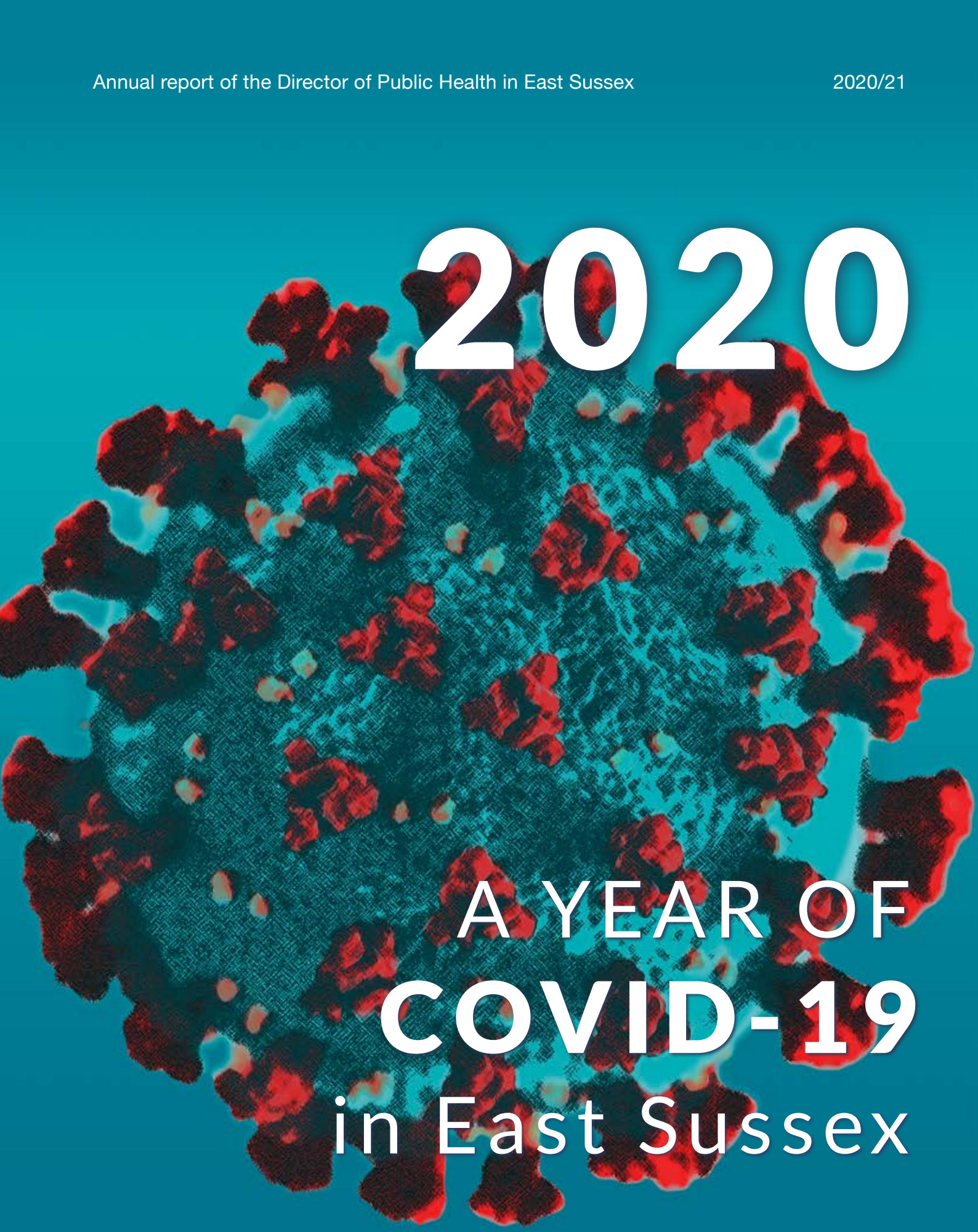
Annual report of the Director of Public Health in East Sussex 2020/21

2020



A YEAR OF COVID-19 in East Sussex

East Sussex County Council

NHS East Sussex

Contents

Foreword

2020 was an extraordinary year for all of us and I certainly didn't expect to be welcoming you to my third annual report by talking about infectious diseases. However, COVID-19 has had a profound impact on everyone's life both personally and professionally. It therefore only felt appropriate that I take the opportunity whilst still in the midst of the pandemic to reflect on 2020 and the first year of COVID-19.

Public health is usually defined by a long-term view and taking preventative steps to improve the population's health in the future. We do this through a wide range of initiatives such as increasing the amount of physical activity, improving housing conditions, and reducing alcohol and drug use. 2020 has required a far more reactive and ever-changing world of public health as our understanding of COVID-19 has grown. This report provides an important opportunity to reflect on 2020 as a whole, to step back and reflect on a truly unusual year, and crucially to look to the future for what we have learned.

Life is still not back to normal in 2021, but as we reflect on 2020 and this first year of COVID-19 we are finally in the privileged position of benefit of the COVID-19 vaccines. With each passing month we will hopefully be closer to COVID-19 being a story in the past rather than a story in the present.

Executive summary

The COVID-19 pandemic declared by the World Health Organisation in March 2020 has had far-reaching effects upon people's lives, health care systems, economies, education, and wider society internationally and within East Sussex.

The virus has led to death, long term morbidity for others and the whole population has felt the impact of the control measures put in place throughout 2020 to try and reduce the spread of the infection.

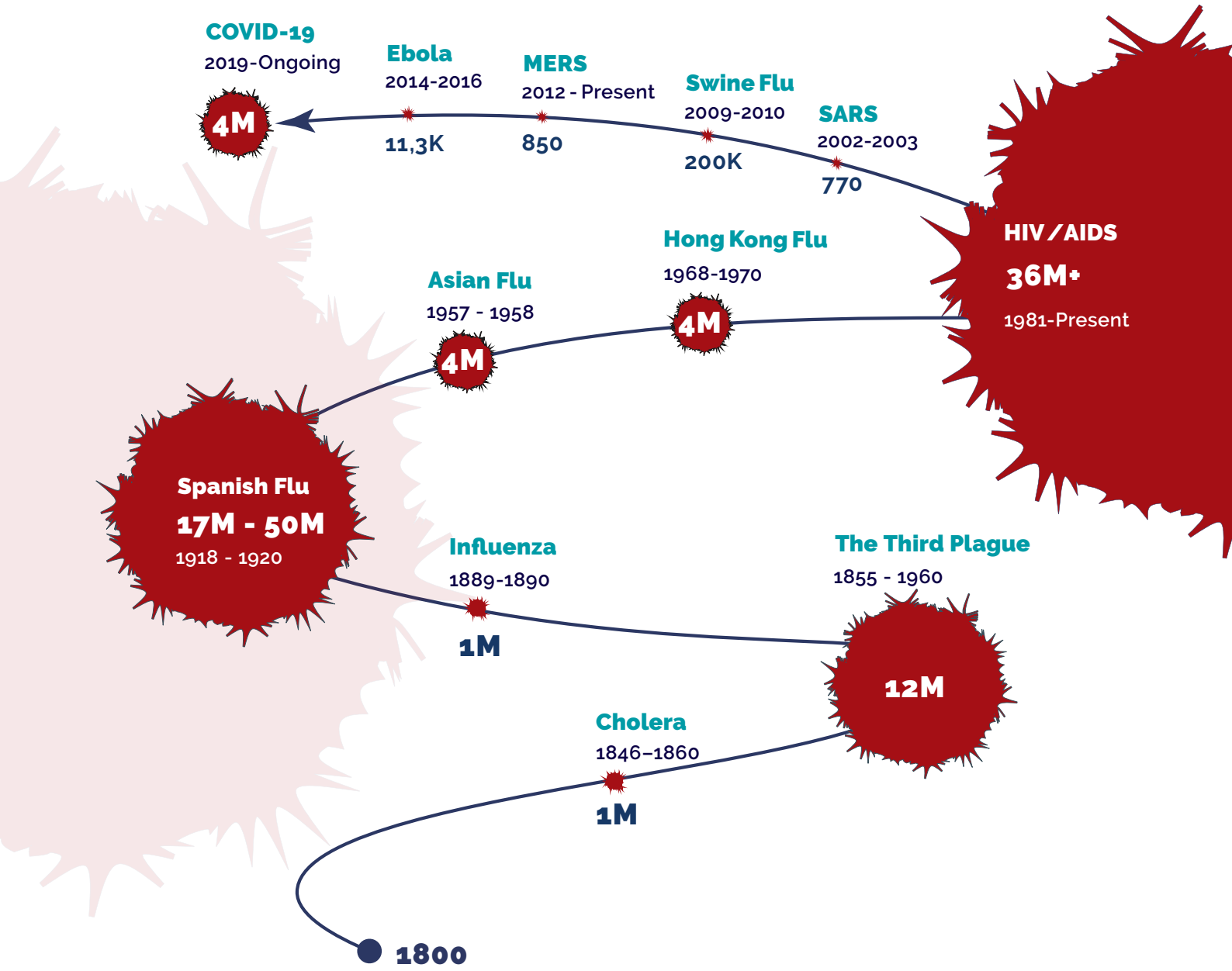
Our attention has often been on responding to the immediate threat that the new disease posed. However as the year has progressed it was clear there was large variation in how local communities experienced the direct and indirect impact of COVID-19. Many of the differences in experience of health and wellbeing that our population experienced in relation to the pandemic are familiar with existing well-known patterns in health and wellbeing inequalities.

This report has several chapters. Chapter 1 details the global context of the pandemic providing a timeline and an overview of the virus and interventions deployed by government. Chapter 2 provides an overview of the health and wellbeing of our local population, services, and workforce. It also highlights those that were identified as clinically vulnerable to COVID-19 and advised to shield. Chapter 3 details some of the direct and immediate impact of the virus in East Sussex. This includes data and trends on confirmed cases throughout the year, hospitalisation data and deaths. Chapter 4 explores the wider impact of COVID-19 and the associated social distancing interventions (such as 'lockdowns') on our population. This section includes a range of sources of insight from partner surveys such as Healthwatch East Sussex as well as qualitative data from the 'COVID-19 stories' project delivered by the University of Brighton. The economic impact of the pandemic is also explored in this penultimate chapter. Within the conclusion section variation in epidemiological trends, experiences of the year, and the reasons for them are explored. These are numerous and complex given the extremes of the two associated 'waves' of infection the county witnessed in the spring of 2020 and the beginning in December 2020.

Many of the inequalities that COVID-19 exposed, are known. These require a long-term solution focussed plan and action on reducing inequalities in health, which requires reducing inequalities in wealth, access to quality housing, education, and employment. This report makes several recommendations which identifies areas for continued action with partners. The recommendations build on programmes already underway across our county as well as being specific to COVID-19.

High burden infectious diseases

The following graphic illustates some of the better know high burden infectious disesases. The timeline depicts aproximate global death rates by infections from 1800 up to the present day.



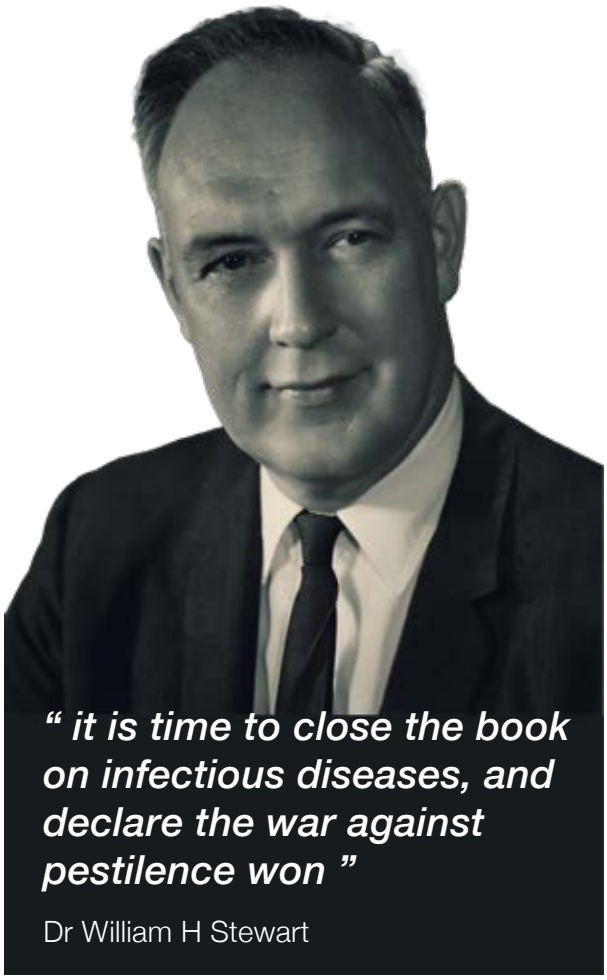
Sources: COVID-19 | covid19.who.int , Ebola | cdc.gov, MERS | emro.who.int, Swine Flu | cdc.gov, SARS | cdc. gov, HIV/AIDS | who.int, Hong Kong Flu | cdc.gov, Asian Flu | euro.who.int, Spanish Flu | cdc.gov, Russian Flu | sfamjournals.com, The third plague | Britannica.com, Cholera | Britannica.com

Chapter 1:

Introduction

Global context

In the 1960s the US Surgeon General Dr William H Stewart is reported to have announced the end of infectious diseases, saying “it is time to close the book on infectious diseases, and declare the war against pestilence won”. Although there is some debate as to the accuracy of this quote, in the 1960s the view that infectious diseases would soon be conquered was widespread. However, infectious diseases have continued to pose a major threat to the health of the population. From the emergence of HIV/AIDS in the 1980s, the resurgence of tuberculosis from the late 1980s to 2005, and most recently the outbreaks of Ebola and Zika, infectious diseases continue to pose a major threat to health.



“ it is time to close the book on infectious diseases, and declare the war against pestilence won ”

Dr William H Stewart

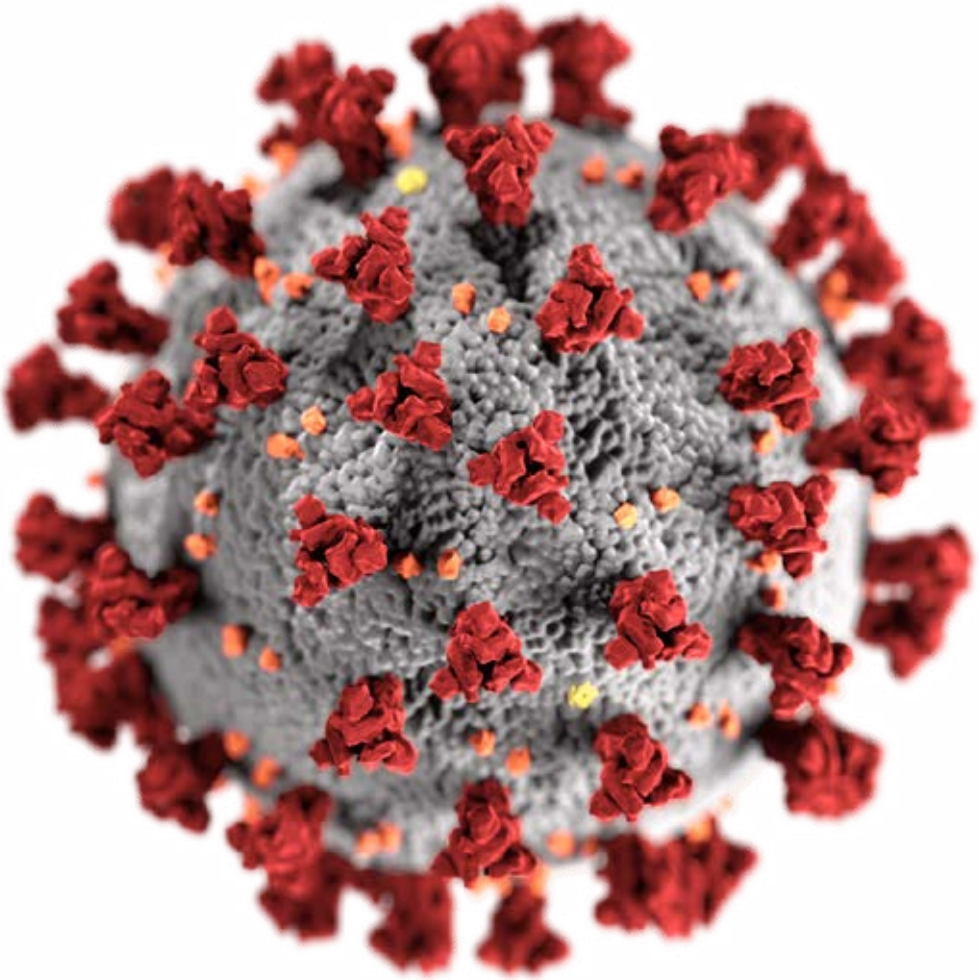
The specific risk of a new respiratory disease spreading globally (a pandemic) is something that has always posed a threat. There have been a number of pandemics since 1900. The influenza pandemic of 1918 is estimated to have infected approximately 500 million and lead to 50 million deaths. Known as Spanish flu because it was mistakenly thought to have originated in Spain (in fact it was only first reported in Spain due to restrictions on the press elsewhere at the time), this was the most severe pandemic in recent history. However, the subsequent influenza pandemics of 1957-58, 1968, and 2009 are estimated to have resulted in between 150,000 and 1 million deaths.

The emergence of a new coronavirus

On the 31st December 2019 the World Health Organisation (WHO) were notified about a cluster of pneumonia of unknown cause. It was identified as a type of coronavirus on the 12th January and later named COVID-19. The WHO subsequently declared an Emergency of International Concern on the 30th January, and on the 11th March the WHO declared that COVID-19 was a pandemic following sustained global transmission. This is the first coronavirus characterised as a pandemic.

Although you would often associate a novel infection such as COVID-19 to initially be concentrated in areas such as London or other transport hubs, East Sussex was affected by COVID-19 right at the beginning with the third UK case linked to a company based here. Chapter 3 gives more detail on how East Sussex was affected by COVID-19 over time.

The following timeline tells the story of COVID-19 in 2020 and when the different policy decisions were implemented. Over the year there were a range of different measures implemented nationally in order to interrupt transmission of COVID-19. The timeline shows how the intensity of these measures varied, which was a constant balancing act that had to be made nationally between on the one hand minimising spread whilst also seeking to avoid the direct and indirect health, and wellbeing effects alongside the social and economic costs.



Key steps in the policy time-line

There have been five key steps taken to ease or increase lockdown measures over time in England:

Step 1 - from 13 May includes:

a. workplaces should follow the new “COVID-19 Secure” guidelines, and those who cannot work from home can travel to work if it is open
b. continue to avoid public transport where possible
c. advice to wear a face-covering in enclosed spaces
d. exercising as much as people like, and can include driving to outdoor spaces and meeting whilst socially distanced with one person from outside the household

Step - from 1 June includes:

a. reopening schools for children in reception, year 1 and year 6, and other early years settings
b. spend time socially distanced outdoors, including private gardens, with up to six people from different households
c. car showrooms and outdoor markets reopen
d. socially distanced exercise outside with up to five others from different households
e. people 'shielding' are able to go outdoors with their household, or if they live alone they can meet socially distanced outside with one other person from another household

Step - from 15 June includes:

a. non-essential shops in England reopen
b. zoos and outdoor attractions where people can stay in their cars reopen
c. secondary schools can offer some face-to-face support for year 10 and 12, to supplement remote education
d. face coverings mandatory on public transport
e. hospital staff, visitors and outpatients must wear face masks and face coverings (respectively)

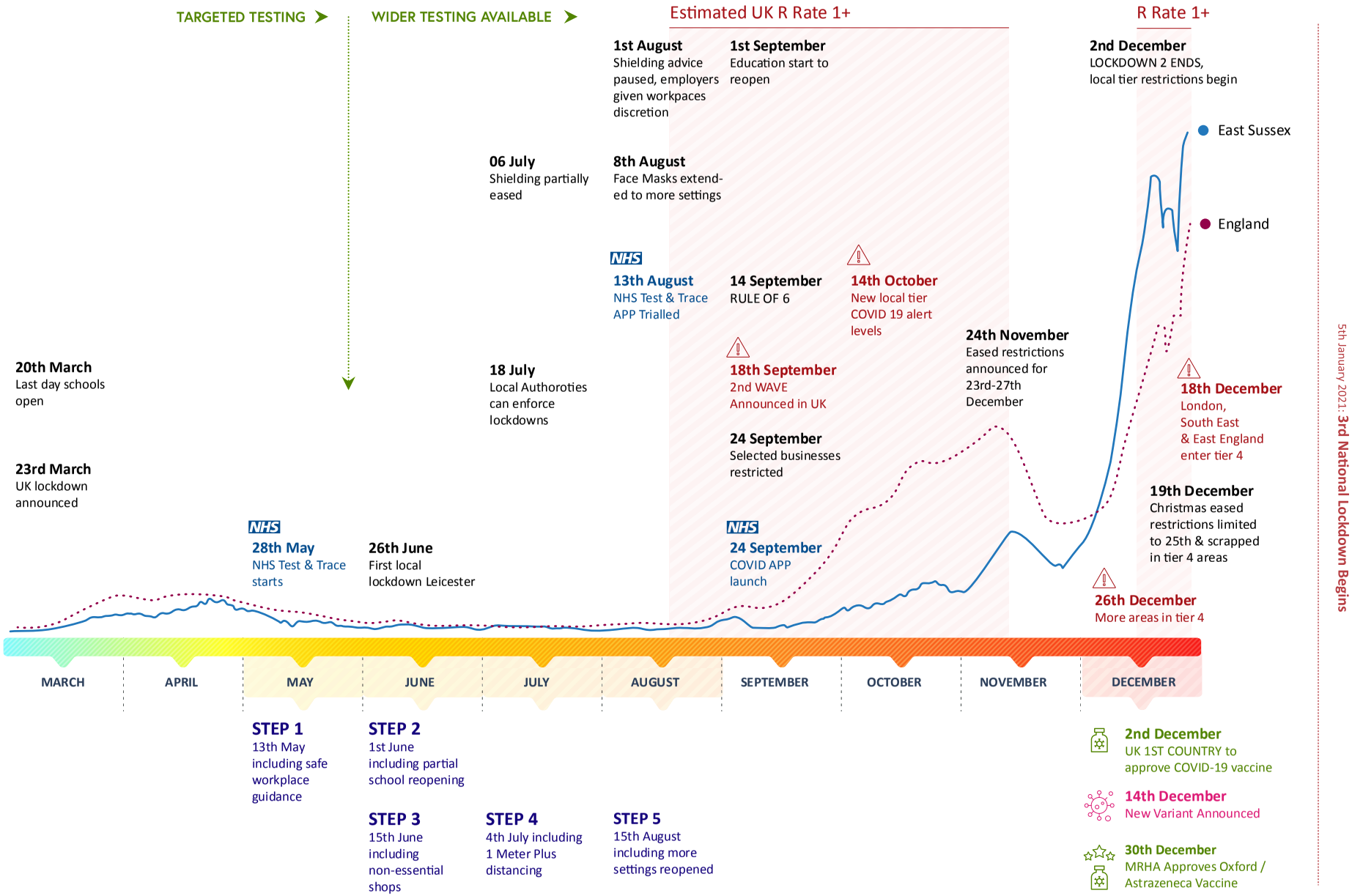
Step 4 - from 4 July includes:

a. social distancing rule to state that 2m or 1m with risk mitigation
b. if guidance is followed, restaurants, pubs and cafés in England, as well as holiday accommodation and some tourist attractions and leisure facilities can reopen
c. places of worship can open, including for weddings with up to 30 guests
d. two households of any size are able to meet indoors or outside socially distanced; outdoors,people from multiple households can meet in groups of up to six - but two households can meet regardless of size

Step 5 - from 15 August includes:

a. some culture, sport, leisure and business sectors can reopen if local restrictions allow
b. COVID secure wedding receptions can include a sit-down meal for up to 30 guests
c. indoor theatres, music and performance venues can reopen with socially distanced audiences
d. dance venues, sexual entertainment venues and hostess bars remain closed in law

COVID 19 within England and the United Kingdom (UK) timeline:



What we know about COVID-19

In order to respond to and control an infectious disease it is really important to have a clear understanding of its particular characteristics.

Some of the key features we are interested in are:

- **incubation period:** this is the time it takes for a person who is exposed to the virus to develop symptoms
- **infectious period:** this can start before, during or after the onset of symptoms. For some diseases people may be infectious without displaying symptoms
- **symptoms:** we need to know not only the range of possible symptoms, but also how common different symptoms are
- **risk factors:** infectious diseases do not affect all people equally, and certain people are more at risk than others. Some risk factors are specific to a particular infection but often risk factors are consistent across a range of infections
- **variants:** new variants may provide more infectious, more serious and may affect the efficacy of available vaccines
- **case fatality rate:** the case fatality rate (CFR) tells us about the severity of a disease and is the proportion of cases of a disease that result in death and long term complications often referred to as Long Covid

As with any new infection it takes a while to build up a comprehensive grasp of the exact features. As the evidence base grows this helps to refine our understanding but there is often a margin of uncertainty, for example new symptoms may be discovered that were not previously known about. Furthermore, infections change over time as new strains emerge and this can lead to changes in some of the features.

Over the last year the evidence base for COVID-19 has grown substantially, but whilst the brief summary below describes what we know so far, it may be over time this gets further refined.

Table 1: Key features of COVID-19, summarised from the Green Book COVID-19 Greenbook chapter 14a | publishing.service.gov.uk

Transmission	Mainly transmitted by person to person spread through respiratory aerosols, direct human contact and fomites [contact with objects]. Symptomatic and pre-symptomatic transmission (1-2 days before symptom onset), is thought to play a greater role in the spread of SARS-CoV-2 than from people with no symptoms.
Incubation period	Typically within 5-6 days
Symptoms	A significant proportion of individuals are likely to have mild symptoms and may be asymptomatic at the time of diagnosis. Symptoms are commonly reported as a new onset of cough and fever, but may include headache, loss of smell, nasal obstruction, lethargy, aching muscles, runny nose, taste dysfunction, sore throat, diarrhoea, vomiting and confusion; fever may not be reported in all symptomatic individuals. Patients may also be asymptomatic. NICE guidelines include definitions for long term symptoms after COVID-19, often described as 'long COVID'. These are: ongoing symptomatic COVID-19 (people who experience symptoms for 4-12 weeks), and post-COVID-19 syndrome (symptoms which continue for longer than 12 weeks).
Risk factors	Severe infection is associated with increasing age, being male, and having underlying conditions such as cancer and severe asthma. Lifestyle factors also increase the risk of more severe disease, including smoking and being an unhealthy weight. Other reported risk factors have been identified by Public Health England . People from Black ethnic groups were most likely to be diagnosed with COVID-19, and death rates are highest amongst people of Black and Asian ethnic groups. The COVID-19 diagnosis rate is highest in the most deprived areas. Mortality rates in the most deprived areas were more than double the rate in least deprived areas. People working in certain occupations have higher mortality rates from COVID-19, including lower skilled workers in construction and processing plants, social and health care workers, security guards, those driving the public, chefs and sales/retail assistants. There has been over twice the rate of mortality from COVID-19 for residents living in care homes, and among people who have learning disabilities. There is also increased risk associated with rough sleeping and being born outside the UK and Ireland.
Case fatality rate	Before the introduction of immunisation, the overall case fatality rate was estimated to be 0.9%, increasing to 3.1% for those aged 65-74, and 11.6% to those over 75.

COVID-19 Variants

There are many thousands of different versions [or variants] of COVID-19 circulating. It is not unexpected that new variants continue to develop. All viruses mutate as they make copies of themselves to spread. Most of these differences are inconsequential. Some new variants of COVID-19 are more contagious and cause more severe disease. They can evade our immunity even after a previous infection or immunisation. These are known as Variants of Concern [VOC].

The WHO uses Greek letters to refer to these variants first detected in countries like the UK, South Africa and India. The UK variant is now labelled as Alpha. The Indian variant of increasing dominance worldwide is known as Delta. The South African variant is Beta. These new names should help remove some stigma from the country names.

When a new COVID-19 infection caused by a variant of concern is found in a person living in the UK detailed checking of their contacts occurs by the NHS Test and Trace service. The process also picks up where they may have caught the infection. The finding of a new variant of concern may also initiate a process of active community testing on a wider scale to see if there has been any spread within a particular community.

Current vaccines were designed around earlier versions of COVID-19, but there is now good evidence from real world studies that they prevent severe illness from the variant strains, although perhaps not quite as well compared to the original strain of COVID-19. There is also evidence that vaccination prevents transmission of the virus in close household contacts. Active ongoing research is developing new vaccines which will offer additional protection against these variants.

Long Covid

Early attention has been on the acute illness generated by the virus, but it is becoming clear that, for some people, COVID-19 infection is a long-term illness. There is an urgent need to understand the journeys of individual people and the clinical features which could explain these. There are significant psychological and social impacts of COVID-19 that will have long-term consequences for individuals and for society if these are not well managed in our community.

Persistent health problems reported following acute COVID-19 disease include:

- respiratory symptoms - chronic cough, shortness of breath; symptoms of lung pathology including inflammation, fibrosis, and pulmonary vascular disease
- cardiovascular symptoms - chest tightness; symptoms of acute myocarditis and heart failure
- protracted loss or change of smell and taste
- mental health problems including depression, anxiety and cognitive difficulties [brain fog]
- inflammatory disorders such as myalgia, multisystem inflammatory syndrome, Guillain-Barre syndrome
- gastrointestinal disturbance with diarrhoea
- continuing headaches
- fatigue, weakness and sleeplessness
- liver and kidney dysfunction
- clotting disorders and thrombosis
- enlarged lymph nodes
- skin rashes

The fluctuating and multisystem nature of symptoms are acknowledged. A common theme is that symptoms arise in one physiological system then abate only for symptoms to arise in a different system. The inability to return to normal activities, as well as adverse emotional and mental health outcomes are apparent.

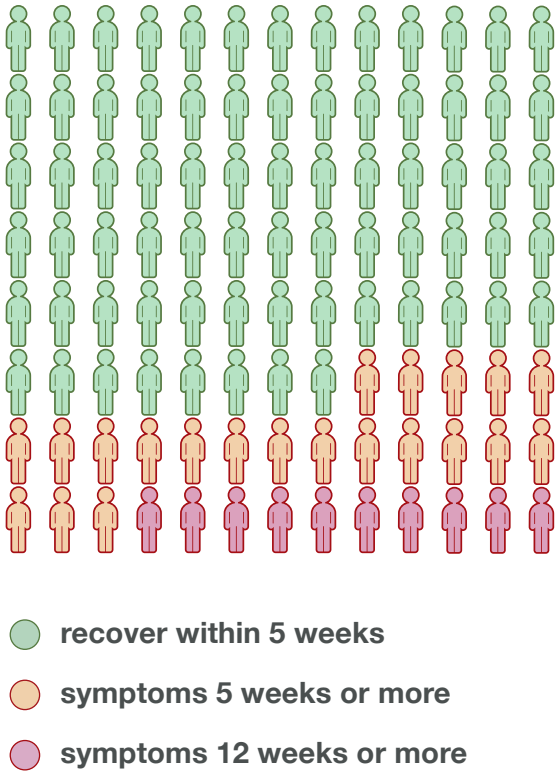
NICE has introduced the following broad case definitions in their guidance:

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

People experiencing similar symptoms may refer to 'Long Covid' or 'Long Haul Covid' but it is unclear if people are suffering from the same phenomenon. The Coronavirus (COVID-19) Infection Survey is a nationally-representative sample of the UK community population and is one way to estimate the proportions of people with ongoing symptoms.

Around 1 in 5 respondents testing positive for COVID-19 exhibited symptoms for a period of 5 weeks or longer. Around 1 in 10 respondents testing positive for COVID-19 exhibited symptoms for a period of 12 weeks or longer. There were 10,958 confirmed cases in East Sussex in December. Just from these confirmed cases alone we would expect nearly 2,200 people still to have symptoms after five weeks and nearly 1,100 to have symptoms after 12 weeks.

Long-COVID Recovery Periods



Long Covid fatigue, weakness and sleeplessness

Many researchers and healthcare professionals are cautious about attributing all the reported problems to a single diagnosis. Some of the symptoms overlap with post-intensive care syndrome. There is much yet that we still do not know.

The implementation of the NICE guidelines about long-COVID by healthcare services, employers and government agencies will facilitate access to much needed support and provide the basis for planning appropriate services locally. Primary care services will need additional capacity to deal with patients with long COVID.

Health and social care workers are likely to have a high burden of long COVID themselves and must have adequate occupational health provision. Long COVID affects even young adults, so effective public health messaging for all individuals about the risks of acquiring the infection is warranted. People, their families and health and care professionals need to be guided and informed further about what to expect in terms of outcomes and about what health and care services can realistically provide. There is a case for standardising the methods of assessment of post-COVID-19 patients, as well as developing educational programmes for patients and care givers.

Novel infection? Same old inequalities

The wider determinants of health

Whilst COVID-19 is a completely new infectious disease, the risk factors described above reveal a familiar pattern that we see mirrored throughout life. Firstly, good health is not experienced equally, but instead is determined by the structural and social conditions that we live in. If you live in the most deprived part of East Sussex your life expectancy is on average 8.4 years (for men) and 4.7 years (for women) lower than if you live in the least deprived area, and with COVID-19 we again see this link between wealth and health.

Last year's annual report on health focussed on the links between health and housing to put a spotlight on how health is shaped by the environment we live in. COVID-19 is another example of how these conditions ultimately lead to poorer health. We often see links between deprivation and infectious diseases, for example TB is well known to be a disease of poverty, with overcrowding and poorer access to health some of the factors behind this association. Whilst COVID-19 has presented an immediate health crisis, many of the inequalities it has exposed require a long-term solution focussed on reducing inequalities in health which requires reducing inequalities in wealth, access to decent housing, education and jobs etc.

COVID-19 has revealed familiar links between the conditions we live in and our health and wellbeing. Variation in the experience of wider determinants (i.e. social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist.

Acknowledging this, a range of activities are being delivered and developed to address the wider determinants of health. This includes the launch of a new programme of work promoting a 'health in all policies' approach and creating healthy places through design and planning.

We are also supporting additional provision of benefits and debt advice, and employability support. This includes supporting our most marginalised residents into learning, work, and independent living through Supported Apprenticeships to develop skills in key sectors where there are currently opportunities within construction, horticulture, health, care and visitor economy.

We will continue with our work with Hastings Borough Council and partners in tackling fuel poverty and upgrading homes to become warmer and more energy efficient.

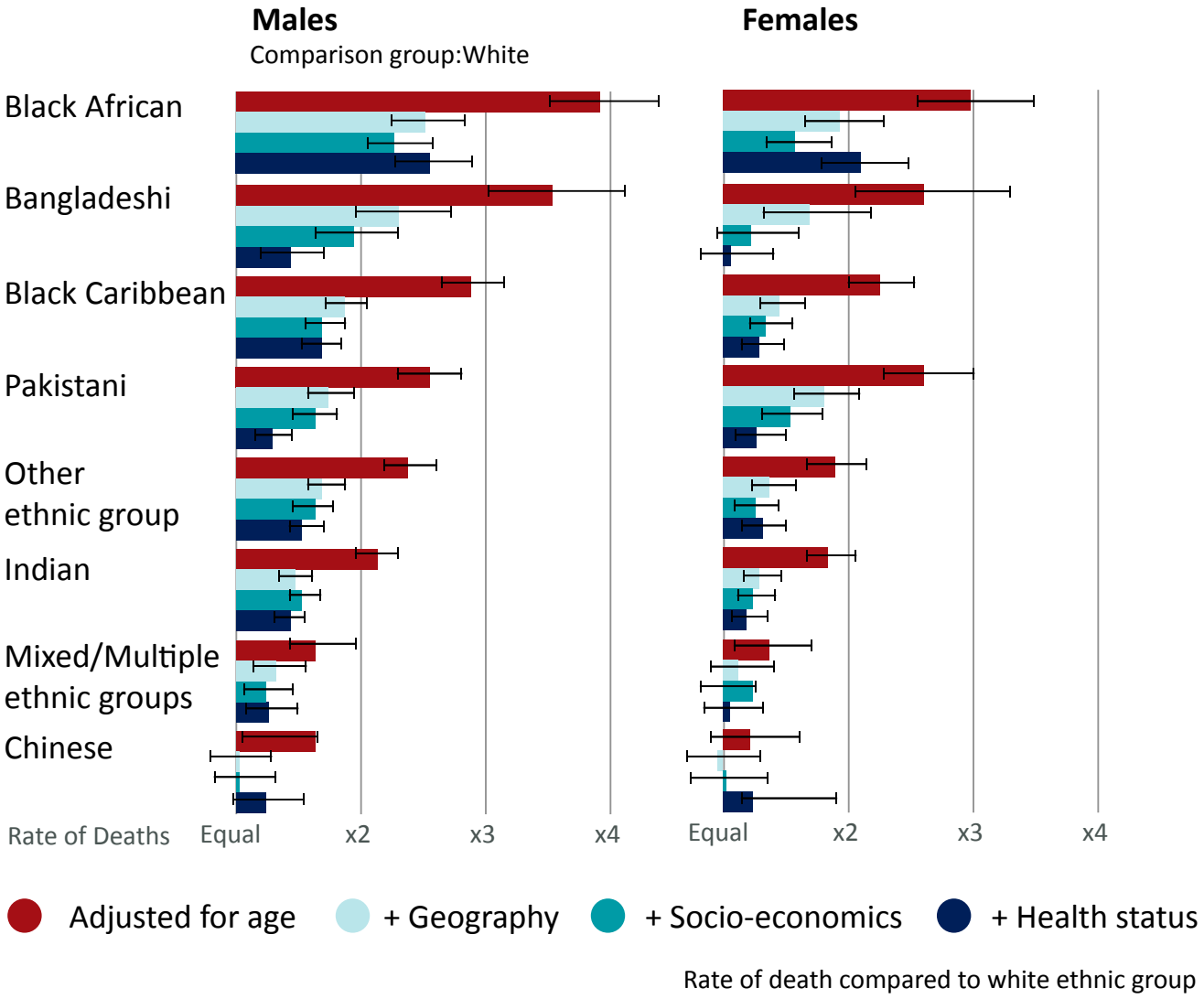
> **Recommendation:**
> COVID-19 has revealed familiar links between the conditions we live in and our health and wellbeing. We will continue to mitigate the impacts of the wider determinants of health to reduce health inequalities through a wide range of existing and new programmes.

Risk to ethnically diverse groups

In the early stages of the pandemic, national data revealed a higher mortality risk from COVID-19 among ethnically diverse groups. This stark finding alongside the death of George Floyd and the BlackLivesMatter movement have put a renewed focus on the structural inequalities faced by ethnically diverse groups.

The following chart details some national modelling on COVID-19 deaths by ethnic group. This includes a series of charts which show how much greater the risk of death is for each ethnic group when compared to the white population. Each ethnic group has four lines which show how the risk of death is increased when accounting for age, geography, socio-economic status, and health status.

Rate of COVID-19 death by ethnic group and sex relative to the white population, England and Wales



Source: ONS: data 2nd March to 28th July, reported 16th October 2020

After adjusting for age (first bar), males and females from all ethnic minority groups (except females of Chinese ethnic background) were at greater risk of death involving COVID-19 than the White ethnic group.

The second and third set of bars show adjusted estimates for geography and demographic and socio-economic characteristics. These adjustments make a sizable contribution to the reduction in estimated risk of death involving COVID-19 for ethnic minority groups relative to the White population. For males, all minority ethnic groups with the exception of Chinese remained at significant increased risk compared to the White population, and for females all minority groups with the exception of Bangladeshi, Chinese and Mixed ethnic backgrounds were at significant increased risk.

The dark blue bar shows the risk of COVID-related death when health status is included. This doesn't significantly change the risk profile for either males or females overall, but this notably increases the risk for people of Black African or Chinese ethnic background, reflecting differences in the prevalence of comorbidities that are associated with COVID-19 mortality risk between each of the ethnic minority groups and the White population.

A detailed report is being produced on the needs of ethnically diverse groups. The report will include national and local disparities of COVID-19 and recommendations.

Recommendation:

We have been working across Sussex, with our Integrated Care System (ICS) partners, to understand the range of issues that disproportionately affect people from ethnically diverse communities and why they experience poorer health and wellbeing. We will act on recommendations to disrupt the structural inequalities faced by these groups in the future.

Lifestyle and Healthy choices

Another familiar lesson learned is that there are important links between people's lifestyle and the impact of COVID-19. Maintaining a healthy weight through frequent regular exercise and eating well reduces your risk of complications from COVID-19, which is just another of the many ways in which exercise and nutrition improves and protects your health.

Even during the toughest restrictions there was a continual emphasis nationally on the importance of exercise as one of the few exceptions to the stay at home message. With many other aspects of our lives restricted, it was heartening to see people taking advantage of the daily opportunity to do exercise.

However, with the implementation of guidance/restrictions in England throughout the pandemic, particularly in lockdown periods, this limited the majority of sports and exercise activities from taking place. Nationally, activity levels had been increasing until COVID-19 restrictions were introduced in March 2020. The restrictions led to unprecedented drops in activity during the first few weeks of full lockdown between mid-March and mid-May. The proportion of the population classed as active dropped and the proportion of the population classed as inactive increased. Therefore, it is important that the promotion of the benefits of exercise is continued once life returns to normal.

Perhaps a less surprising link between lifestyle and health is the evidence showing that smokers were more at risk of complications from COVID-19 than those who do not smoke. In East Sussex we have a really effective stop smoking service that means you are much more likely to be successful in quitting smoking than if you try on your own. We know that during 2020 a lot of people took steps to quit smoking, some as a direct result of the risk posed by COVID-19, and the great news is that this will lead to a range of lasting health benefits.

We have begun to implement the new Healthy Weight Plan (2021-2026). The Plan, which has been co-produced by partners, takes a whole-system approach to address the complex issue of healthy weight and the biological, environmental, and societal cultural factors which influence it. It sets out the intention of partners to come together and work as a unified system in order to improve outcomes for our residents by addressing over 100 identified local causal factors associated with healthy weight.

Our continued work with general practice and other providers will ensure that NHS Health Checks are delivered to those most at risk of cardiovascular disease, severe complications from COVID-19 and non-communicable disease such as cancer.

A newly launched workplace health programme will support businesses and workplaces of all sizes to support the health and wellbeing of their employees.

We will maintain our use of evidence based, behaviourally informed public health messages about how our local population can maintain good physical and mental health and well-being including the national Better Health campaign.

Recommendation:

Our choices have a substantial impact on our health. We will continue to ensure that the healthy choice is the easy choice across East Sussex and that our new and existing programmes support our population to experience good health and wellbeing.

Chapter 2:

Background - our population

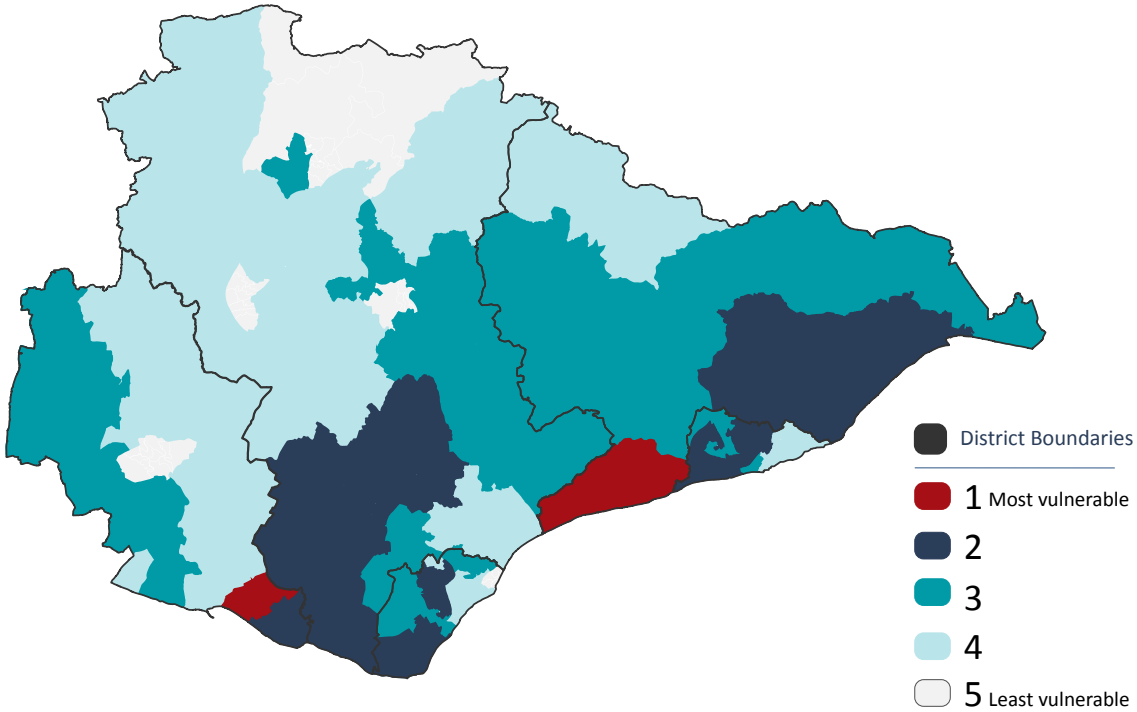
From the previous chapter we know that COVID-19 is an infection that does not affect people equally. Certain groups are much more at risk than others and therefore to fully understand how East Sussex has been impacted by COVID-19, we first need to understand the characteristics and unique features of this county.

Population of East Sussex

Over half a million people live in East Sussex. It is a mixture of urban and rural areas with a large elderly population, particularly in some of its coastal towns. There are stark inequalities within the county with some areas having significantly worse health, as well as significant differences across the determinants of health.

The COVID-19 vulnerability index combines multiple sources of data to identify vulnerable areas and groups within Local Authorities and Neighbourhoods. The Index currently maps clinical, demographic and social vulnerabilities and health inequalities. The map below shows how vulnerability varies across East Sussex. We can see how the areas with the greatest vulnerability are concentrated along the coast of East Sussex.

British Red Cross Covid-19 Vulnerability Index



ONS Middle Super Output areas (2011) Vunerablity Index

If you live in the most deprived areas of East Sussex your life expectancy is on average 8.4 years (for men) and 4.7 years (for women) lower than if you live in the least deprived areas, and with COVID-19 we again see this link between wealth and health.

LIFE EXPECTANCY AT BIRTH

	MALE	FEMALE
Least deprived decile	83.2	85.9
Most deprived decile	74.8	81.2
Difference in years	8.4	4.7

Health Inequalities Dashboard | (phe.gov.uk)

The East Sussex Community Survey identifies that nearly three quarters of people have a strong sense of secure identity and sense of belonging, and over three quarters are more than satisfied with their local area. People are also engaged and willing to support each other with half of those responding to our community survey reporting they have volunteered in the past year.

559,409
Residents in 2020
ESiF:2020

8% Non-white British / northern Irish
(20% in England)
Census:2011

288,042
Females

271,367
Males
ESiF:2020

20% People have a long term limiting illness or disability
(18% in England)
Census:2011

3% Identify as lgbt+
Lesbian, gay, bisexual, transgender & other sexual / gender identities
Community Survey, 2017

74% Urban city & Town

11% Rural village & Dispersed

15% Rural town & Fringe
ONS:2018 |Census:2011

24,347 People into the county

20,220 People out of the county
ONS,2018

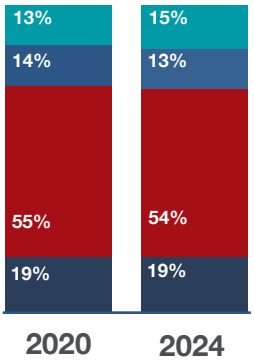
East Sussex has an older, ageing population. The over 65s represent a quarter of the county's population and are projected to make nearly a third of all people by 2030. The fastest rate of growth will be seen in the 85 and over group. Those aged 85 and over are the largest users of health and social services.

by 2024 in East Sussex

4.3%

of people will be 85+

(2.7% for England)



ESiF 2020 | ONS 2019

146,962

People aged 65 or over in 2020

ESiF 2020

55% Females

Die after the age of **85**

37% Males

ONS,2019

Females 55%

80,681

Males 45%

66,281

ESiF 2020

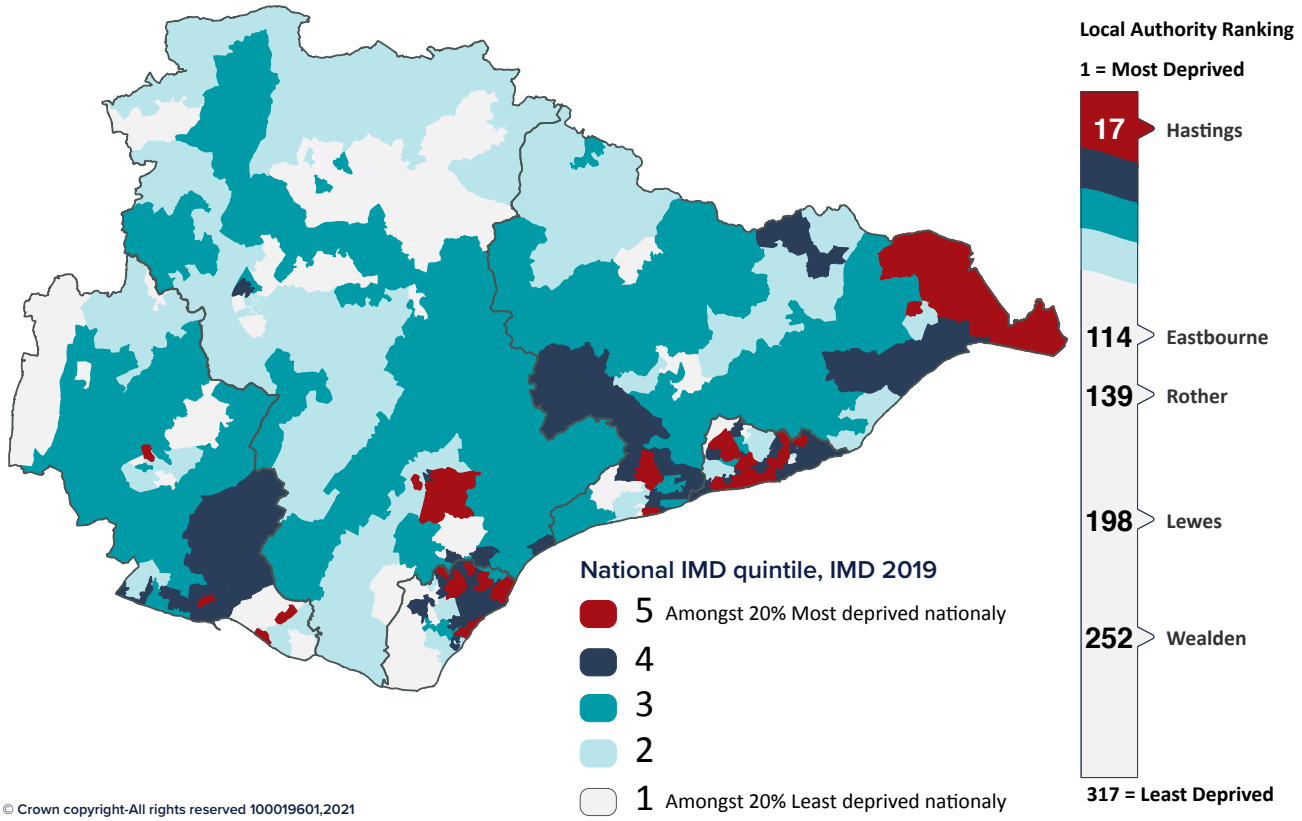
The increase in the 75+ population by 2024 is an increase of:

1,379 Males

941 Females

A girl born in East Sussex can expect to live to 84, and a boy to 80. Healthy life expectancy has increased for males from 62 to 65 between 2009/11 and 2014/16, but it has fallen for females from 65 to 63 years. Those living in our most deprived communities have the lowest life expectancy and can expect to live fewer years in good health.

East Sussex is the 5th Most Deprived of 26 County Councils



Index of multiple deprivation, 2019

Services and workforce

The following diagram gives an overview of how many of the core services are structured across East Sussex, including a summary of the health and social care system and a summary of education.

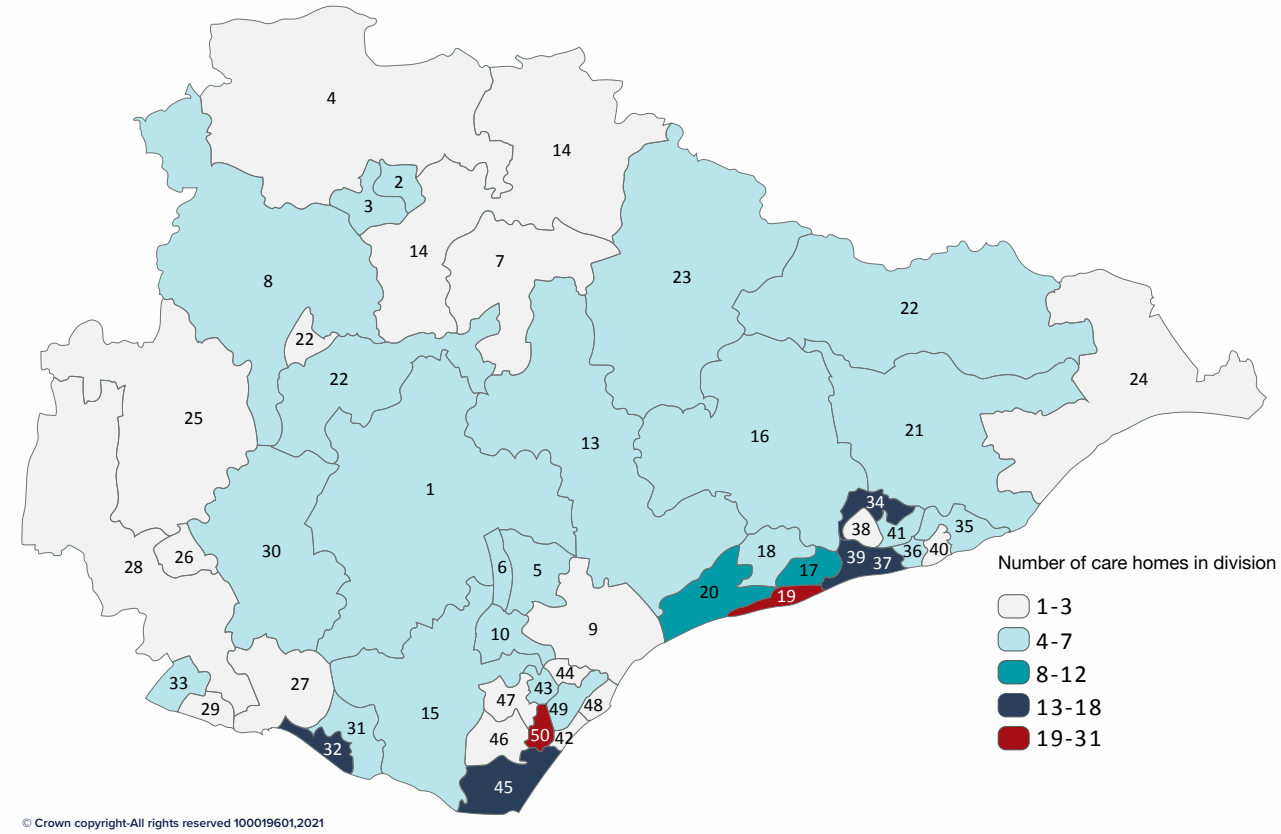
East Sussex Core Services

Care homes

East Sussex has a large number of care homes. There are a total of 312 homes with approximately 8,220 beds. The following map shows how the concentration of care homes varies across East Sussex, with the highest density being in coastal and more densely populated areas of East Sussex.

Throughout the pandemic there has been a huge amount of appreciation for all the key workers who have kept working which was typified by the weekly ‘Clap for NHS and Key Workers’ that was a feature during the first lockdown.

Care Home Distribution as at 4th January 2021



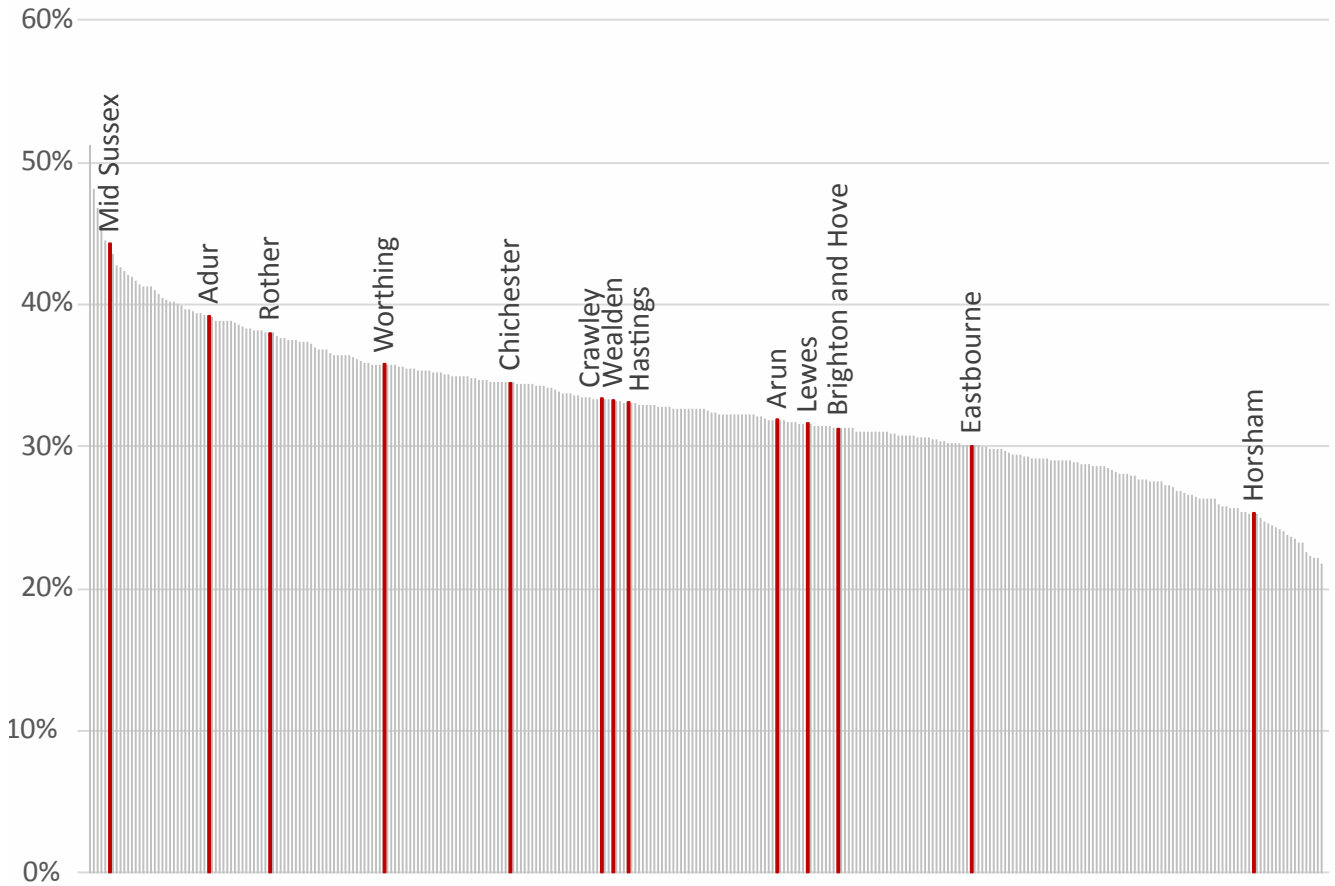
No.	Electoral Division
1	Arlington, East Hoathly & Hellingly
2	Crowborough North
3	Crowborough South & St. Johns
4	Forest Row & Groombridge
5	Hailsham Market
6	Hailsham New Town
7	Hartfield & Mayfield
8	Hailsham New Town
9	Heathfield & Mayfield
10	Pevensy & Westmill
11	Uckfield North
12	Uckfield South & Framfield
13	Wealden East
14	Wealden North East
15	Willingdon & South Downs
16	Battle & Crowhurst
17	Bexhill East
18	Bexhill North
19	Bexhill South
20	Bexhill West
21	Brede Valley & Marsham
22	Northern Rother
23	Rother North West
24	Rye & Eastern Rother
25	Chailey
26	Lewes
27	Newhaven Bishopstone
28	Ouse Valley & West Downs
29	Peacehaven
30	Ringmer & Lewes Bridge
31	Seaford North
32	Seaford South
33	Telscomb
34	Ashdown & Conquest
35	Baird & Ore
36	Brabrook & Casetle
37	Central St Leonards
38	Holington & Wishing Tree
39	Maze Hill & West St Leonards
40	Old Hastings Town
41	St Helens & Silverhill
42	Devonshire
43	Hampden Park
44	Langley
45	Meads
46	Old Town
47	Ratton
48	Sovereign
49	St Anthony's
50	Upperton

Key Workers

Key workers are a core part of the overall workforce in East Sussex. In 2019 the Office for National Statistics (ONS) used a number of surveys to assess how the workforce is structured, using the Key Worker categories defined by the government. The following chart shows how the Districts and Boroughs of Sussex compare in their proportion of workers that are key workers. In East Sussex this ranges from approximately 30% in Eastbourne to just under 40% in Rother.

The Office for National Statistics (ONS) provides an indication of the number of people who were employed in 2019 in key worker occupations and key worker industries, based on interpretation of the UK government guidance. This analysis is based on various sources (The Annual Population Survey, The Labour Force Survey and the Annual Survey of Hours and Earnings).

Percentage of workers who are key workers



The Brighton and Hove Public Health team commissioned extra breakdowns of these surveys results for Brighton & Hove, East Sussex and West Sussex.

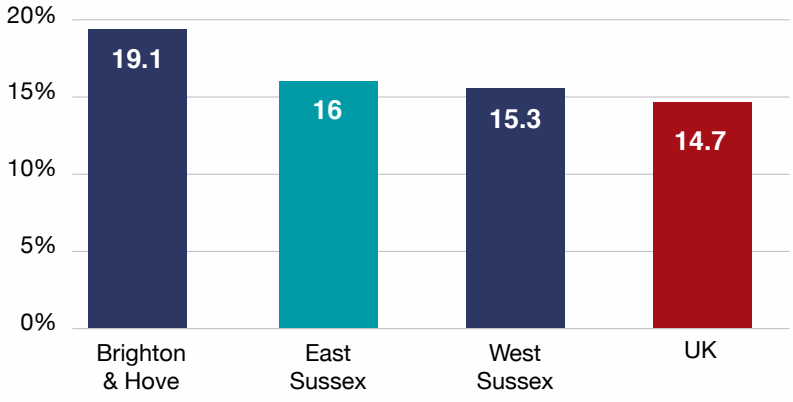
When looking at this key worker survey in more detail we can see that East Sussex has a lower proportion of key workers than the UK and the rest of Sussex who are from ethnic minority backgrounds, a slightly lower proportion than the UK that are female, and a slightly higher proportion than the UK that are at moderate risk (those with certain conditions including heart disease, severe asthma and diabetes).

Percentage of key workers who are non white

Percentage of key workers who are female

Percentage of key workers at moderate risk.

(People with certain health conditions such as asthma, heart disease & diabetes)



Source: Produced by Public Health Intelligence, Brighton and Hove City Council

Need: Clinically Vulnerable / Shielding

It is useful to compare East Sussex to the England average across different measures to determine if COVID-19 poses a greater or lesser risk to our population. This includes the direct risk of COVID-19 in terms of people at greater risk of disease, but also the indirect risk of COVID-19 such as through increased support, disrupted employment etc.

Compared to England, East Sussex has:

- an older, ageing population: over 65s represent a quarter of the county's population and is projected to increase by another 8% by 2024
- a significantly lower population who are non-White British or have English as a second language
- a lower percentage of Lower Super Output Areas (LSOAs) in the most deprived quintile, but significant variation within the county, with Hastings significantly worse than England across a range of wider factors influencing health, including deprivation
- a higher percentage of people working in skilled trades and caring/leisure occupations
- significantly lower mortality from preventable causes, but significantly higher in Hastings
- a higher % of people on primary care registers for hypertension, kidney disease, Chronic obstructive pulmonary disease (COPD) and dementia
- a significantly higher % of deaths in care homes and therefore and therefore a higher percentage of deaths in carehomes.
- a significantly lower proportion of key workers who are from ethnically diverse groups

Local needs during the pandemic:

- 21,600 people currently clinically shielding (at greatest risk of severe cases of COVID-19)
- estimated 200,000 clinically vulnerable people in East Sussex (at increased risk of severe cases of COVID-19)
- 22,000 more people claiming Universal Credit in November 2020 than in March 2020
- 15.7% working age people currently receive either Universal Credit or Job Seekers Allowance
- There has been a 115% increase in claimants since March 2020
- 40,100 jobs in East Sussex supported by government employment schemes as at 31st October 2020: 15,400 employments furloughed and 24,700 Self Employed Income Support Scheme (SEISS) claims

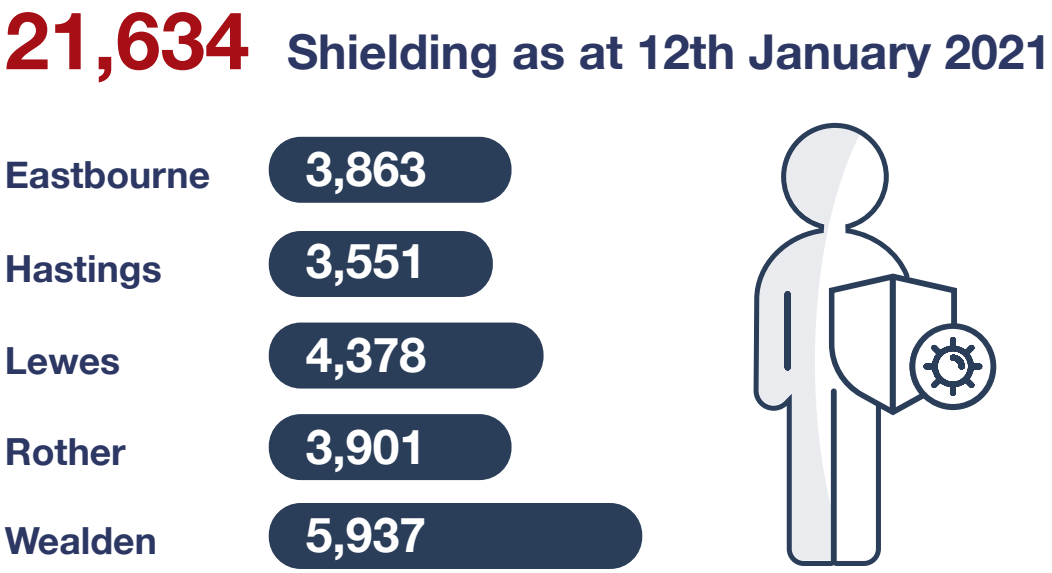
Clinically vulnerable

Classified as at increased risk of severe cases of COVID including those aged over 70 years; those under 70 with an underlying health condition; and those who are pregnant.

In East Sussex an estimated 190,000 - 210,000 people are clinically vulnerable, with over one quarter of this cohort estimated to live in Wealden.

Clinically Extremely Vulnerable (Shielding)

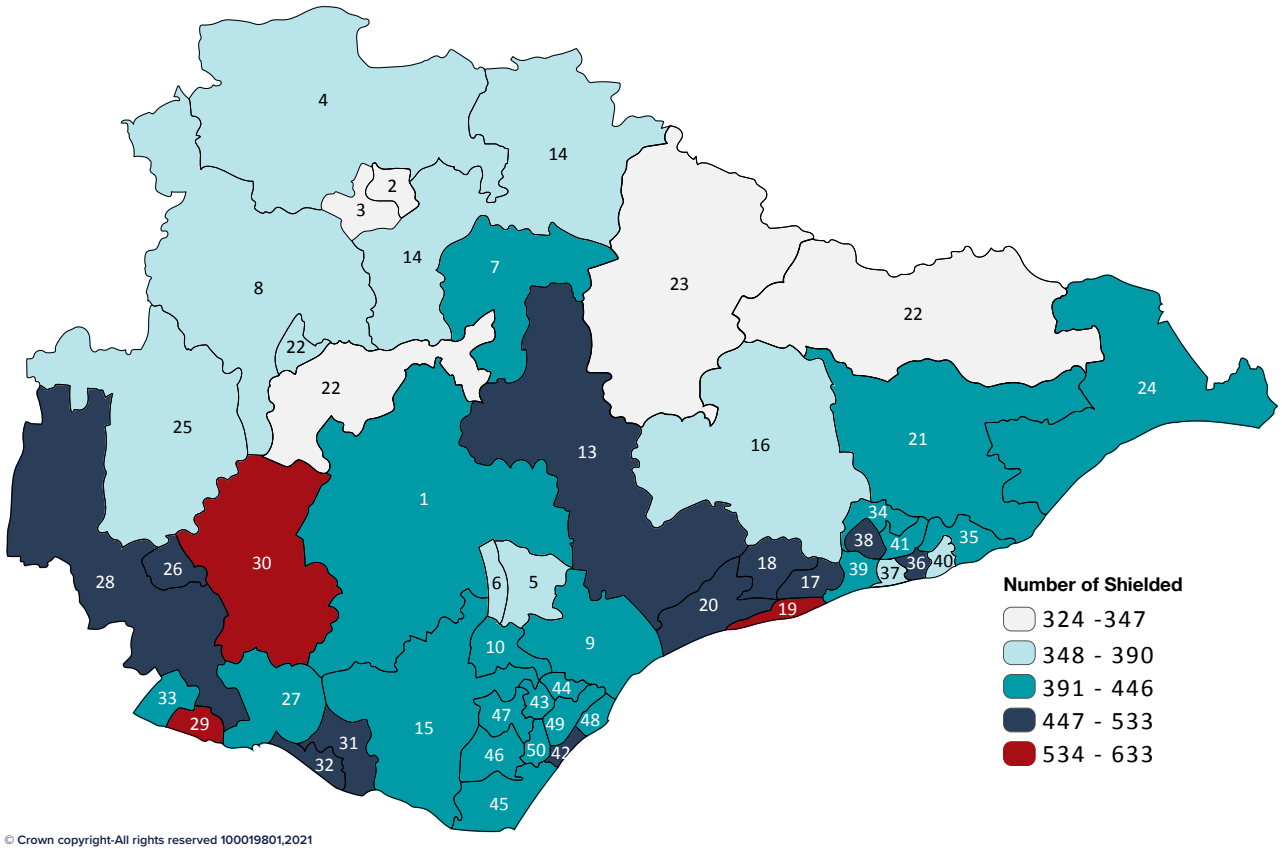
During the pandemic the government issued guidance for people to shield who were classified as at greatest risk of severe cases of COVID-19 due to significant underlying health conditions and/or weak immune systems, including: solid organ transplant recipients; specific cancers; severe respiratory conditions; people at significantly increased risk of infections; people on immunosuppression therapies; and women who are pregnant and have significant heart disease.



Source: Ministry of Housing, Communities & Local Government

The map below shows how those classified as Clinically Extremely Vulnerable (CEV) as at 12th January 2021 were distributed across East Sussex.

Shielded as at 12th January 2021



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24	Rye & Eastern Rother
25	Chailey
26	Lewes
27	Newhaven Bishopstone
28	Ouse Valley & West Downs
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Chapter 3:

East Sussex COVID-19 in 2020

Google movement

The Community Mobility Reports show movement trends by region, across different categories of places. These reports are created by Google with aggregated, anonymised sets of data from users who have turned on the Location History setting, which is off by default.

It groups people's movement into six categories: 1. Retail and recreation, 2.Supermarket and pharmacy, 3. Parks, 4. Public transport, 5. Workplace, 6. Residential.

The East Sussex movement trends: up to 29th December 2020 chart gives us an indication of how people people's behaviour changed over time. There is a pronounced change in people's movement trends in East Sussex once the initial lockdown was announced. We can see that other than residential settings which increased, movement in all other settings decreased.

When looking at how people's movement has varied across East Sussex, we can break this down by looking at how movement has changed in each District or Borough. The East Sussex movement trends: up to 29th December 2020 chart looks at each movement category and compares the five Districts and Boroughs. We have chosen a day outside of national lockdown restrictions (we chose the first Monday outside of the second national lockdown – 7th December) and compared this to a reference point (the median value from the 5-week period Jan 3 – Feb 6, 2020).

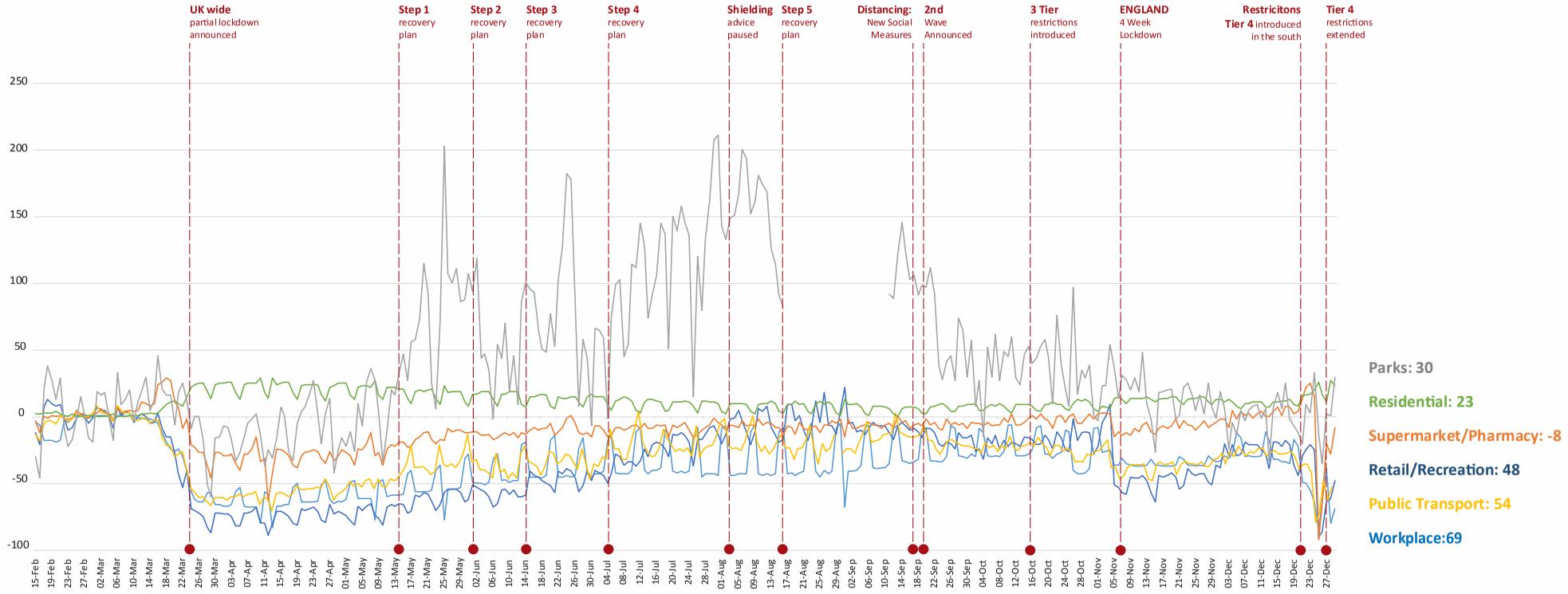
Although this is just a snapshot in time, what we can see is that there is a similar pattern of movement across East Sussex. All areas saw a reduction in retail and recreation, public transport, and the workplace. In contrast all areas had a similar increase in residential movement. There was slightly more variation in supermarket/pharmacy and parks activity. Eastbourne and Hastings saw an increase in supermarket and pharmacy activity whilst the other three areas saw reductions, and with parks Hastings saw a much larger increase than Lewes and Wealden, whilst Rother and Eastbourne saw decreases.

There have been a range of different social distancing measures announced nationally, and this has meant a protracted period of asking the public to change some of the very basic ways in which they interact. This has sometimes led to a sense of 'pandemic fatigue'. The WHO have produced a useful guide in how to use well established health promotion principles to maintain and reinvigorate the public[1].

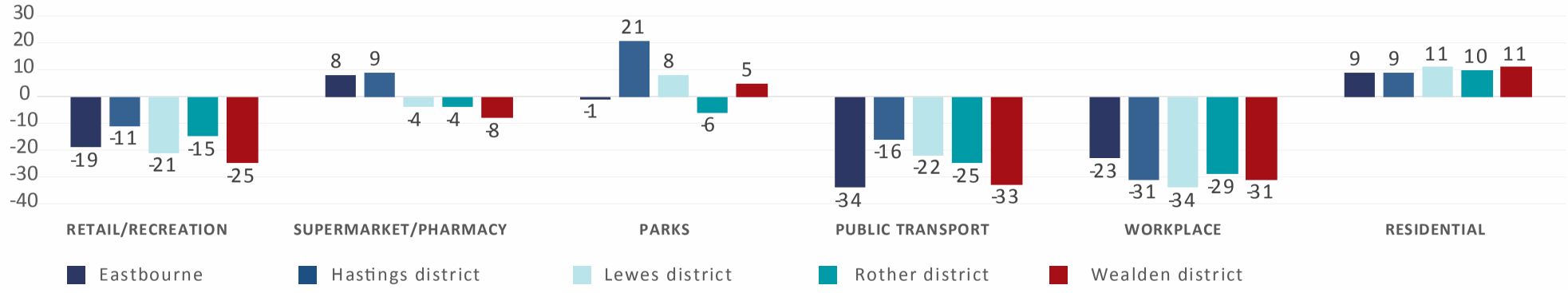
> **Recommendation:**
> We will continue to link with partners, use evidence and the available communications methods to ensure the effectiveness of our messages to our residents about the COVID-19 pandemic.

1. WHO (World Health Organisation) - Europe - Pandemic Fatigue

Movement chart one: East Sussex movement trends up to 29th December 2020



Movement chart two: East Sussex Trends by District and Borough as at 7th December 2020



Cases in East Sussex

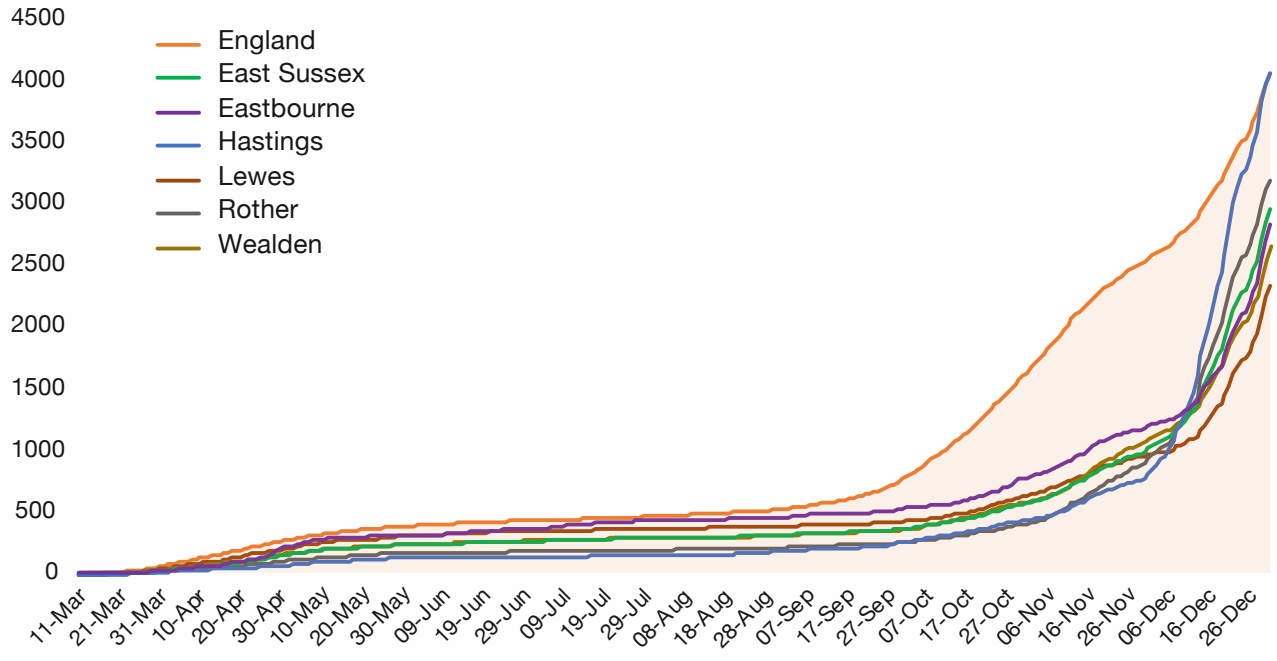
The first reported case of COVID-19 in the UK was on the 31 January 2020 in York. Perhaps surprisingly East Sussex was indicated very early in the story of COVID-19 in the UK: the third UK case was an individual who lived in Brighton and worked in East Sussex.

This section will describe what we know about COVID-19 during 2020 in East Sussex. All case data presented within this section is based on confirmed COVID-19 positive results. However, it is important to note that the national testing strategy varied over time and therefore some comparisons need to be treated with caution. Community testing run by the Department of Health only commenced on 18th May 2020, so confirmed cases before this date are based on a much smaller cohort of people (primarily those tested in hospital). Therefore, whilst the relative comparisons between East Sussex and the UK can be made at different points in time, the trends before and after this date are not directly comparable.

When looking at cases over time, if we want to understand the total number accumulated by that date, we call this the cumulative number of cases. This can also be expressed as a rate per 100,000 population, which we do to allow direct comparisons with other areas that have a different population size.

The following chart shows the rate of cumulative number of COVID-19 per 100,000. The story of COVID-19 in East Sussex in 2020 really involves two distinct periods with very different patterns: up to December 2020, and then a very different trend during December 2020.

Rate of cumulative cases per 100,000 population



Trend up to December 2020

The trend throughout this first period (up to December 2020) was characterised by a remarkably stable pattern across East Sussex. Hastings (green line) generally had the lowest cumulative rate of cases in the county, other than a brief period where it was replaced by Rother, until the beginning of December. During this same time period Eastbourne (yellow line) generally had the highest cumulative rate of cases, followed by Lewes (dark blue). Wealden (light blue) throughout most of this period had a similar pattern to the East Sussex rate as a whole, ranking in the middle for East Sussex, with the exception of November where the rate increased more sharply than elsewhere, and Wealden ended up having the second highest cumulative rate.

When comparing East Sussex to the national rate over this same time period we can see that East Sussex has consistently had a lower cumulative rate than the England average. This is a trend that is particularly notable from September where the national rate started increasing more sharply than East Sussex.

Trend from December 2020

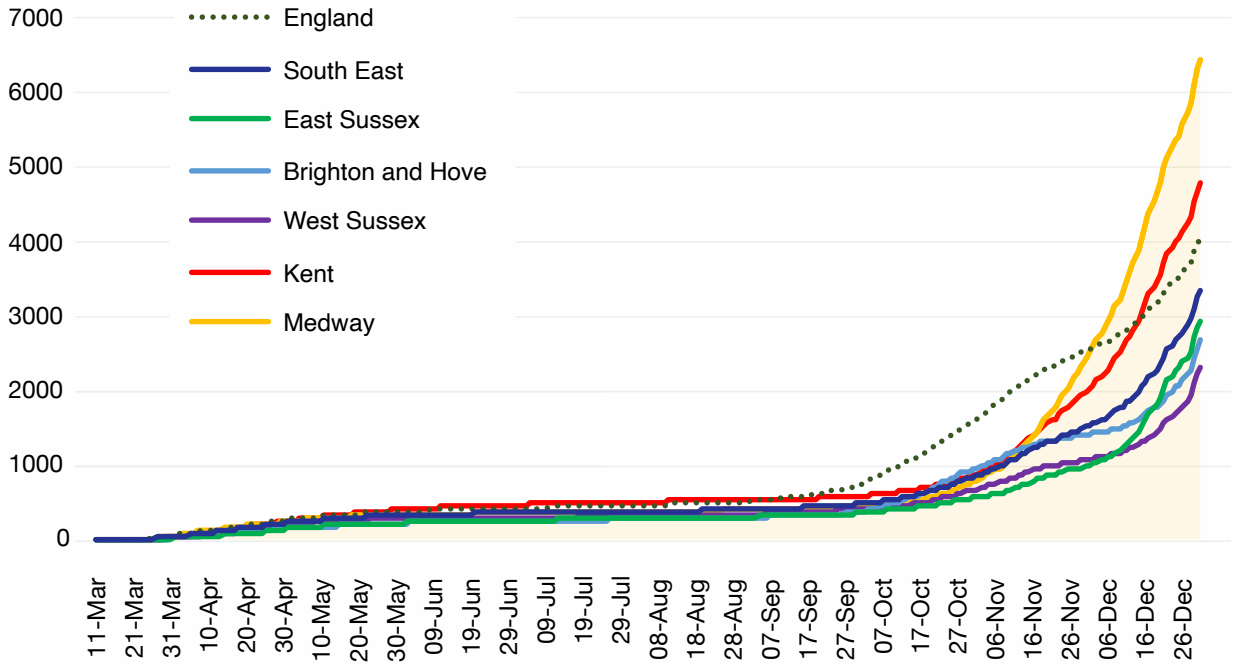
December 2020 saw a completely different pattern to the rest of 2020. During the latter part of November 2020 rates throughout Kent started increasing despite the national restrictions that were in place. Public Health England investigated this, and it is now known to be related to a new strain of COVID-19 that is much more transmissible[2].

These high rates in Kent ended up also being experienced in London, the South East and into the East of England. In East Sussex, Hastings was the first to see this new pattern of exponential growth, followed soon after by Rother. This completely reversed the ranking of the cumulative rates seen previously in East Sussex, leading to Hastings going from the lowest cumulative rate to the highest cumulative rate in East Sussex, and Rother going from the second lowest to the second highest. You can then see this pattern shift from East to West, with Wealden and Eastbourne increasing next, followed finally by Lewes.

The following graph give a regional context to the pattern described above. You can see from the graph how the cumulative rate in Medway (orange) started increasing sharply in November followed closely by Kent (red). The cumulative rate in East Sussex (green) was the lowest in October but this started increasing sharply in December followed by West Sussex (purple). The only area that followed a different pattern was Brighton. We can see how the rate in Brighton (blue) started increasing earlier than elsewhere from early October. However, we know that this was largely driven by rates in University students which appeared to stabilise in November, before this most recent rate of increase towards the latter part of December.

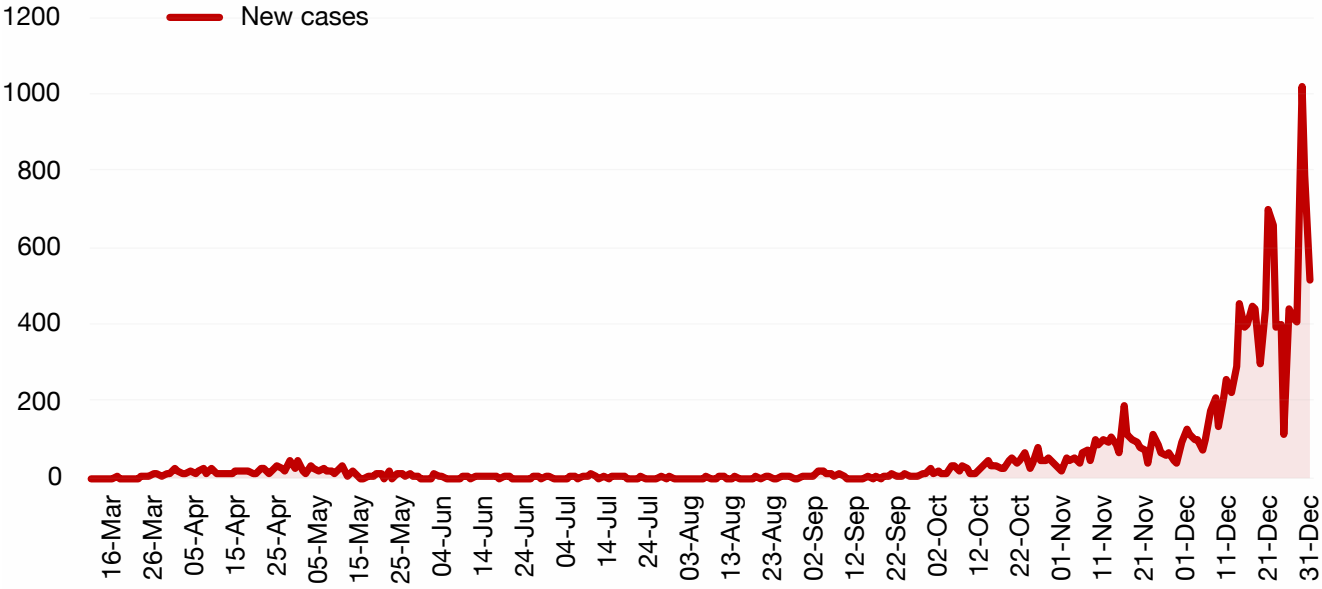
2. New SARS-CoV-2 variant | www.gov.uk

Rate of cumulative cases (per 100,000 population)



To put the previous graphs in context, another way to view cases over time is to see the daily number of new COVID cases over time. Again the pattern before and after the beginning of December 2020 is stark, with no more than approximately 200 cases in a single day before December 2020, compared to a high of approximately 1,000 cases in late December.

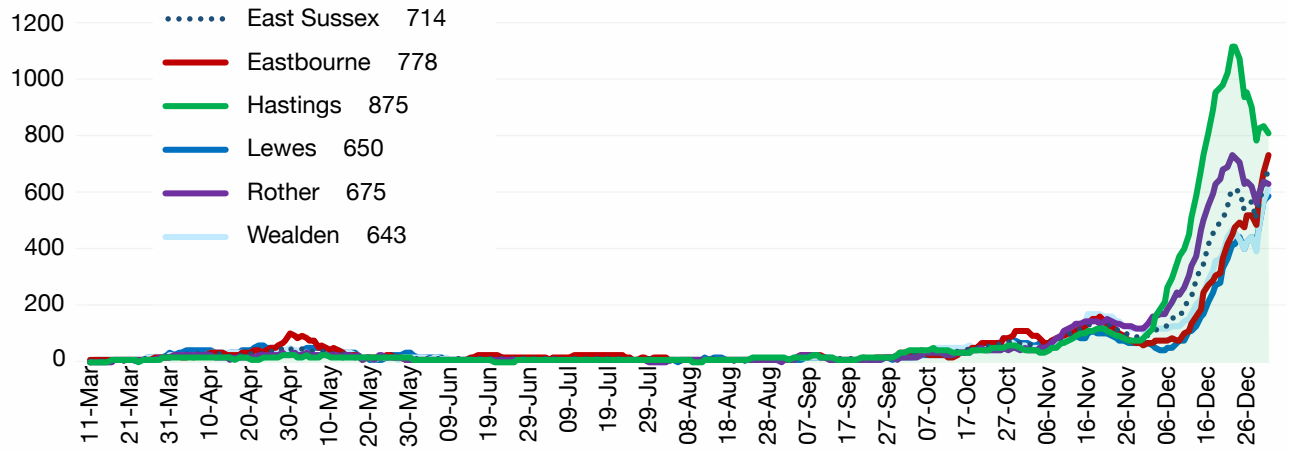
Daily cases for East Sussex Residents



The total number of cases based on people that have been tested up to 31st December 2020 is 16,494.

The daily number of cases gives a sense of scale, and the cumulative rate enables us to be compared to other areas. However, one of the measures that has been widely reported throughout the pandemic is the weekly rate of COVID-19. This statistic has been a useful measure to give a sense of any immediate trends as it is reporting on the number of cases in the previous week, expressed as a rate. The graph below shows the weekly rate over time. Again you can see in this graph the clear increase in Hastings and then Rother during December 2020.

7-Day Rolling Rates per 100,000 population all ages

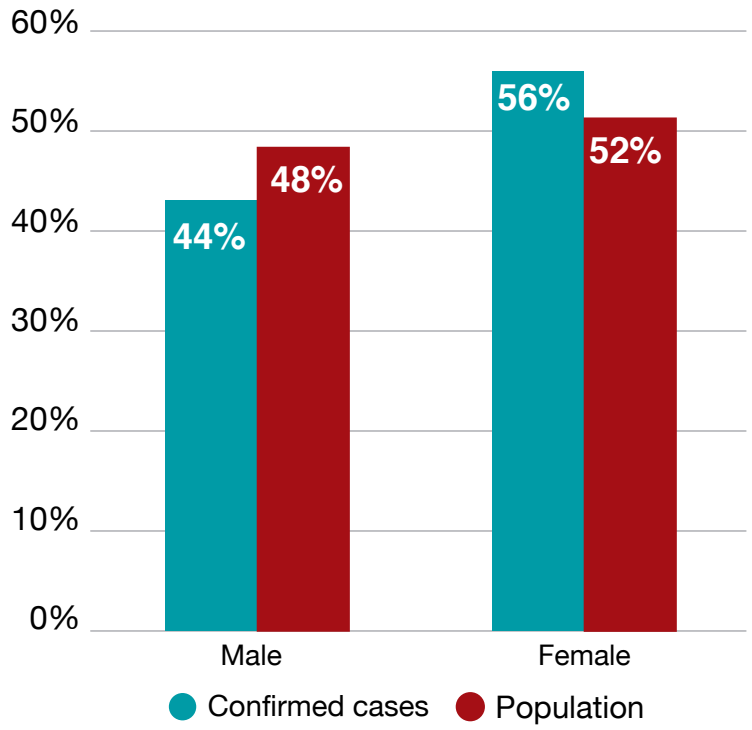


Key Demographics

When we look at the demographics of the cases in East Sussex in 2020 we see some interesting patterns. Firstly, we had a smaller proportion of our cases that were male compared to the proportion of our total population that is male (48% of our population are male, but only 44% of our confirmed cases).

Gender

Overall distributed by sex



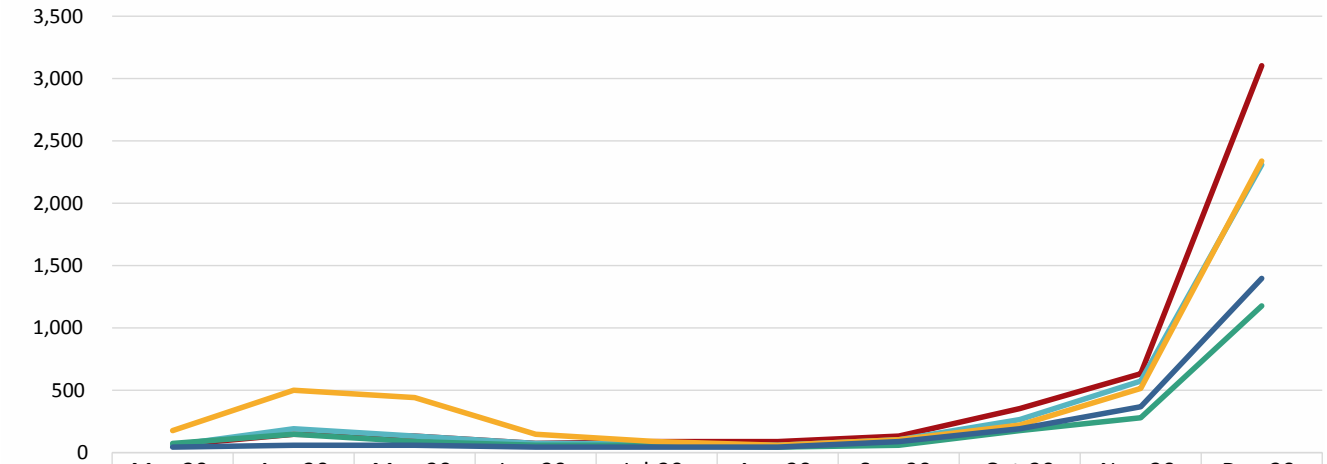
Confirmed cases per 100,000 population by sex

The following chart reveals some patterns when we look at the COVID-19 data by age group. However, it is important to note that not all age groups have been tested equally. For example, regular testing of care home staff and residents means that a higher proportion of cases in those age groups are likely to have been detected compared to other age groups.

During the early part of the pandemic the highest rate of confirmed COVID-19 cases were in those aged 80+ (yellow line), although this may be explained by the fact that the majority of testing was carried out in hospitals. Otherwise there were no particular patterns in the age profile of cases until September where we see the 20-39 age group (red line) with the highest rate. This is likely to be partly explained by the rise in cases in university age groups. This is followed by the 80+ (yellow line) and 40-59 age group (light blue line– but partly covered by the 80+ line). The lowest rates were seen in the 0-19 and then the 60-79 age groups.

Age

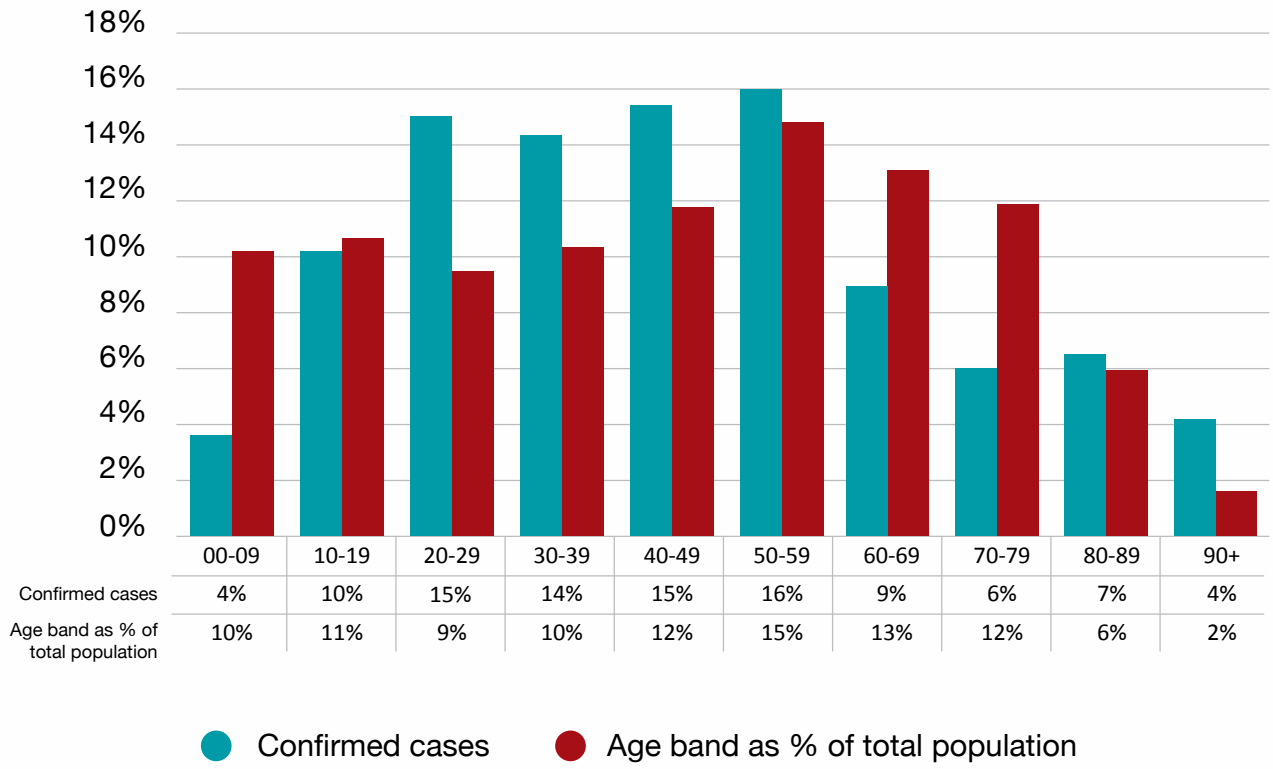
Confirmed cases per 100,000 population by age



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
00-19	1.7	17.0	12.8	10.2	9.3	10.2	44.3	151.9	328.5	1355.3
20-39	10.8	102.4	86.1	34.4	40.8	45.3	88.8	317.3	596.6	3058.6
40-59	14.8	151.0	86.3	35.7	31.0	20.2	57.3	229.2	532.0	2272.4
60-79	38.0	102.7	45.2	19.4	17.2	6.4	23.7	139.4	239.2	1136.0
80+	134.6	460.6	399.2	99.2	49.6	21.2	63.7	181.9	477.2	2296.4

The following chart gives a more detailed breakdown of the confirmed cases in East Sussex. The chart shows the 10-year age bands and compares the proportion of positive cases to the proportion of the population in that age group.

Confirmed cases - age as % of total population



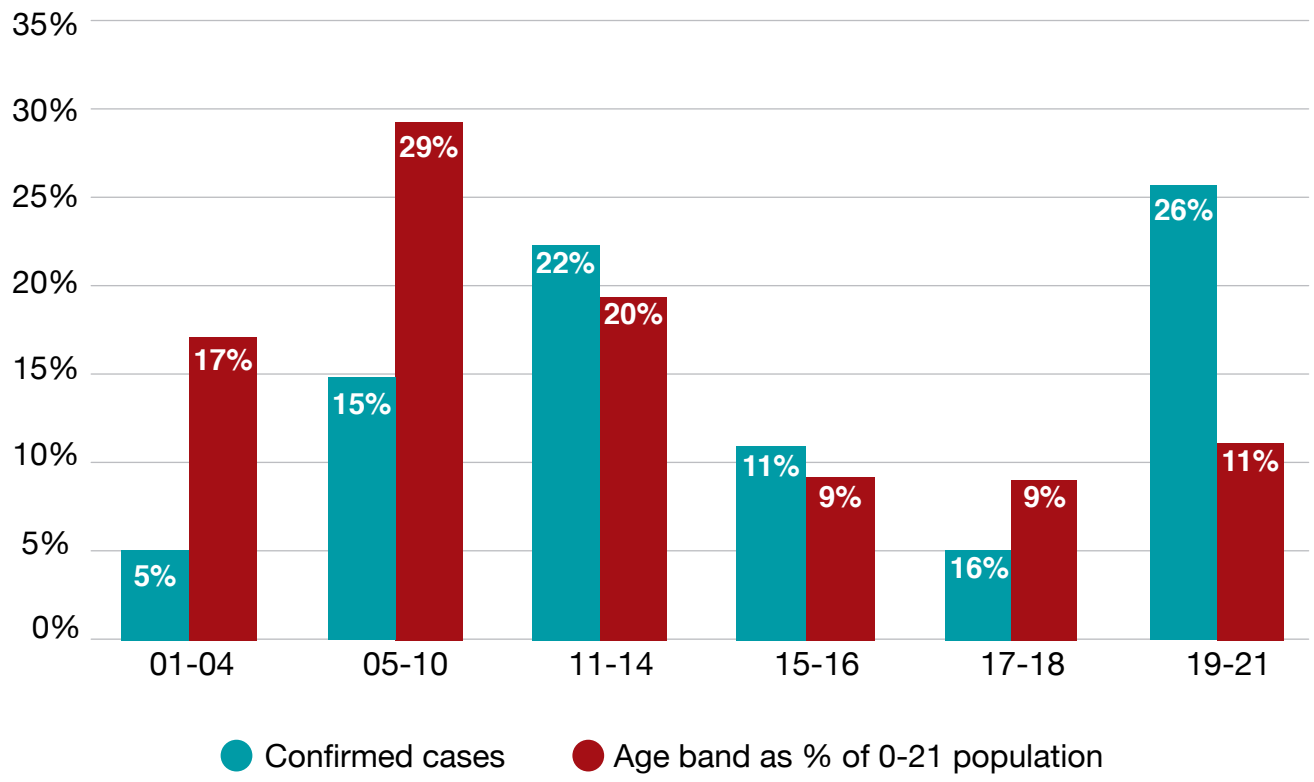
	00-09	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Confirmed cases	4%	10%	15%	14%	15%	16%	9%	6%	7%	4%
Age band as % of total population	10%	11%	9%	10%	12%	15%	13%	12%	6%	2%

Confirmed cases Age band as % of total population

For those aged 20 to 50, and over the age of 90, there was the biggest difference between the proportion of the population that have tested positive and the size of population, with more positive cases relative to the amount of people that age. In contrast, people aged under 10, and aged 60-79 had a much lower proportion of positive cases compared to the proportion of people in that age group. For those aged 10-19, 50-59 and 80-89 there was little difference between proportion of age band and proportion of confirmed cases.

There has been a lot of interest in how education settings have contributed to the overall number of cases of COVID-19, so we can look at these age groups in greater detail. People age 1-4 and 5-10 had a lower proportion of positive cases compared to the number of people that age, whereas the reverse is true for people age 17-21. There was a small increase in the proportion of people 11-16 testing positive compared to the overall proportion of the population that age.

Confirmed cases for people aged under 22 years per 100,000 population

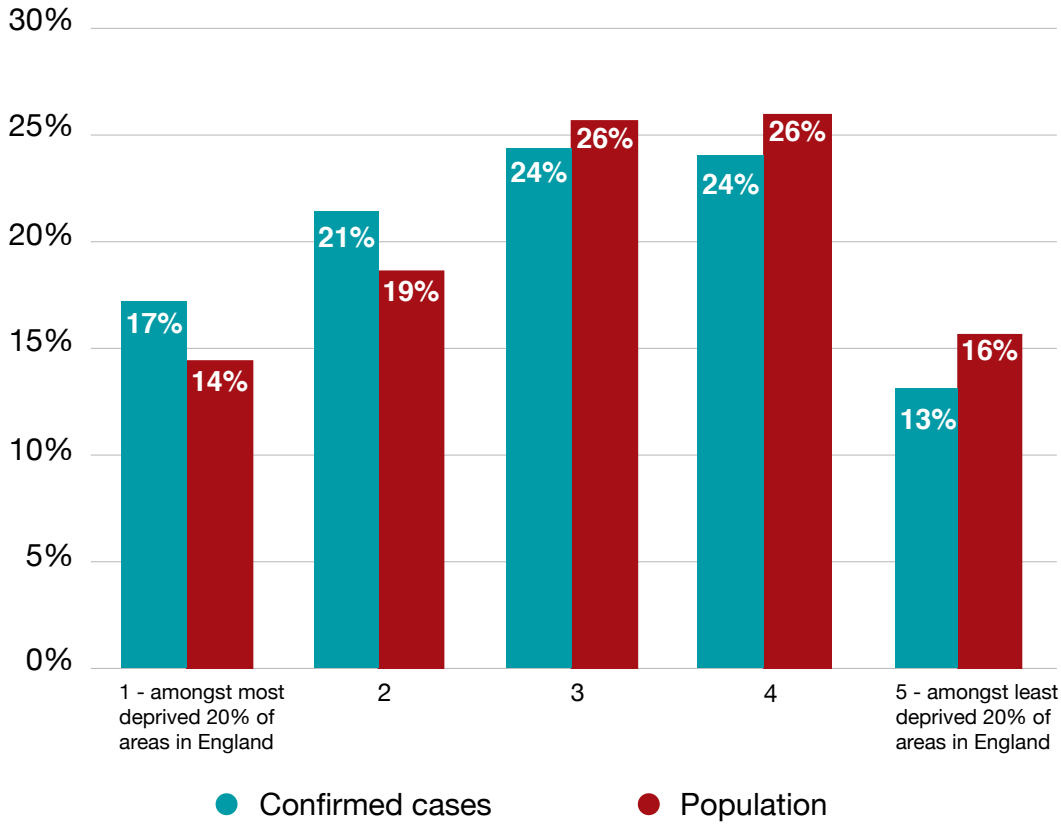


Deprivation

In the earlier chapter on risk factors there was reference made to the evidence base showing links between deprivation and infectious diseases more generally, but also specifically with COVID-19.

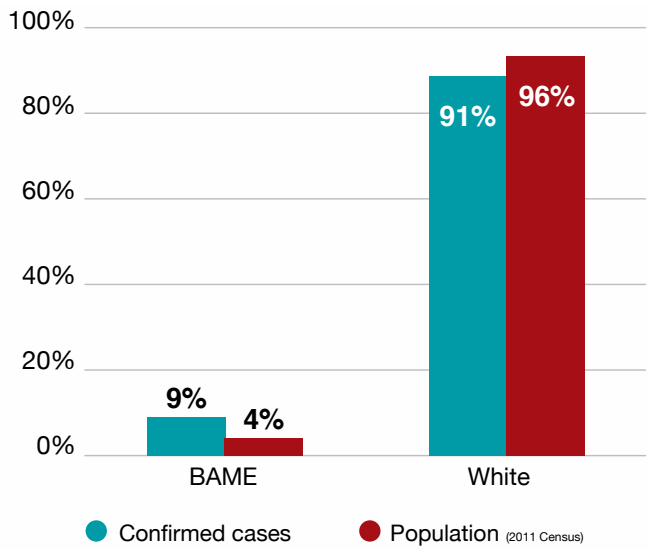
The graph below shows us that we had a higher proportion of confirmed cases in our more deprived areas compared to the size of population, and fewer cases in our less deprived areas. For example, only 14% of the population of East Sussex is in the most deprived 20% of areas in England, but 17% of our confirmed cases were in these areas. In contrast 16% of East Sussex is in the least deprived 20% of the population, but only 13% of the confirmed cases were in these areas.

Confirmed cases by deprivation quintile



The earlier chapter on risk factors for COVID-19 described how the minority ethnic population are more likely to test positive for COVID-19 and also have a higher mortality rate. The following chart compares the white and ethnic minority population size with the proportion of those groups testing positive in East Sussex. However, please note that the population data (red bar) used for comparison is from the 2011 national census and there have likely been changes to the ethnic minority population since this data. We can see that only 4% of the East Sussex population are estimated to be from an ethnic minority, but this group contributed 9% of the confirmed cases. In contrast the White population are estimated to form 96% of East Sussex but contributed only 91% of the confirmed cases.

Confirmed cases by BAME categorisation

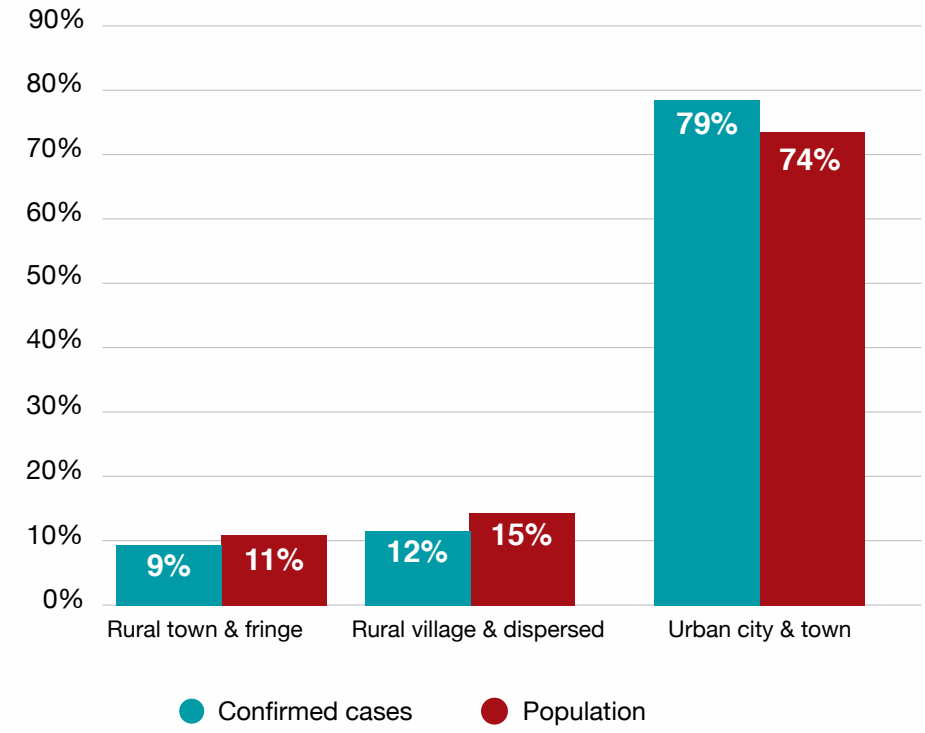


Covid-19 patient in intensive care

Rural and Urban

Another way of understanding how COVID-19 has been distributed across East Sussex is to analyse where people lived in terms of their rural urban classification. When grouping according to three categories (rural town and fringe, rural village and dispersed, and urban city and town) we see some slight differences of confirmed tests compared to the composition of the county. There was a higher percentage of confirmed tests in urban city and town (79%) compared to the percentage of the population living there (74%).

Overall distribution by Rural Urban Classification

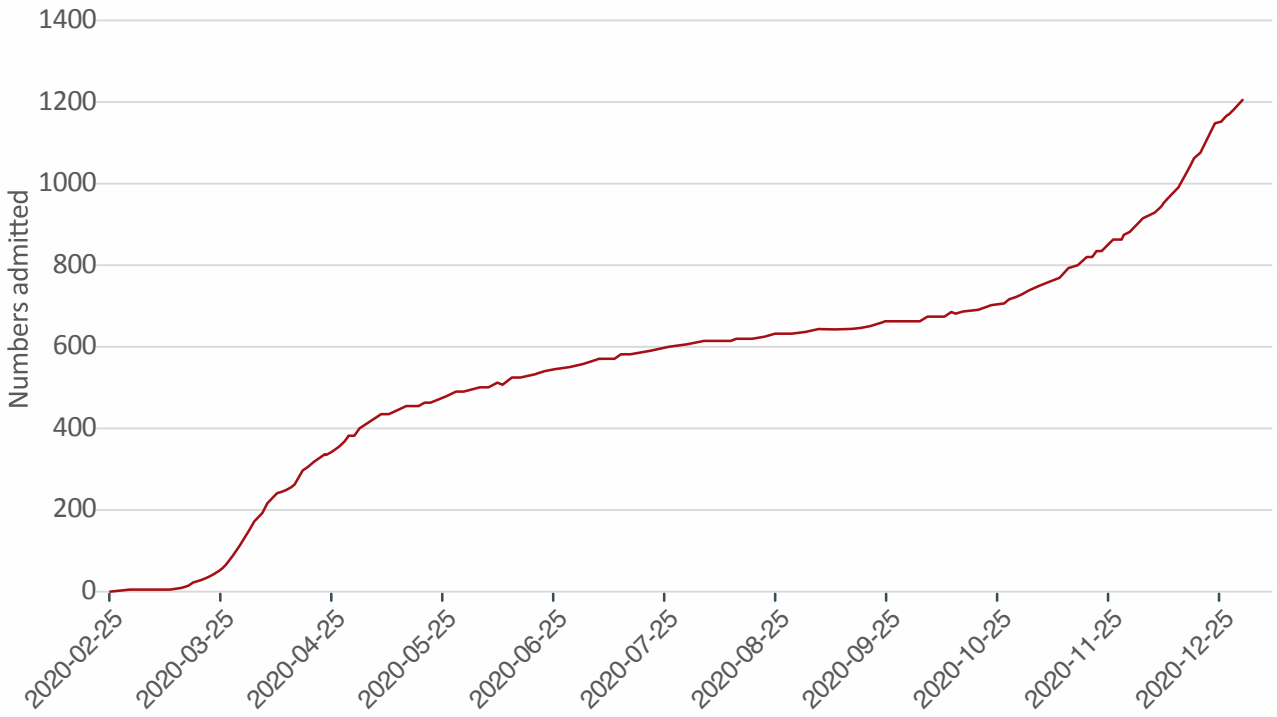


Hospitalisations

Although most of the analysis within this report is for the full calendar year of 2020, there is always a delay with the hospitalisations data we have access to, and therefore we are only able to report on data up to the end of October 2020.

The following graph shows the cumulative count of hospital admissions for East Sussex residents who had a COVID-19 diagnosis. By the end of December there had been a total of 1,208 admissions. 40% of these occurred in the three months March, April and May; and a further 40% in November and December.

East Sussex COVID-19 admissions - cumulative



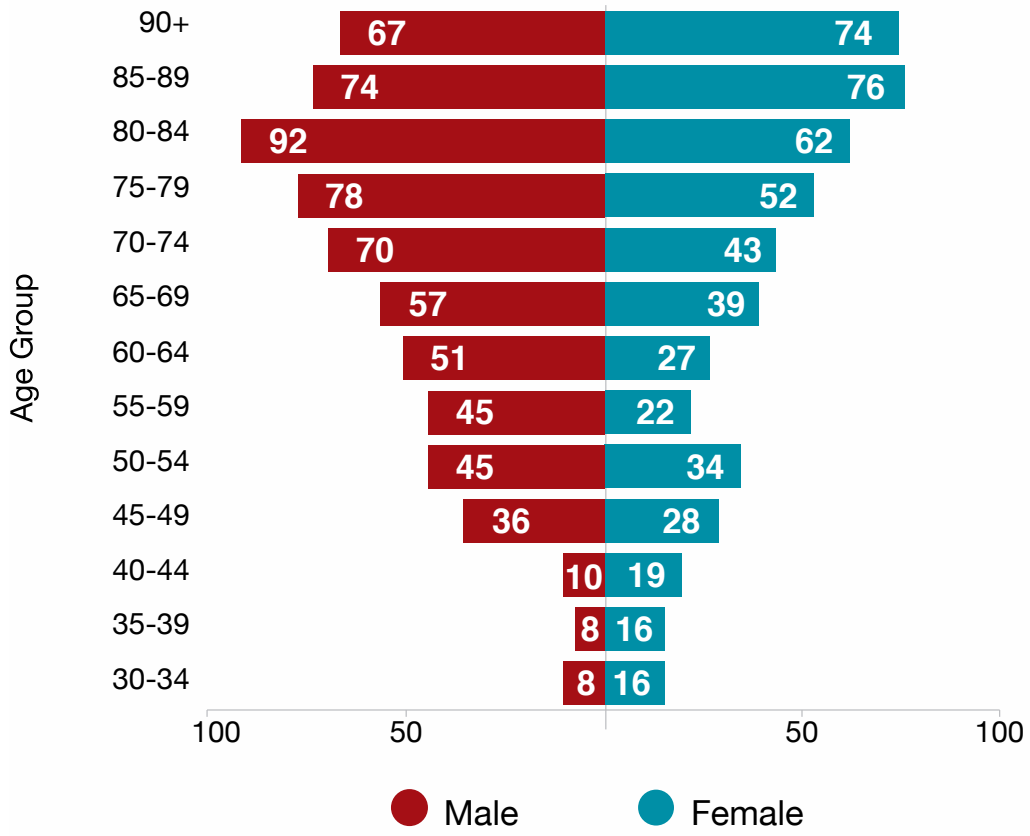
Data source: Hospital Episode Statistics (HES) data accessed via DAE, NHS Digital[3]

3. Due to the way HES data is submitted by Trusts, processed by NHS Digital and made available to local Public Health teams, the numbers are subject to change. Some details for the admissions may be incomplete and would likely be updated with future data uploads. Analysis by date is based on date of admission. For admissions with a COVID-19 diagnosis, it is not possible to know from HES data the date of the diagnosis. We can tell if COVID-19 was the reason for admission (if recorded as primary diagnosis), but we cannot tell if it co-existed at time of admission or whether the patient subsequently caught it in hospital. COVID-19 admission: any mention of COVID-19 defined as ICD-10 U07.1 (confirmed by laboratory) and U07.2 (clinical or epidemiological diagnosis where laboratory confirmation is inconclusive or not available) in any diagnosis position.

From detailed analysis of these admissions:

- 55% are for males
- 57% are for persons aged 70 years or over.
- 12% of admissions are for persons aged 90 years or over
- Wave 1 admissions (March/April/May) had a slightly older age profile (62% aged 70 years or over) compared to wave 2 (Nov/Dec, 51% aged 70 years or over)
- There were 10 admissions for children aged under 5 years and a further 14 admissions for children and young people aged 5 – 19 years

Covid admission age 30+



COVID-19 was recorded as the primary diagnosis (the condition which is chiefly responsible for causing the admission) in 72% of admissions.

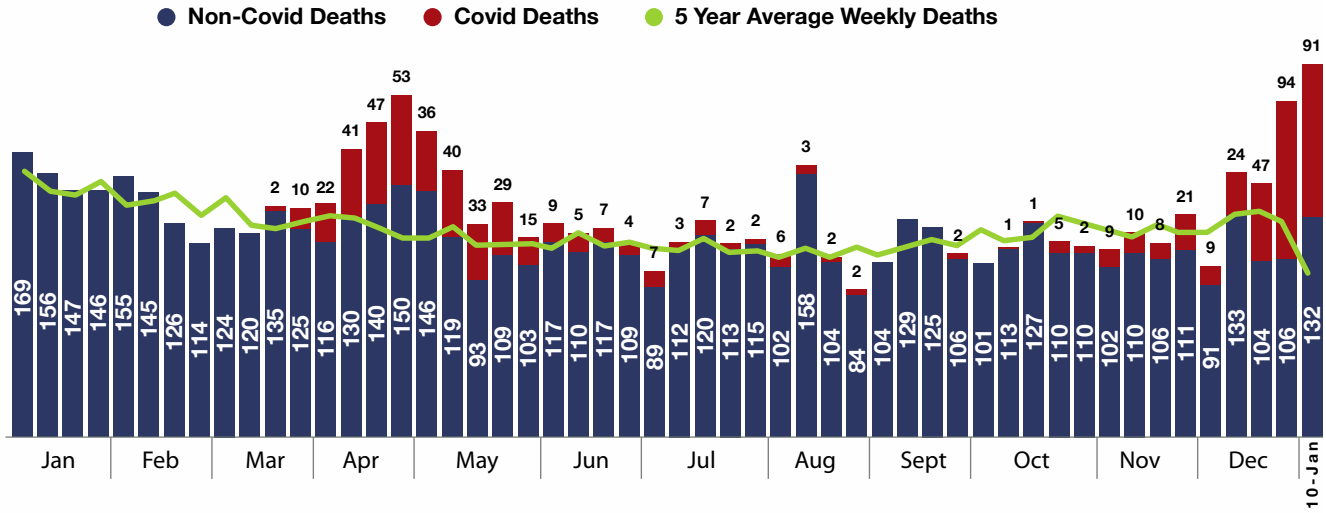
- 66% of COVID-19 admissions also have a cardiovascular disease diagnosis
- 41% have hypertensive disease diagnoses (subset of cardiovascular disease)
- 21% have diabetes

Deaths

There have been 713 deaths for East Sussex residents involving COVID-19, based on any mention of COVID-19 on the death certificate[4]. (The data covers weeks from the beginning of 2020 up to and including the week ending 01-Jan 2021, for deaths that had been registered by 09-Jan 2021).

To understand the overall picture of mortality it is important to note the change in the numbers of deaths as a result of COVID-19 and excess mortality. Excess mortality is defined as deaths beyond the expected number. The weekly average from the previous 5 years is being used as the 'expected number'. It is not possible to identify which deaths would be expected and which ones contribute to excess mortality.

It is important to note that the graph presented below on deaths is subject to change and further deaths can be added retrospectively.



More detailed analysis of COVID-19 deaths is possible using data from the death certificate. Due to the time delay of the detailed information available to local public health teams, further analysis is only available on those deaths registered by the end of December (as opposed to deaths that occurred by the end of December). Based on the 626 COVID-19 deaths that were registered by the end of December 85% had COVID-19 recorded as the underlying cause of death and 54% were for males. Also:

- 90% were aged 70 years or over and 28% were aged 90 years or over
- 47% had mention of cardiovascular disease (45% nationally)
- 27% had mention of dementia (26% nationally)
- 15% had mention of diabetes (21% nationally)
- 17% had mention of hypertensive diseases (20% nationally)
- 10% had mention of chronic obstructive pulmonary disease (COPD) (12% nationally)
- 11% had mention of chronic kidney disease (11% nationally)

4. Data source: ONS Public Health Mortality Files. Deaths registered to 31st December 2020. Numbers are provisional and subject to change with future data releases. Analysis is based on date of death. COVID-19 death: any mention of COVID-19 defined as ICD-10 U07.1 (confirmed by laboratory) and U07.2 (clinical or epidemiological diagnosis where laboratory confirmation is inconclusive or not available). For COVID-19 deaths, any comparisons to nationally use data from 'COVID-19: review of disparities in risks and outcomes', Public Health England, published 2 June 2020. Covid-19-review-of-disparities-in-risks-and-outcomes | gov.uk

Chapter 4:

Wider Impacts of COVID-19

The previous chapter talked through the range of direct impacts of COVID-19 in terms of who across East Sussex were affected with COVID-19, where they lived and what the main characteristics were. However, one of the biggest challenges nationally has been reconciling the direct threat of COVID-19 and the harm posed by the infectious disease, with the indirect risks associated to measures aimed at reducing COVID-19. The whole premise of social distancing is asking people to interact in a way that is contrary to human instinct, and we know how vital social contact is for wellbeing. A strong economy is vital for health and wellbeing – jobs help people create purpose, and the links between income and wellbeing as discussed earlier in this report are profound. And with health services being disrupted there are other wider risks to the health of the population, such as access to preventative services (e.g. screening programmes), or through delays in accessing treatment such as stroke where we know early intervention is key.

Everyone has been impacted, but each experience has been unique and every person will have their own story. Babies and toddlers will have been deprived of seeing faces and born into a world of people wearing masks. Young people have had their education disrupted. Adults have lost employment. People in care homes have had visiting restricted. And everyone has had plans and routines completely altered.

It will take time to really understand the breadth of these issues, but this provides a starting point as we look to understand some of the initial wider impacts of COVID-19.

COVID Surveys

Healthwatch surveys

Healthwatch East Sussex, the local independent health and care watchdog launched a survey in May 2020 to explore the direct and indirect impacts of the lockdown, social distancing measures and changes to services on people's health and wellbeing. The aim of the survey was to capture a snapshot of people's experiences to inform the COVID-19 response, and identify any longer-term effects from the crisis.

Analysis from the 1,209 adult respondents identified that:

67%	Identified anxiety about the future as most common issue experienced more often since the outbreak.
40%	Identified becoming serous ill with COVID-19 as the issues they were most anxious about.
25%	Felt it is difficult to get clear government guidance on actions to take during the pandemic.
55%	Were receiving treatment / care, and 46% of these had experienced changes or disruption to services. For 20% it had a significant impact.
39%	Identified physical activity as most common issue undertaken less often since the outbreak.
13%	Had concerns about emotional / physical well-being during the outbreak, 16% had sought help.
39%	Felt they were having some difficulty or not coping at all well during the COVID-19 crisis.
7%	Experienced changes or disruption to social care services. For 49% it had a significant impact.

A further 970 children and young people aged 11 to 18 years were surveyed.

Analysis from the 970 children and young people revealed:

66%	Identified physical activity as most common issue undertaken less often since the outbreak.
65%	Strongly agree that they feel safe at home.
45%	Felt they were coping well but with some worries during the COVID-19 crisis.
23%	Had experienced changes or distribution to health services or treatment, and for 8% of these it had a significant impact.
43%	Identified fast food / takeaways as most common issue undertaken less often since the outbreak.
19%	Felt it was difficult or very difficult to understand what was happening during the outbreak.
6%	Felt they were having some difficult or not coping at all well during the COVID-19 crisis.
85%	Felt confident / very confident accessing healthcare for non-covid related treatment or worries.

Healthwatch in Sussex public survey on digital consultations

The Healthwatch in Sussex public survey[5] on digital consultations final report focused on establishing people's experiences of digital or remote consultations during the COVID-19 period and their expectations and preferences for service redesign and delivery in the restore and recovery stages post COVID-19. This survey and the Sussex CCG's survey on NHS communications with patients (which contained many of the same questions) provided a combined sample of 2,185 people, and the following headline findings:

Analysis of combined sample 2,185 people revealed:

37% chose not to make an appointment during the pandemic despite having a need to access healthcare, social or emotional care.

79% did not make an appointment because they felt their condition wasn't serious enough (42%) or didn't want to burden the NHS (28%).

30% were not happy to have remote emotional and mental health support, including counselling and therapy. This rose to 44% of people with long-standing and serious mental health issues.

63% who had a remote appointment had a phone appointment.

80% who had a phone, video and online appointments during the pandemic were satisfied or very satisfied with phone appointments (76% with video and 79% with online).

Phone Appointments were preferable to video / online for triage, medication, GP, test results, emotional and mental health support.

Younger People Were generally happier to receive phone, video and online appointments compared to older people.

People with disabilities Were less happy to have any forms of remote appointment then those without disabilities.

5. Preferences towards the future of Health Social Care-services in Sussex Full Report.pdf | healthwatcheastsussex.co.uk

Care Homes: Keeping families connected in East Sussex

The Pan-Sussex Healthwatch 'Care Home Families & Friend Support project', sought to explore family and friends' experiences of care homes during the COVID-19 pandemic, engaging 64 families and 4 professionals in August and September 2020.

During the pandemic, family members / friends:

- recognise the challenges care homes face due to COVID-19, yet their experiences during the pandemic significantly varied across homes
- had greatly varied experiences of receiving up to date information on the health of their relative / friend and of COVID-19 infections within the care setting
- broadly understand and accept the reasons for carehomes restricting visiting arrangements
- reported being frustrated / distressed when they had received no communication from care homes or care home residents during the pandemic
- had significantly less contact with those living in care homes, which as substantially impacted on the health and wellbeing of family members / friends and those in care homes
- greatly valued the efforts many care homes had made to facilitate communication between family members / friend and their relatives or friends
- are concerned about how sustainable the already limited visiting arrangements will be during the winter, given the use of outdoor spaces to facilitate visits
- found a major barrier to communicate to be where there were technical issues or resident capacity / health issues preventing telephone or video calls
- have found absence of physical contact with those in care homes particularly difficult
- expressed concern about gaps in support due to health services being prevented from visiting, and from additional care they would provide during a visit
- note that arranging new care home placements, admissions and settling in has been a particular challenge
- report that the period following a friend or relative moving into a carehome, can be a time of isolation and poor mental wellbeing
- feel the government failed to provide comprehensive, timely guidance to care homes during COVID-19, which has negatively impacted on care home provision and residents' family members / friends experiences

University of Brighton - COVID-19 Stories

The University of Brighton was commissioned to explore the impacts of COVID-19 on a range of individuals within East Sussex. Understanding these impacts is important so that appropriate support can be developed.

Twenty-five people were interviewed across East Sussex including single parents with young children, young people having just left college (18+), those with disabilities, those furloughed or unemployed during the pandemic, and people living in temporary accommodation. A series of case studies and a final report will be available in May 2021. A summary of the key findings is presented below.

'Life on-hold': Several people spoke about how the pandemic had made them "shut down", describing that their "day-to-day life has pretty much curtailed". Overall, people had mixed views about the course of the pandemic. Some said it was becoming harder through time, whereas several people reported being "a bit more prepared for it because I know we've got through it before."

Impacts on family: Impacts within the immediate (household) family were considered by most to be beneficial in the early stages of the first Lockdown, describing it as "Just nice to spend time together because you couldn't do anything else." Most people were unable to see or visit their children (who had left home), parents, grandparents or other family members as much as they would normally do which was distressing: "The hardest thing for me is not meeting up with my family… , we're quite a big family." Sadly, two people also reported that someone in their family (a parent and a grandparent) had died with COVID-19.

Impacts on friends: For many people they had "really lost contact with a lot of people." Many holidays, regular social events, or weekly activities were cancelled. Some had deliberately avoided friends for fear of infection. For those who had kept in touch with friends they were described as leading to "much tighter relationships." Keeping in touch during the warmer weather was easier.

Impacts on jobs and finances: A number of people had been furloughed, had experienced reduced trade ("literally overnight"), or had lost their job. Most enjoyed the flexibility of working at home despite the blurred boundaries between home and work. Those who were furloughed generally "loved it. I was loving furlough; I was loving all the time off."

Impacts on education: The earlier than planned end of the final year was described as "anticlimactic." Plans had changed for some, "I'm working in my hometown. I'm saving up money and getting working experience but it's very different. It feels really frustrating, I really want to go and travel." People were frustrated by learning online and missed face-to-face contact.

Impacts on mental health: Most people reported some kind of mental health impact. This ranged from being "cross", "stressed" "frustrated", or "just a lack of motivation" to more serious health anxieties. The latter included fear about being infected or "very conscious of, we're all inside together [at Christmas], am I going to pass anything on?" Coping strategies included having routines, exercising, and investing in new online courses.

The research produced the following recommendations:

- The pandemic has limited people's social contact with friends and family, especially for those living alone or those shielding. There is a need for community-based services to combat social isolation
- For those with pre-existing mental health conditions, the times of entering a lockdown or significant media coverage of cases or deaths is particularly distressing. There is a need to recognise these periods of stress and to raise confidence in people's ability to prepare for ongoing restrictions including future pandemics

Read COVID-19 stories: Investigating the impact of COVID-19 on local communities within East Sussex | eastsussexjsna.org.uk

Mental Health

Data and evidence to date show that self-reported mental health and wellbeing (including in anxiety, stress and depression) worsened during the pandemic and still remains worse than pre-pandemic levels. Young adults and women have been more likely to report worse mental health and wellbeing than older adults and men[6].

Other key groups that have been impacted are those,

- with low household income or socioeconomic position
- with long term physical health problems
- living in urban areas
- living with children
- who have had corona virus related symptoms

For many COVID-19 has clearly exacerbated pre-existing mental health conditions and disrupted the care and support they have been accustomed to. For others, the worst impacts are still to be felt as restrictions are eased but the wider socio-economic factors are not.

We continue to work as part of the East Sussex Integrated Care Partnership. That has been developing a single adult mental health plan and programme which sets out initial work required to develop emotional wellbeing services, community services enhancements, and housing and supported accommodation needs and pathways.

A joint Oversight Board has also been set up to ensure the recommendations of 'Foundations for our Future', the independent review of children and young people's emotional health and wellbeing services across Sussex, are fully implemented.

A new project will also bring partners together to help develop a whole system approach to tackling loneliness and social isolation in East Sussex using a collaborative design and innovation process. The aim of the work will be to better understand the nature and impact of loneliness on residents and identify future opportunities and approaches to mitigate its worst effects.

Recommendation:

We know people's experiences changed as the pandemic progressed. Therefore, it is important that we continue to collect information to understand the experiences of people, how they have been impacted, and how we can plan for the future.

Recommendation:

We will continue to progress our programmes to address mental health including the factors around social isolation with Sussex Partnership NHS Foundation Trust and through our partnership with the voluntary sector called Partnership Plus [7].

6. Mental health and wellbeing in the time of coronavirus – tracking the impact | Public Health Matters.blog.gov.uk
7. East Sussexv County Council and the voluntary sector partnership plus | essp.org.uk

Homelessness

The government-led drive 'Everybody in' brought together councils, charities, the private hospitality sector, and community groups with the joint aim of protecting some of the most vulnerable people in society from COVID-19 and helping them turn around their lives and get them off the streets for good. In East Sussex there are approximately 200 rough sleepers now in temporary accommodation and 30 people still on the streets.

Financial insecurity

Financial insecurity and problem debt are pre-COVID-19 issues, made worse by the current pandemic. Low-income households are particularly vulnerable to changes in the cost of living and suffer the social exclusion and increased health risks of poverty.

Pre-COVID-19 it is estimated that 1 in 14 (7%) of the adult population were in problem debt[8,9,10]. According to the Money Advice Trust, before COVID-19, 33% were already behind with their bills, a quarter had been negotiating repayments/request they hold action and 17% were in the process of setting up a solution for their debt[11].

Loss of income through redundancy and furlough has pushed many into an uncertain financial future including the prospect of homelessness. For others, such as those leaving higher education it has made the prospect of achieving financial interdependency and security much harder.

Economic impact

Government employment support schemes

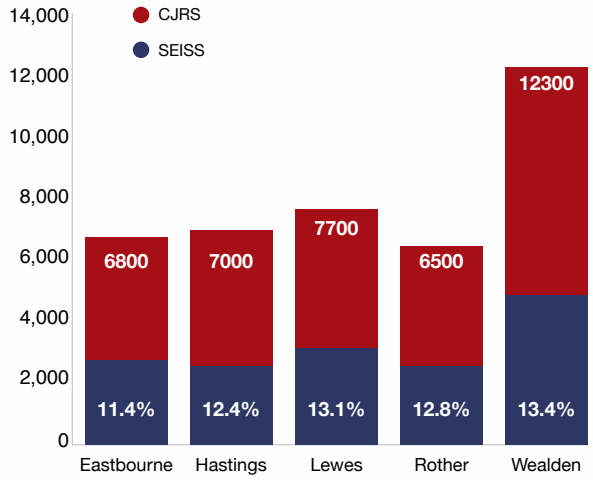
In spring 2020, the government announced two schemes to support people who work for businesses unable to trade because of the COVID-19 restrictions. The Coronavirus Job Retention Scheme, otherwise known as the Furlough scheme) enabled companies to furlough employees rather than terminate their employment, paying 80% of people's wages, up to a maximum of £2,500 per month. The scheme, which has been amended and now includes 'flexible furlough' where the employee can undertake some work for their employer, has been extended until the end of March 2021.The Self-Employment Income Support Scheme was set up by the government to provide support for those who are self-employed. The data below shows those supported by the schemes as of 31st October 2020.

8. which means they are seriously behind on payments for bills or credit agreements or have been disconnected by a utilities provider in the past year
9. Money and Mental Health.org | A-Silent-Killer-Report
10. Household debt in Great Britain - April 2016 to March 2018 | Office of National Statistics
11. The impact of Covid 19 on recent National Debtline caller | Money Advice Trust.org

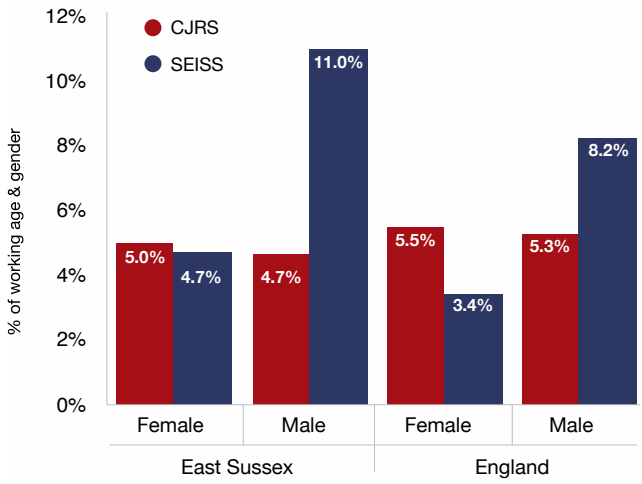
40,100 Jobs in East Sussex supported by government schemes at 31st October 2020 = **15,400** Coronavirus Job Retention Scheme: CJRS (Furlough)

24,700 Self Employment Income Support Scheme: SEISS

Number of people covered by Government employment Support Schemes



% of working age population covered by Government Employment Support Schemes by gender



East Sussex Research and Information Team, Unemployment in Brief December 2020

Job Seekers Allowance (JSA) and Universal Credit claimants

In November 2020, 15.7% of the working age population were receiving either JSA or Universal Credit (including those in work and searching for work).

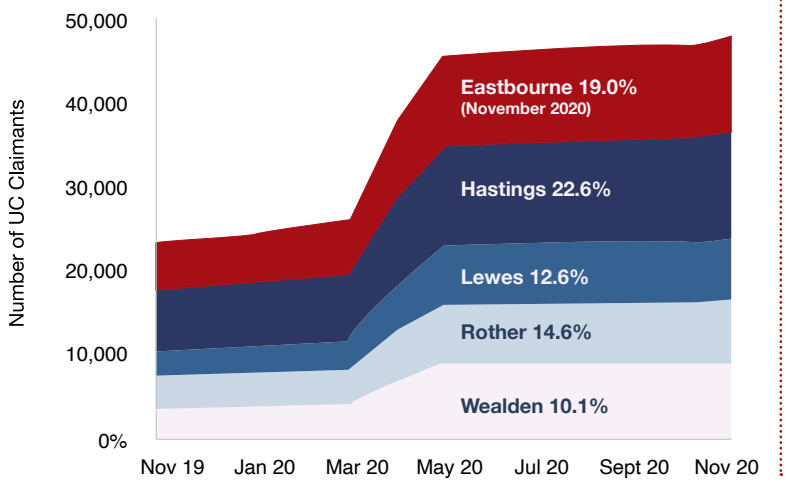
Universal Credit Claimants

48,208 People claiming Universal Credit in November 2020, 22,041 more than March 2020

23% Working age people in Hastings are claiming Universal Credit

37% Universal Credit claimants are in work

Universal Credit Claimants by: District, Borough and % of working age population



Change in number of Universal Credit claimants since November 2012

Eastbourne	5,811	up 107%
Hastings	5,315	up 71%
Lewes	4,493	up 154%
Rother	3,558	up 93%
Wealden	5,683	up 159%
East Sussex	24,872	up 107%

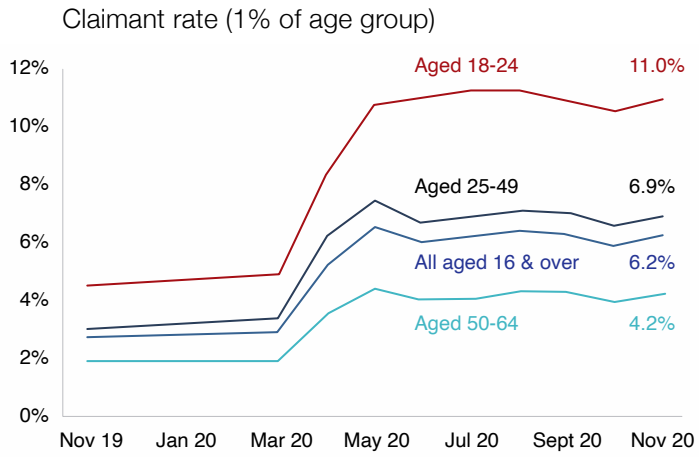
Job Seekers Allowance and Universal Credit Claimants

6.2% **(19,680) unemployed working age people were claiming Jobseekers Allowance and Universal Credit (searching for work) in November 2020**

4.4% **Increase since October 2020**

11% **18-24 year olds compared to 4.5% in November 2019**

115% **Increase in claimants since March 2020**



In April 2020, ESCC co-ordinated the development of an Economy Recovery Plan ("East Sussex Reset") with partners to provide a clear focus for the economy recovery effort. This is not a plan for the County Council, it is a plan for Team East Sussex , the county's de-facto Growth Board, and partners to take forward. The Plan is complementary and supportive of other activities being progressed at a local level, including climate change and health and wellbeing initiatives.

Consisting of six "missions": 1. Thinking Local / Acting Local, 2. Building Skills / Creating Jobs, 3. Fast-forwarding Business, 4. Better Places, Fuller Lives, 5. Cleaner Energy / Greener Transport, 6. The Future is Digital.

The Plan has resulted in a total of circa £87.85m is being invested into East Sussex. This is a combination of £53.47m newly secured monies and a further £34.38m aligned from ongoing monies committed or already secured from external sources to support the survival, reset, recovery and growth of businesses in East Sussex.

East Sussex Reset

The Growth Hub, has been the front-line support for business owners helping them to understand and access the range of support available. The impact of COVID-19 as expressed by business owners has changed and evolved as successive restrictions on trade have been implemented in response to the pandemic. The Job Retention scheme has allowed vital employees to be retained and is generally viewed as a success. Businesses are now planning for the future and, in many cases, do not believe that they will be able to support previous numbers of staff. Serious consideration is being given to reduction in staff numbers and redundancies.

As restrictions subside and we move towards a new 'recovery' period from COVID-19, the economic impacts will play out and be felt for some time. It is vital that economic recovery benefits all and helps to reduce the inequalities in our society. The basis for this should be access to training and good quality employment opportunities. Our approach needs to go beyond this and foster a sense of hope and opportunity in those whose plans and ambitions have been so disrupted by the pandemic.

Recommendation:

The COVID-19 pandemic had a significant impact on the economy. Organisations at every level will continue to focus on the local economy and employment security through Team East Sussex and wider partnership working.

The Wider Health System

The East Sussex Integrated Care Partnership, as part of the wider Sussex Health and Care Partnership (Integrated Care System) are currently working towards a new integrated model of primary and community mental health care which will support adults and older adults. The new model of care will need to reflect the changing needs of those affected by COVID-19 and build on the strengthened relationships developed over the past year between agencies supporting vulnerable people.

For children and young people, it becomes ever more important to implement the recommendations of Foundations for Our Future, the Sussex-wide review of Emotional Health and Wellbeing Support. This requires a system approach and a focus on public health approaches to prevention, to help ensure our young are able to thrive and meet the ever-increasing challenges they face.

During April 2020, A&E attendances and outpatient attendances were around half of what they usually would be. Emergency admissions were two-thirds, and elective admissions around a third of what would usually be expected. By the end of the summer activity numbers had pretty much returned to more normal levels. For electives and outpatients, admissions/attendances dropped slightly in December. For A&E, numbers peaked in August and have been on a slight downward trend since to the end of the year.

Analysis of emergency admissions (up to the end of November) since April 2020 for ischaemic heart diseases, acute myocardial infarctions, stroke, cancer, diabetes, asthma or epilepsy does not appear to show a subsequent increase due to any wider ramifications of patients not seeking treatment or issues accessing services (though it is noted that it may be too early to tell). Emergency admissions for persons with dementia or as a result of self-harm, up to the end of November, also appear to within the normal range.

During the eight month period April-November 2020 there were more emergency admissions as a result of an assault that occurred in the home (a proxy indicator for domestic abuse) (n=27) than in the full year April 2019 – March 2020 (n=18)[12].

We continue to work as part of the East Sussex Integrated Care Partnership to ensure all partners can respond to the wider impact of COVID-19 on the system.

12. Data source: Hospital Episode Statistics (HES) data accessed via DAE, NHS Digital. Hospital activity up to the end of November 2020 (likely incomplete for admissions for the last week of November, outpatients and A&E attendances should be reasonably complete for the full month) Due to the way HES data is submitted by Trusts, processed by NHS Digital and made available to local Public Health teams, the numbers are subject to change. Some details for the admissions may be incomplete and would likely be updated with future data uploads. The following ICD-10 codes have been used: Acute myocardial infarction I21-I22; Ischaemic heart diseases I20-I25; Stroke I60-I69; Diabetes E10-E14; Dementia / Alzheimer's disease F00-F03, G30, G318, G310; Cancers C00-C99; Asthma J45, J46; Epilepsy G40, G41; Self-harm X60-X84; Assaults X85-Y09 (with place of occurrence=0 for home)

Chapter:5

Conclusions

A variable epidemiology

One of the clearest stories about COVID-19 in East Sussex is that this was not defined by one pattern, one trend, or a simple narrative. If the pandemic had been over by November 2020 when East Sussex had one of the lowest cumulative rates in the country, this could have led to conclusions that there was something fundamentally protective about living in East Sussex, the geography and the links to elsewhere that predisposed it to having a lower incidence of COVID-19 compared to many other areas. However, we have seen throughout December 2020 a completely different pattern that was in stark contrast to previously. Although it could be easy to reduce this to a new, more infectious strain of COVID-19, it is likely to be a more complicated set of factors.

There are a number of protective factors about East Sussex that could have contributed to the low rates earlier on. For example, the county has large rural areas and a lower population density than many other counties which could have helped to keep rates low, but this is contrasted to being relatively close to London and a large amount of tourism which you would potentially expect to increase the risk of COVID-19. Similarly, the third reported case in the UK having links to East Sussex could have posed a risk earlier on, but on the other hand this could have raised the attention of the public to the importance of social distancing and respiratory hygiene.

We have seen across the UK that most areas with a high incidence are not concentrated in a particular town or city, but rather a feature of a wider region, and therefore for East Sussex the rates across the borders in Surrey, Kent and the rest of Sussex are also likely to have played a part. Throughout 2020 rates in Brighton and West Sussex have experienced similarly low rates to East Sussex, which is likely to have contributed to the spread of infection we have seen, but this is contrasted to late in the year where high rates first appeared in Kent, before being experienced in the east of the county and then spreading west.

Repeating inequalities

We know how health is not experienced equally by all, and COVID-19 has shown yet again how certain groups are affected disproportionately.

The fact that if you are Black, Asian, or from a minority population you are more likely to get COVID-19 and more likely to die is unacceptable. The fact that COVID-19 is more prevalent in areas that are poorer, and that those populations will suffer worse health outcomes, is unacceptable.

These experiences of COVID-19 reveal existing inequalities that will not be solved through a single initiative but rather expose structural inequalities.

Recommendations

Recommendation:
COVID-19 has revealed familiar links between the conditions we live in and our health and wellbeing. We will continue to mitigate the impacts of the wider determinants of health to reduce health inequalities through a wide range of existing and new programmes.

Recommendation:
We have been working across Sussex, with our integrated care system (ICS) partners, to understand the range of issues that disproportionately affect people from ethnically diverse communities and why they experience poorer health and wellbeing. We will act on recommendations to disrupt the structural inequalities faced by these groups in the future.

Recommendation:
Our choices have a substantial impact on our health. We will continue to ensure that the healthy choice is the easy choice across East Sussex and that our new and existing programmes support our population to experience good health and wellbeing.

Recommendation:
We will continue to link with partners, use evidence and the available communication methods to ensure the effectiveness of our messages to our residents about COVID-19.

Recommendation:
We know people's experiences changed as the pandemic progressed. Therefore, it is important that we continue to collect information to understand the experiences of people, how they have been impacted, and how we can plan for the future.

Recommendation:
We will continue to progress our programmes to address mental health including the factors around social isolation with Sussex Partnership NHS Foundation Trust and through our partnership with the voluntary sector called Partnership Plus.

Recommendation:
The COVID-19 pandemic had a significant impact on the economy. Organisations at every level will continue to focus on the local economy and employment security through Team East Sussex and wider partnership working.

References

1. WHO (World Health Organisation) - Europe - Pandemic Fatigue

2. New SARS-CoV-2 variant | www.gov.uk

3. Due to the way HES data is submitted by Trusts, processed by NHS Digital and made available to local Public Health teams, the numbers are subject to change. Some details for the admissions may be incomplete and would likely be updated with future data uploads. Analysis by date is based on date of admission. For admissions with a COVID-19 diagnosis, it is not possible to know from HES data the date of the diagnosis. We can tell if COVID-19 was the reason for admission (if recorded as primary diagnosis), but we cannot tell if it co-existed at time of admission or whether the patient subsequently caught it in hospital. COVID-19 admission: any mention of COVID-19 defined as ICD-10 U07.1 (confirmed by laboratory) and U07.2 (clinical or epidemiological diagnosis where laboratory confirmation is inconclusive or not available) in any diagnosis position.

4. Data source: ONS Public Health Mortality Files. Deaths registered to 31st December 2020. Numbers are provisional and subject to change with future data releases. Analysis is based on date of death. COVID-19 death: any mention of COVID-19 defined as ICD-10 U07.1 (confirmed by laboratory) and U07.2 (clinical or epidemiological diagnosis where laboratory confirmation is inconclusive or not available). For COVID-19 deaths, any comparisons to nationally use data from 'COVID-19: review of disparities in risks and outcomes', Public Health England, published 2 June 2020. Covid-19-review-of-disparities-in-risks-and-outcomes | gov.uk

5. Preferences-towards-the-future-of-Health-Social-Care-services-in-Sussex-Full-Report.pdf | healthwatcheastsussex.co.uk

6. Mental health and wellbeing in the time of coronavirus – tracking the impact | Public Health Matters.blog.gov.uk

7. East Sussexv County Council and the voluntary sector partnership plus | essp.org.uk

8. which means they are seriously behind on payments for bills or credit agreements or have been disconnected by a utilities provider in the past year

9. Money and Mental Health.org - A-Silent-Killer-Report

10. Office of National Statistics - Household debt in Great Britain - April 2016 to March 2018

11. Money Advice Trust.org - The impact of Covid 19 on recent National Debtline caller

12. Data source: Hospital Episode Statistics (HES) data accessed via DAE, NHS Digital. Hospital activity up to the end of November 2020 (likely incomplete for admissions for the last week of November, outpatients and A&E attendances should be reasonably complete for the full month) Due to the way HES data is submitted by Trusts, processed by NHS Digital and made available to local Public Health teams, the numbers are subject to change. Some details for the admissions may be incomplete and would likely be updated with future data uploads. The following ICD-10 codes have been used: Acute myocardial infarction I21-I22; Ischaemic heart diseases I20-I25; Stroke I60-I69; Diabetes E10-E14; Dementia/Alzheimer's disease F00-F03, G30, G318, G310; Cancers C00-C99; Asthma J45, J46; Epilepsy G40, G41; Self-harm X60-X84; Assaults X85-Y09 (with place of occurrence=0 for home)

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