



Stockport JSNA

joint strategic needs assessment

Impacts of COVID-19 on health and wellbeing in Stockport

March 2021
Second Report

The COVID-19 Global Pandemic has led to shift in our ways of life, limits on social contact with friends and family, changes to the way we work or educate our children, strains faced by those who have been furloughed, lost their jobs or seen their businesses suffer and unprecedented pressure put on our key workers and healthcare staff. COVID-19 has had devastating impact on health and wellbeing of those who have had a serious infection and tragically has caused loss of life that has affected so many families in our communities.

This is the second in a series of JSNA analysis into the impact of the COVID-19 Pandemic on the health and wellbeing of the people of Stockport. The first report, produced in September 2020, reviewed trends for the first wave of cases over the first half of 2020, described emerging inequalities and differences between communities and set out what was known at that time about the wider impact of lockdown.

This second report comes after Stockport has experienced a further two waves of infection through the autumn and winter of 2020 / 2021 which has lead to further impacts on the way we live and health of the population, but also comes after the initiation of the COVID-19 vaccination programme in December 2020.

This JSNA report aims to bring together further evidence about some of the impacts of the COVID-19 pandemic, and carries on a series of analyses which will continue to develop. The focus of this report is on the direct impact of the pandemic, as research about the indirect and long-term impacts is still to emerge.

It is intended to further explore what is known so far about:

- The direct impact of the second and third wave of the pandemic in on the health and wellbeing of Stockport's population
- Inequalities in health and wellbeing of the people of Stockport and in particular vulnerable groups
- The initial role out of the COVID-19 vaccination programme

With the aim of summarising the situation as it's known at the beginning of April to provide an overview to help the system:

- In supporting those who have particular vulnerabilities to COVID-19, especially through any future waves
- In maximising the uptake of the COVID-19 vaccine
- To help identify priorities for building back better.

The effects of the epidemic and the measures implemented to control it's spread will be felt for many years to come, and despite being a year into the pandemic many of the impacts have not yet materialised. It is therefore still to soon to quantify the full impact of the pandemic on the population of Stockport, however, we are now a year since the start of the pandemic and some further evidence about the impacts of COVID-19 on the health and wellbeing of the population are emerging.

A further JSNA into the wider impacts of COVID-19 will be presented later in 2021.

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Key Findings

It is likely that 48,000 people in Stockport have been infected with coronavirus (COVID-19) – with a confidence range between 40,000 to 53,000 – around 15% to 18% of the total population.

Over 20,000 people have been diagnosed with COVID-19 in Stockport, and more than 1,900 people have been admitted to hospital as a result.

There have been around 700 deaths due to COVID-19 so far, and around 14% more deaths (all causes) in 2020 than would have been expected (excess mortality), this is similar to the national average.

23% of COVID-19 deaths occurred in care homes, and mortality levels in care homes in 2020 were 55% higher than average, again this is similar to the national average.

COVID-19 is exacerbating existing inequalities in health and is particularly affecting:

- Older people
- Males
- Black Asian and Minority Ethnic Groups
- Those living in deprived areas

National life expectancy modelling shows a loss in life expectancy of 0.9 years for females and 1.3 years for males between 2019 and 2020.

54.7% of the 18+ population in Stockport have had their first dose of the COVID-19 vaccine.

What we need to understand more about

Nationally research is underway to estimate the true rate of infection earlier in the pandemic, this is needed to help us prepare for future waves.

There still a number of scenarios for how the pandemic will progress over the coming months, and no certainty about the future.

There is still more to understand about the long term impact of COVID-19 on those who have been discharged, the duration of these effects, and the full extent of the level of increased need due to long Covid in Stockport.

ONS modelling suggests that there will be both positive and negative effects on health from pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences. It is possible that any future recession due to the impact of restrictions may have as big of an impact on health as the direct impact of the disease.

The long term consequences for education, employment, the economy and our communities are likely to be significant but as yet the level of impact is still not clear.

COVID-19, the story so far....

On 31st December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 31st January the first cases were confirmed in the United Kingdom.

On 11th March 2020 the World Health Organisation declared Covid-19 a global pandemic. The UK Government moved from the “Contain” phase to the “Delay” phase on 12th March 2020 and on the 23rd March the UK moved to “Control” with a full lockdown announcement and the population ordered to stay at home.

Restrictions started to lift in May, and by 4th July the UK moved back to Contain measures with pubs and restaurants reopening and friends and families again permitted to meet. Over August and September the government implemented a series of local control measures in areas where numbers of cases began to rise, which effected Stockport and Greater Manchester through August to October. A second national lockdown was instituted in November, relaxed in December, and a third lockdown was in place over January to March 2021.

There have been significant developments over the year in terms of the systems and process to undertake case identification and contact tracing through NHS Track and Trace and Stockport’s local outbreak management processes, as well as the introduction of interventions to limit the ongoing spread of COVID-19 such as social distancing and face coverings.

After a sustained period of COVID crisis-response, the health and care system now faces the complex challenge of supporting those people affected by COVID-19 to recover, vaccinating the adult population, re-starting non-urgent services and tackling the backlog of elective care that has been on hold and building up during the crisis; while preparing for and managing any future outbreaks of the virus.

The UK has experienced a large epidemic of Covid-19 which has led to considerable loss of life, evidence suggests that the potential remains for significant future waves of epidemic as restrictions are relaxed or lifted and although the development and implementation of vaccines for COVID-19 reduces this risk, the possible emergence of variants across the world remains significance.

The following section sets out what we know about the progress of the pandemic in Stockport in terms of numbers of cases, data is emerging on a daily basis so all the findings here should be treated as interim and with caution.

Key Findings

It is likely that around 48,000 people in Stockport have been infected with coronavirus (COVID-19) – with a confidence range between 40,000 to 53,000 – around 15% to 18% of the total population.

So far 20,524 people have been diagnosed, meaning around 40-50% of these have been identified.

Rates of detection have improved over time and it is likely that we are now identifying at least 50% of new cases.

The first wave of the pandemic peaked in April 2020, the numbers of cases identified at this time were a significant undercount. A second wave peaked in November 2020 and a third in January 2021. At the height of these later peaks around 190 cases a day were diagnosed.

Following national trends, Stockport residents who are younger adults and or from BAME ethnic groups have higher rates of diagnosed COVID-19 in Stockport.

Rates of diagnosed cases have been highest areas of deprivation, a trend that has emerged during the later two waves of the pandemic.

At least 6% of diagnosed cases are linked to care homes.

What we need to understand more about

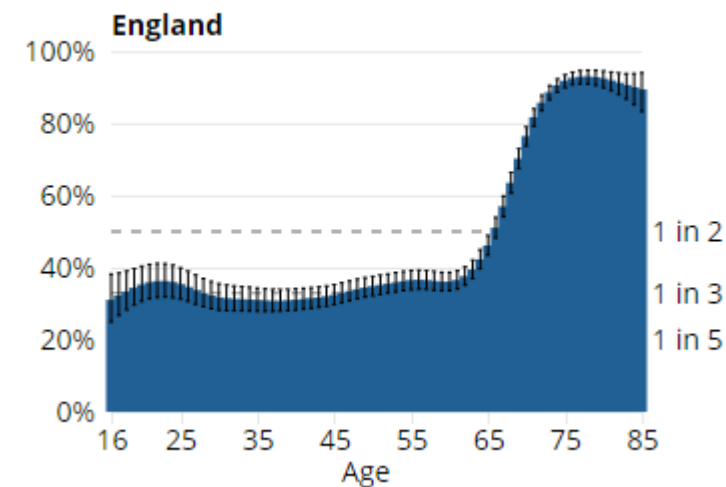
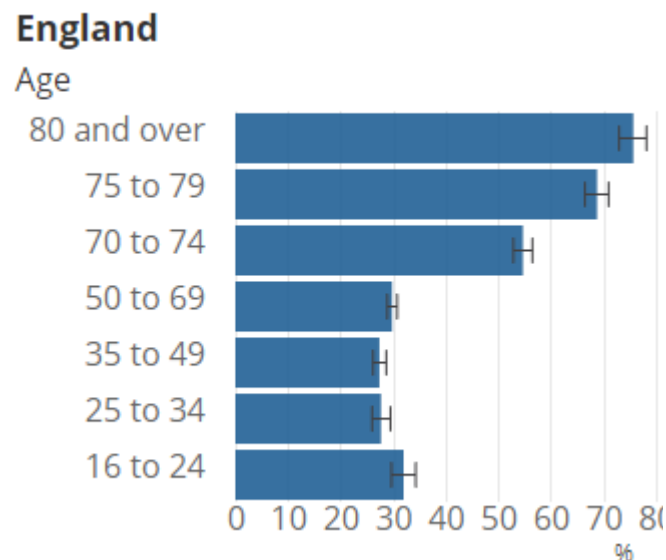
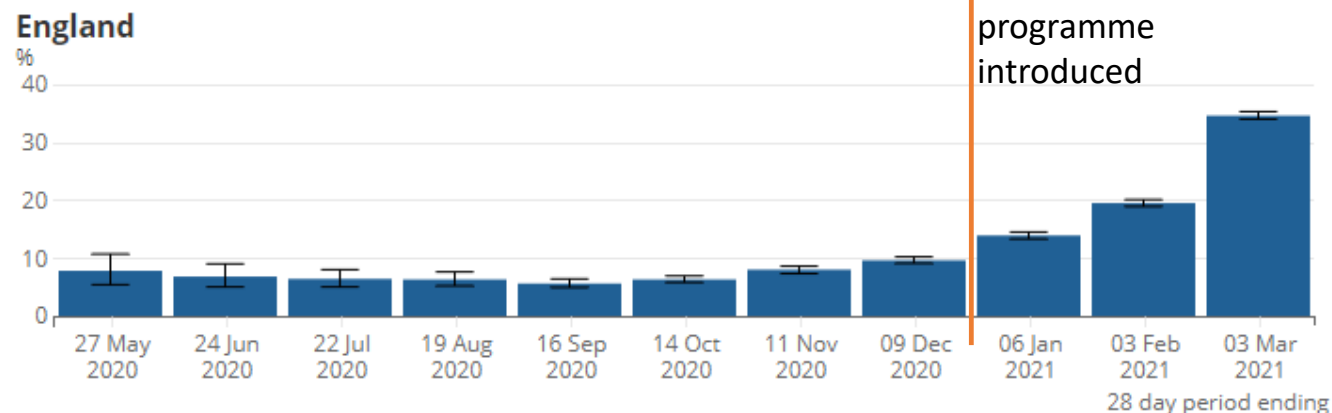
We still do not understand comprehensively how COVID-19 infection rates have varied locally by different:

- occupational groups
- those with specific needs, such as those with learning disability or serious mental illness or informal carers
- those with certain protected characteristics such as religion or sexual orientation.

There still a number of scenarios for how the pandemic will progress over the coming months, and no certainty about the future.

- ONS regularly test a sample of the population to test for presence of antibodies to the coronavirus (COVID-19) within the community population; community in this instance refers to private residential households, and it excludes those in hospitals, care homes and/or other institutional settings.
- The presence of antibodies suggests they had the infection in the past or have been vaccinated.
- In England, currently 34.6% (95% confidence interval: 34.0% to 35.3%) of the population tested positive for antibodies to SARS-CoV-2 from a blood sample in the 28 days up to 3 March 2021. This equates to 1 in 3 people aged 16 years and over.
- The highest percentages of people testing positive for antibodies are for those targeted by the vaccine programme, those aged 80 years and over at 75.7%, followed by people aged 75 to 79 years (68.8) and aged 70 to 74 years (54.7%).
- The percentage of people testing positive for antibodies is lower for those aged under 70 years, ranging from 27.4% to 32.0%.
- By 6th January 13.9% of the population tested positive for antibodies, these are likely to be people who have had an infection.
- **This would equate to around 40,800 people in Stockport.**

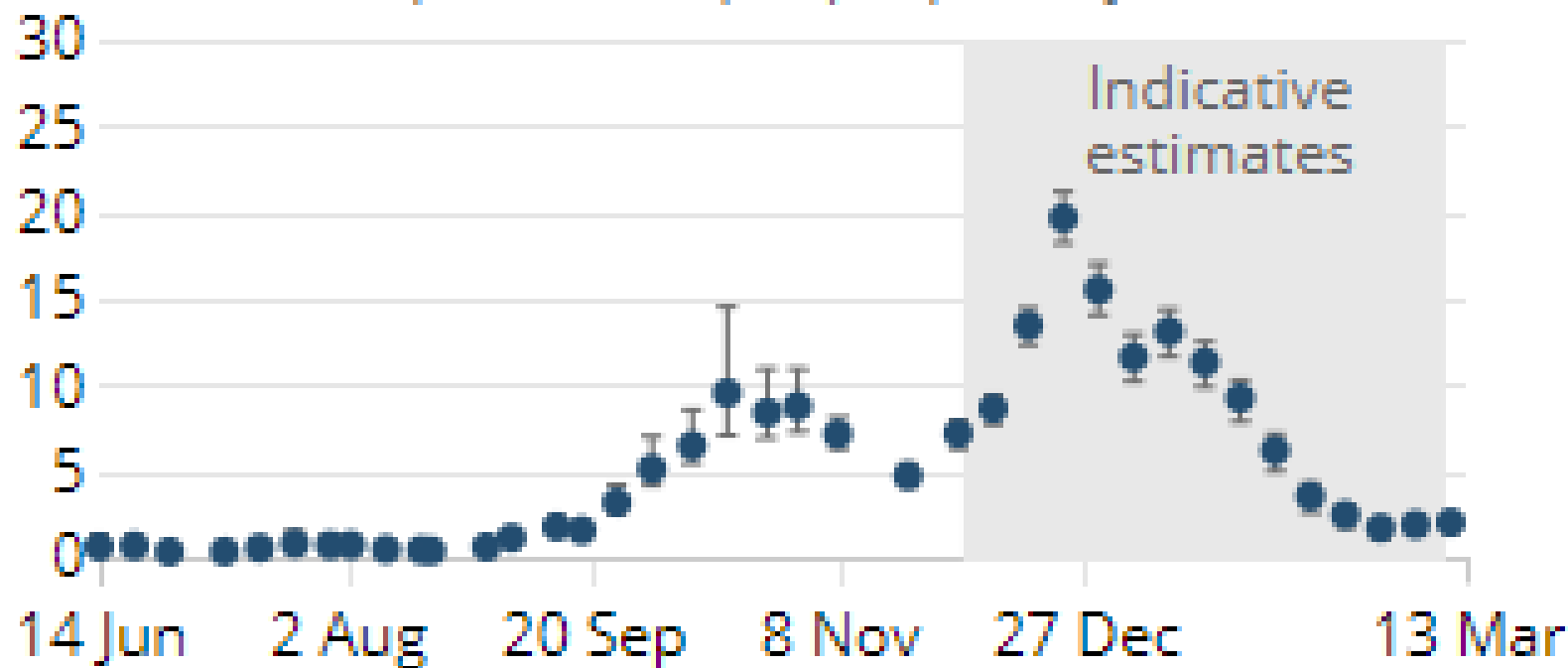
Estimated percentage of people testing positive for antibodies to SARS-CoV-2 from a blood sample, by 28-day periods, 30 April 2020 to 3 March 2021, UK

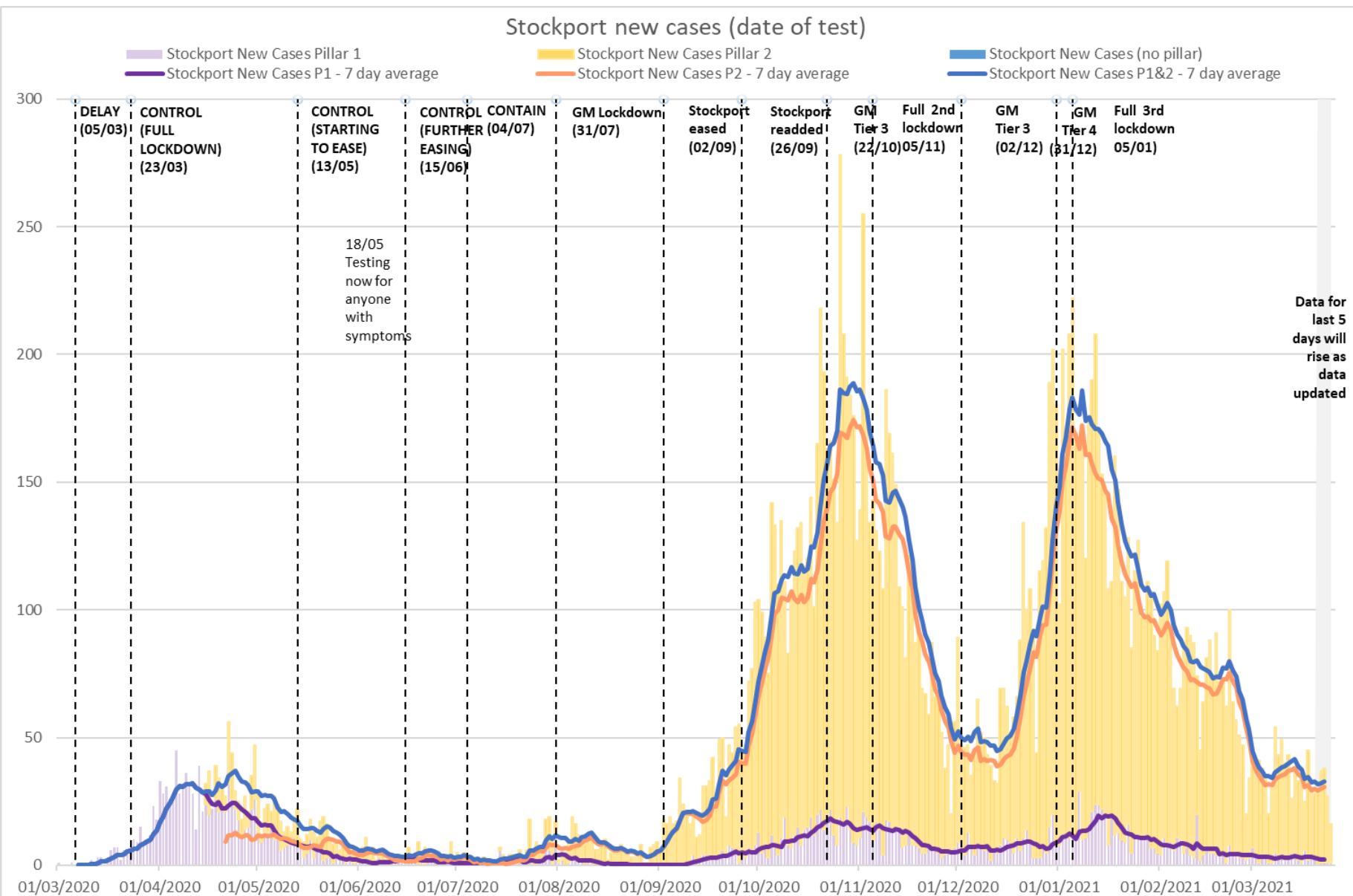


- During the most recent two weeks (7 to 20 March 2021), ONS estimate there were around 310 (95% credible interval: 270 to 340) people who had COVID-19 for every 100,000 people in the community population in England.
- **In Stockport this would equate to around 910 people having COVID-19 currently (credible interval 790-1,000).**
- The ONS infection survey began at the end of April, and therefore does not include estimates about the trends in new cases through the first wave of the pandemic, however using the available trend data for the levels of infection (see chart) we can roughly estimate that **since 3rd May there are likely to have been 48,500 people in Stockport who have had COVID-19 (credible interval 45,800-53,400).**
- **This is around 15 to 18% of the population.**

England

Incidence rate per 10,000 people per day





20,524 cases of COVID-19 have been diagnosed so far (25th March) for Stockport residents. This is 18,438 new cases since the last JSNA analysis in early September.

Following national trends there was a first wave of cases in April 2020, though these cases reported are a significant undercount as at this time testing capacity was limited and targeted.

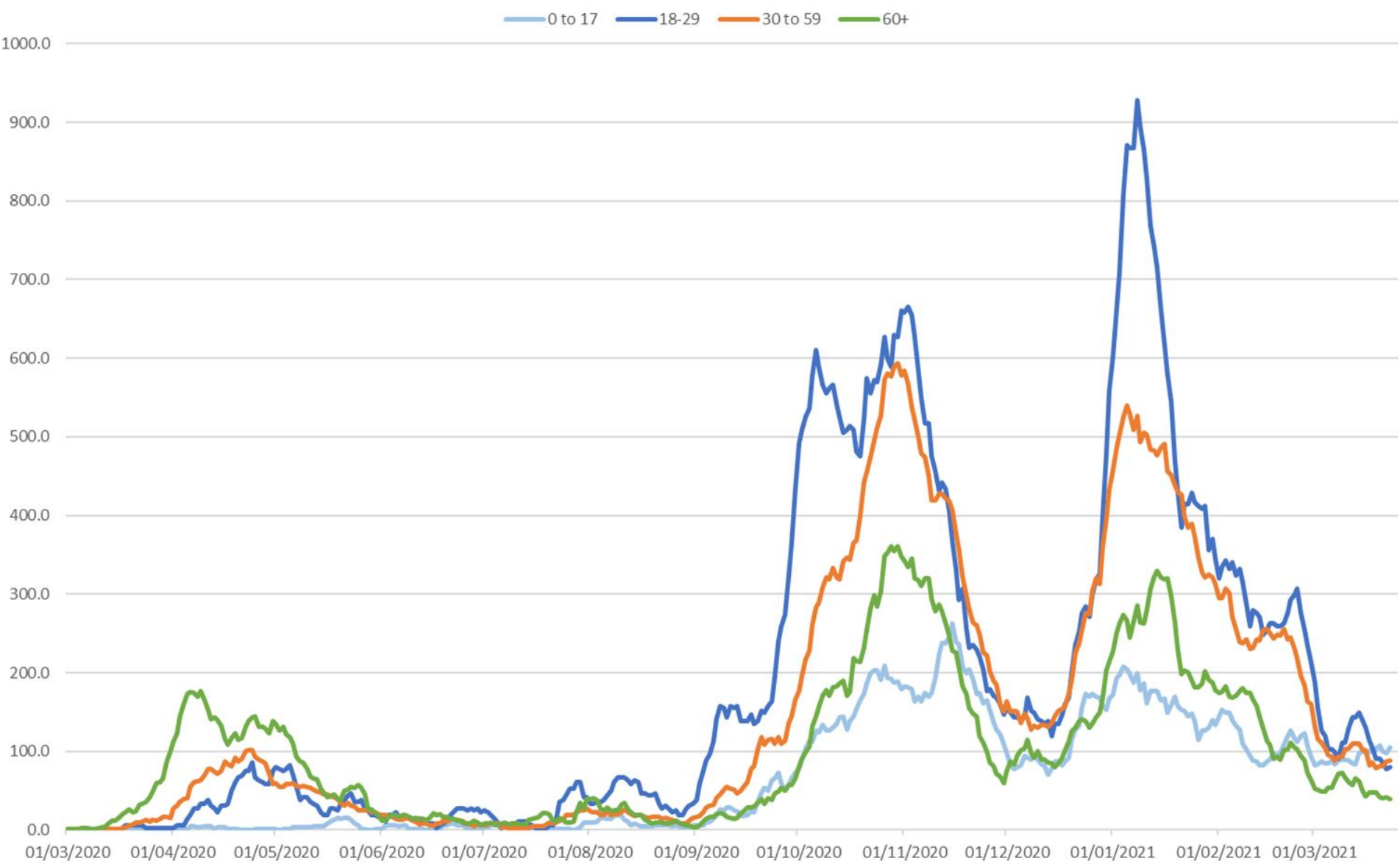
From 18th May testing has been available to all and therefore data from this point forward is more reliable, though still a significant undercount as many people with COVID-19 have not had symptoms.

The number of new cases per day has varied through two further waves of COVID-19 before and after Christmas, reaching a high of around 190 cases per day at each peak. Currently there are around 33 cases reported daily.

These trends are reviewed weekly by the COVID-19 Health Protection Board.

Comparing these diagnosed cases with the estimates of total case volumes suggest that around 50% of cases have been identified.

New cases per 100,000 in Stockport by age



Age Group	Cases	Rate per 100,000
0 to 17	2,393	3,767
18 to 29	3,882	10,725
30 to 59	10,001	8,490
60 +	4215	5,553

Following national trends diagnosed rates over the course of the pandemic in Stockport have been highest in younger adults, and lowest for children.

During the first wave testing was targeted at the those in hospital and therefore rates were highest in the 60+ population, but since testing became available to all the patterns have changed.

In the most recent month asymptomatic testing of secondary school pupils has been introduced and there are early signs that this may be leading to increased identification in the younger age group.

National analysis has shown that people from all minority ethnic groups apart from Chinese and Mixed are at greater risk of a coronavirus (COVID-19).

In Stockport, although numbers are small this trend is evident, with the crude rate per 1,000 of diagnosed cases being more than double in Asian / Asian British, Black / Black British and other ethnic groups.

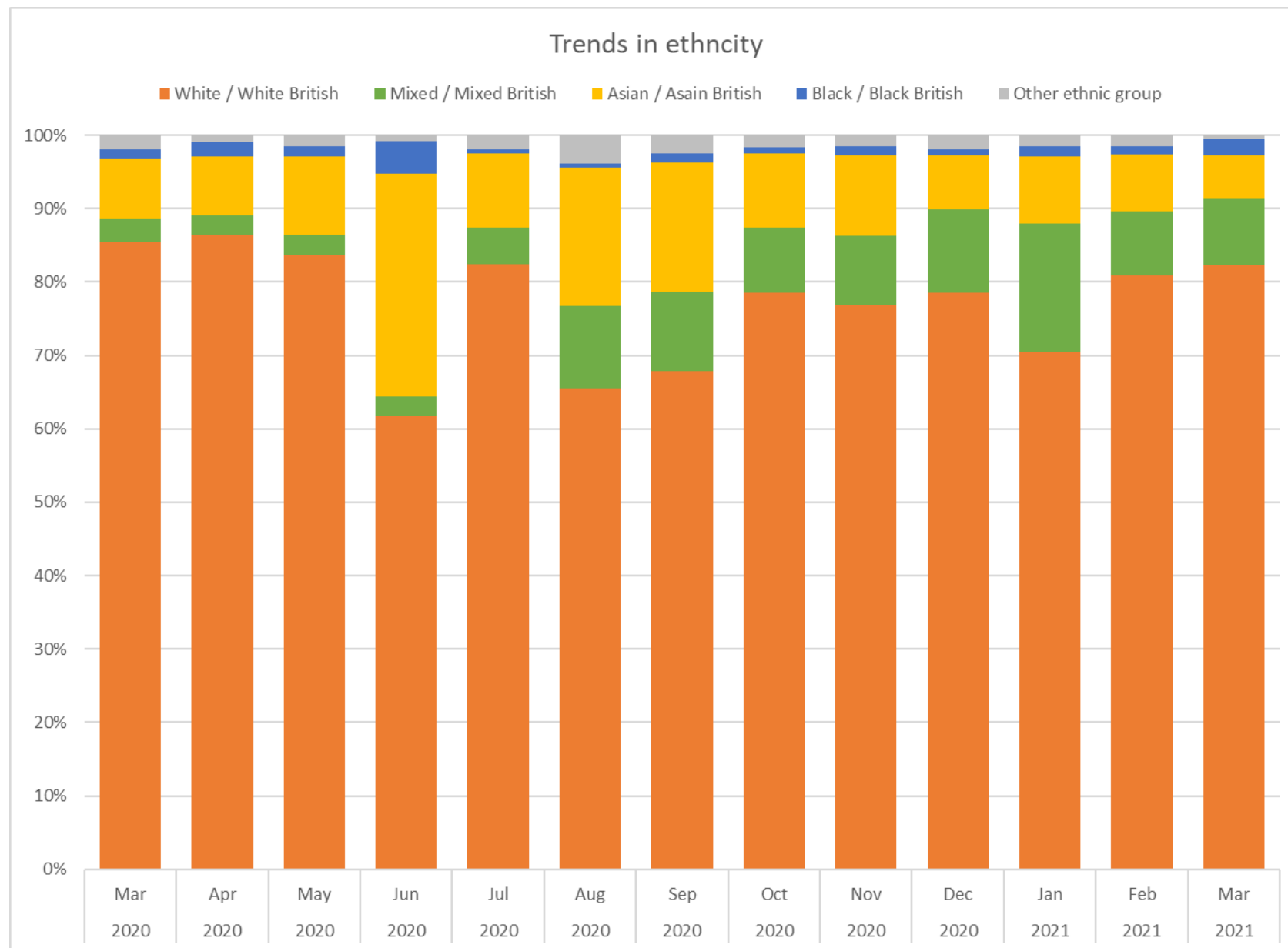
Due to population size the numbers of cases are highest for people from Pakistani ethnic group.

There are still a significant number of cases where the ethnicity is not known, which could affect these rates.

Analysis over times shows that the proportion of cases from BAME populations was highest during the summer, when case numbers were lower but has moved to reflect the population average over time, especially over the most recent wave.

Analysis by age and ethnic group show that children and younger adults diagnosed with COVID-19 are disproportionately more likely to come from a Black Asian or other Minority Ethnic Group (BAME) than those at older ages, this in part reflects the age profile of the BAME population.

As the BAME population of Stockport is geographically clustered these trends will particularly impact areas to the east of Stockport, including Heald Green, Gatley, Cheadle and Heaton Mersey.

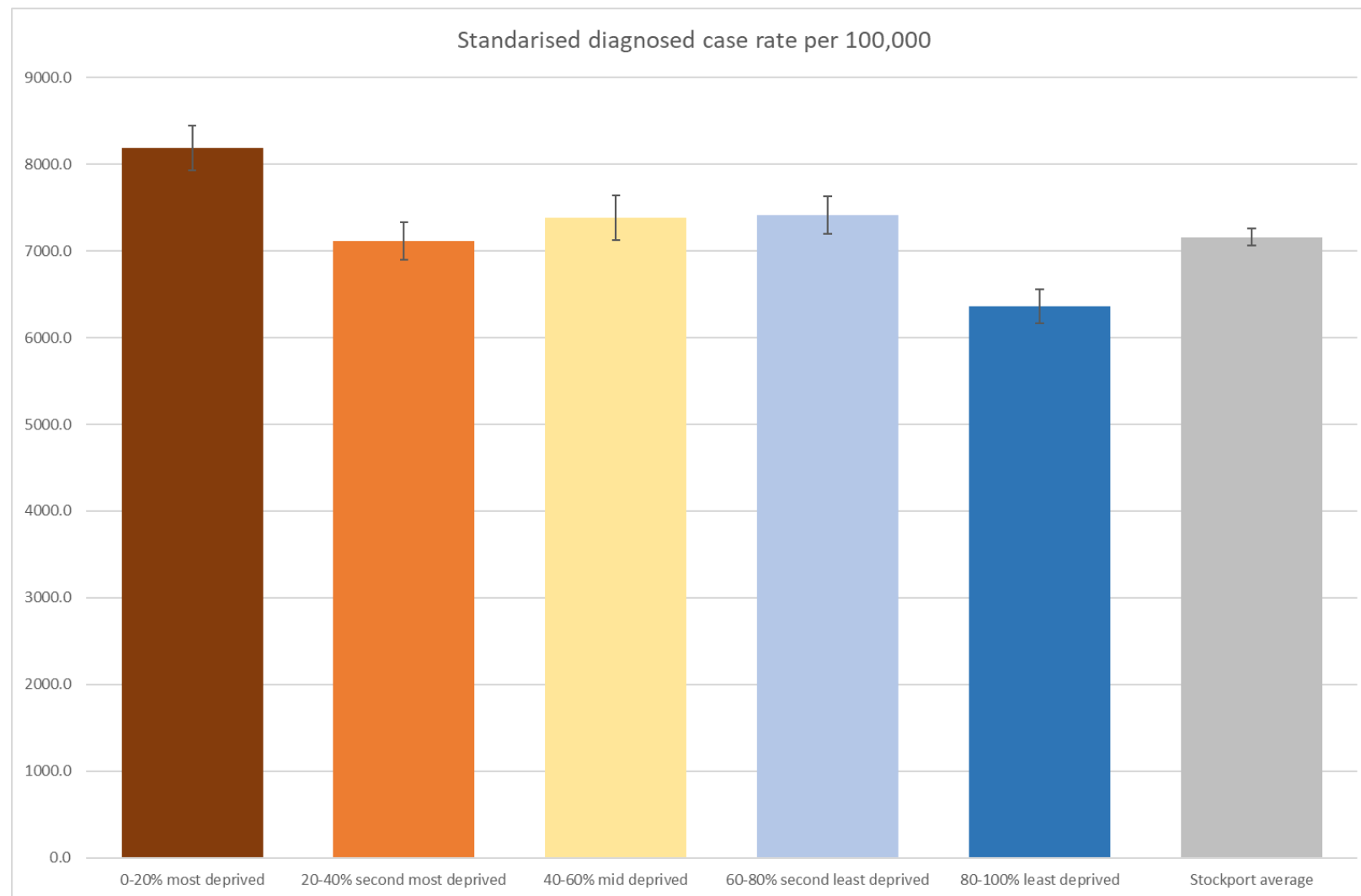


Age standardised analysis of diagnosed cases by deprivation shows that the rate of cases in the least deprived areas was significantly higher than in other parts of Stockport, this trend has changed since June when the pattern was for lower case rate in deprived areas.

This change in part is likely due to the different rules within each period of lockdown, with more people attending places of work during the second and third waves. It may also be in part due to the channels in which the virus first arrived in the UK (mainly by travel from other parts of Europe in the January and February), before spreading throughout the population.

There is no significant difference in rates of diagnosed cases between the three middle deprivation quintiles, and rates in the least deprived areas are lower than elsewhere.

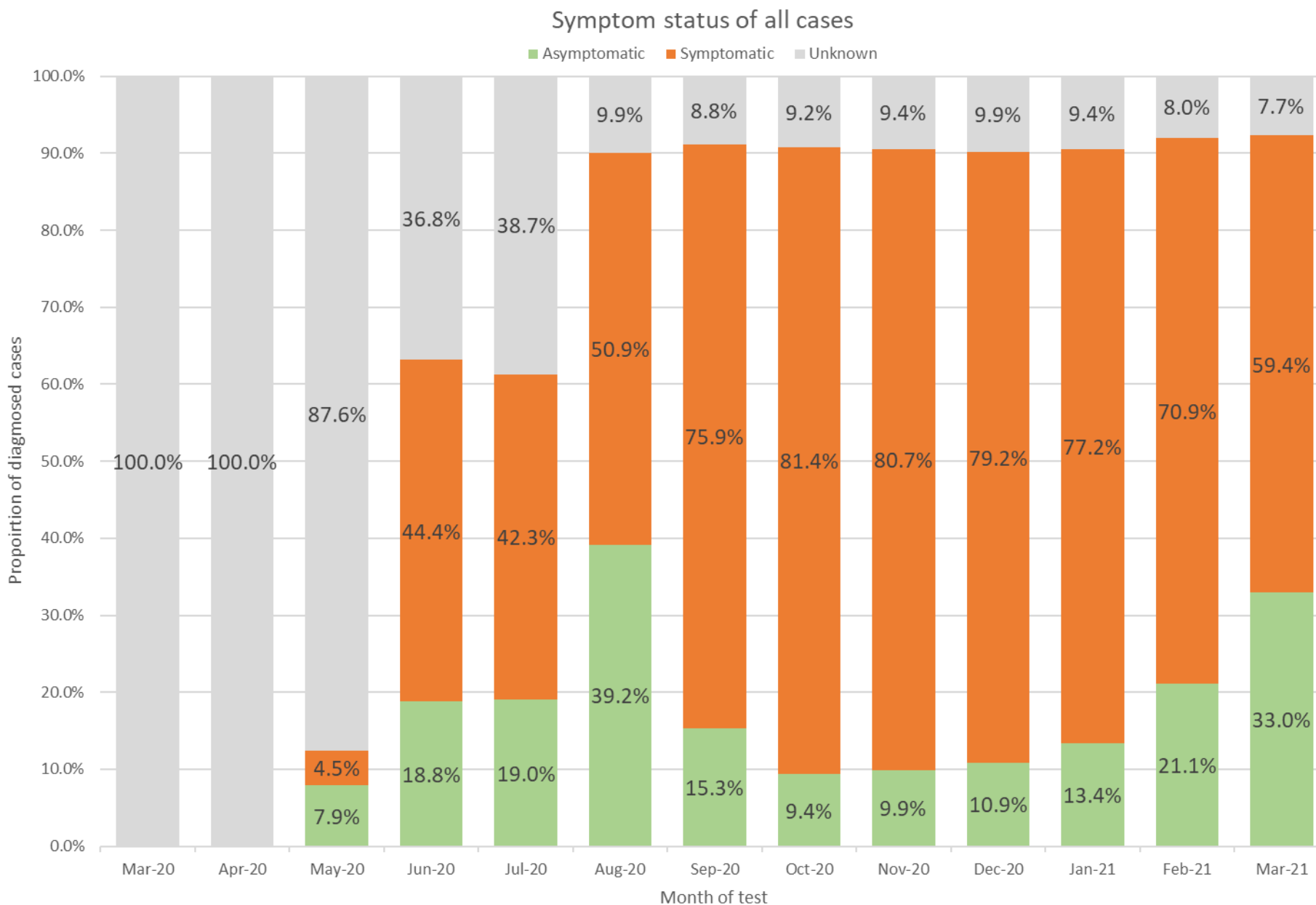
The impact of severe COVID-19 and lockdown are likely to be felt more in areas of deprivation.



This analysis is based on the diagnosed cases identified for Stockport residents and therefore should be treated with caution as those not diagnosed may have different characteristic to those diagnosed.

The table below shows the count of positive cases by ward by week since March 2020. This data excludes 1,286 known cases linked to care homes (residents and staff) and 6 cases without a reported postcode. It includes cases linked to hospital or where a care home link was not clearly identified (for example care home staff before July). There have been cases in each ward, and wards with higher BAME populations and those with higher levels of deprivation have had the highest rates.

Ward Name	Mar 2020	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2021	Feb	Mar*	Total	Crude rate per 1,000
Bramhall North	5	26	19	6	3		49	165	99	111	174	52	11	720	55.8
Bramhall South & Woodford	6	23	7		3	4	44	174	72	123	172	33	7	668	54.4
Bredbury & Woodley	3	39	21	6	7	7	38	221	164	104	209	98	31	948	71.5
Bredbury Green & Romiley	5	24	10	3	8	5	31	184	118	96	182	114	33	812	56.5
Brinnington & Central	4	47	29	4	3	12	53	250	169	135	261	195	89	1,251	73.5
Cheadle & Gatley	18	52	28	6	5	16	80	268	198	144	204	82	30	1,131	73.7
Cheadle Hulme North	10	25	10	13	7	3	40	186	111	109	171	63	52	800	59.4
Cheadle Hulme South	4	45	9	6	6	10	63	192	164	119	246	57	39	960	67.1
Davenport & Cale Green	5	48	17	12	6	10	44	218	210	86	216	190	53	1,114	70.6
Edgeley & Cheadle Heath	4	33	17	4	6	13	55	183	146	79	200	86	71	897	61.2
Hazel Grove	6	55	37	2	8	3	36	149	138	131	202	106	46	919	64.5
Heald Green	6	33	20	10	12	19	71	274	173	126	241	74	35	1,094	85.7
Heatons North		29	18	7	7	16	75	216	177	135	195	64	19	958	65.6
Heatons South	9	26	23	12	3	17	71	222	145	105	135	54	57	879	61.8
Manor	2	38	14	4	15	8	44	204	144	128	214	103	46	964	69.8
Marple North	5	21	15	2	3	5	31	125	107	85	90	36	18	543	42.9
Marple South	3	13	17	1	7	5	25	96	102	85	106	72	27	559	48.3
Offerton	7	42	21	9	12	11	22	180	134	91	244	104	43	920	64.7
Reddish North	1	36	15	5	6	9	40	280	162	135	260	132	38	1,119	74.7
Reddish South	3	31	13	5	11	12	37	230	172	124	249	121	42	1,050	76.9
Stepping Hill	8	47	11	3	5	9	43	200	149	121	199	95	34	924	69.7
STOCKPORT none care home	114	733	371	120	143	194	992	4,217	3,054	2,372	4,170	1,931	821	19,232	65.5
Care home total	45	204	72	13	25	28	60	193	152	127	178	139	50	1,286	

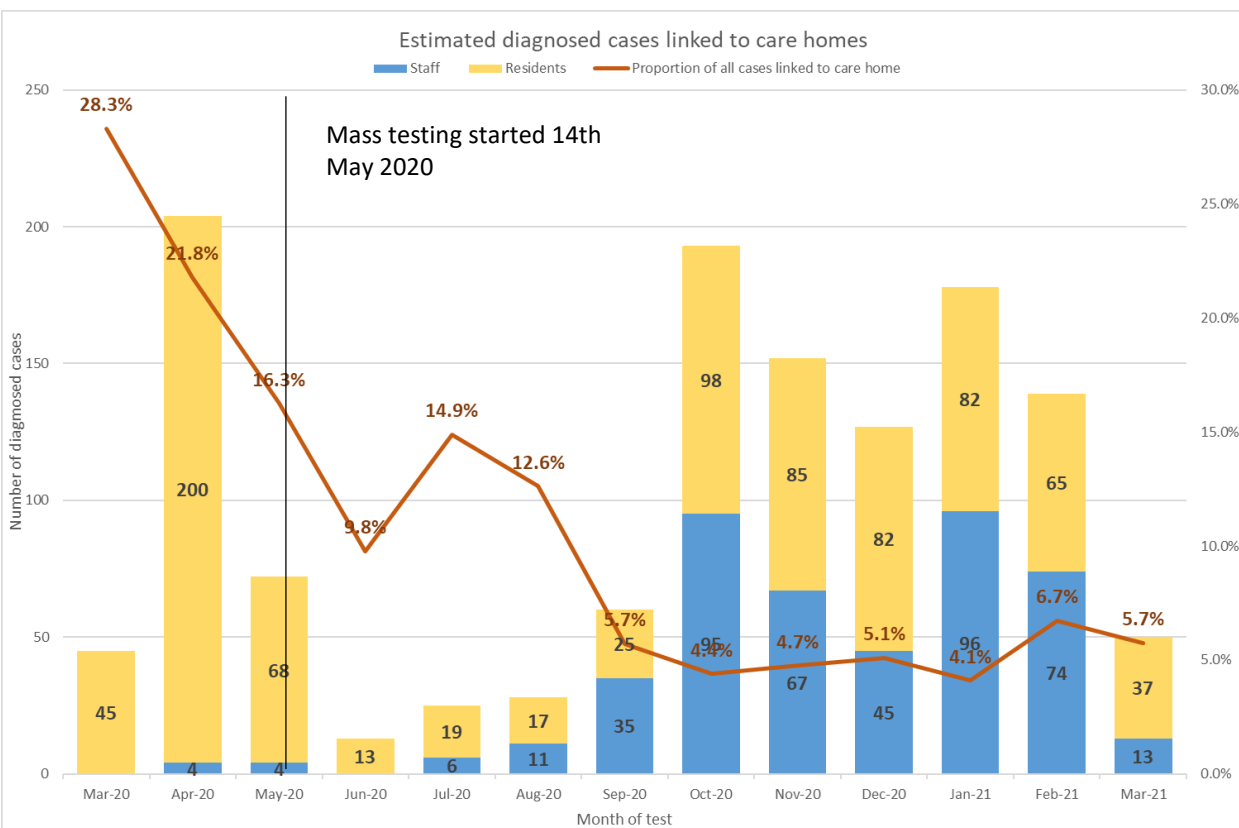


Since May data about the symptom status of people diagnosed with COVID-19 has been recorded.

During the second and third waves of the pandemic around 80% of cases diagnosed were symptomatic.

Since February the proportion of cases that are asymptomatic has risen significantly, this is likely to be due to:

- the expansion of regular asymptomatic testing, which previously focused on health and care settings but now includes teachers, secondary school pupils, workplaces and their families
- the impact of the vaccination programme



6% (1,286) of diagnosed cases have been linked to care homes, although this is an estimate*.

Mass testing has been in place in care homes since mid May and therefore levels of detection are likely to be higher in these settings than in the general community and therefore the trend of around 6% of cases being linked to care homes is probably an overestimate. Early in the pandemic when testing was limited those in care homes were prioritised for testing.

Mass testing also meaning many of the more recent cases have been asymptomatic and this is especially true since the COVID-19 vaccination programme started in January, currently less than 5% of care home cases are symptomatic.

**Identifying cases linked care homes is not an exact science, especially identifying staff whose test details may be linked to their home address rather than the care home. Reporting has improved but a significant number of staff cases from earlier in the pandemic maybe missing from this analysis. Equally some residents may have been in hospital at the time of infection, but the case record will still register their home address.*

The following section sets out what we know about the those who have experienced COVID-19 severely enough to required hospital admissions.

Key Findings

Stockport residents have had 1,900 admissions as a result of COVID-19 by end of January 2021.

The average length of stay was 15.2 days, 33% of patients were in hospital for at least 2 weeks and 17% more than 4 weeks.

Demographic trends were different to those for diagnosed cases:

- Those admitted had an older profile
- Those admitted were more likely to be from a white ethnic background.
- Those admitted were more likely to be care home residents.

At least 1,180 people have been discharged from hospital to the community after receiving care for COVID-19.

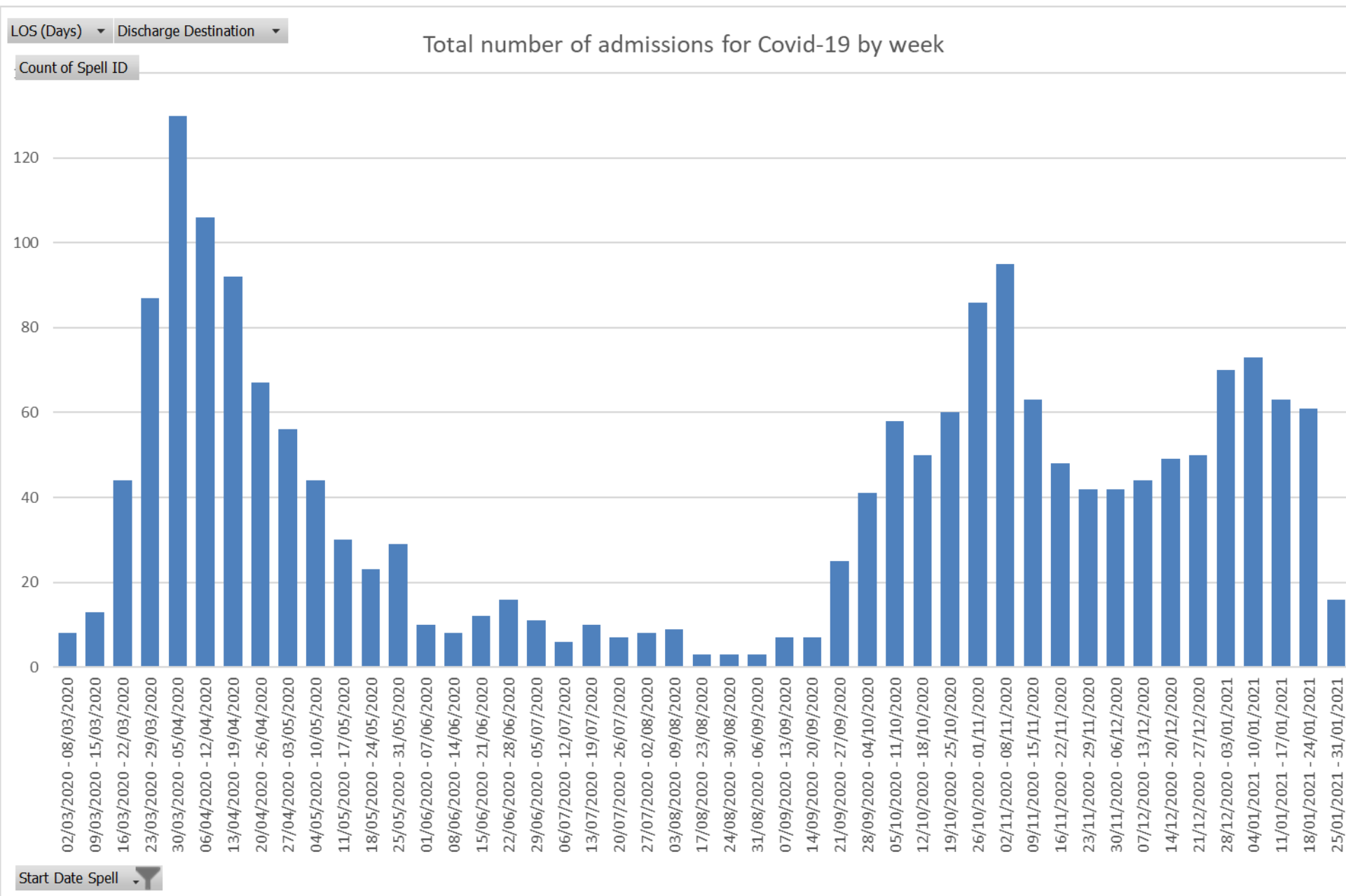
What we need to understand more about

There is sill more to understand about the long term impact of COVID-19 on those who have been discharged, evidences is emerging about the need for support for:

- Repository health care
- Chronic fatigue
- Diabetes, and more rapid progression from pre-diabetes to diabetes
- Mental Wellbeing

What is not known is the duration of these effects, or the full extent of the level of increased need in Stockport.

COVID-19 Stockport – March 2021 – hospital admissions over time



1,900 Stockport residents had been admitted and discharged by 31st January 2021, with any diagnosis of COVID-19.

The number of admissions peaked at the beginning of April 2020 with an average of over 18 admissions a day. During July and August the average number of admissions dropped to under 1 a day. Admissions rose to a peak of 13 a day in November

The average length of stay was 15.2 days, 33% of patients were in hospital for at least 2 weeks and 17% more than 4 weeks.

80% of Stockport resident admissions were at Stockport NHS foundation Trust and 16% at Manchester University Foundations Trust.

Data for Stockport NHS Foundation Trust (for all patients) shows that the maximum number of patients in hospital at any one time with COVID-19 was 193, of whom 20 were high dependency.¹⁷

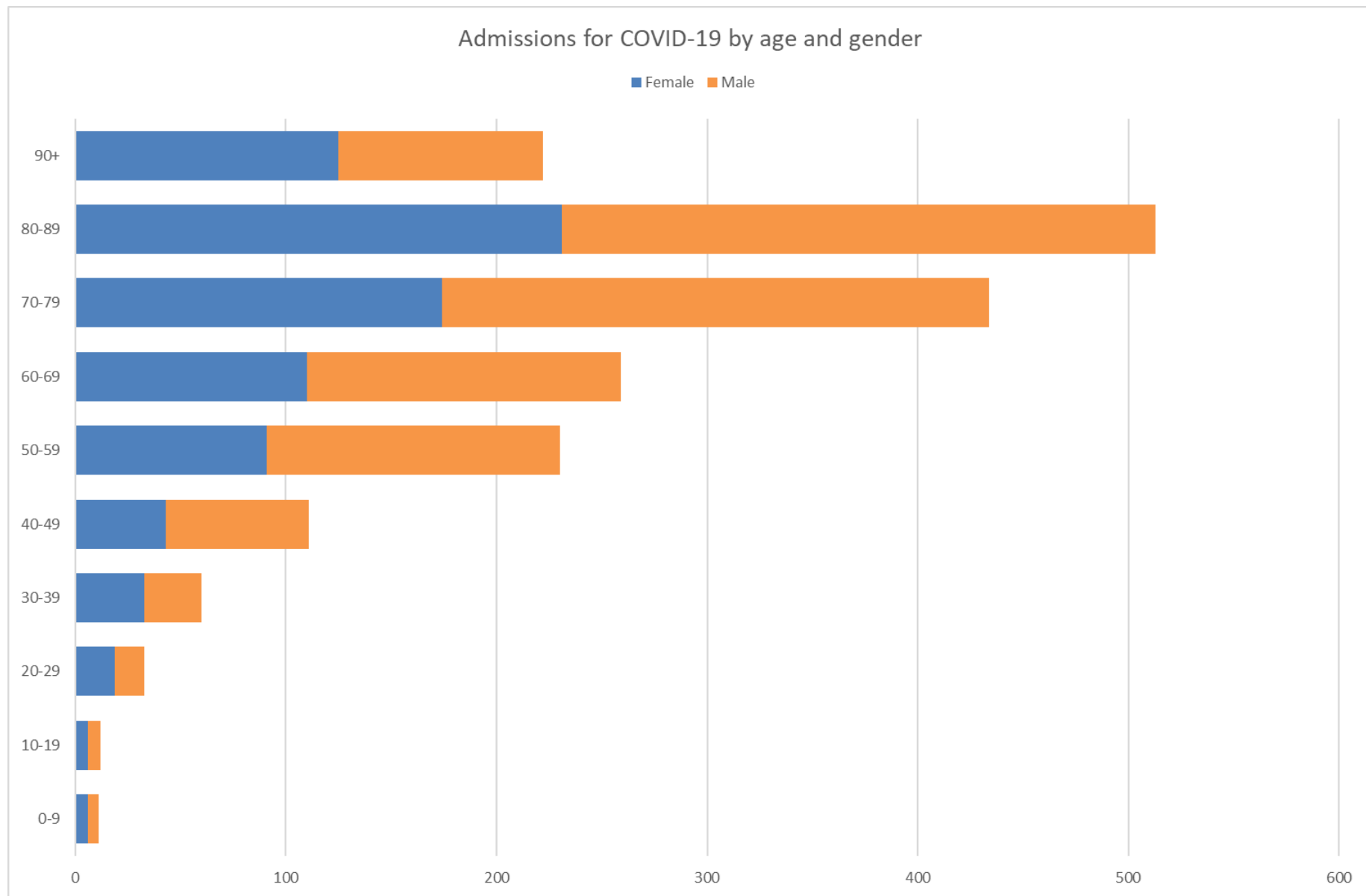
88% of these 500 admissions were for those aged 50+, and 62% of admissions were for those aged 70+, an older age profile than the diagnosed cases

56% of admissions were for males.

92.3% of admissions were for people from a White ethnic group, and 5.0% from an Asian group, a trend that more closely follows the demographics than the diagnosed cases.

14% of admissions were for residents of care homes, a higher proportion than the overall diagnosed cases, reflecting the older age group of this population.

By end of January 63% admissions had resulted in a discharge to the community and 11% in discharge to other care. 25% admissions had sadly resulted in a death.



The following section sets out what we know about the those who have sadly died as a result of COVID-19.

Key Findings

There have been around 700 deaths due to COVID-19 in Stockport so far, and around 14% more deaths in 2020 than would have been expected (excess mortality), a rate that is the same as the national average.

There are significant inequalities evident in mortality rates, showing that COVID-19 has disproportionally effected the health of people in deprived areas.

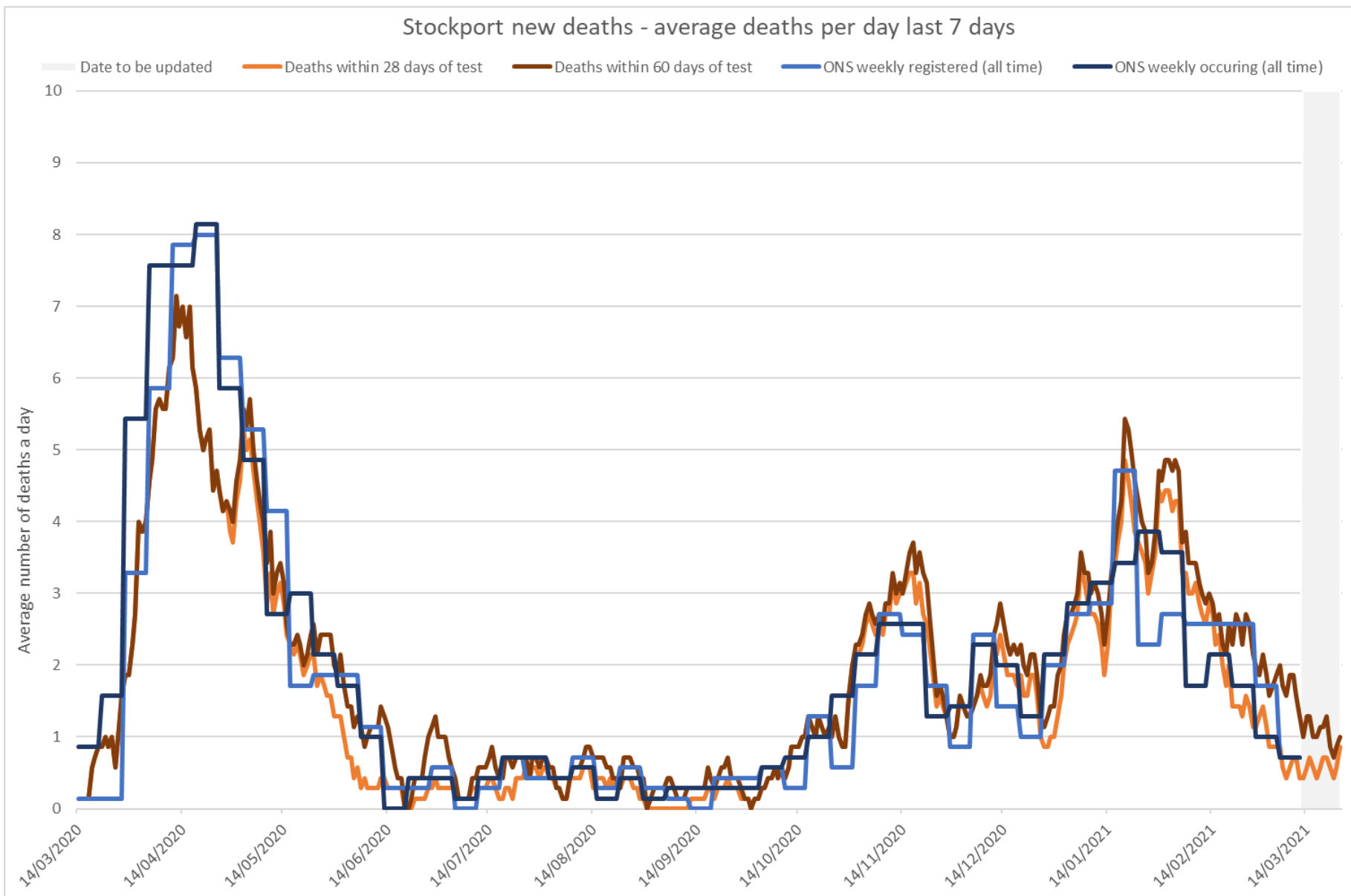
Following national trends mortality rates for those under 50 are low, and then increase at each age to almost 50 per 1,000 for those age 90+.

For age groups 60- 79 the mortality rates for males are more double than for females.

23% of COVID-19 deaths in Stockport occurred in care homes, and total mortality levels in care homes in 2020 are 55% higher than average, rates similar to the national average.

What we need to understand more about

Local mortality data does not include data about ethnicity, national trends show that mortality rates for those from BAME groups are higher than for those from White groups.



There are many ways to count the number of deaths that can be attributed to COVID-19 in Stockport. This chart shows the trends over time for these measures.

PHE measure:

- The number of deaths within 28 of deaths of a positive test[^]
 - To 25th March there have been a total of 634 in Stockport
- The number of deaths within 60 of deaths of a positive test[^]
 - To 25th March there have been a total of 743 in Stockport

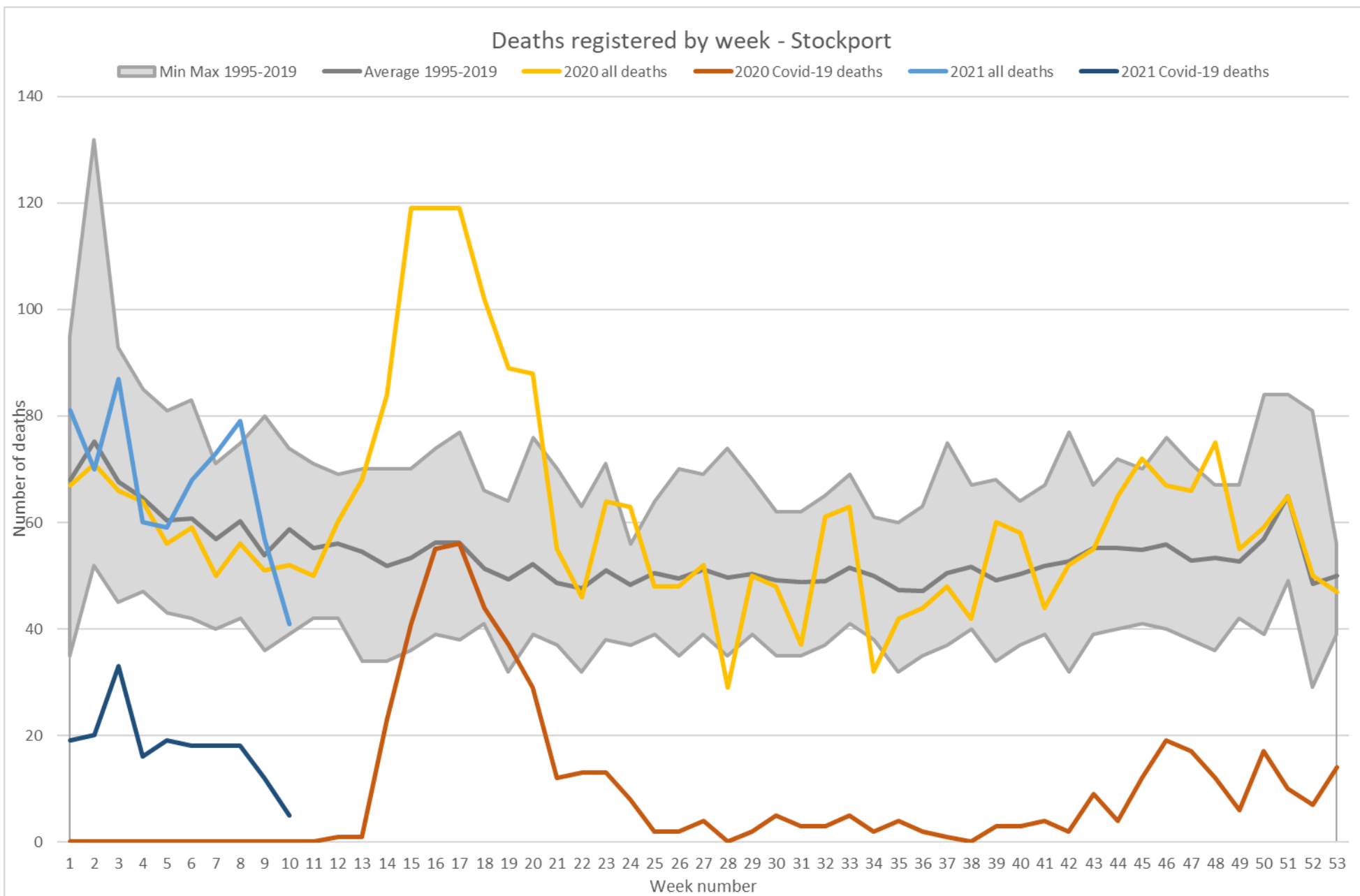
ONS measure:

- The number of deaths with a mention of COVID-19 **registered**
 - To 12th March there have been a total of 685 in Stockport
- The number of deaths with a mention of COVID-19 occurring
 - To 12th March there have been a total of 727 in Stockport

Deaths were highest in April 2020, at around 8 deaths a day. Rates fell to fewer than 1 death a day in the summer, before rising again through the second and third waves to an average of 5 a day.

* available weekly on a Tuesday, two weeks in arrears includes all deaths certificates with a mention of COVID-19 on the Medical Cause of Death Certificate

[^] Includes deaths only for those with a positive test for COVID in the 28 /60 days before death, whatever the cause of death. This undercounts deaths early on due to testing capacity at this time



In 2020 3,252 deaths from all causes were registered for Stockport. The 5 year average 2015-2019 number of deaths registered for the same period was 2,854; meaning there have been **around 398 excess deaths** (13.9%).

Across England and Wales there have been 75,031 excess deaths, a similar proportion to in Stockport at 13.9%.

507 of the 2020 registered deaths were directly attributed to COVID-19 (15.7%).

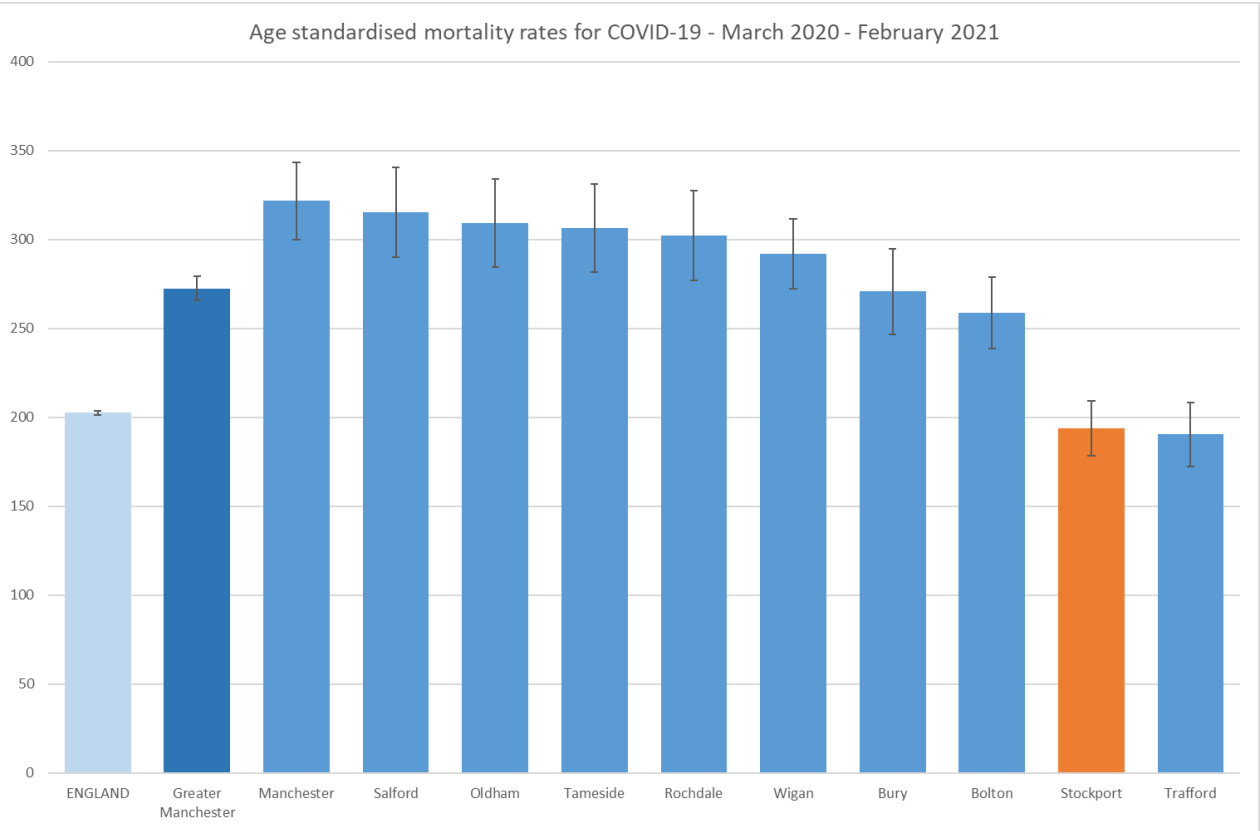
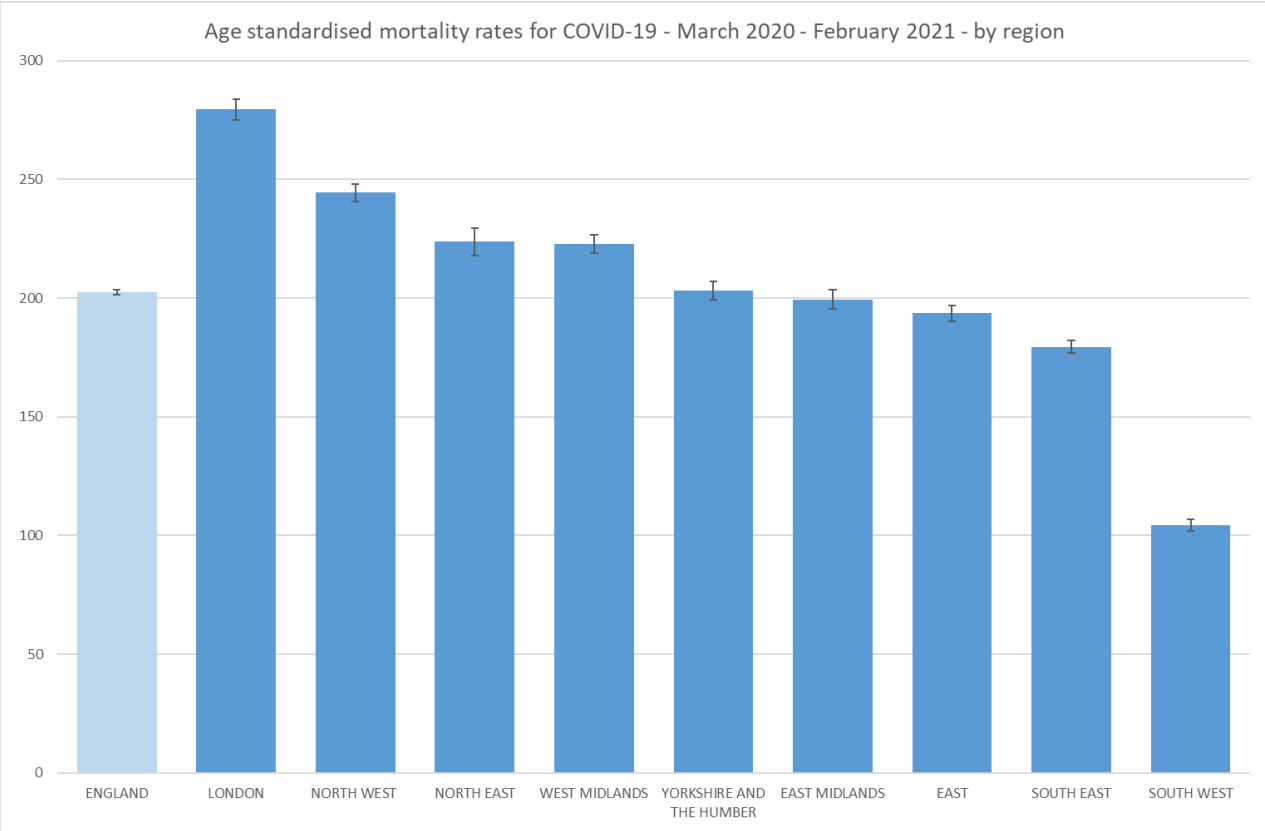
The second and third wave have not seen significant increases in excess mortality.

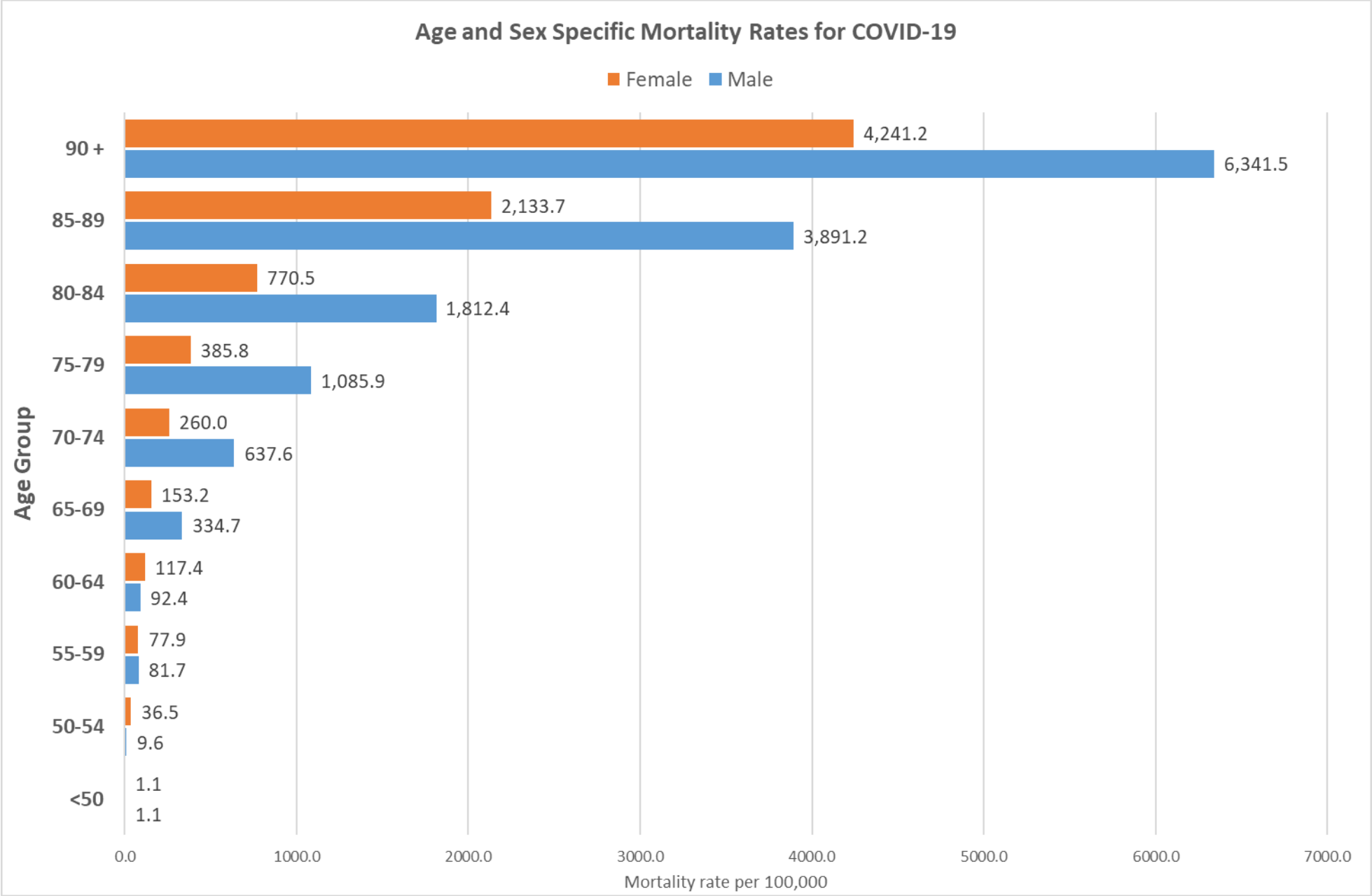
Taking into account the size and age structure of the population, there were 202.5 deaths involving COVID-19 per 100,000 people in England over the period March 2020 to February 2021.

There have been significant regional variations in the mortality rate from COVID-19 reflecting the way in which the pandemic has moved across the country, rates were significantly higher in London (279.5), followed the North West (244.5); the South West has experienced the lowest rates so far (104.4).

Stockport has the second lowest mortality from COVID-19 within Greater Manchester, after Trafford (193.9 and 190.4 respectively) and rates are significantly lower than the other GM authorities, Manchester (321.7) and Salford (315.3) have the highest rates.

Mortality rates in Greater Manchester (272.4) are higher than the national average. Rates for Stockport are not significantly different to the national average.





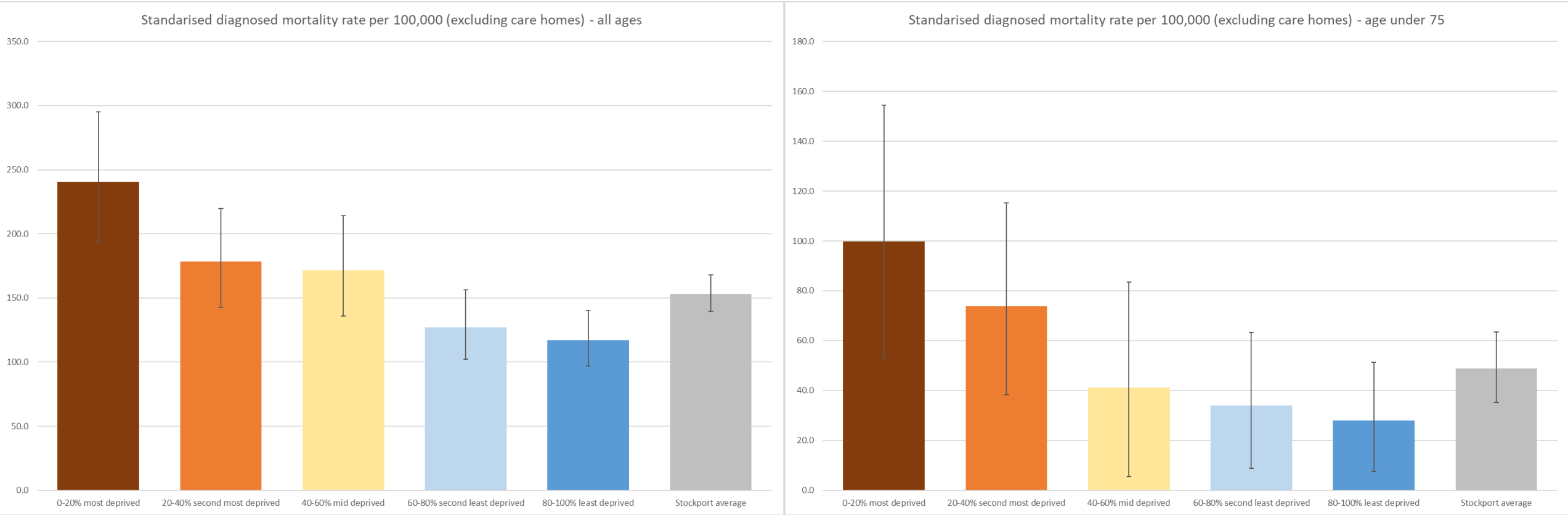
For those who have died as a result of COVID-19 the age and gender patterns in Stockport are similar to those seen nationally with a low rate of mortality below 50, which rises to around 50 per 1,000 by the age of 90.

It should be noted however that 23 people aged under 65 have died in Stockport.

For all age groups over 65 years the mortality rates for males are higher than for females, and are more than double for ages 60 to 79 years.

Age standardised analysis of mortality rates from COVID-19 by deprivation shows that there are significant inequalities affecting the most deprived quintile, and in particular adults aged under 75.

27% of all deaths under 75 were for people who live in the most deprived quintile, where around 17% of the population live, mortality rates in these are double the average.

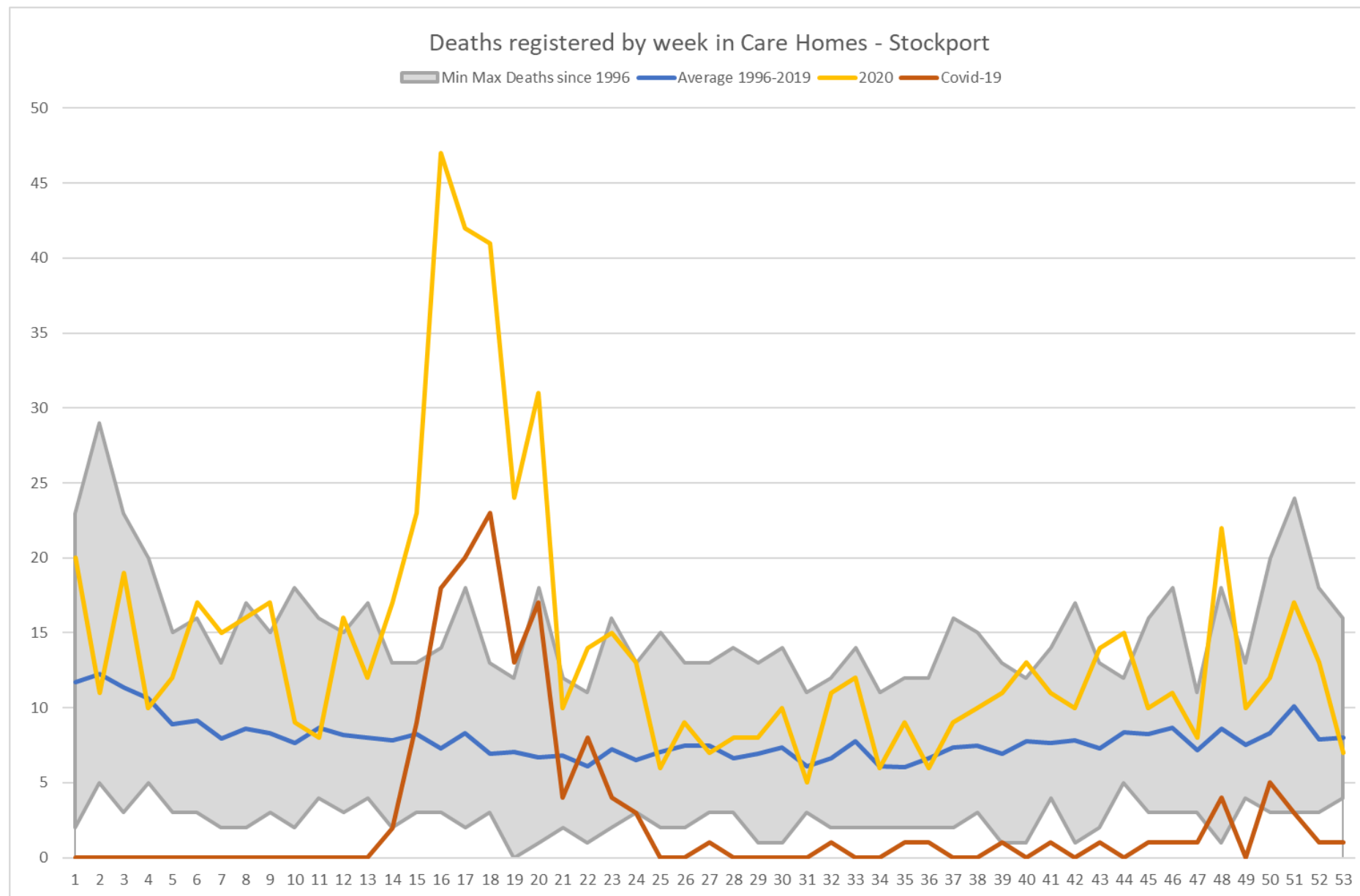


Deaths that occurred in care homes have been excluded from this analysis as they effect geographic analysis.

ONS data shows that 160 deaths directly related to COVID-19 have been registered as occurring in care homes to 12th March 2021. This represents 22.9% of total registered COVID-19 deaths in Stockport. Nationally the proportion of COVID-19 deaths to 12th March occurring in care homes was 23.2%

There have been 759 deaths registered as occurring in care homes in 2020 in total, which is almost double the average for previous years (55% excess mortality), deaths in the early part of the year were also higher than average in care homes, again a rate similar to the national average.

Comparisons to our nearest statistical neighbours for all deaths in care homes shows that the increase in Stockport is similar to that seen elsewhere.



The following section sets out what we know about the progress of the COVID-19 vaccine deployment.

Key Findings

Since the vaccine programme started in late December 2020 over 138,340 first doses of the vaccine have been given, covering 54.7% of the adult population of Stockport.

Coverage is 95.2% for people aged 70+, 90.3% for those aged 60-69 and 74.9% for those aged 50-59 – with further vaccines secluded for these age groups over the next few weeks.

Analysis is ongoing into the inequalities in vaccination rates and there is evidence of lower uptake in areas of deprivation and BAME groups. Work is underway to maximise uptake in all populations and as the programme continues some gaps in uptake are narrowing.

Uptake in care home residents is at 94%, for staff the uptake is 77%.

What we need to understand more about

Work is underway locally and nationally to understand reasons which may make people not take up the offer of the COVID-19 vaccination.

There is some overlap between those who are clinically extremely vulnerable and those with a **disability or learning disability**, however not all people with a disability will be Clinically Extremely Vulnerable (CEV) or in priority group 6. We are unlikely to get local data on uptake for this group.

We are also unlikely to get local data on uptake by other protected characteristics including:

- Religion or belief
- Sexual orientation
- Gender reassignment

COVID-19 Stockport – March 2021 – what we know about COVID-19 vaccine deployment

Since the vaccine programme started in late December 2020 over 138,340 first doses of the vaccine have been given, covering 54.7% of the adult population of Stockport. Coverage is 95.2% for people aged 70+, 90.3% for those aged 60-69 and 74.9% for those aged 50-59 – with further vaccines secluded for these age groups over the next few weeks. Coverage is also high for the clinical risk groups, the initial impact on antibodies can be seen on page 7.

Summary at Thursday, 25 March 2021

Stockport CCG

138,347 (54.7%) of adults have received their first dose.

12,113 (4.8%) have received their second dose.

42,643 (95.3%) people aged 70+ have had their first dose. **2,086** not vaccinated.

14,734 (92.4%) people aged 65-69; **1,214** not vaccinated.

49,844 (78.9%) people aged 50-64; **13,367** not vaccinated.

16,599 (91.3%) people CEV have had their first dose. **1,578** not vaccinated.

24,768 (79.3%) people at higher risk of severe disease or mortality; **6,475** not vaccinated.

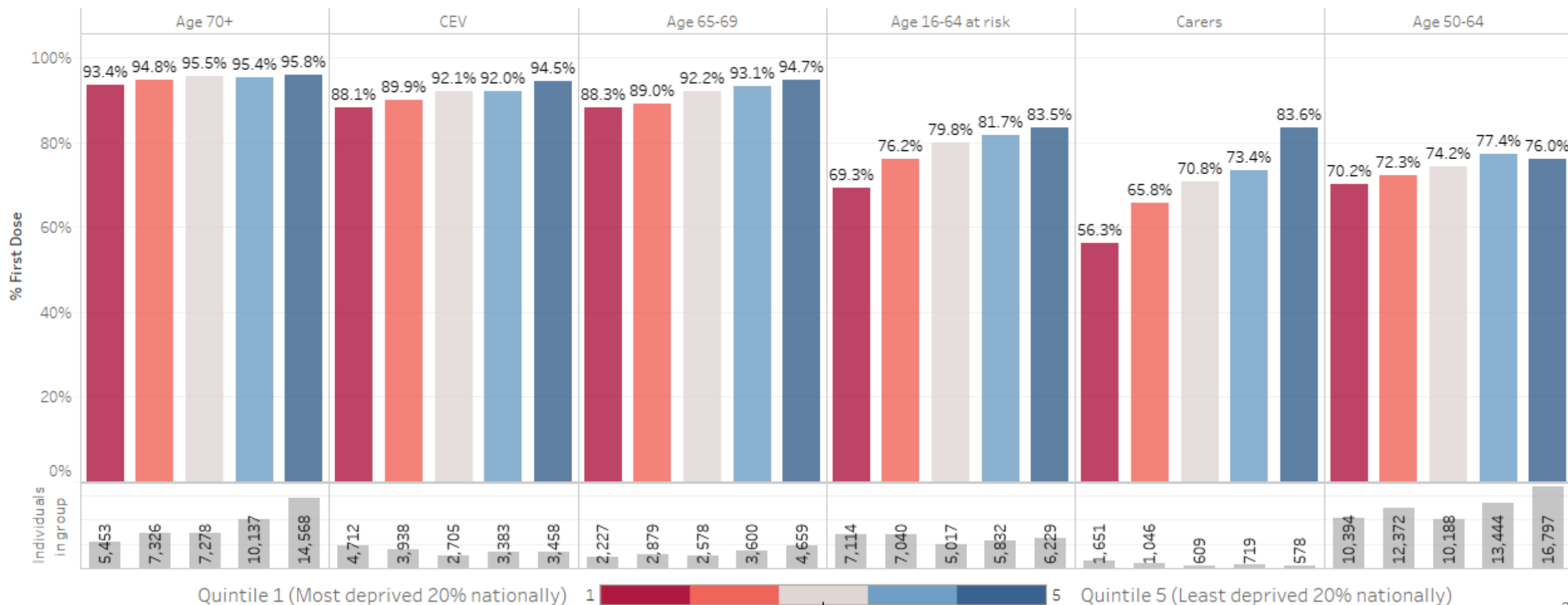
Cohort	% 1st Dose	% 2nd Dose	Individuals	1st Dose	2nd Dose	Not Vaccinated	Timeline since 31/01
Healthcare Worker	88.0%	41.1%	6,510	5,726	2,675	775	
Age 80+	95.7%	29.1%	16,978	16,252	4,933	717	
Age 75-79	95.5%	4.5%	11,673	11,153	526	501	
Age 70-74	94.6%	2.1%	16,114	15,238	342	868	
CEV	91.3%	12.5%	18,181	16,599	2,279	1,578	
Age 65-69	92.4%	1.8%	15,948	14,734	281	1,214	
Age 16-64 at risk	79.3%	3.5%	31,243	24,768	1,098	6,475	
Carers - DWP	66.1%		4,119	2,724		1,395	
Carers - LA	86.6%		479	415		35	
Age 60-64	88.5%	3.8%	18,796	16,643	713	2,153	
Age 55-59	80.5%	4.4%	22,034	17,733	967	4,301	
Age 50-54	69.1%	4.3%	22,381	15,468	967	6,913	
Age 40-49	32.3%	3.8%	42,542	13,727	1,611	28,815	
Age 30-39	22.9%	2.7%	45,565	10,427	1,223	35,138	
Age 18-29	16.8%	1.7%	40,324	6,758	688	33,566	

Note that individuals can appear in more than one cohort. 'NHS & social care worker' is not a complete list and may also include people incorrectly coded as a healthcare worker.

Source: National Immunisation Management System (NIMS) | Author: graham.smith16@nhs.net

Some inequalities in uptake between deprivation groups are evident in people aged 70+ but vaccination levels are high across all areas. Over 90% of the CEV and aged 65-69 populations have received a first dose but there remains an 6.4% gap between the most and least deprived quintiles. These gaps are reducing slowly over time as the programme continues but work is required to maximise uptake across the population.

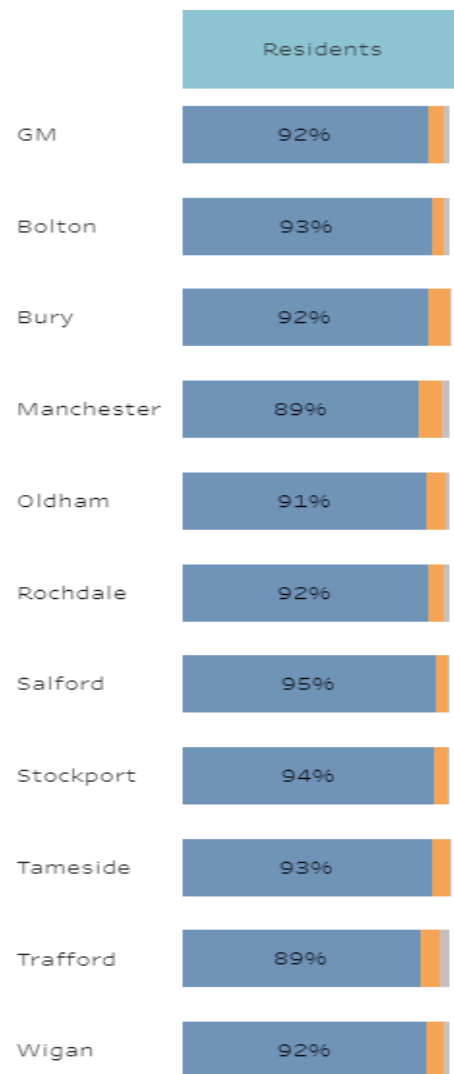
There are more people still to be vaccinated in the 16-64 at risk group and carers (priority group 6) but at the moment there is a significant difference in uptake by deprivation quintile.



Analysis shows that there are significant differences by ethnic group, following national trends. Uptake is lowest for people from a Black / Black British African or Bangladeshi / Bangladeshi British background, where rates are between 60 and 75% for those aged 65+. Rates are higher in other Asian / Asian British populations and Black / Black British Caribbean, but are still lower than the White British population. Overall around 280 people aged 65+ from a BAME background would need to receive a first dose of the vaccine to reach the uptake in the White British population. Since mid Feb uptake has increased across all groups, and has done so at a higher rate across different BAME groups - the overall gap between BAME groups has narrowed by 2.6 percentage points.

		Aged 65+			Aged 50-64			Clinically Extremely Vulnerable			Aged 16-64 at risk		
White / White British	Any other White background	93.8%	2,861	65	75.7%	3,308	208	89.0%	885	40	75.8%	1,841	96
	British	96.0%	49,460	0	82.0%	47,713	0	93.6%	13,990	0	81.0%	24,528	0
	Irish	95.2%	664	6	79.6%	348	8	94.9%	177	2	86.4%	184	
Mixed / Mixed British	Any other mixed background	82.4%	85	12	67.2%	201	30	75.4%	57	10	72.6%	124	10
	White and Asian	88.1%	42	3	72.5%	109	10	81.6%	38	5	76.9%	78	3
	White and Black African	75.0%	12	3	58.5%	65	15	81.3%	32	4	72.5%	51	4
	White and Black Caribbean	87.5%	16	1	55.4%	92	24	60.5%	43	14	58.3%	72	16
Asian / Asian British	Any other Asian background	80.3%	218	34	71.5%	487	51	74.8%	143	27	71.3%	320	31
	Bangladeshi or British Bangladeshi	73.5%	49	11	77.0%	87	4	80.8%	52	7	78.6%	70	2
	Chinese	79.8%	208	34	66.7%	375	57	83.5%	91	9	75.4%	142	8
	Indian or British Indian	89.8%	452	28	81.4%	544	3	89.4%	236	10	80.3%	346	2
	Pakistani or British Pakistani	81.6%	602	87	69.5%	1,148	143	72.8%	592	123	67.8%	997	131
Black / Black British	African	60.4%	96	34	64.1%	231	41	73.8%	160	32	64.9%	114	18
	Caribbean	78.9%	76	13	64.0%	161	29	66.7%	66	18	67.2%	64	9
	Any other Black background	58.8%	34	13	69.1%	139	18	72.3%	47	10	63.6%	88	15
Other ethnic group	Any other ethnic group	83.7%	307	38	68.4%	636	86	83.7%	203	20	67.0%	345	48
Not Known	NotKnown	85.9%	5,490	555	65.5%	7,566	1,245	87.4%	1,369	85	73.2%	1,878	146
<div>First dose %</div> <div>Individuals</div> <div>For equity</div>	White / White British	95.9%	52,985	70	81.6%	51,369	216	93.3%	15,052	38	80.7%	26,553	86
	Mixed / Mixed British	83.9%	155	19	64.9%	467	80	74.1%	170	33	70.5%	325	34
	Asian / Asian British	83.3%	1,529	194	72.2%	2,641	259	77.8%	1,114	175	71.7%	1,875	174
	Black / Black British	67.0%	206	60	65.3%	531	88	71.8%	273	59	65.0%	266	42

Care homes are a priority for the initial vaccination programme, residents are being vaccinated in the home by GP Practices, staff are being vaccinated at the hospital hub:



What we know about uptake so far:

- Vaccination of dose 1 to residents was completed by 26th January, second doses are now underway.
- Reporting for residents suggests an uptake of 94.3% for dose 1 (1,754 residents) by 26th March
 - 51 care homes have an uptake of over 90%
- Reporting for staff suggest an uptake so far of 77.6% for dose 1 (2,166 staff) by 26th March

The following section sets out updates to what we know about the wider impact of COVID-19 on the health and wellbeing of Stockport residents so far, these affects are wide ranging and not fully clear as yet.

Key Findings

Around 1 in 5 respondents testing positive for COVID-19 exhibit symptoms for a period of 5 weeks or longer. Around 1 in 10 respondents testing positive for COVID-19 exhibit symptoms for a period of 12 weeks or longer

ONS indicative modelling suggests that the impact of any future recession could be as significant as the direct impact of the pandemic itself on health.

ONS modelling suggests that there will be both positive and negative effects on health from pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences. Modelling suggests that these impacts are smaller than the consequences of letting the pandemic running its course without any control.

National life expectancy modelling shows a loss in life expectancy of 0.9 years for females and 1.3 years for males between 2019 and 2020. There have been reductions in each deprivation decile, but the decreases have been largest in the most deprived areas, with a loss of 1.6 years for females and 1.9 years for males in the most deprived decile.

Mortality rates for heart disease, respirator disease and dementia have fallen this year.

What we need to understand more about

Work is underway to understand the long term impacts of COVID-19 on those who have been infected. Research is in place to define Long COVID and to understand how it may impact people in the future.

The impacts of the changes in health service availability and demand and lockdown have still to be seen in local data about the health and wellbeing of the population in Stockport, monitoring future rates of hospital activity, diagnosis of cancer, depression and mortality rates from other causes over the next few months will be key to understanding the long term impacts.

There have been a number of reports of COVID-19 symptoms extending beyond the acute phase of infection, colloquially termed "long COVID". A range of multiorgan complications following COVID-19 infection – including respiratory, cardiovascular, metabolic and renal impairments – have also been hypothesised among commentators. There is currently a lack of robust evidence on the prevalence of these symptoms or conditions with which to inform government policy and treatment provision.

The Office for National Statistics (ONS) has announced plans for estimating the prevalence of, and risk factors for, long COVID symptoms and health complications following coronavirus (COVID-19) infection. An initial set of early [experimental](#) results has also been released.

- Around 1 in 5 respondents testing positive for COVID-19 exhibit symptoms for a period of 5 weeks or longer
- Around 1 in 10 respondents testing positive for COVID-19 exhibit symptoms for a period of 12 weeks or longer

This is ONS first attempt at producing these estimates, and the analysis is very much a work in progress. Future analysis will seek to further refine the estimates, for example by using more sophisticated statistical techniques to account for the possibility of relapse and, should sample sizes allow, investigate symptoms persisting beyond 12 weeks. A new long COVID question is being added to the COVID-19 Infection Survey, allowing respondents to state the impact long COVID has had on their day-to-day activities, and including an expanded list of symptoms. This new data will allow us to enrich our analysis, for example by estimating the proportion of people with long COVID symptoms who are burdened by the condition.

In addition a further research strand aims to characterise the nature of complications following COVID-19 infection and diagnosis using linked primary care and hospital records, national COVID-19 testing data, death registrations, and data from the 2011 Census of England and Wales.

To date ONS have analysed the healthcare records of patients in hospital with COVID-19 until the end of August 2020. They have compared the rates of adverse events experienced by these patients (until the end of September 2020) with those of a group of matched control patients; that is, patients similar to those in hospital with COVID-19 in terms of their demographic and clinical characteristics, but who themselves have not been in hospital with COVID-19. In summary:

- patients in hospital with COVID-19 experienced elevated rates of metabolic, cardiovascular, kidney and liver disease compared with patients of similar demographic and clinical profiles over the same period
- the rates of diabetes and cardiovascular disease were particularly pronounced at: 179 and 112 per 1,000 patient-years, respectively, among patients in critical care; and 131 and 162 per 1,000 patient-years, respectively, among patients outside of critical care

While these results do not confirm the presence of a causal relationship between COVID-19 hospitalisation and subsequent adverse health events, they are suggestive of a statistical association that warrants further investigation.

The ONS updated report Direct and Indirect Impacts of COVID-19 on Excess Deaths and Morbidity estimates the number of excess deaths in England from COVID-19, changes to the healthcare system, and lockdown measures. These estimates are based on a winter scenario of weekly COVID-19 deaths assume rising levels of infections through October and November to a peak in early December 2020, with a slow decline thereafter. It does not attempt to reflect government policy or recent government interventions; they are not a forecast. The report quantifies mortality and morbidity differences due to eight different impacts, including direct COVID-19, changes to health and social care services, impact of restrictions, improvements due to restrictions and the impact of a possible future recession.

The indicative modelling suggests that the impact of any future recession could be as significant as the direct impact of the pandemic itself.

Mortality impacts

- In total, there could be approximately 1.5 million lost quality-adjusted life years (QALYs) due to mortality across all categories and time periods in the main “Winter Scenario”.
- In the short-term across all categories of harm, 61,000 excess deaths may have occurred between March and Sept. 2020, and 100,000 additional excess deaths may occur under the Winter Scenario between October 2020 and the end of February 2021.
- The greatest number of excess deaths in the short-term (until March 2021) is likely to be seen in direct COVID-19 deaths (Category A) – approximately 120,000 excess deaths.
- Additionally, approximately 40,000 excess deaths may occur in the longer-term (up to 50 years) as a result of economic impacts from the recession (Category D2).

Morbidity impacts

- In total, approximately 2.9 million lost QALYs because of morbidity across all categories of harm and time periods in the main Winter Scenario.
- The most significant morbidity impacts may occur not directly because of COVID-19 itself, but for the wider population living through a pandemic, as a result of restrictions introduced to control COVID-19, voluntary behaviour changes related to the presence of COVID-19, or the economic impacts of a recession.
- A total 174,000 lost QALYs that could occur for people who contract COVID-19 and develop lasting health impacts (for example, fatigue), in order to provide an estimate for the impact of the condition or conditions termed as “long COVID” (Category A).

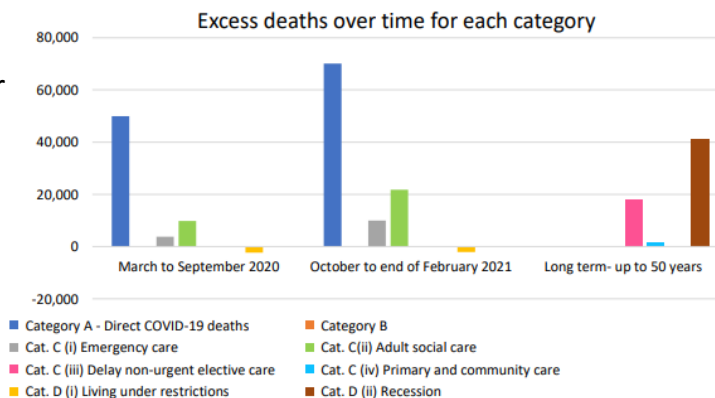


Figure 1. Summary of excess deaths over short and longer-term timescales

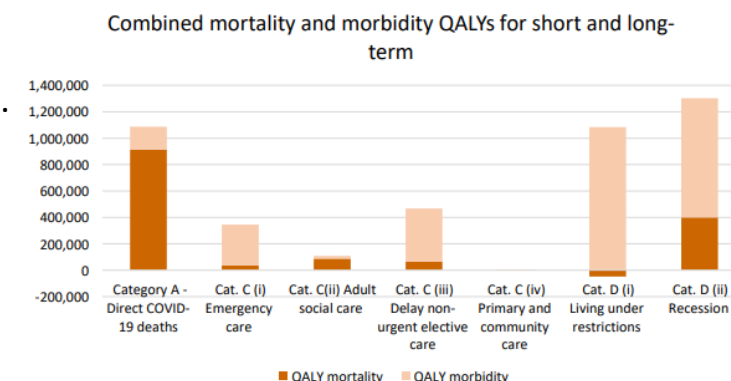


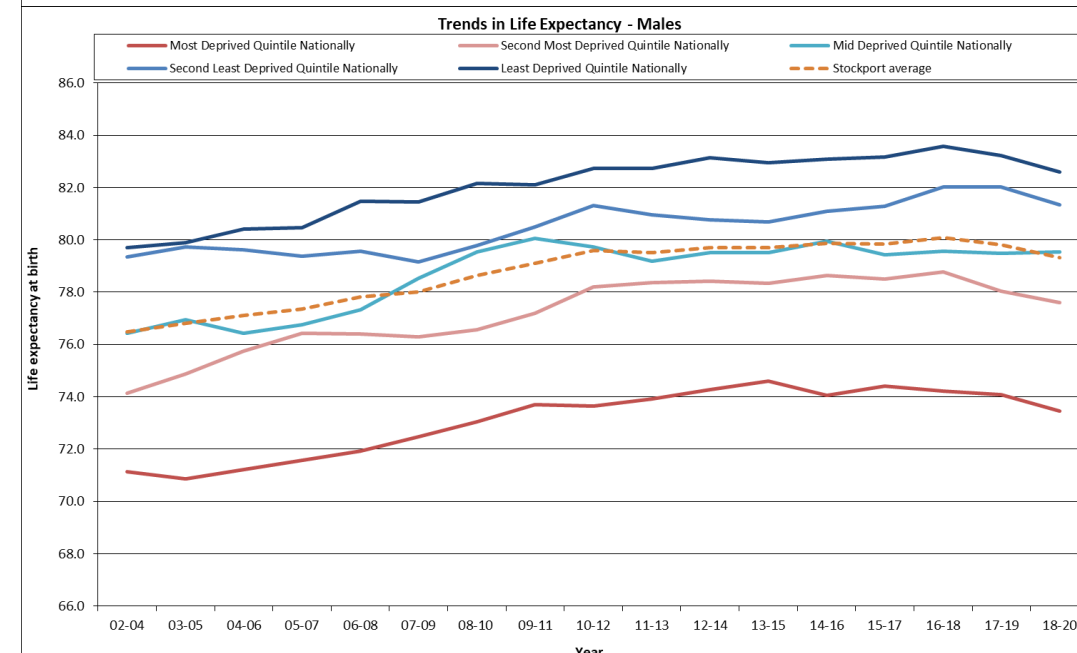
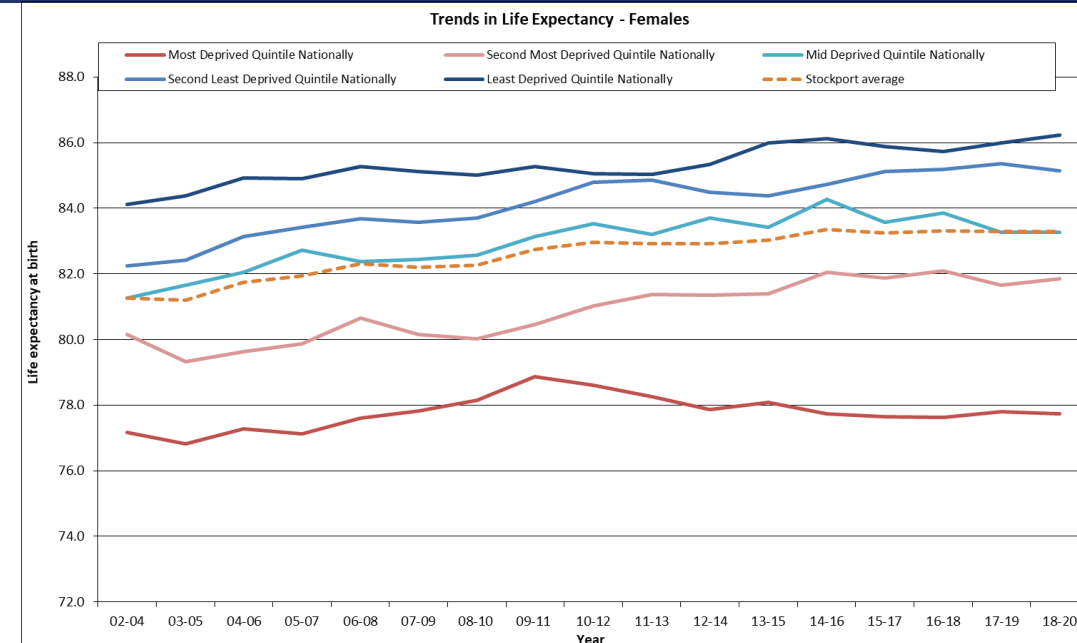
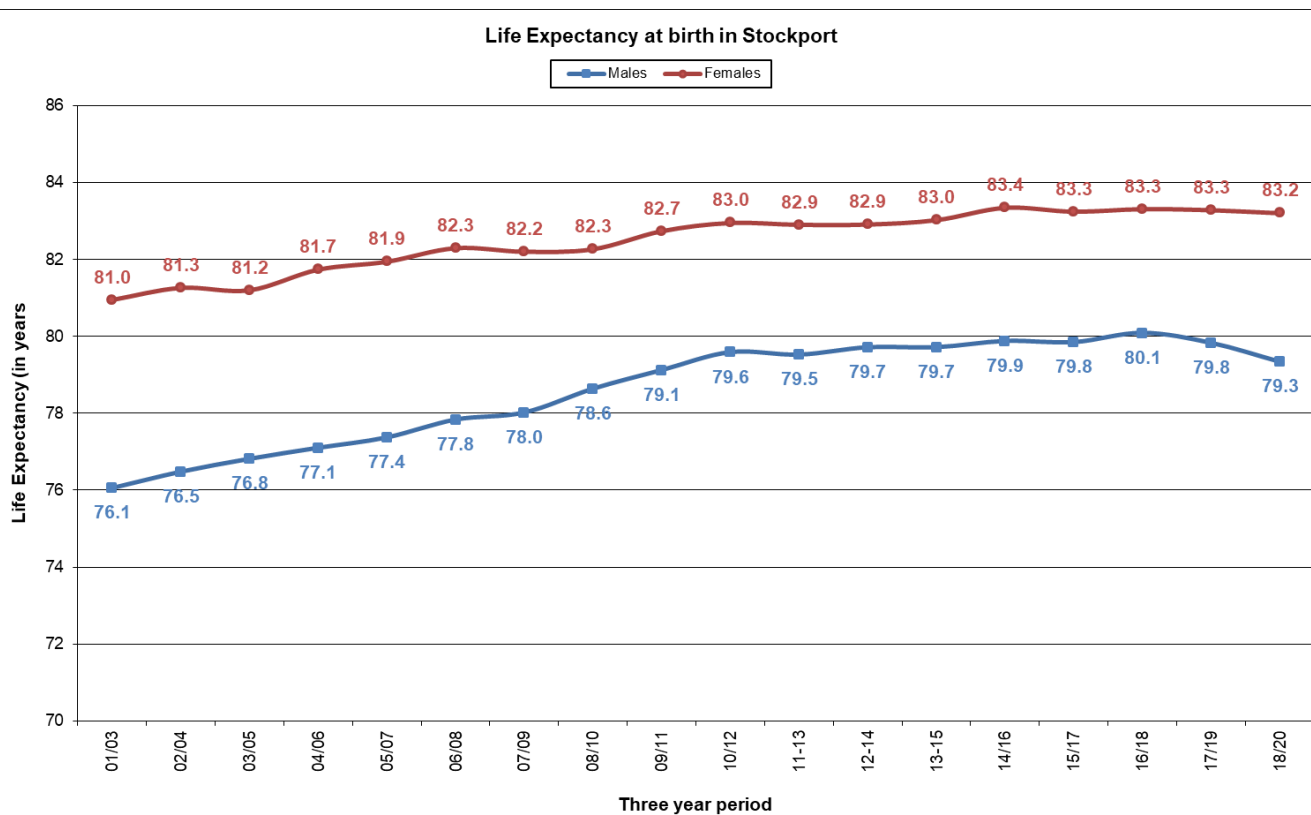
Figure 2. Summary of QALYs for mortality and morbidity, timescales combined

The analysis does not explicitly account for the new variant “VUI – 202012/01”, as it was written before evidence of this variant’s increased transmissibility was available; as such, health impacts could be greater than estimated in the paper. This analysis of the COVID-19 pandemic’s impact of excess deaths and morbidity is likely to be updated in the future, when new scenarios and/or evidence emerge.

The first analysis of the full mortality data for 2020 for Stockport is now available. This shows the impact of COVID-19 on life expectancy so far. At a Stockport level life expectancy for females has not changed significantly, for males the life expectancy has fallen by ½ a years – back to the levels seen in in 2009/11.

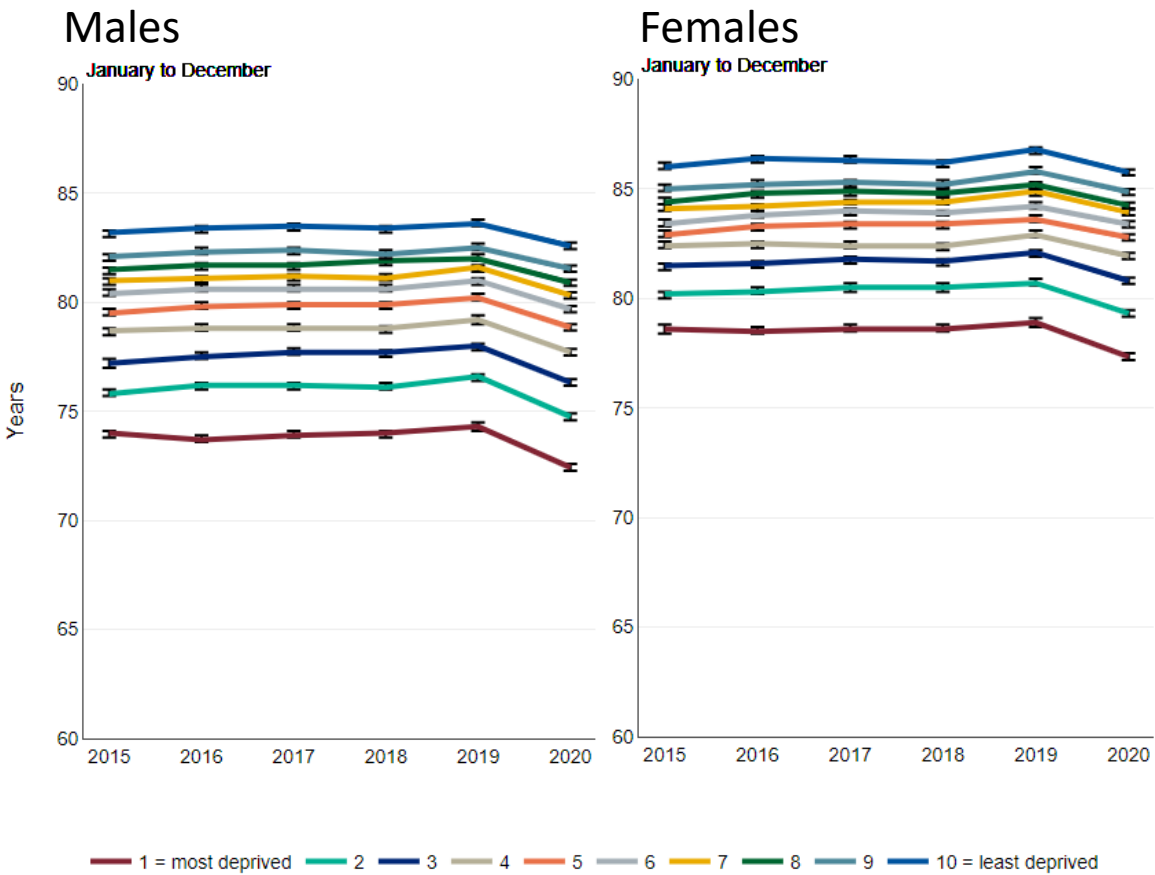
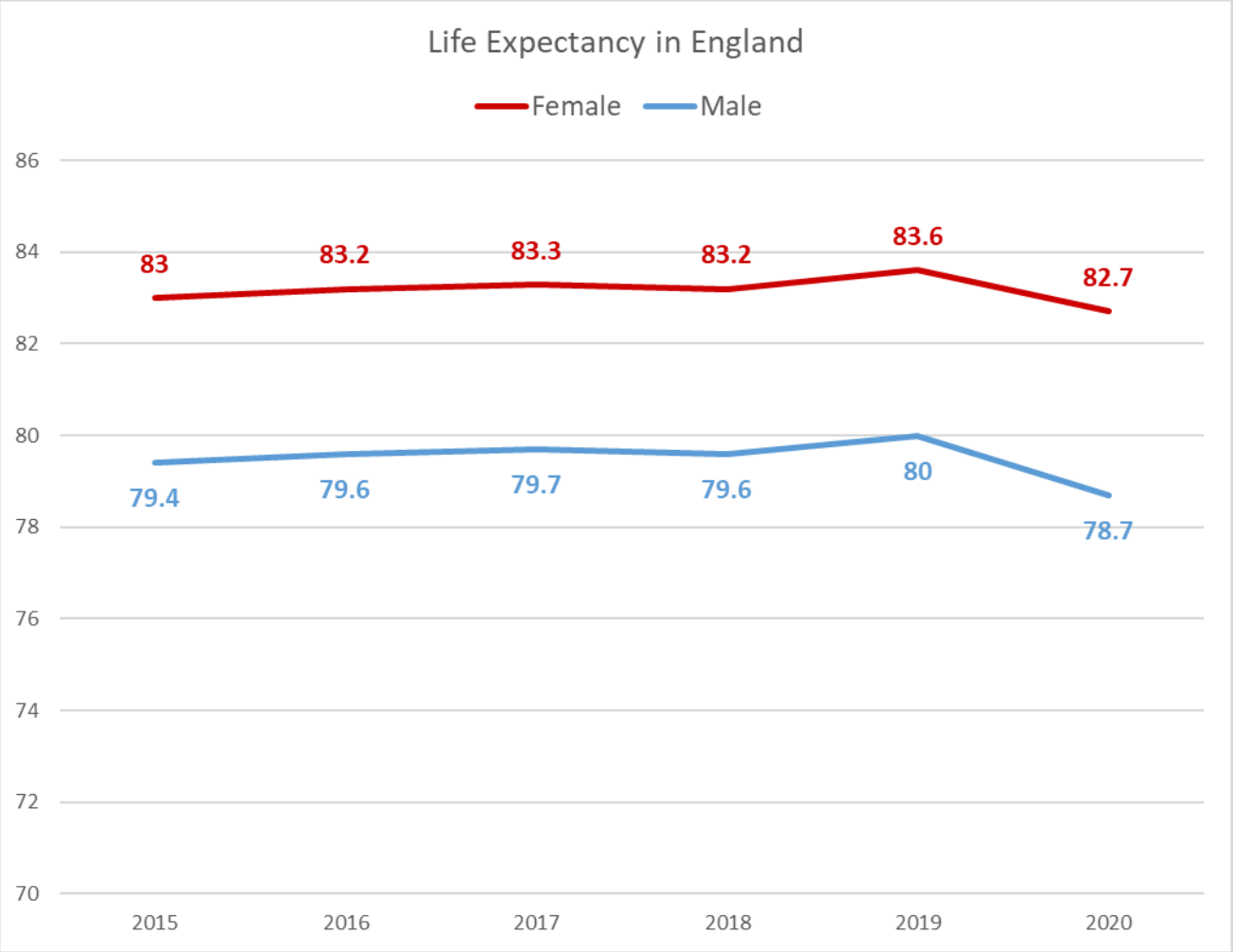
The fall in male life expectancy has been see in both the deprived and non-deprived areas of Stockport.

This data is based on a three years 2018-2020 and therefore only shows a partial effect, we may see further reductions in 2021 and 2022 too.



Nationally, the life expectancy data is capable of analysis for a single year, rather than a three year average, meaning that the impact of COVID-19 can be seen more clearly. This analysis shows a loss in life expectancy of 0.9 years for females and 1.3 years for males between 2019 and 2020.

There have been reductions in each deprivation decile, but the decreases have been largest in the most deprived areas, with a loss of 1.6 years for females and 1.9 years for males in the most deprived areas.



Source: Figures calculated by Public Health England using mortality data and population estimates from the Office for National Statistics.

This shows the first analysis of full mortality data for 2020 for Stockport, this has only just become available so the analysis and interpretation is not yet complete.

COVID-19 deaths have been assigned nationally to 'other unclassified' for the time being, until the International Classification of Diseases is updated.

The direct impact of first year of COVID-19 has been a fall in the mortality rates for heart and respiratory disease and dementia, the causes of death that are most common for older people, as people have instead died of COVID-19.

Mortality rates for cancer have not changed significantly.

National data shows similar trends, with the largest falls in mortality being seen in reparatory disease and stroke.

Causes of death		Standardised rate per 100,00 for causes where rate is > 20 per 100,000			% change
		2017-2019	2018-2020	Change	
All Causes		930.6	963.1	32.5	3.5%
All Circulatory Disease		238.5	229.4	-9.1	-3.8%
	Coronary Heart Disease	116.9	113.9	-3.0	-2.6%
	Cerebrovascular Disease	54.7	48.8	-5.9	-10.7%
All Malignant Cancers		265.4	265.0	-0.4	-0.2%
	Lung Cancer	57.5	55.9	-1.7	-2.9%
	Digestive Cancer	81.7	84.2	2.5	3.1%
	Colorectal cancer	26.9	27.6	0.7	2.7%
	Female Breast Cancer	27.3	27.8	0.5	1.7%
	Male Prostate Cancer	41.8	43.0	1.2	3.0%
All Respiratory Diseases		113.9	104.8	-9.0	-7.9%
	COPD	52.9	50.7	-2.1	-4.1%
	Pneumonia	38.1	32.2	-6.0	-15.7%
All Digestive Diseases		49.9	46.8	-3.1	-6.3%
All External Causes		46.2	96.0	49.8	107.9%
	All Accidents	32.3	33.9	1.6	5.0%
	Accidental Falls	23.4	23.0	-0.4	-1.5%
	Other unclassified	6.2	54.9	48.7	786.4%
All Nervous & Sense		65.7	69.5	3.7	5.7%
All Mental Health		90.5	84.6	-5.9	-6.5%
	Dementia	135.6	132.7	-2.8	-2.1%
All other causes of death		60.5	67.1	6.6	10.9%

In the previous JSNA we set what we knew about the wider impact of COVID-19 on the wider determinants of health and the impacts on different communities so far. Unfortunately it has not been possible to update this analysis in time for this report, and the intention will be to focus on these impacts in the third JSNA report.

What we need to understand more about

The long term impact on the development and mental wellbeing of children and young people will only become clear in time. Monitoring levels of need during the first year after the return to school will be key to learning more. A Greater Manchester survey about children and young peoples mental and emotional wellbeing is underway.

Coronavirus Job Retention Scheme (CJRS) statistics show that 31% of Stockport's workforce have been furloughed at some point between March and June 2020, by January 2021 15% of employments in Stockport were furloughed. The long term economic consequences of the lockdown are being modelled by the Office of Budget Responsibility, but again will only emerge in time as will the impact on our high streets.

Early research shows that trends for home working and travel changed significantly in April but since then levels of have gradually moved back towards pre pandemic patterns (see chart). Until restrictions are fully removed we will not know how many of these changes will be permanent.

The long term impact on lifestyles again is yet to emerge, impacts on alcohol consumption and physical activity in particular will be important to the long term health of the population.

There are likely to be significant impacts to different communities in Stockport, especially BAME and LGBT+ populations with the pandemic exacerbating existing inequalities.

Mobility data: percentage change compared to baseline (7 day rolling average)

Source: Google LLC "Google COVID-19 Community Mobility Reports". <https://www.google.com/covid19/mobility/>

