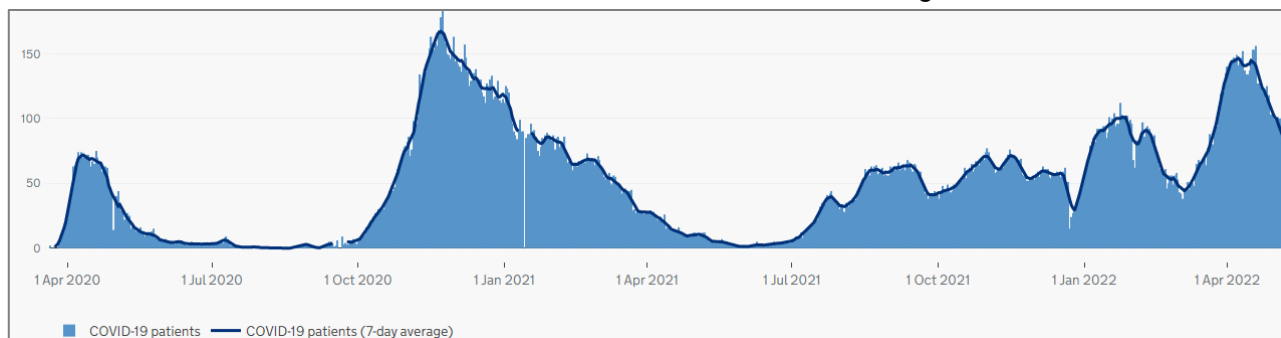
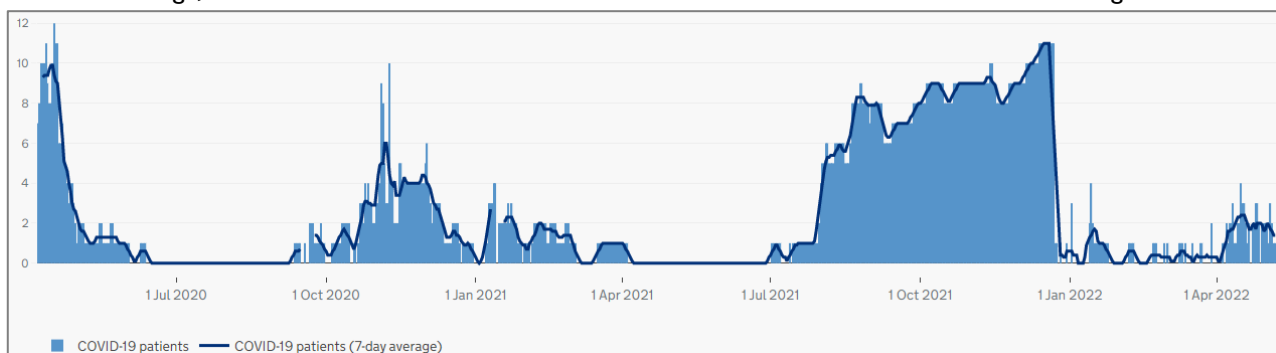


Figure 59. Daily count of COVID-19 patients (not just East Riding residents) in mechanical ventilation beds, and 7-day rolling average, Northern Lincolnshire and Goole NHS Foundation Trust. Source: coronavirus.data.gov.uk



18.2 Life Expectancy

Figure 60 - Life expectancy at birth East Riding wards (2016-18 versus 2019-21)

Deprivation rank*	Ward name	Males			Females		
		2016-18	2019-21	Life expectancy difference	2016-18	2019-21	Life expectancy difference
1	Bridlington South	73.6	72.9	-0.7	79.8	79.9	0.1
2	Bridlington Central and Old Town	78.7	76.2	-2.4	82.6	81.4	-1.1
3	South East Holderness	77.6	78.3	0.8	81.5	81.1	-0.4
4	Goole South	77.9	76.4	-1.5	82.1	80.0	-2.1
5	North Holderness	76.8	75.0	-1.8	84.2	84.2	0.0
6	Bridlington North	81.3	76.7	-4.6	84.9	84.2	-0.7
7	East Wolds and Coastal	81.6	80.4	-1.2	85.8	84.2	-1.6
8	Goole North	78.3	77.9	-0.4	82.2	80.9	-1.2
9	Cottingham South	80.0	78.9	-1.2	84.2	81.4	-2.9
10	Mid Holderness	81.9	81.6	-0.3	87.2	84.1	-3.1
11	South West Holderness	80.3	79.3	-1.0	83.7	81.6	-2.0
12	Driffield and Rural	79.0	80.8	1.8	82.1	82.2	0.1
13	Minster and Woodmansey	81.0	80.0	-1.0	83.3	83.2	-0.1
14	Snaith	79.6	79.9	0.2	81.3	81.9	0.5
15	Tranby	80.7	82.5	1.8	84.3	83.7	-0.6
16	Hessle	79.1	78.6	-0.5	81.6	82.3	0.7
17	Howdenshire	80.2	78.5	-1.7	83.5	84.9	1.4
18	Wolds Weighton	82.3	81.9	-0.4	85.3	83.6	-1.6
19	Howden	80.1	82.3	2.2	86.5	83.7	-2.8
20	St Marys	79.9	81.3	1.4	85.9	84.5	-1.4
21	Cottingham North	80.8	81.8	1.0	83.0	82.8	-0.2
22	Beverley Rural	82.5	80.7	-1.8	87.1	86.4	-0.7
23	Pocklington Provincial	80.7	80.6	-0.1	84.2	84.8	0.5
24	Dale	82.3	81.4	-0.8	84.4	84.6	0.2
25	Willerby and Kirk Ella	83.3	82.4	-0.9	85.7	86.8	1.1
26	South Hunsley	83.1	81.3	-1.8	86.4	84.8	-1.5
	ERY	80.0	79.4	-0.6	83.7	83.2	-0.6

*1 is most deprived (IMD 2019)

2019-21 life expectancy uses the 3 year pooled population of 2018-20 as mid year 2021 estimates have not as yet been released



18.3 Premature mortality

Figure 61. Under 75 Mortality Directly Standardised Rate from Cardiovascular Disease pooled for 2019-21 by electoral ward. Source: ONS & NHS D mortality records

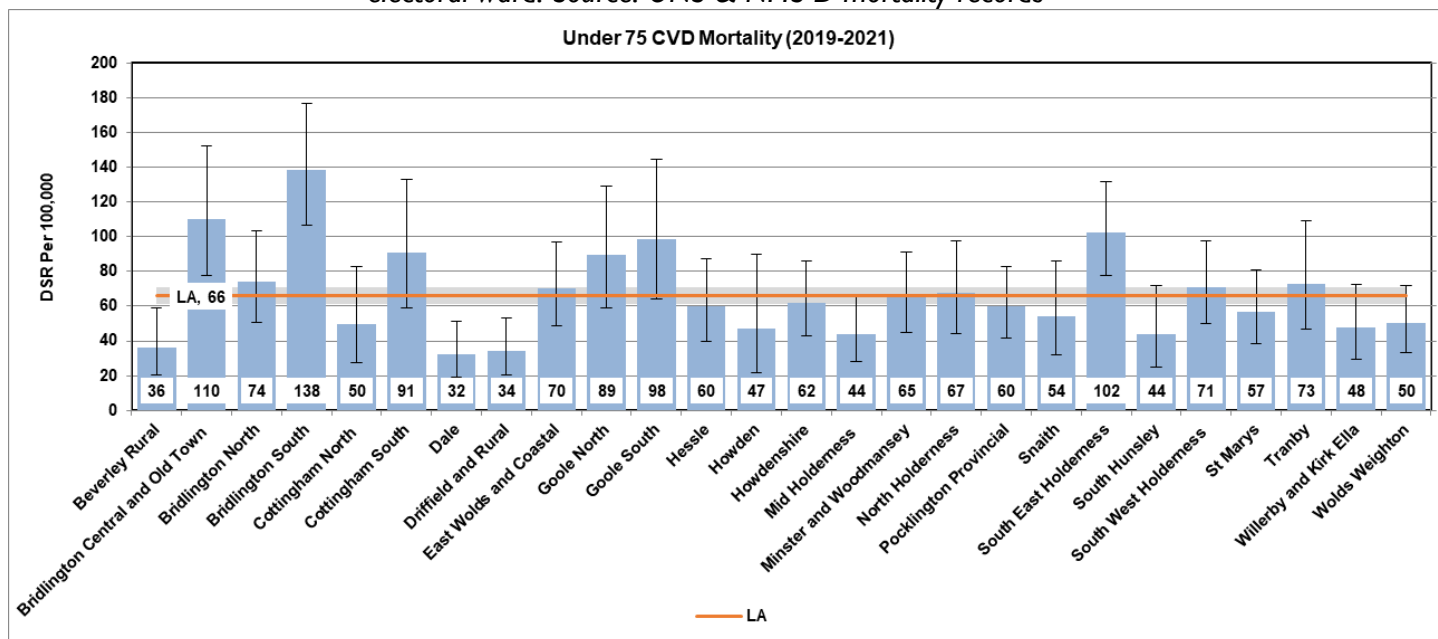
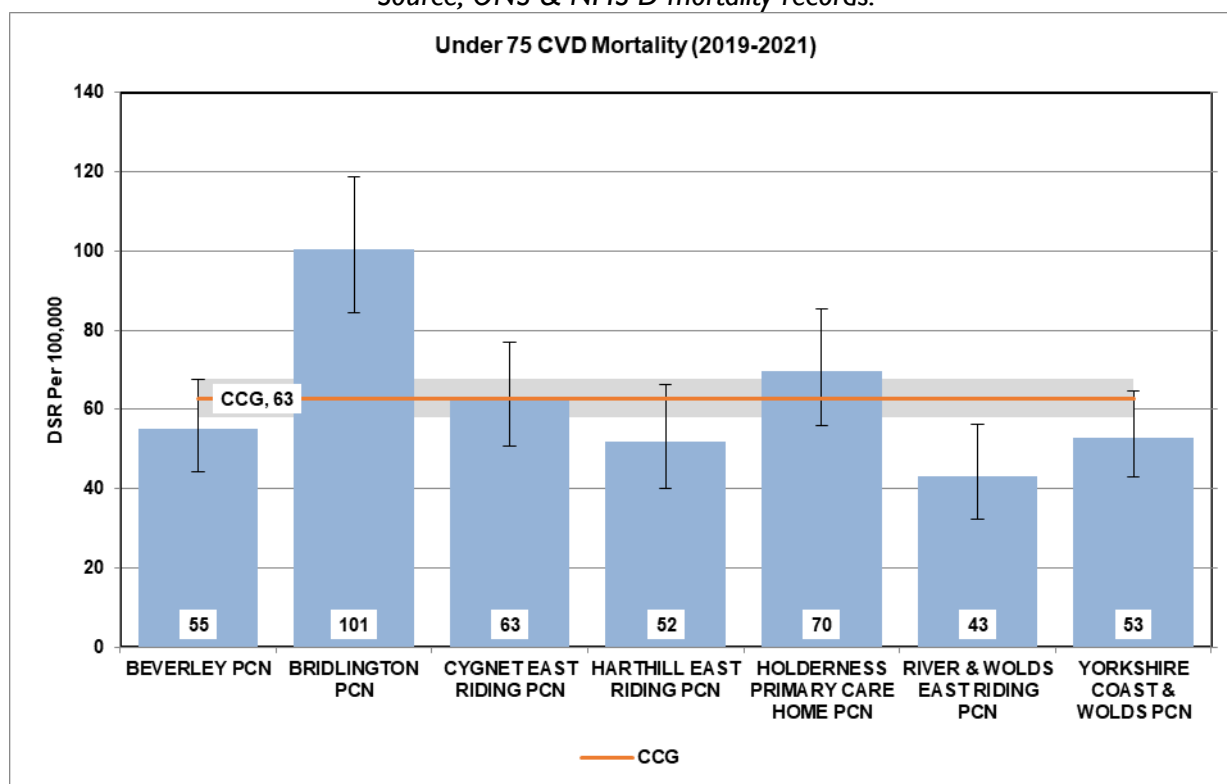


Figure 62. Under 75 Mortality Directly Standardised Rate from Cardiovascular Disease pooled for 2019-21 by PCN. Source: ONS & NHS D mortality records.



18.4 Childhood obesity

Figure 63. Reception year obesity prevalence – trends in England. Source: OHID

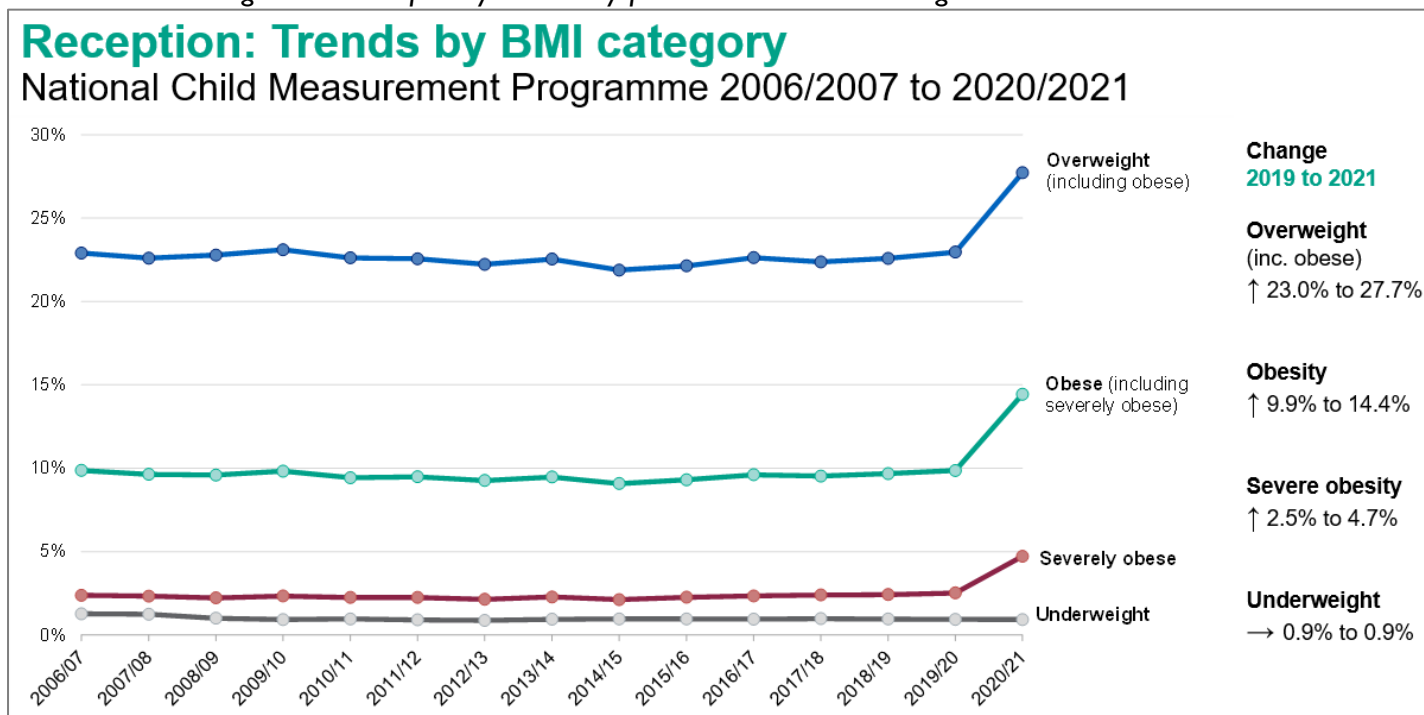


Figure 64. Year 6 obesity prevalence – trends in England. Source: OHID

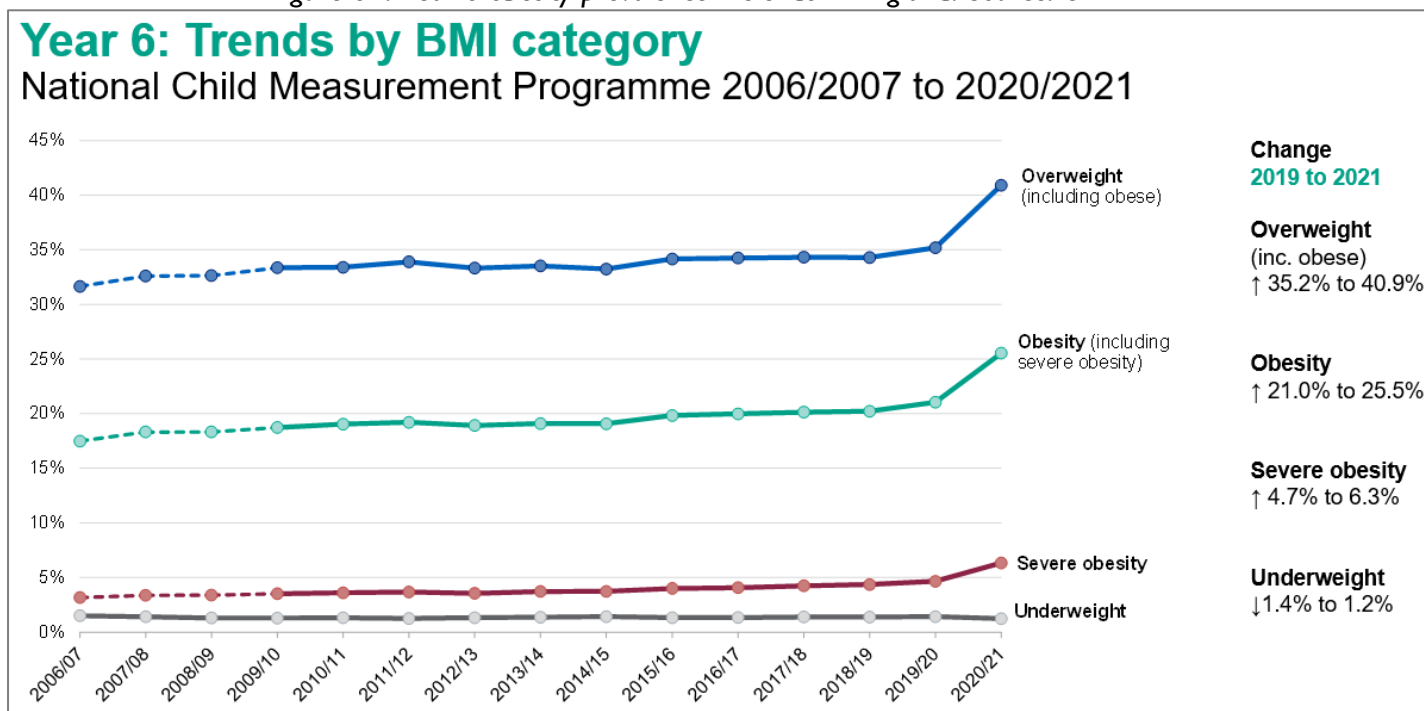


Figure 65. Reception year obesity prevalence – trend of disparity gap in England. Source: OHID

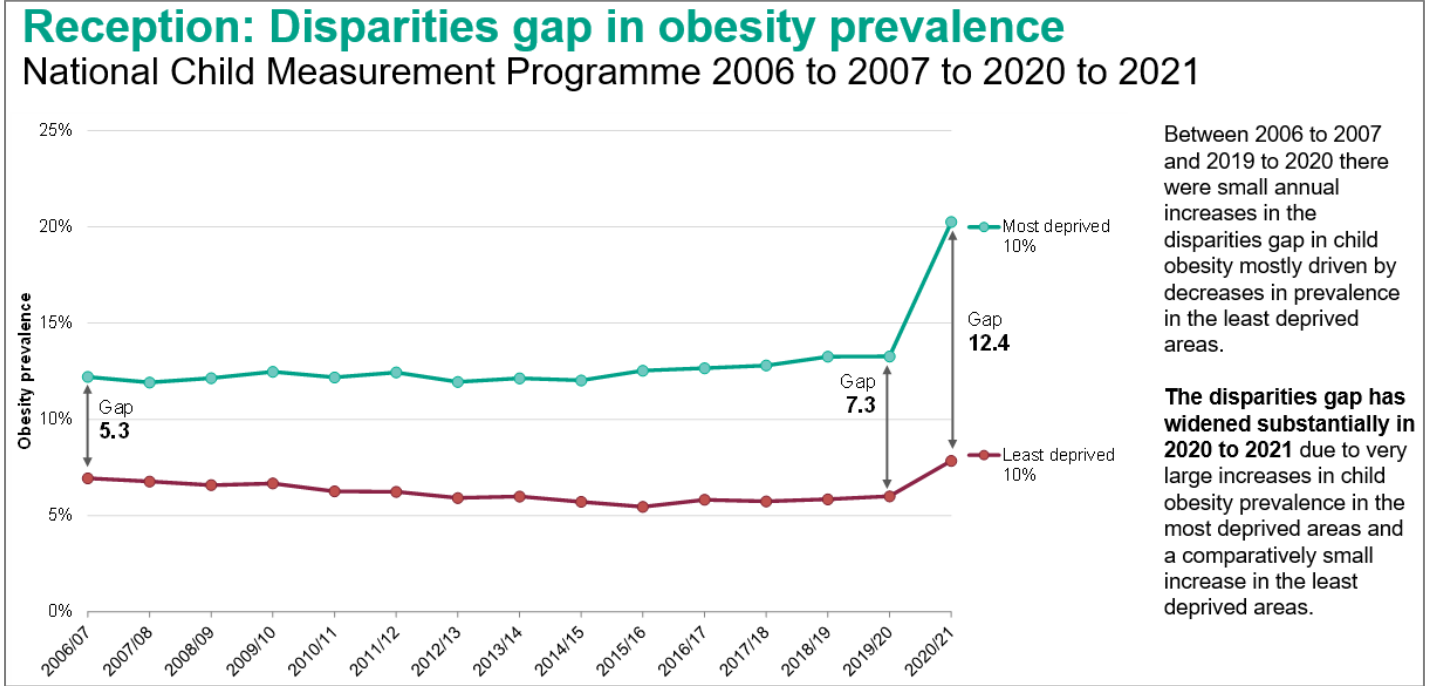


Figure 66. Year 6 obesity prevalence – trend of disparity gap in England. Source: OHID

