JSNA Healthy People

June 2022

Contents

Introduction

Our health is one of the most important assets we have as individuals, communities, and as a society. Health is a state of physical, mental, and social wellbeing, and can be different for different people. For example, for one person, the most important thing for their health might be whether they are able to spend time with those they love. For another, it might be their ability to work and support their family. Summary statistics can help us describe key aspects of health across different life stages within our communities and population on the Isle of Wight.

Local public health teams work in collaboration with other organisations to empower people to take control of their own health, reduce health inequalities and, ultimately, to prevent people experiencing ill health in the first place. To support this, Public Health commission and provide a range of public health services for Isle of Wight residents such as smoking cessation, weight management, NHS Health Checks and substance misuse services.

It is important to have an understanding of data describing the current and future health needs of the population, in order to be able to provide services in the best way possible. This will ensure optimal health outcomes for the population of the Isle of Wight.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions, or determinants, influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.[1]

This chapter focuses on the health outcomes of our population, the health inequalities which are evident and the potential impacts of the COVID-19 pandemic. The data in this report can be explored further by smaller local geographical areas and Primary Care Networks in the JSNA Healthy People data report.[2]

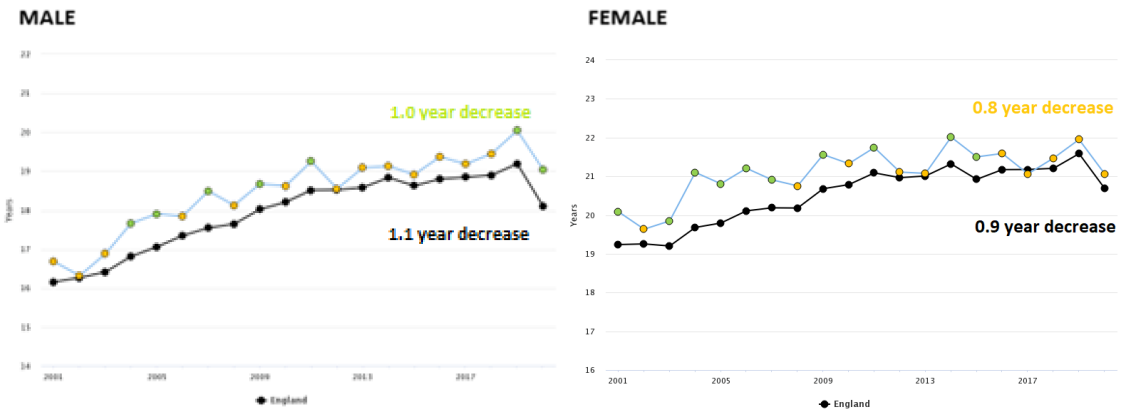
Our behaviours, personal circumstances including demographics and where we live hugely affect our own life expectancy and health. These influences and risk factors on our health and wellbeing should also be considered when exploring health outcomes and are discussed in more detail in the accompanying JSNA reports.[3]

Life expectancy and healthy life expectancy

The Isle of Wight's overall population health is similar to that observed in England as a whole. The latest life expectancy figures published for the Isle of Wight (2018-20) are similar to the national average, 79.6 years for men (0.2 years longer) and 83.4 years for women (0.3 years longer). Life expectancy across the Isle of Wight has remained fairly constant over the past decade, improvements have slowed and this has been particularly noticeable for women and men living in the more deprived areas of the Island.

Life expectancy trends by single year clearly show the impact of COVID-19, with a decrease in estimated life expectancy at birth for males and females in 2020. This is particularly marked in the population aged over 65. Figure 1 shows the decrease in life expectancy at 65 years during 2020, nationally the impact has been fairly similar to that observed on the Island. A gender inequality is evident both on the Isle of Wight and England with females having greater life expectancy at 65 years then males. Ongoing trend analysis will be important to understand the long-term impact of the pandemic on life expectancy on the Isle of Wight.

Figure 1: Isle of Wight life expectancy trends at 65 compared to England (1 year range), please note the difference in axes between males and females.

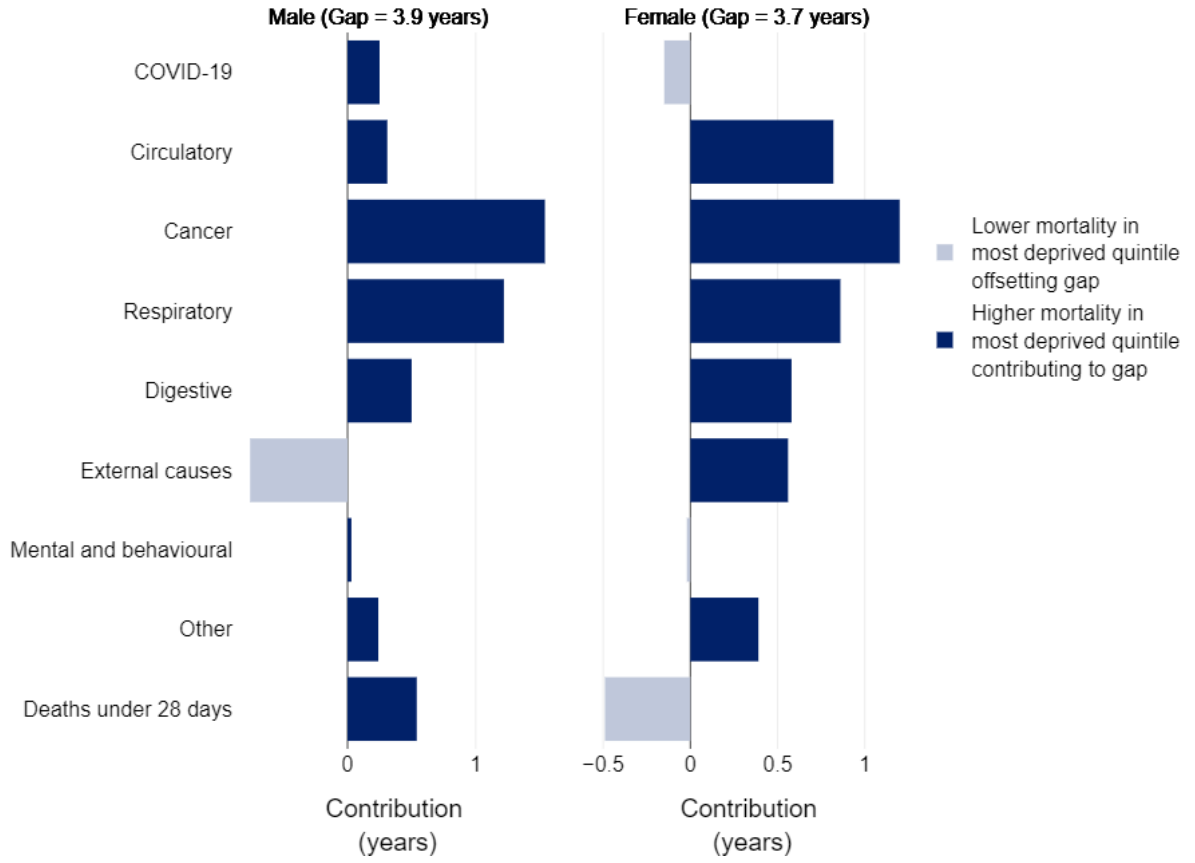


Source: Public Health Outcomes Framework | OHID[4]

Life expectancy varies with deprivation across the Isle of Wight, the most recent provisional figures (2020/21) show a difference of 3.9 years between males living in the least deprived areas of the Island and those living in the most deprived and a difference of 3.7 years between these two groups for females.[5]

Deaths from cancer and respiratory diseases make the greatest contribution to the life expectancy gap between the most deprived and least deprived quintiles on the Isle of Wight. Sixty-four respiratory disease deaths and 59 deaths from cancer would be avoided in the most deprived quintile of the Island if it had the same mortality rates as the least deprived quintile.[6]

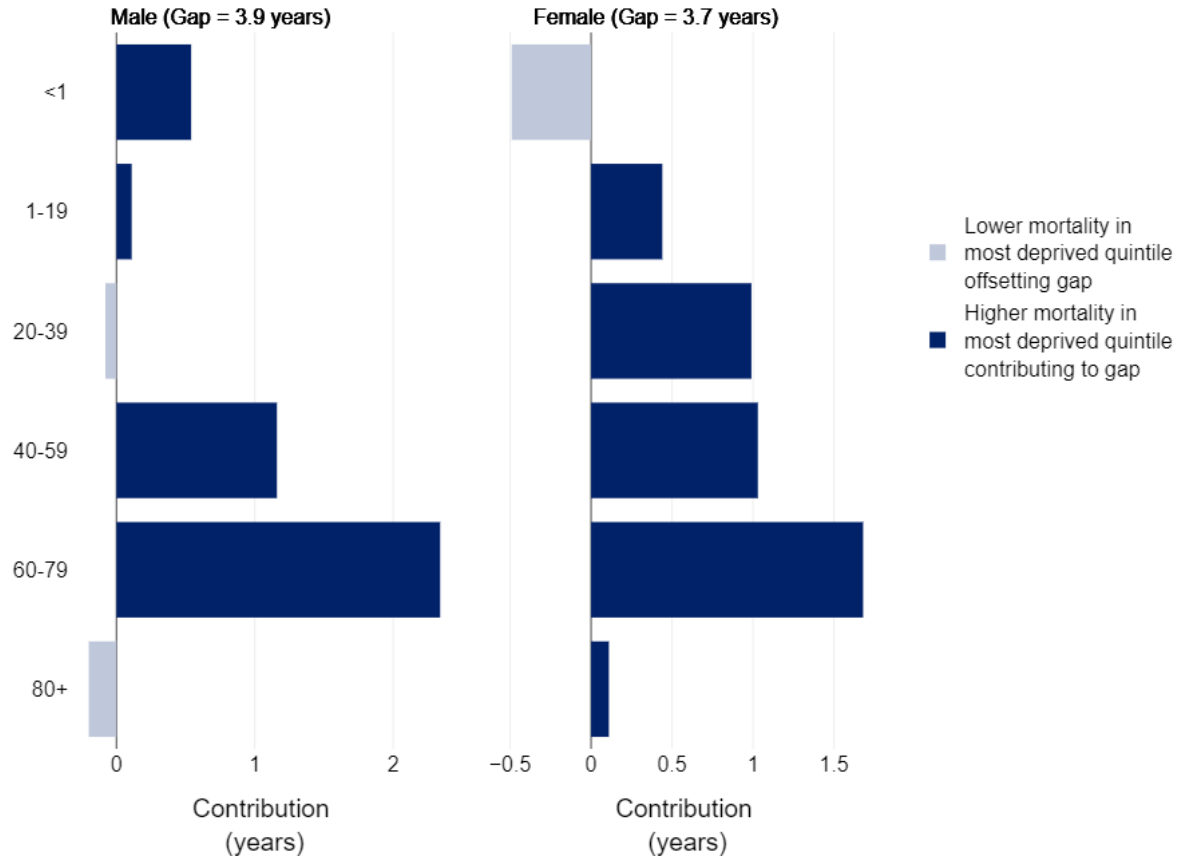
Figure 2: Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile on the Isle of Wight, by broad cause of death, 2020/21 (Provisional)[7]



Source: Segment Tool | OHID[8]

When the life expectancy gap between the most and least deprived quintiles on the Isle of Wight is examined by age band and gender, mortality amongst the population aged between 60 and 79 years represents the largest contribution, 56.3% for males and 39.6% for females. Sixty-five male and 42 female deaths in this age band would be avoided in the most deprived quintile on the Island if it had the same mortality rate as the least deprived quintile. This equates to a reduction of 2.34 years for males and 1.68 years for females in the life expectancy gap.

Figure 3: Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile on the Isle of Wight, by broad age group, 2020/21 (Provisional).



Source: Segment Tool | OHID[9]

The percentage of the population in good health deteriorates as people age. However, this happens earlier and at a faster rate for men and women living in the most deprived 10% of local areas than for those in the least deprived 10%. Analysis produced by The Health Foundation reports that at age 60 to 64, 81% of people living in the least deprived areas report good health, compared with just 45% in the most deprived areas. At age 55 to 59, more than half of people living in the most deprived areas report having less than good health. For those living in the least deprived areas, this occurs 20 to 25 years later, at age 75 to 79 for women and 80 to 84 for men.[10]

Over the last five years, healthy life expectancy at birth had been decreasing for both males and female residents on the Isle of Wight and was significantly below the national average for the three year period 2017-19. However, the most recent data available (2018-20) suggests a small improvement in healthy life expectancy at birth for both males and females.[11]

At older ages, healthy life expectancy at age 65 for Isle of Wight females is now statistically significantly higher than England for the first time since 2014-16. Healthy life expectancy for males at age 65 is higher than the national average, although not significantly so, also for the first time since 2014-16.

Inequalities highlighted nationally are evident across the Isle of Wight with those living in the most deprived areas living a smaller proportion of their lives in good health. Males and females living in the most deprived areas of the Island live in poor health for 10.3 years and 7.5 years longer respectively, compared to those living in the least deprived areas.

Life expectancy and healthy life expectancy can be explored in more detail and for smaller geographical areas on the Isle of Wight in the JSNA Demography chapter.[12]

Multimorbidity

Around one in four people have two or more long-term conditions, known as multimorbidity, and this rises to two thirds of people aged 65 years or over.[13] The proportion of patients who have two or more medical conditions simultaneously is rising steadily.[14] Patients with multimorbidity have the greatest healthcare needs and generate the highest expenditure in the health system.[15]

Multimorbidity was a key risk factor identified during the COVID-19 pandemic. People with multiple conditions were more likely to experience severe health outcomes from COVID-19.[16] This is discussed later in this report and in the Isle of Wight COVID-19 Health Impact Assessment.[17]

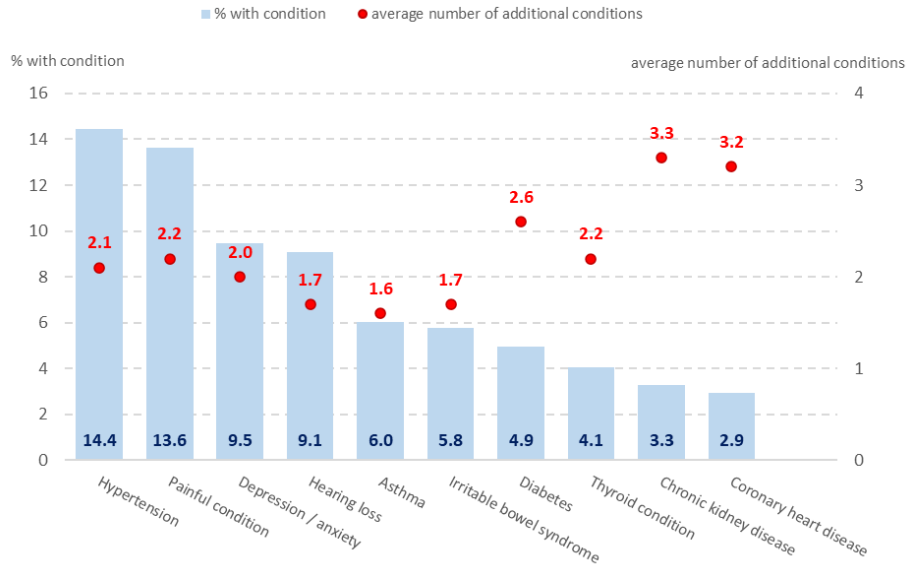
Multimorbidity increases with age, however other circumstances can mean certain people are more vulnerable to having multiple long-term conditions and almost a third of people with four or more conditions are under 65 years of age.

People in disadvantaged areas are at greater risk of having multiple conditions and are likely to have multiple conditions ten to 15 years earlier than people in affluent areas.[18] Around 28% of people in the most deprived quintile of England have four or more conditions, compared with 16% in the least deprived quintile.[19]

Children or young adults with serious congenital or acquired impairments often have multiple physical or mental illnesses. Certain periods of life, including pregnancy, increase the probability that multiple conditions will present simultaneously.[20]

A Health Foundation study[21] shows that 82% of people with cancer, 92% with cardiovascular disease, 92% with chronic obstructive pulmonary disease and 70% with a mental health condition have at least one additional condition. Hypertension and pain were the most common additional conditions. Figure 4 from this study shows that a person with hypertension had an average of 2.1 additional conditions and a person with depression or anxiety had 2.0 additional conditions. People with chronic kidney disease had 3.3 additional conditions.

Figure 4: Common conditions and average number of additional conditions.



Source: [Understanding the health care needs of people with multiple health conditions | The Health Foundation](#)[22]

Across the Isle of Wight, just under 33,000 residents have two or more long-term conditions. This equates to almost one in four people (23.1%). Deprivation may explain some of the variation across the Island. However, age is also likely to be a significant contributing factor; the 2021 Census reported that almost 30% of the population on the Isle of Wight are aged 65 years and over.

Figure 5: Number of patients with two or more long term conditions

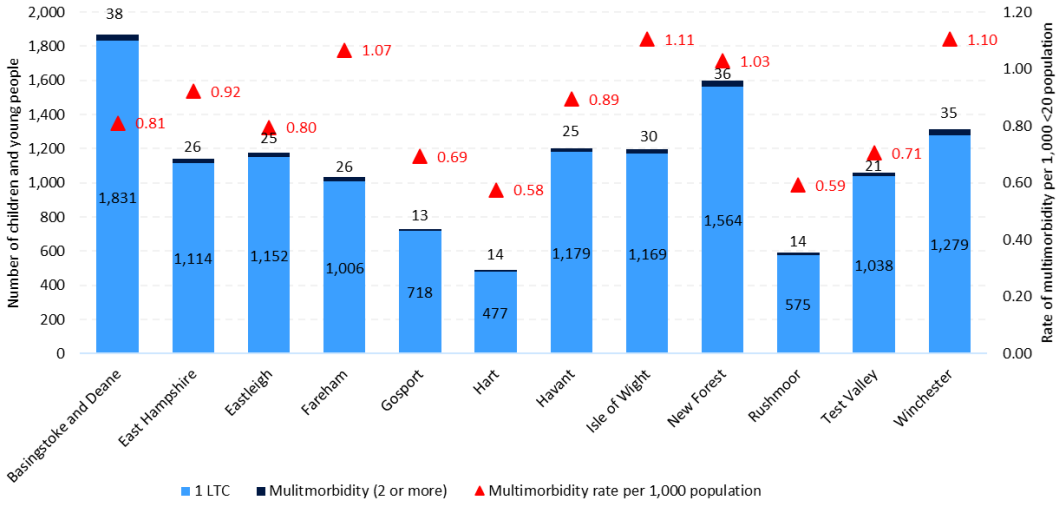
Source: NHS South, Central & West Commissioning Support Unit (SCW CSU)[23]

Figure 5 shows that there is distinct small area variation across the Island, with an area to the west, Freshwater Yar, reporting the highest number of people with multimorbidity.

On the Isle of Wight, a total of 1,169 children and young people aged under 20 have at least one long-term condition, this is a rate of 0.86 per 100,000 population aged under 20 years. Of these 2.6% (n=30) have two long-term conditions.

Figure 6 presents the number of children aged under 20 years with one or more long-term conditions. The Isle of Wight has over 1,000 resident children and young people with at least one long-term condition. As a rate per 1,000 population, the Isle of Wight has a higher rate than Hampshire overall. The Island has been compared to Hampshire, rather than to a national or 'similar area' comparator, as this data has been locally sourced and is only available for Hampshire and the Isle of Wight.

Figure 6: Number of children and young people aged under 20 years with 1 and 2+ long-term conditions.



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

Local analysis by deprivation suggests there is a very weak correlation between the number of children and young people with a long-term condition and deprivation. Therefore, deprivation does not fully explain the variation across the Island.

Royal College of Paediatrics and Child Health (RCPCH) State of the Nation report[24] found that many long-term conditions develop during childhood and these children are more likely to develop mental health conditions. Local data is not available to understand what specific long-term conditions these children have. However, this national report found that:

- Asthma is the most common long-term condition among children and young people and is one of the top ten reasons for emergency hospital admission in the UK. Deprivation continues to be a risk factor for emergency hospital admissions for asthma.

- Epilepsy is the most common long-term neurological condition of childhood, and it affects an estimated 112,000 children and young people in the UK, although diagnosis is not straightforward. Emergency admissions for epilepsy are associated with a deprivation gradient. Thirty-seven per cent of children with epilepsy have a mental health condition.
- Diabetes is increasingly common among children and young people in the UK. While 90% of diabetes cases are Type 1, Type 2 is increasing in prevalence. Health inequalities persist in outcomes for children and young people with diabetes.
- Childhood cancers are varied, and incidence rates have increased by 15% in the UK since the 1990s; however, more children that are diagnosed are surviving for longer, with 75% in Great Britain surviving ten years from cancer diagnosis. The most common cancer diagnoses in children are leukaemia, brain, and other central nervous system and intracranial tumours and lymphomas.

The review 'Is work good for your health and wellbeing?' [25] concluded that work was generally good for both physical and mental health and wellbeing, where appropriate for the individual. The gap in the employment rate between those with a long-term health condition and the overall employment rate, provides a good indication of the impact limiting long-term illness has on employment among those in the 'working well' life stage.

Data for the Isle of Wight shows that over the last three years the trend has been unstable, rising from a low of 11.2% in 2018/19 to a 13.7% gap in employment rate between those with a long-term health condition and the overall employment rate in 2019/20. The Isle of Wight has a larger gap in employment rate than that reported nationally.[26]

The majority of patients who require treatment in an acute hospital setting are older people and as discussed there is a higher likelihood of them having multiple chronic conditions. A larger number of chronic conditions is associated with higher odds of hospital admission or death.[27] The EPIC-Norfolk cohort study[28] explored the relationship between multimorbidity and potentially modifiable lifestyle factors such as smoking, obesity, physical inactivity and low plant-based food intake.

The study found that in people initially free of disease:

- Age and being male predicted subsequent incident hospital admissions with multimorbidity.
- Smoking, body mass index (BMI) greater than 30, physical inactivity and a diet low in fruit and vegetables were all independently associated with multimorbidity.

The study concluded that modest differences in lifestyle may have the potential to mitigate the future burden of multimorbidity in the population.

Mental Health and Wellbeing

Wellbeing is not just the absence of disease or illness and can be impacted by a person's physical, mental and emotional health and social wider determinant factors. Wellbeing is strongly linked to happiness and life satisfaction. In short, wellbeing could be described as how you feel about yourself and your life.[29]

Impact of COVID-19

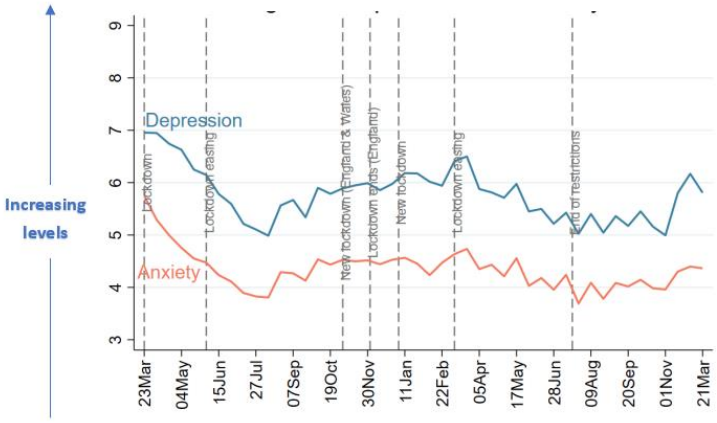
The Office for National Statistics (ONS) measures wellbeing through self-reported questions, asking respondents about life satisfaction, happiness, loneliness and how worthwhile they feel their lives are. Across the Isle of Wight trend data suggests that population wellbeing has worsened slightly over the last few years with: [30]

- 1 in 15 people reporting a low life satisfaction score
- 1 in 33 people reporting a low worthwhile score
- 1 in 11 people reporting a low happiness score
- 1 in 4 people reporting a high anxiety score

This data was reported before the pandemic and we are beginning to understand that COVID-19 has had a profound impact on our population's health and wellbeing. The policies during the pandemic, including social distancing and furlough, impacted how we interacted and accessed health and social care, education and work.

Deterioration and then improvement in mental health and wellbeing coincided with the periods of national lockdown and high COVID-19 cases followed by easing of lockdown and reducing cases.[31] Levels of depression and anxiety were higher amongst younger adults, with older adults showing lower levels and the smallest changes over time.[32]

Figure 7: Self-reported depression and anxiety, March 2020 to March 2021



Source: COVID-19 Social Study | UCL[33]

Samaritans 'One year on' report[34] explored the emotional support contacts to Samaritans where COVID-19 was a specific concern. These calls peaked during the

first lockdown in April 2020 where COVID-19 was a concern in over a third of calls (36%) and then again in the January 2021 lockdown (29% of calls).

Calls where loneliness and isolation were a concern were the most likely to involve concerns about COVID-19. This was especially among those who were already isolated before lockdown or living alone. Calls related to family (concerns of health and increasing rifts and disagreements), finance (job and income loss, benefits, food costs and homeless threats), unemployment, work or study, benefits, bereavement, mental health and physical illness were also strongly associated with having concerns about COVID-19. By contrast, calls where violence and abuse or sexuality were a concern were the least likely to involve concerns about COVID-19.

Evidence shows that the mental health and wellbeing impact of the COVID-19 pandemic has been different for different groups of people and during the different waves. Long-term distress was highest among younger people, women, people living without a partner, those who had no work or lost income, and those with previous health conditions or COVID-19 symptoms.[35]

Young people (aged 16 to 24 years) have been particularly vulnerable due to education restrictions and economic policy. National data suggests their wellbeing has been impacted more than any other age group, reporting low levels of happiness and life satisfaction, and increased anxiety.[36] In addition, young adults with long-standing physical or mental health conditions, lower household incomes or who were unemployed or not in school reported higher levels of loneliness than their peers.[37]

Women were more likely to have had to adapt to the ever-changing circumstances, for example caring and home schooling. However, studies found women were more likely to have a supportive social network compared to men and so loneliness was higher in men.

Older and clinically vulnerable people's wellbeing was impacted due to a number of factors including suffering depression, anxiety and loneliness from shielding. Older people are also less likely to use online communications to supplement their interactions, as they are one of the population groups who are less likely to have home internet access.[38] Therefore feelings of loneliness were compounded for many older people due to reduced face to face contact and a move to virtual online contact.

Adults with pre-existing mental health conditions have reported higher levels of anxiety, depression and loneliness than adults without pre-existing mental health conditions.

A Hampshire and Isle of Wight mental wellbeing vulnerability index has been created which shows that no group across the population of the area has been unaffected by COVID-19 restrictions. Throughout COVID-19 the entire population has been at risk of poor mental wellbeing, not just those with certain characteristics or existing mental health conditions.

The Island is particularly vulnerable to poorer health outcomes across a range of physical and mental health conditions due to its coastal nature.[39] The general pattern of mental wellbeing vulnerability across the Isle of Wight shows that those living in the urban areas of the Island, such as Cowes, Newport, Ryde and the Bay, are more likely to be vulnerable to poorer outcomes. There is also a pocket of vulnerability in the West Wight, a less densely populated urban area. The 2021-2022 Annual Report of the Director of Public Health[40] focussed on the local impact of COVID on the Isle of Wight's population in relation to mental health and wellbeing.

Common Mental Health Disorders

Common mental disorders (CMDs) comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great.[41]

Prevalence in children and young people aged under 16 years

The Mental Health of Children and Young People in England Survey (MHCYP) [42] series provides trend data on the prevalence of different types of specific mental disorders for children and young people aged 5 to 15 years. During 2020 and 2021 surveys were conducted to explore the mental health of children and young people during the COVID-19 pandemic and changes since 2017.[43]

In 2021, 17.4% of children aged 6 to 16 years had a probable mental disorder; this is a marked increase from 11.6% in 2017. For boys, the prevalence was 18.6% in 2021, up from 12.4%, whereas in girls, the prevalence was 16.2% up from 10.9%. Probable mental health disorder prevalence in young women aged 17 to 19 years has increased significantly from 13.4% in 2017 to 24.8% in 2021. There was a smaller increase observed in young males (7.0% to 10.3%). For those aged 20 to 22, 19.1% had a probable mental disorder.

Probable mental health prevalence varied by population group:

- Boys aged 6 to 10 years were more likely to have a probable mental disorder (21.9%) than girls (12.0%). In 17 to 23 year olds, this pattern was reversed, with rates higher in young women (23.5%) than young men (10.7%).
- Ethnic group: Rates of probable mental disorder were higher among 6 to 23 year olds in the White British (18.9%) and the mixed or other (22.5%) groups, than in the Asian/Asian British (8.4%) and Black/Black British (8.3%) groups.
- Special educational need or disability: More than half of children with a special educational need or disability (SEND) had a probable mental disorder (56.7%), compared with 12.5% of those without SEND; this was an increase from 43.9% and 8.2% in 2017 for these respective groups.
- Long-term physical health conditions: In 2021, 6 to 16 year olds with a long-term physical health condition were twice as likely to have a probable mental

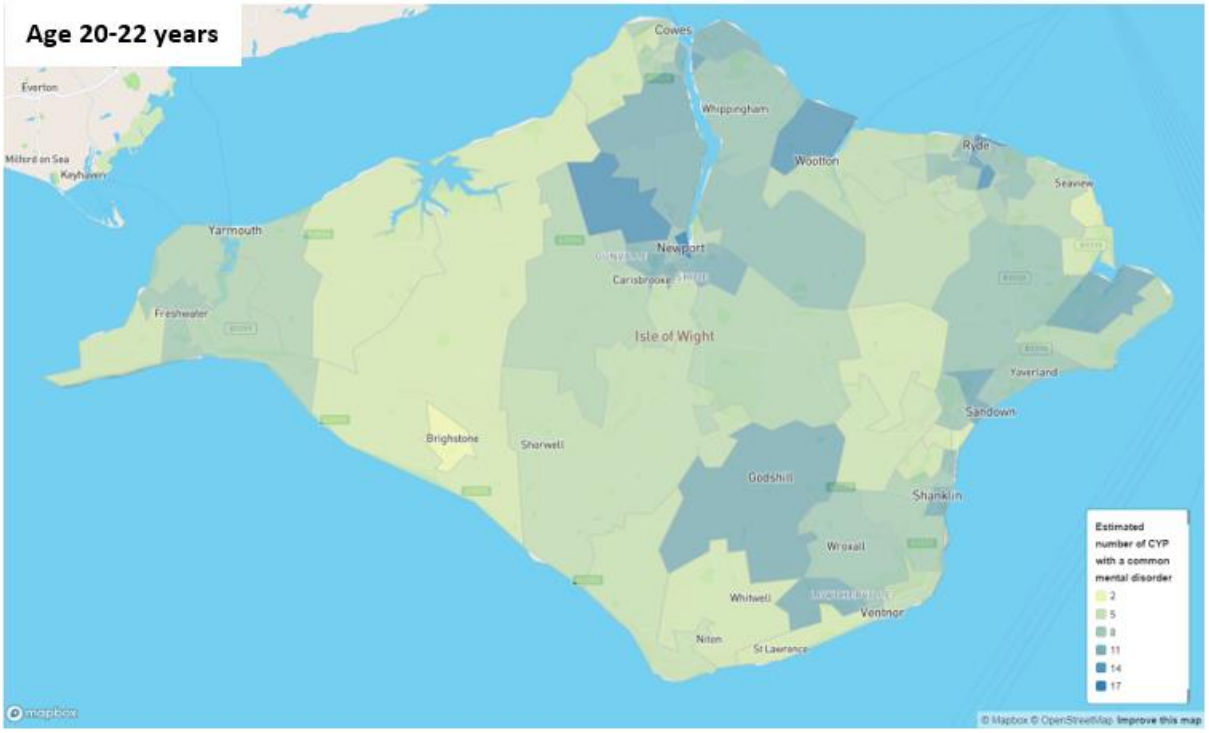
disorder (29.6%) as those without a long-term physical health condition (14.9%).

- Over one third (39.0%) of young people aged 17 to 22 years with a probable mental health disorder always or often felt lonely, compared to 4.8% of the total 17 to 22 year old cohort.

The change in children and young people's mental health between 2017 and 2021 was recorded, 39.2% of children aged 6 to 16 years in 2021 had experienced deterioration in mental health since 2017, and 21.8% experienced improvement. Deterioration in mental health was greatest among those aged 17 to 23 years, 52.5% had experienced deterioration in mental health since 2017, and 15.2% experienced improvement.

Applying these national prevalence estimates to our local population suggests there are approximately 2,780 children aged 6 to 16 years, 667 young people aged 17 to 19 years and 702 young people aged 20 to 22 years with a probable mental health disorder. This is a total of 4,153 children and young people estimated to have a mental health disorder across the Isle of Wight. Figure 8 shows the variation across the Island. Higher numbers can be observed in areas around Ryde, Newport and Cowes.

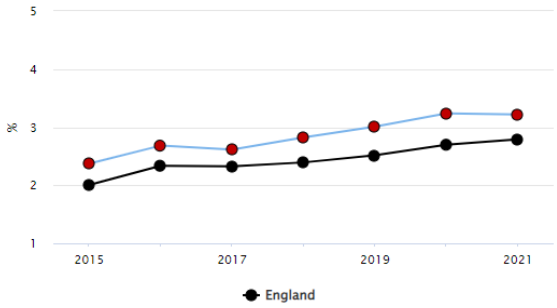
Figure 8: Estimated number of children with a probable mental disorder aged 6 to 16 years, 17 to 19 years and 20 to 22 years



Source: [Mental Health of Children and Young People Surveys | NHS Digital](#)[44]

Within school settings the number of school pupils with Special Educational Needs (SEN) where the primary type of need is considered to be social, emotional and mental health is recorded. On the Isle of Wight, the percentage of SEN pupils with this type of need is 3.22%. This is significantly higher than the proportion in England overall, 2.79%. This translates to 540 school pupils on the Isle of Wight. The Island shows an increasing number of school children with SEN where the primary need identified was considered to be social, emotional and mental health, which is the same as the national trend.

Figure 9: Percentage of school pupils with social, emotional and mental health needs



Recent trend: ↑ Increasing & getting worse

Period		Isle of Wight Count	Value	95% Lower CI	95% Upper CI	South East	England
2015	●	421	2.4%	2.2%	2.6%	2.1%*	2.0%*
2016	●	451	2.7%	2.4%	2.9%	2.4%	2.3%
2017	●	438	2.6%	2.4%	2.9%	2.3%	2.3%
2018	●	472	2.8%	2.6%	3.1%	2.4%	2.4%
2019	●	503	3.0%	2.8%	3.3%	2.5%	2.5%
2020	●	544	3.2%	3.0%	3.5%	2.7%	2.7%
2021	●	540	3.2%	3.0%	3.5%	2.8%	2.8%

Source: Department for Education special educational needs statistics: https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england

Source: Public Health profiles | OHID[45]

Children and young people aged up to 25 who require more support than is available through special educational needs support may need an Education Health and Care (EHC) Plan. This is a legally binding document outlining educational, health and social needs and setting out the additional support necessary to meet those needs. An EHC Plan replaced Statements of Special Educational Needs in England, as a result of the Children and Families Act 2014.

Over the last five years the number of children with a current statement or Education Health and Care (EHC) plan where the primary need identified was related to social, emotional or mental health has increased locally. In 2021/22, there were 147 school age children on the Isle of Wight with a statement or EHC plan where social, emotional or mental health were identified as the primary need. This accounted for a little over one in six children (15.2%) with a current statement or EHC plan and represents a 14.8% increase from the previous year.[46]

Hospital admissions for mental health conditions in the under 18 year old population have increased on the Isle of Wight over the recent years. During 2020/21, 65 young people were admitted due to a mental health condition, this equates to an admission rate of 263.5 per 100,000 population and is significantly worse than the England admission rate of 87.5 per 100,000 population.[47]

Prevalence in people aged 16 years and over

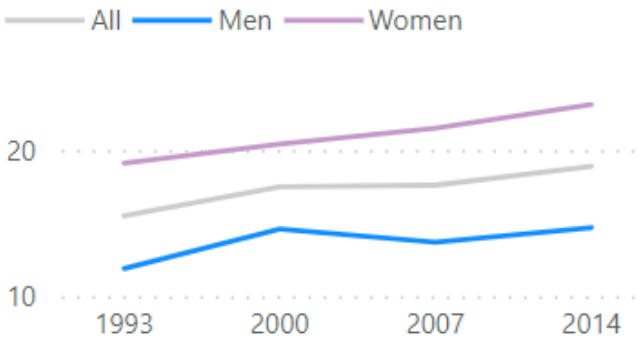
The Adult Psychiatry Morbidity Survey[48] identifies six types of CMD in people aged 16 years and over. These are: depression, generalised anxiety disorder (GAD), panic disorder, phobias, obsessive compulsive not otherwise specified (CMD-NOS). Surveys have been carried out in 1993, 2000, 2007 and 2014. Although this survey data is now quite old and pre-date any impact the pandemic has had on our mental health, the trends and differences between men and women remain important to understand.

Around one in six reported experiencing a common mental health disorder (CMD), in any given week in England, this included any type of anxiety or depression. Women were more likely than men to have reported CMD symptoms. Mixed anxiety and

depression were the most reported mental health problem for both males and females.[49]

Trend data show an increase in the prevalence of CMD since the year 2000, this is particularly evident for women. The survey also reported that since the last survey (2007), increases in CMD have also been evident among late midlife men and women (aged 55 to 64).[50]

Figure 10: National prevalence of common mental health disorders, 16 to 64 years



Source: Adult Psychiatric Morbidity Survey | NHS Digital[51]

There are an estimated 19,700 people aged 16 years and over on the Isle of Wight with a common mental health disorder and 4,150 people aged over 65 years.[52] Local trend data is not available.

Mental Health problems can be experienced by anyone, however there are certain population groups who are more likely to experience poor mental health. A Mind report[53] states that these are:

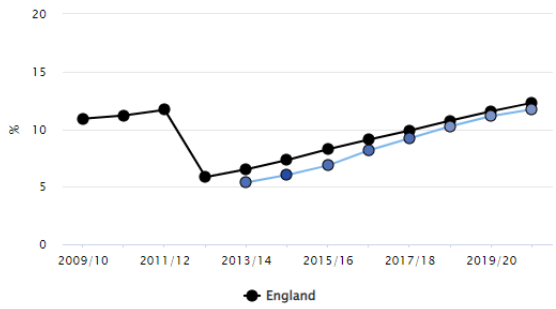
- People who identify as LGBTIQ+: LGBTIQ+ people are between 2–3 times more likely than heterosexual people to report having a mental health problem in England.
- Black or Black British people: 23% of Black or Black British people will experience a common mental health problem in any given week, compared with 17% of White British people.
- Young women aged 16-24: An increasing number of young women aged 16 to 24 (26%) report having a common mental health problem in any given week compared with 17% of adults.
- Around 40% of people in England who have overlapping problems including homelessness, substance misuse and contact with the criminal justice system in any given year also have a mental health problem.

The Adult Psychiatry Morbidity Survey also found CMDs were more prevalent in adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked. These associations are in keeping with increased social disadvantage and poverty being associated with higher risk of CMD.[54]

Depression

There are a little over 14,200 patients on the Isle of Wight aged 18 and over who have depression recorded on their practice disease register.[55] Figure 11 shows that the prevalence of depression on the Isle of Wight, 11.7%, is lower than the England prevalence of 12.3% but has been increasing over the last nine years. Figure 12 show the variation across the Island at a small geographical level.

Figure 11: Depression: Recorded prevalence (aged 18+)



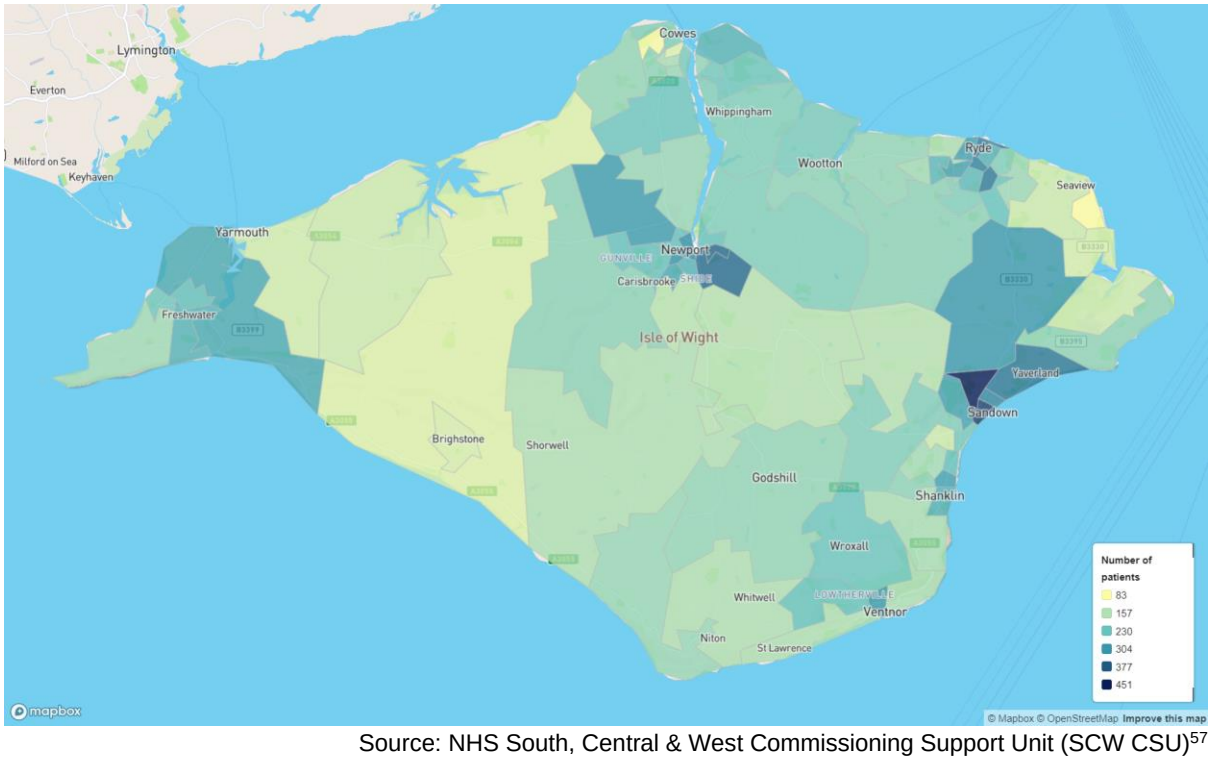
Recent trend: Increasing

Period		Isle of Wight Count	Value	95% Lower CI	95% Upper CI	South East	England
2009/10		-	-	-	-	-	10.9%
2010/11		-	-	-	-	-	11.2%
2011/12		-	-	-	-	-	11.7%
2012/13		-	-	-	-	-	5.8%
2013/14		6,254	5.4%	5.3%	5.5%	6.4%*	6.5%
2014/15		7,037	6.0%	5.9%	6.2%	7.3%	7.3%
2015/16		8,067	6.8%	6.7%	7.0%	8.4%	8.3%
2016/17		9,695	8.2%	8.0%	8.3%	9.3%	9.1%
2017/18		11,023	9.2%	9.1%	9.4%	10.1%	9.9%
2018/19		12,320	10.3%	10.1%	10.4%	11.0%*	10.7%*
2019/20		13,410	11.1%	11.0%	11.3%	12.0%	11.6%
2020/21		14,211	11.7%	11.5%	11.9%	13.0%*	12.3%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Source: Public Health Profiles | OHID[56]

Figure 12: Prevalence of depression, 2020/21



Source: NHS South, Central & West Commissioning Support Unit (SCW CSU)[57]

Perinatal Mental Health

Perinatal Mental Health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. The first 1,001 days, that is from conception to the age of two, is a period of uniquely rapid growth, when babies' brains, their sense of self, and their understanding of the world are shaped by their experiences and environments. Sensitive, responsive caregiving including early attachment and bonding during the earliest years of life lay the foundation for later health and wellbeing, the benefits of which last a lifetime. More detail on the first 1,001 days can be found in the JSNA Healthy Lives Report.[58]

Perinatal mental illness affects up to 20% of new and expectant mothers and covers a wide range of conditions. If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. Studies have also suggested that around 10% of fathers also experience depression during the perinatal period.[59]

Prevalence

Nationally, an estimated 100 to 150 in 1,000 women who have given birth will experience mild-moderate depressive illness and anxiety in the perinatal period. An additional 30 in 1,000 women are estimated to have severe depressive illness. On the Isle of Wight, this equates to an estimated 90 to 135 mothers a year with mild-moderate depressive illness and anxiety in the perinatal period and approximately 30 women with severe depressive illness and anxiety in the perinatal period.[60]

Contact with specialist perinatal mental health community services

NHS Digital statistics show that a total of 40 people were in contact with specialist perinatal mental health community services in 2020/21. This represents a rate of 20.35 per 10,000 women aged 15 to 44 years. This is slightly lower than the national rate of 29.82 per 100,000 women aged 15 to 44 years over the same time period.[61] It is unclear whether this is attributable to variations in levels of mental illnesses, service provision or data quality limitations.

Severe Mental Illness (SMI)

Severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia, bipolar affective disorder and other psychoses are included under SMI.

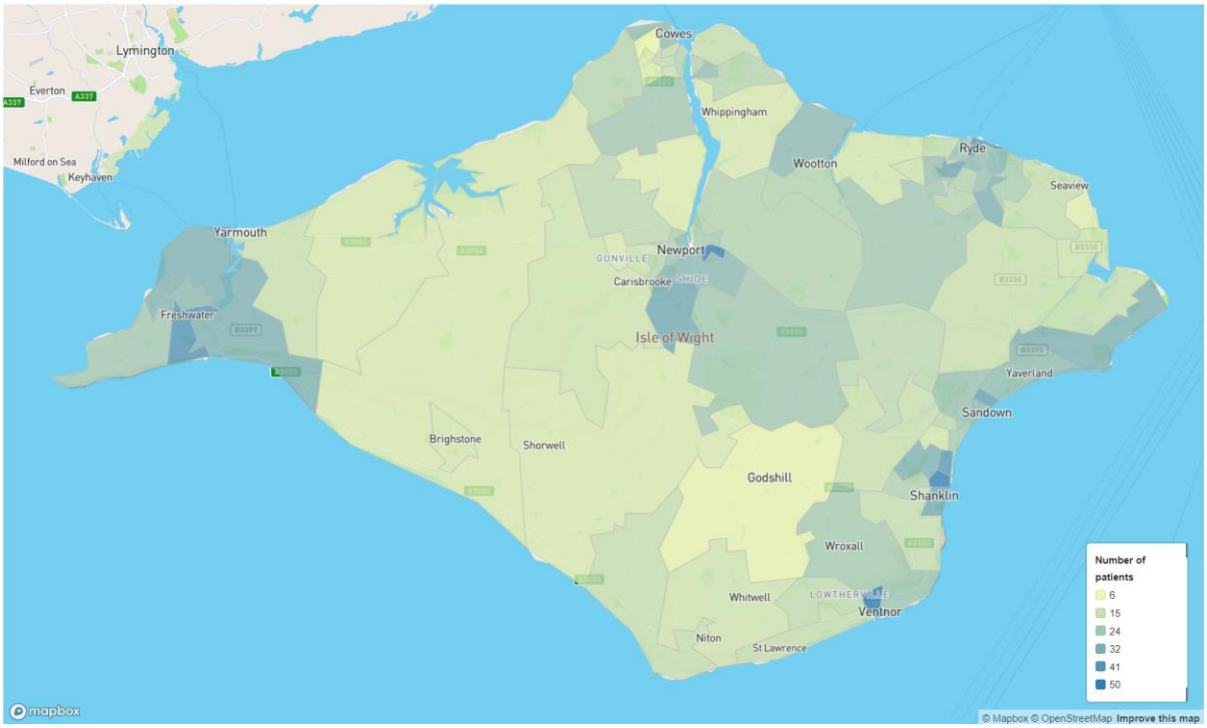
Prevalence

The number of patients with SMI registered with a GP practice is recorded through the Quality and Outcomes Framework (QOF). Nationally the prevalence of SMI is 0.95% for all ages, across the Isle of Wight prevalence is higher at 1.19%. This equates to a little under 1,730 people across the Island.[62] The map in Figure 13

highlights small area variation which is often masked at higher geographical levels, with areas around Newport, Shanklin, Ventnor and Freshwater having higher numbers of residents with SMI.

Nationally the rates of SMI have gradually increased from 2012/13 to 2018/19, however in recent years the proportion has been relatively stable. On the Isle of Wight, the prevalence of SMI has remained stable, fluctuating between 1.1% and 1.2%.

Figure 13: Prevalence of severe mental illness, 2020/21



Source: NHS South, Central & West Commissioning Support Unit (SCW CSU)[63]

People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Compared with the general patient population, patients with SMI are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with SMI make more use of secondary urgent and emergency care, and experience higher premature mortality rates.[64]

Public Health England conducted analysis exploring the inequalities of physical health in people with SMI.[65] It found that SMI patients are more likely to have one or more of the physical health conditions compared with all patients and this inequality was greatest in the younger age bands. Patients living in more deprived areas have a higher prevalence of SMI and higher prevalence of co-occurring physical health conditions.

Health checks for people with SMI

The health inequalities faced by people living with SMI are stark. The life expectancy gap for people with SMI continues to deteriorate, with recent data from 2018-20 highlighting that people with SMI are five and a half times more likely to die prematurely than those without an SMI, due to preventable physical health conditions.[66]

Annual health checks for this vulnerable population have been identified as a priority in the NHS Long Term Plan[67] and Core20PLUS5 initiative.[68] A national ambition has been set of 75% of people with SMI receiving their annual health check. There are six physical health checks measures that are offered: alcohol, blood glucose, blood lipid, blood pressure, BMI and smoking.

NHS England have published quarterly data by Clinical Commissioning Group on the uptake of health checks in people with a SMI.[69] The data presented here is experimental as they are known to be incomplete because not all CCGs have supplied information, and of those who have, some only supplied partial data. Care must therefore be taken when interpreting these results.

Figure 14 shows the annual uptake by CCG over time, however due to the experimental nature of the data and fluctuations in the registered population this data is indicative only. This data suggests variation between the CCGs and highlights the impact of the COVID-19 pandemic on the health check programme over 2020 and 2021.

Figure 14: Percentage of patients with SMI who have had all six physical health checks (Experimental data)

CCG	2018/19	2019/20	2020/21	2021/22
Frimley				56.4%
Hampshire, Southampton and IOW				32.2%
Portsmouth				40.7%
Fareham and Gosport	57.3%	11.1%	13.4%	
Isle of Wight	40.7%		9.6%	
North East Hampshire and Farnham	35.9%		19.6%	
North Hampshire	58.1%		15.2%	
Portsmouth	33.1%	41.7%	18.5%	
South Eastern Hampshire	58.5%	11.2%	11.0%	
Southampton	25.8%		17.5%	
West Hampshire	10.6%		24.1%	

Source: Physical Health Checks for people with Severe Mental Illness | NHS England[70]

Hospital Admissions

Across the Isle of Wight there were a total of 335 admissions to NHS funded secondary mental health, learning disabilities and autism services in 2020-21 and this number has remained stable over recent years. This is a rate of 23.5 per 10,000

of the population, a slightly higher than that reported for England (19.5 per 10,0000).[71]

Premature Mortality

On the Isle of Wight there were 425 premature deaths in adults with SMI over the three-year period 2018 to 2020. Premature mortality rates in adults with SMI are significantly higher for the Island when compared to England (117.8 compared to 103.6 per 100,000). Excess premature mortality (under 75 years) experienced by adults with SMI over adults without an SMI is also significantly worse than the national figure. There is a 458% higher risk of premature mortality experienced by adults on the Isle of Wight with SMI, over adults without SMI, compared to 389.9% in England.[72] Trend data suggests this inequality is increasing.

People with SMI have similar rates of cancer to the rest of the population, but case fatality rates are higher and survival rates are lower for people with SMI.[73] The premature mortality rate due to cancer in adults with SMI has decreased slightly for the Isle of Wight between 2015 and 2020, falling from a rate of 26.3 per 100,000 in 2015-17 to 23.5 per 100,000 by 2018-20. This is in contrast to the national picture where rates have slightly increased. This decreasing trend is also apparent on the Island for premature mortality rates due to respiratory and cardiovascular diseases. However, whilst rates of premature mortality due to cardiovascular diseases in adults with severe mental illness are falling on the Isle of Wight, they are still significantly higher than those reported nationally.

Conversely rates for premature mortality due to liver diseases in adults with SMI have increased although the rate on the Island is not significantly higher than that observed nationally. Most liver disease is preventable, and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions. People with SMI are at higher risk of obesity than the rest of the population.[74] This stresses the importance of Health Checks as a preventative measure to identify people with a SMI and pre-existing risk factors such as excess weight and high alcohol intake levels.

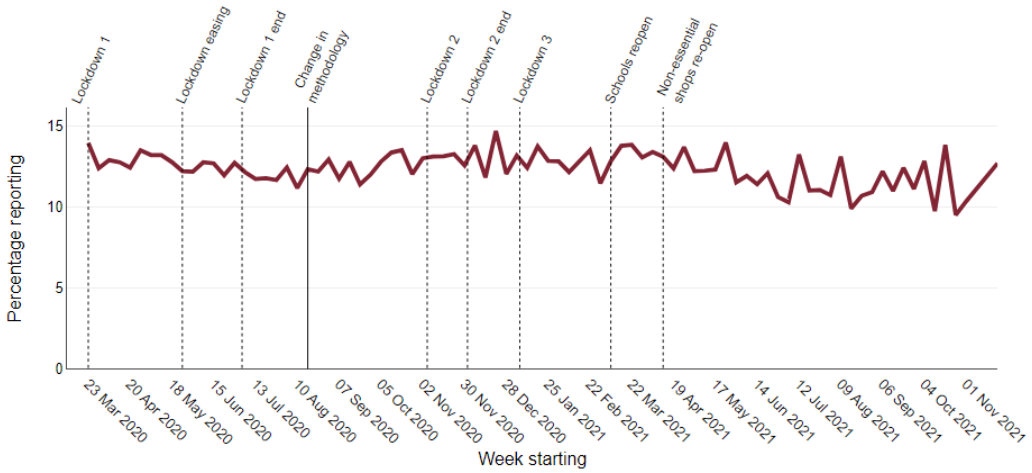
Self-harm and Suicide

Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.[75]

Nationally, the rate of young people being admitted to hospital as a result of self-harm is increasing. This is also the case on the Isle of Wight with increasing rates since 2016/17, with a slight fall in the most recent figures available for 2020/21. Despite this recent decline, the hospital admissions rate as a result of self-harm is still significantly higher than England. During 2020/21, 115 young people on the Isle of Wight aged 10 to 24 years were admitted to hospital as a result of self-harm.[76] Levels of self-harm are higher among young women than young men.

The impact of the COVID policies on the entire population's emotional wellbeing has previously been discussed. Figure 15 suggests that overall thoughts of death or self-harm remained stable throughout the pandemic. UCL conducted a large panel study which focused on the psychological and social experiences of adults living in the UK during the COVID-19 pandemic.[77] This study found that self-harm was higher amongst younger adults (aged 18 to 29), people with lower incomes, people with a diagnosed mental health condition, males, non-white ethnic groups, people living alone, and carers.

Figure 15: Percentage of respondents reporting thoughts of death or self-harm, UK



Source: Wider Impacts of COVID-19 on Health (WICH) monitoring tool | OHID[78]

There were initial concerns about the impact of COVID-19 on suicide rates, however ONS report there is no evidence that the number of suicides increased between April and December 2020 during the COVID-19 pandemic, with monthly suicide rates remaining consistent with previous years. However there is concern over how the coronavirus pandemic has affected well-being and suicide risk and consequently the longer term impact.[79]

There were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people. This was statistically significantly higher than the 2020 rate of 10.0 deaths per 100,000, but consistent with the pre coronavirus pandemic rates in 2019 and 2018. The fall in suicide rates observed in 2020 was likely to have been driven by two factors; a decrease in male suicides at the start of the COVID-19 pandemic, and delays in death registrations because of the pandemic.[80]

The latest local data is for the three-year period 2019 to 2021. The suicide rate for the Isle of Wight was 13.8 per 100,000 population (48 deaths over the three years).[81] Trend data shows a gradual, small increase in the suicide rate on the Island, but it is still not statistically significantly higher than the national rate. The suicide mortality rate on the Island is higher for males than females and this reflects national trends.

Although the suicide rate is not significantly higher than that recorded for England, we must be mindful that there are approximately 16 deaths by suicide in every year. Some studies estimate that for every suicide up to 135 people can be affected and therefore the impact on our communities is significant.[82]

National inequalities data show that suicide rates are significantly higher in more deprived areas. Communities in the most deprived 10% of the country experience a further 6.2 deaths from suicide and injuries of undetermined intent per 100,000 population than those populations resident in the least deprived areas.[83]

COVID-19

The COVID-19 pandemic has had a profound impact on people's health and their livelihoods, many people have seen their health deteriorate with more unhealthy behaviours.[84] This is explored further in the JSNA Healthy Lives chapter.[85]

Inequalities from the severe outcomes of COVID-19 are evident by gender, age, ethnic group, socio economic group and deprivation. On the Isle of Wight, the gradient in the overall COVID-19 admission rate by deprivation was evident although it is less pronounced than that observed nationally, likely due to the relatively small number of admissions involved. The highest admission rates were seen in deprivation quintile two where admission rates were eight times higher than in the least deprived areas.[86] Further analysis of these inequalities and the direct and indirect impact of COVID-19 on Island residents can be found in the Isle of Wight COVID-19 Health Impact Assessment Report.[87]

Post COVID-19 syndrome or Long COVID

Long COVID is currently defined as people who suffer with poor health for 12 weeks or more beyond the initial acute phase of infection. ONS estimate that around one in five people testing positive for COVID-19 exhibit symptoms for five weeks or longer and around one in ten for 12 weeks or longer.[88]

Those experiencing long COVID will present ongoing challenges for health and social care systems with increased need for care.

The Health Foundation[89] reported that the impacts of long COVID differ by age, gender and pre-existing health status. ONS found similar inequalities with the prevalence of self-reported long COVID greatest in people aged 35 to 49 years, females, people living in more deprived areas, those working in teaching and education, social care or health care (likely reflecting increased exposure to COVID-19 infection in these sectors), and those with another activity-limiting health condition or disability.

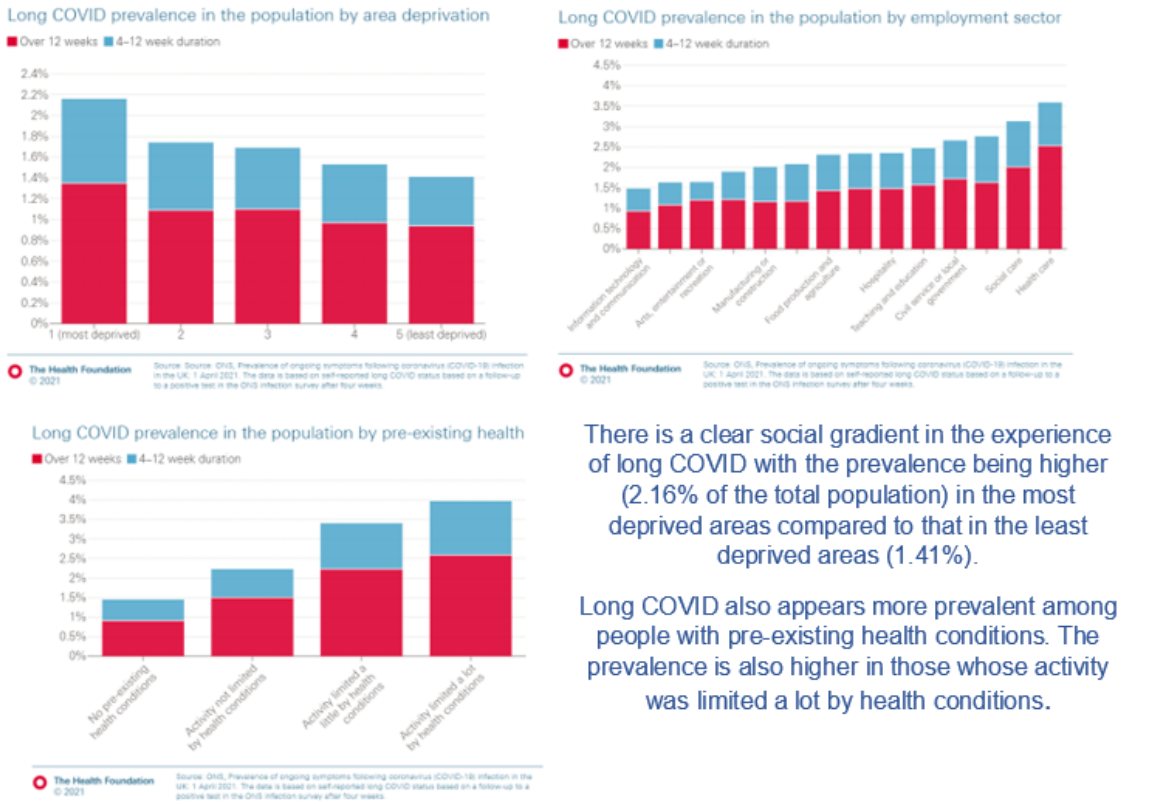
Across the Island, local data supports the national findings with working age women, especially those aged 45 to 64, most likely to require on-going support with their health after contracting COVID-19.[90]

The impact of long COVID on children is particularly concerning with only 10% of children (average age of 10 years) returning to previous levels of physical activity, with over four in five reporting a change in energy levels. A change in mood, sleep and appetite was seen in about half the children.[91]

Social consequences of long COVID are also apparent. As of 6 March 2021, 674,000 people in the UK reported that long COVID was adversely affecting their day-to-day activities, and 196,000 reported that their ability to undertake these activities had been limited a lot.[92] Of those who were working before being hospitalised for COVID-19 and contracting long COVID almost 19% reported a

health-related change to their occupational status.[93] A change in occupational status was more likely in people with co-morbidities or obesity.[94]

Figure 16: The impacts of long COVID differ by age, gender and pre-existing health status



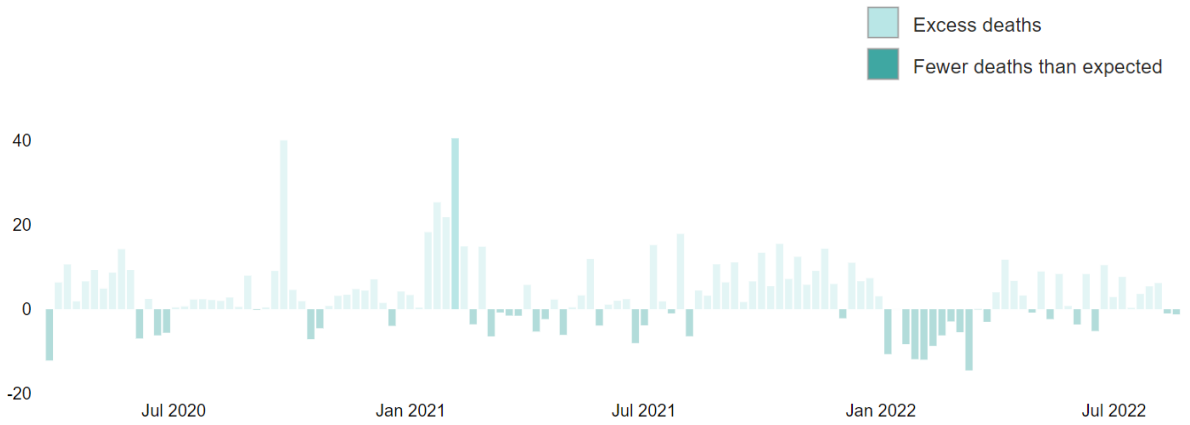
Source: [What might long COVID mean for the nation's health? | The Health Foundation](#)[95]

Excess Mortality

Excess mortality provides an understanding of the impact of COVID-19 during the course of the pandemic and beyond. Up to 2 September 2022, there had been 464 deaths on the Isle of Wight where COVID-19 was mentioned on the death certificate. Inequalities from the severe outcomes of COVID-19 are evident by gender, age, ethnic group, socio economic group and deprivation.[96]

Figure 17 shows that the majority of excess deaths observed on the Isle of Wight occurred shortly after the conclusion of wave one (March 2020 to June 2020) and during wave two (December 2020 to February 2021). Excess mortality on the Island hit a peak of 40 deaths above what would normally be expected, in the week ending the 25 September 2020 and again in the week ending 5 February 2021. This represents double the average number of deaths that would be expected during these weeks of the year.

Figure 17: Weekly Excess Deaths by Date of Registration, Isle of Wight. Date range (week ending): 27/03/2020 to 19/08/2022



Source: Excess Mortality in England Tool | OHID[97]

COVID-19 only partly explains the excess death trends observed. National analysis suggests that excess deaths in hospital are, on the whole, attributable to COVID-19 however, deaths at home and care homes show other causes significantly contributed to these trends.

Population Groups

Carers

The 2011 Census reported that just over 16,400 residents of the Isle of Wight provided some form of unpaid care, equating to approximately one in ten of the total population. A little over 4,100 residents provided 50 hours or more unpaid care a week on the Island.[98] Just over 700 (4.3%) of those providing unpaid care were young people aged 16-24 years and a further 302 (1.8%) were aged under 16 years. One quarter of these young carers provided 20 hours or more of unpaid care.[99]

Unpaid carers are more than twice as likely to suffer from poor health compared to people without caring responsibilities.[100] A national survey of carers found that many stated caring had a negative impact on their physical health (83%) and mental health (87%) and 39% had put off medical treatment as a result of their caring responsibilities.[101]

Between 2020 and 2040 the number of people aged 65 and over providing between one and 50 hours of unpaid care is estimated to increase by 33%. The highest number of unpaid carers are estimated to be aged 70 to 74 years, who account for a quarter of the total number of 65 years and over carers.[102]

Carer's Allowance

Carer's Allowance is the main benefit for carers and is payable if a person provides at least 35 hours of care per week to someone. Carer's Allowance is means tested and the person being cared for must be in receipt of qualifying benefits, therefore this data will not provide a comprehensive picture of the carers across the Island.[103] However, the data can be used as a proxy for the prevalence of care provision. Carer's Allowance is £67.60 per week (for April 2021/22) and is usually paid every four weeks.

As at February 2022, just over 1.5% of the population of the Isle of Wight, approximately 2,300 people receive carer's allowance. Of the total number claiming Carer's Allowance, 29% (985) were entitled to the benefit but do not receive payments which is comparable to the national position.

The number of people receiving Carer's Allowance increased from August 2019 peaking in August 2020, from 2,277 to 2,379 (4.5% increase). Since August 2020, the number of people receiving Carer's Allowance has fallen back to 2,316 (2.6% decrease). Nationally, the number of claimants has increased steeply since August 2019.[104]

People with Learning Disabilities

People with learning disabilities often have different and complex health care needs leading to increased prescribing and polypharmacy. They also have a higher prevalence of depression, asthma, diabetes and epilepsy.[105]

People who have a learning disability are more likely to have a visual problem as part of the underlying cause of their learning disability. This likelihood increases with the severity of the learning disability and with age. Overall, 30% of people with a learning disability are estimated to have a significant visual impairment.[106]

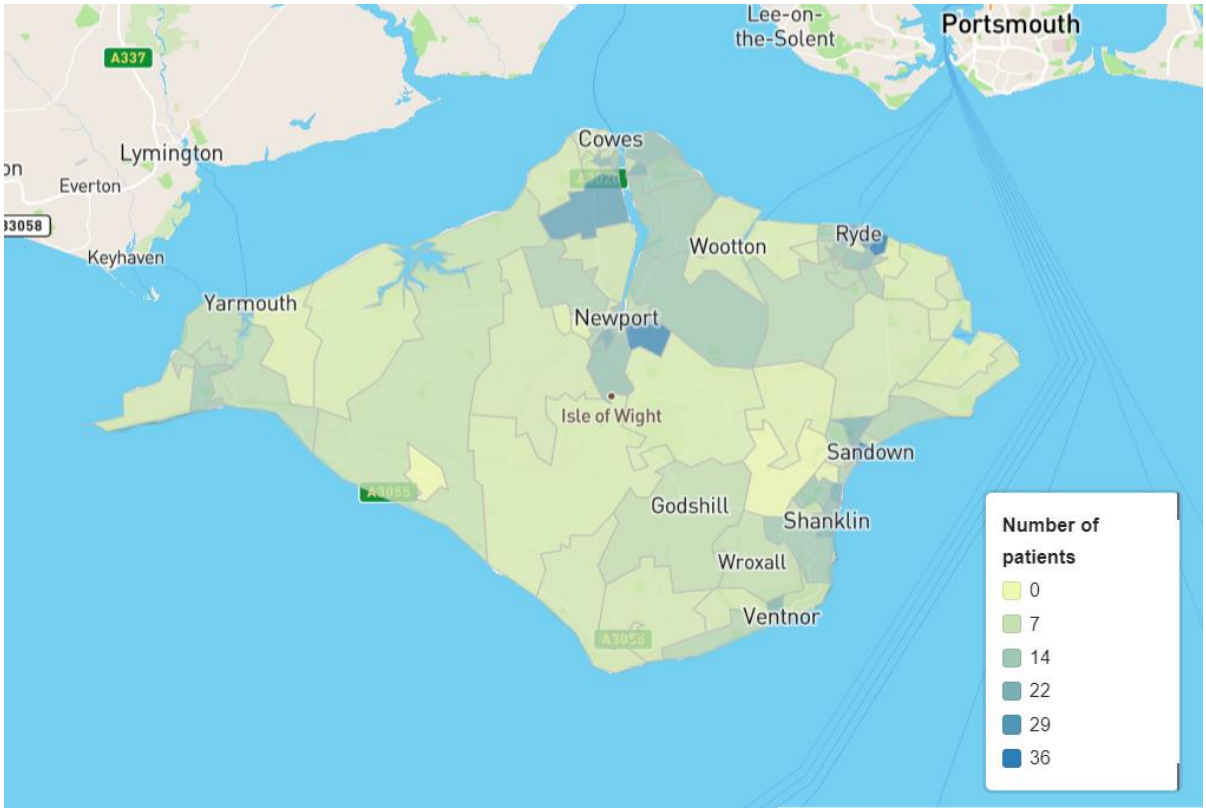
People with a learning disability are three times more likely to die from an avoidable medical cause of death than the general population.[107]

There is no definitive record of the number of people with learning disabilities in England. No government department collects comprehensive information on the presence of learning disabilities in the population and learning disabilities are not recorded in the census. There are a number of different data sources which can be used to try and provide a best estimate of the number of people with a learning disability living in an area.

Prevalence

The number of people on the GP learning disability register has increased slightly in 2020/21 when compared to the previous year. However, as a percentage of the population, levels have remained stable with 0.7% of the population (1,044 people) across the Isle of Wight registered with a learning disability. This is higher than the proportion recorded nationally (0.5%).[108]

Figure 18: Prevalence of people registered with a learning disability, 2020/21



Source: NHS South, Central & West Commissioning Support Unit (SCW CSU)[109]

It is estimated that only 23% of adults with learning disabilities in England are identified as such on GP registers.[110] In 2020, there were an estimated 2,724 adult residents with a learning disability across the Island.[111] Comparison with the GP learning disability registered number to this estimate suggests only 38.3% of adults with a learning disability have been identified on the Isle of Wight.

It is essential to identify and understand the needs of people with learning disabilities, so that local authorities can plan services accordingly. Those requiring long-term support naturally need more resources in terms of time and money spent. Approximately 56% of people on the Isle of Wight who are on the GP learning disability register are receiving long-term support.[112]

Learning disability health checks and screening

Anyone aged 14 or over who is on the GP learning disability register can have a free annual health check. Health and Care of People with Learning Disabilities experimental statistics[113] provide information about the key differences in healthcare between people with a learning disability and those without.[114] It contains aggregated data on key health issues for people who are recorded by their GP as having a learning disability, and comparative data about a control group who are recorded by their GP as not having a learning disability. The data is presented by CCG. Across the Hampshire, Southampton and Isle of Wight CCG, 3,617 patients registered with a learning disability were included in this analysis which represents 41% of patients with a learning disability registered across the CCG.

The NHS Long Term Plan set an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check. In 2020/21, 75.4% of people across the CCG who were registered with a learning disability had received a health check. Females with a learning disability were more likely to have had their annual health check when compared to males with a learning disability (78% compared to 74% respectively).

Further health check analysis for Hampshire, Southampton and Isle of Wight CCG is comparable to national findings and suggest that when compared to the control group people with a learning disability are:

- Less likely to have a health check if they are in a younger age band.
- Less likely to get screened for breast and cervical cancers.
- Illnesses are more common, for example, epilepsy.
- More likely to be given antipsychotic, benzodiazepines or antidepressant medicine.
- More likely to be diagnosed with autism.
- More likely to be diagnosed with ADHD.

Mortality and life expectancy.

The 2018 Learning Disabilities Mortality Review (LeDeR) [115] found that the median age at death for people with learning disabilities (aged 4 years and over) was 60 years for males and 59 years for females. This highlights the disparity in the age at death between people with learning disabilities and the general population of 23 years for males and 27 years for females.

Life expectancy varied by levels of impairment:

- 62 years for people with a mild learning disability
- 63 years for people with a moderate learning disability
- 57 years for people with a severe learning disability
- 40 years for people with profound and multiple learning disabilities.

For people with learning disabilities, the most frequent causes of death were diseases of the respiratory system (19%), congenital malformations and chromosomal abnormalities (16%) and diseases of the circulatory system (16%). The medical conditions most recorded as a subsidiary cause were: pneumonia (25%), aspiration pneumonia (16%), sepsis (7%), dementia (syndrome) (6%), ischaemic heart disease (6%) and epilepsy (5%). These causes of death were more frequently reported in people with severe or profound and multiple learning disabilities. The report concluded that people with learning disabilities who had experienced gaps in service provision that may have contributed to their death more frequently died from sepsis compared to others.

People with learning disabilities were disproportionately impacted by severe health outcomes from COVID-19. Between the start of February and 5 June 2020, adults with learning disabilities had between 2.3 and 3.6 times the COVID-19 death rate of the general population. COVID-19 death rates were particularly high among those with a severe to profound learning disability or Down's syndrome.[116]

Children and Young People

In England, a child or young person has Special Educational Needs and Disabilities (SEND) if they have a significantly greater difficulty in learning than the majority of others of the same age, or have a disability which prevents or hinders him or her from making use of facilities generally provided for others of the same age in mainstream schools.[117] This can affect their:

- behaviour or ability to socialise, for example they struggle to make friends
- reading and writing, for example because they have dyslexia
- ability to understand things
- concentration levels, for example because they have ADHD
- physical ability

Not all children and young people with SEN have a learning disability. In 2021/22, 73,669 children in England with a statement of SEN or an Education, Health and Care (EHC) plan had a primary SEN associated with learning disability, this represents 22% of all children with a statement of SEN or an EHC plan.[118] National trends suggest the total number of children with a Statement of SEN or an EHC Plan and a primary SEN associated with moderate learning disabilities in mainstream school has increased, from 12,393 in 2018 to 16,937 in 2022.

Learning disabilities are more prevalent in boys and overall people with learning disabilities are more likely to be eligible for Free School Meals. Differences in prevalence are also observed by ethnic group with a higher rate per 1,000 children of primary SEN associated with learning disabilities in:

- traveller children of Irish heritage
- children of Romany gypsy heritage
- children of Pakistani heritage
- children of Bangladeshi heritage
- children of Black Caribbean heritage. [119]

Local children's services data for the Isle of Wight shows that, over the last five years the number of children with a current statement or EHC plan with a learning disability need has increased. In the academic year 2021/22 there were 308 children with a learning disability identified as the primary need. This accounted for almost one third (32%) of children's needs from the total of those with a current statement or EHC plan. The majority of these children had a moderate learning difficulty identified (141 children) and this number has increased by 38% over the previous year. The number of children with a severe learning difficulty is similar (138 children) and this need has also increased within the last year, up by 17%. The number of children with a current statement or EHC plan where the primary type of need identified is profound and multiple learning difficulties on the Island has remained fairly consistent in recent years, 29 children in 2021/22.[120]

Special Educational Needs and Disabilities (SEND)

As mentioned in the previous chapter, 'special educational needs' is a legal definition and refers to children with learning problems or disabilities that make it harder for them to learn than most children the same age. This can affect their:

- behaviour or ability to socialise, for example, struggling to make friends
- reading and writing, for example, because they have dyslexia
- ability to understand things
- concentration levels, for example, because they have ADHD
- physical ability

A child can receive SEN support in school, such as speech therapy, and a child may need an education, health and care (EHC) plan if they need more support than their school provides.[121] Nationally in 2021/22, there were just under 1.5 million pupils in

England who had special educational needs, this number increased by 77,000 from the previous year. Both the number of pupils with an EHC plan and the number of pupils with SEN support have increased since 2016.

- The percentage of pupils with an education, health and care (EHC) plan has increased to 4.0%.
- The percentage of pupils with SEN but no EHC plan (SEN support) has increased to 12.6%.

Nationally the most common type of need for those with an EHC plan is autistic spectrum disorder (ASD), almost one in three pupils with an EHC plan are identified as having a primary need of ASD. For those with SEN support speech, language and communication is the most common type of need, followed by social, emotional and mental health needs and moderate learning difficulty.[122]

Risk factors and drivers influencing the SEND population

Low birth weight increases the risk of childhood mortality, developmental problems for the child and is associated with poorer health in later life. Nationally there is a higher rate of low birthweight babies in areas of greater deprivation. A high proportion of low birthweight births could indicate maternal lifestyle factors and/or issues with maternity services.[123] In 2020, 8.2% of live births on the Isle of Wight were low birth weight (under 2.5kg). 1.1% were born with a very low birth weight (under 1.5kg).[124] Further information on low birth weight and variation across the Island can be found in the JSNA Vital Statistics report.[125]

Multiple pregnancies, largely related to in vitro fertilisation (IVF) treatments, are associated with a higher risk of disability in children, including cerebral palsy.[126] In 2020 the multiple birth rate was 14.4 births per 1,000 maternities across England as a whole. This is slightly lower on the Isle of Wight, at 13.0 per 1,000 maternities (13 maternities in total).[127]

Prematurity is an important predictor of SEND. Premature babies are more likely to have problems that affect their hearing, vision, movement, learning and behaviour. Children and teenagers who were born prematurely are more likely to have emotional and attention difficulties. Children born before 28 weeks have a higher risk of attention deficit hyperactivity disorder (ADHD) or Autistic Spectrum Disorder (ASD).[128] On the Isle of Wight, 1.6% of live births in 2020 were extremely or very premature, defined as born at less than 32 weeks gestation.[129] This is slightly higher than the national figure of 1.1% of all live births in 2020.[130] Although this is a small proportion of all live births, the number of very or extremely premature babies being born remains constant which therefore has implications for future SEND trends. Further information on preterm births and the variation across the Island can be found in the JSNA Vital Statistics report.[131]

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. Smoking status at time of delivery trends show that the percentage of mothers smoking is decreasing, most recent data

for 2020/21 report 13.5% of mothers on the Isle of Wight were known to be smoking at the time of delivery (131 mothers).[132] This is significantly higher than the national rate of 9.6%. National inequalities data show that those mothers living in the 20% most deprived areas have a significantly higher proportion of mothers smoking when compared to the national average.

Foetal Alcohol Spectrum Disorder (FASD) is the umbrella term for the range of preventable alcohol-related birth defects, which are a direct result of prenatal alcohol exposure, and it is used for those who are diagnosed with some, but not all, of the symptoms of FASD. According to the British Medical Association, FASD is in fact the most common, non-genetic cause of learning disability in the UK, although it is often misdiagnosed as ASD or ADHD.[133]

International research proposes that between 2% and 5% of the population may be affected by FASD (May 2018). The most recent research in the UK highlights that for planning and commissioning purposes we need to be considering a prevalence rate of 3% to 4%.[134] Applying these recent national prevalence estimates suggests an estimate of 4,270 to 5,690 people on the Isle of Wight affected by the disorder.[135]
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Substance misuse in pregnancy is a key public health issue not only because of the associated negative impacts on foetal outcomes, including low birth weight and/or premature birth and infant outcomes, but because these harms also are preventable. Data are not available locally but treatment data for England (2019/20) reports that of pregnant women presenting to treatment for the first time 3% (360 women) are parents and living with children, 4% (425 women) are parents but not living with children, and 2% (273 women) are not already parents.[136]

The risk of domestic violence increases if a woman is pregnant.[137] Domestic violence during pregnancy puts a pregnant woman and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, low birth weight, foetal injury and foetal death.[138]

National review of domestic abuse community-based services[139] found that

- 60% of service users in community-based services had children and 5.9% were pregnant. On average there were 1.2 children per service user.
- 59.7% of women in refuge services had children and 7.3% were pregnant. On average, there were 1.1 children per service user.

In addition there are new concerns of the impact of the pandemic on domestic abuse incidents, this is explored further in the Isle of Wight COVID-19 Health Impact Assessment.[140]

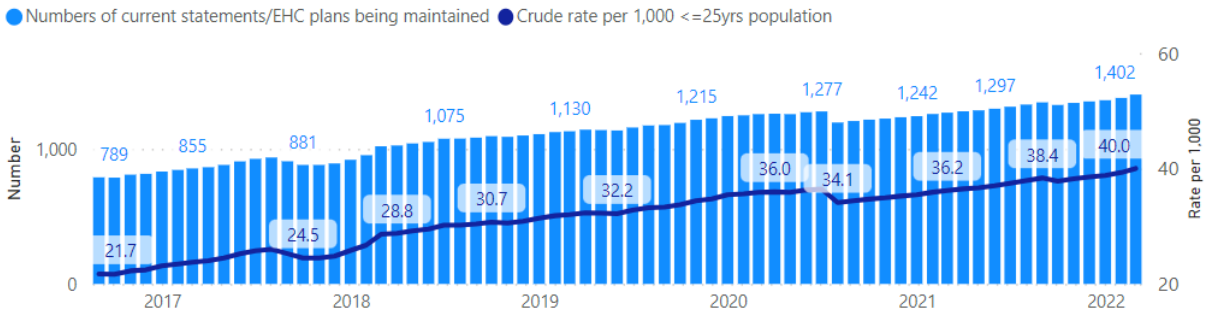
Mothers who are overweight or obese have increased risk of complications during pregnancy and birth including diabetes, thromboembolism, miscarriage and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.[141]

Obesity in early pregnancy data from 2018/19 suggest that nearly one in four mothers (24.0%) on the Isle of Wight are obese, this is comparable to England.[142]

Prevalence

Similar to the national trend, the number of children and young people with a current statement or EHC plan maintained by the Isle of Wight Council is increasing year on year. Figure 19 shows this increase. As at March 2022, data supplied by Children's Services indicated there were just over 1,400 children with a statement or EHC plan, this equates to a crude rate of 40 children per 1,000 aged 0 to 25 years per population.

Figure 19: Number and crude rate of current statements/EHC plans, March 2017 to March 2022

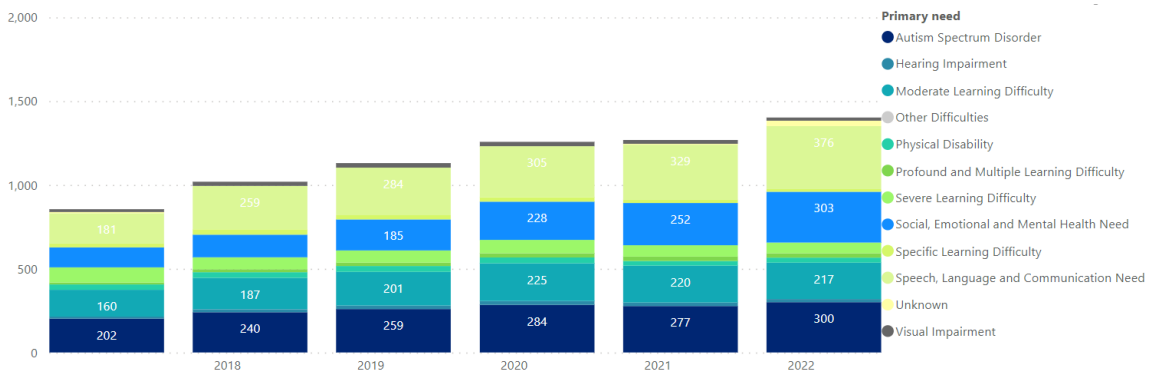


Source: Isle of Wight Council Children's Services

When a child has a review for an EHC plan, a number of needs may be identified which then form the basis of the child's ongoing care. However, the data reporting system can only record one of these needs as the primary need and therefore caution must be taken when interpreting the following results as there is currently no process which prioritises what is recorded in the system.

Exploring local SEN data suggests that speech, language and communication needs, autism spectrum disorder, social, emotional and mental health moderate learning difficulty, as well as severe and moderate learning difficulties have been the most common need types over the six years.

Figure 20: Number of current statements/EHC plans by need type



Source: Isle of Wight Council Children's Services

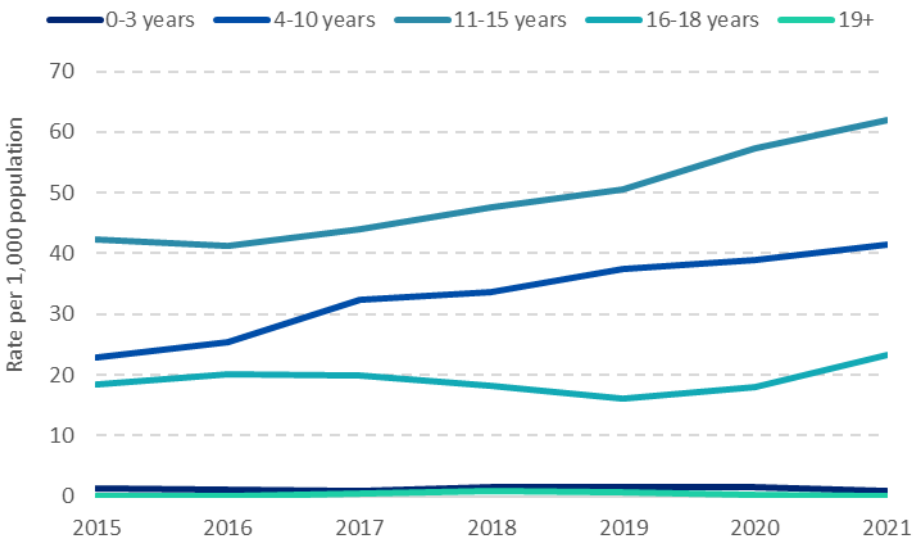
Pupil Characteristics

Gender: Around three quarters of statements or EHC plans on the Isle of Wight are for boys, and trend data suggest this is consistent over the years. The number of plans or statements for boys is increasing at a greater rate than girls, 60.5% increase for boys from 2015/16 to 2021/22 compared to a 48.0% increase for girls over the same time period.

Ethnic Group: The majority of children and young people with a statement or EHC plan are of White ethnic group (95%). This is reflective of the general population of the Isle of Wight with 97% of the population in the White ethnic group. The number of children with a statement or EHC plan is very small when split by ethnic group making it difficult to make robust conclusions about recent trends.

Age: The number and rate per 1,000 population of children with a current statement or EHC plan increases with age, peaking at 11 to 15 years. In 2014 the SEN statutory guidance increased the age to 25 years and may explain why the older age group have a seemingly lower number of SEN children.[143]

Figure 21: Crude rate per 1,000 population of current statements/ EHC plans – Isle of Wight



Source: Special educational needs in England | GOV.UK[144]

SEND and Free School Meals (FSM)

All children in Key Stage 1 are entitled to free school meals. The following analysis excludes children who receive free school meals under the Universal Infant FSM policy.

Children in state-funded schools in England are entitled to receive free school meals if a parent or carer are in receipt of any of the following benefits:

- Income Support
- Income-based Jobseekers Allowance
- Income-related Employment and Support Allowance
- Support under Part VI of the Immigration and Asylum Act 1999
- The guaranteed element of State Pension Credit
- Child Tax Credit (provided they were not also entitled to Working Tax Credit and had an annual gross income of no more than £16,190, as assessed by His Majesty's Revenue and Customs).
- Working Tax Credit run-on – paid for 4 weeks after you stop qualifying for Working Tax Credit
- Universal Credit - if you apply on or after 1 April 2018 your household income must be less than £7,400 a year (after tax and not including any benefits)

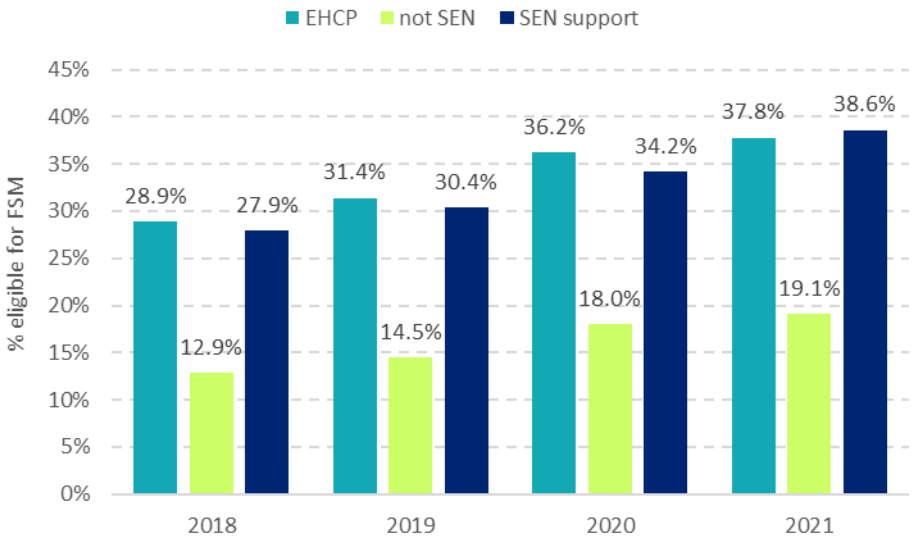
Children in nursery schools are eligible if they meet the criteria and attend for full days. Pupils are still eligible for free school meals in school in sixth form, but not sixth form college or further education.

Figure 22 suggests that on the Isle of Wight a higher proportion of pupils who have an Education, Health and Care Plan (EHCP) or receive SEN support are eligible for free school meals when compared to non-SEN pupils.

In 2021, nearly 40% of pupils with either SEN support or an EHCP were eligible for free school meals (37.8% and 38.6% respectively). This is a significantly higher proportion than non-SEN pupils (19.1%).

Overall, the number of pupils eligible for free school meals has increased in all SEN status groups across the year. This is a reflection of the national trend. The percentage of all pupils across England eligible for free school meals has increased sharply since the introduction of transitional protections which will continue to be in place during the roll out of Universal Credit. This has meant that pupils eligible for free school meals on or after 1 April 2018 retain their free school meals eligibility even if their circumstances change.

Figure 22: Isle of Wight pupils eligible for Free School Meals by SEN Status



Source: Special educational needs in England | GOV.UK[145]

Outcomes for SEND population

Health needs: The prevalence of children and young people with healthcare need is increasing. Demographic factors alongside the increasing rate of survival of children with once life-threatening conditions has led to rising numbers, as well as increasing complexity of need. Children with sensory impairments will continue to require appropriate support to enable them to achieve their academic potential. Indications are that more children with a severe disability are living longer due to advances in medical technology. Optimising the management of their conditions and improving their health outcomes will positively impact on their life chances (educational attainment, living independently, and employment opportunities).

Exploring the primary need data of children with a current statement or EHCP resident on the Isle of Wight:

- 0.6% (six) children had a visual impairment
- 1.0% (ten) had a hearing impairment

- 24.6% (238) had a speech, language and communication need

The number of children with speech, language and communication needs has increased over time, from 177 in 2017 to 238 in 2022.[146]

Overall, the number of 0 to 15 year olds in receipt of Disability Living Allowance (DLA) on the Isle of Wight in February 2022, was 1,609. Over 70% of these had learning difficulties recorded as the main disabling condition. Behavioural disorders, musculoskeletal, diabetes, hyperkinetic disorders and neurological diseases account for some of the other most disabling conditions among children and young people on the Isle of Wight but how many of these children also have a SEN is not clear.
In 2013 Personal Independence Payment (PIP) replaced DLA for adults aged 16-64. DLA continued as a separate benefit for children aged under 16 years. The latest data reporting Child DLA to PIP reassessment shows two thirds of the disability benefit awards were maintained. [147] It is not possible to identify learning disabilities in the PIP data as this is not a recorded disability.

Currently there is no single data source that provides detailed information on the health needs of children, and for some health conditions that impact on educational needs, there are little or no data.

Child development: From 2015, all children became eligible for a Healthy Child Programme development review, delivered as part of the universal health visitor service, around their second birthday. The Ages and Stages Questionnaire (ASQ-3TM) is used to measure child development outcomes.

Data is submitted voluntarily by local authorities, and national experimental statistics have been produced which explore the inequalities in child development at age 2 to 2.5 years. Due to the experimental status of this data, it should be interpreted with caution.

Results show that children with a known disability when compared to those without a known disability are statistically less likely to be at the expected level of development in all the skill domains. This inequality is wider in communication and personal and social skills. Overall, just over half of children (58%) with a disability are at the expected level of development compared to 89% of those without a known disability.

Figure 23: Proportion of children at or above expected skill level at 2 to 2.5 years

Skill domain	Children with known disability	Without known disability
Communication skills	65.5%	92.7%
Gross motor skills	83.8%	96.7%
Fine motor skills	86.7%	97.5%
Problem solving skills	79.9%	96.9%
Personal and social skills	77.9%	96.3%
All	57.9%	88.8%

Source: Special educational needs and disability: an analysis and summary of data sources | DfE[148]

GCSE attainment: The early years development outcomes data show how development and progression for children with a disability is challenging from an early age. Educational outcomes are measured by GCSE attainment and children with high special educational needs may not be entered into these exams.

Over the last three years just over half (54%) of children on the Isle of Wight with a SEN statement or EHCP have been entered into English or Maths GCSEs; this is significantly lower than the 97% of pupils with SEN support and the 99% of pupils with no SEN. However, this is better than the position for England as a whole, where 50% of children with an SEN Statement or EHCP have been entered into the GCSE subjects.[149]

In 2020/21, just over one in seven (13.4%) of SEN pupils entered into GCSEs gained a grade 4 or above in English and Maths on the Isle of Wight. This is slightly worse than England where one in six (15.8%) achieved a grade 4 or above.[150]

In 2021, on the Isle of Wight 13.7% of 19 year olds with a statement or EHCP qualified to level two (including English and Maths) and 11.8% qualified to level 3.[151,152]

The data suggests that children with SEN are more likely to have lower educational attainment. However, for some SEND young people this is expected given their levels of learning difficulties and health needs. This is therefore not a good measure of outcomes for many SEND children and young people. Data reporting skills of independent living is not available but is essential to understand the long-term quality of life for this population and the challenges they may face in later life.

Further education, employment and training: On the Isle of Wight, almost nine out of ten young people with a statement or EHCP remain in education, employment or training. This is encouraging, and this proportion has been higher than, or similar to the national average since 2016. Latest data for the Isle of Wight[153] shows:

- 89.0% of Key Stage 4 SEN cohort are in education, employment or training at 17 years (including special schools). The trend has decreased slightly over the last year but is comparable to England (89.2%).
- 92.1% of 16 to 17 year olds with SEN are in education and training. This has declined over the past year but remains higher than the national average of 89.2%.

Inclusion Health Groups

Inclusion Health Groups is a ‘catch-all’ term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in accessing healthcare. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence

issues. These factors lead to extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities.[154,155]

Evidence shows that people who are socially excluded underuse some services, such as primary and preventative care, and often rely on emergency services such as A&E when their health needs become acute. This results in missed opportunities for preventive interventions, serious illness and inefficiencies, and further exacerbates existing health inequalities.

There is evidence that the COVID-19 pandemic has disproportionately impacted inclusion health groups. There were high rates of COVID-19 infection and mortality among vulnerable migrants in high-income countries and prison populations in England and Wales. Measures introduced early in 2020 in England to protect people experiencing homelessness from COVID-19 infection, such as the use of hotel accommodation, are estimated to have prevented hundreds of deaths among homeless people.[156]

These population groups are discussed in more detail in the JSNA Inclusion Health groups chapter.[157]

Older adults

Older people have higher rates of multimorbidity and health conditions, in addition are also more likely to suffer from conditions which are associated with ageing. This section looks at frailty, reduced mobility, urinary incontinence, sensory impairment, falls and dementia. Much of the data used in this section applies national survey proportions to local population data to estimate the numbers of people experiencing these conditions as no reliable local data exists. Development of these conditions can be interlinked and therefore older people may experience a number of these conditions simultaneously. As a result, the separate counts should not be combined together. Many of these conditions can be mitigated through healthy lifestyle factors such as good diet and physical activity.

During the pandemic, many older people may have been shielding and unable to get out and about, or simply have reduced activities during periods of social distancing restrictions. This may have resulted in deconditioning. Deconditioning is the syndrome of ‘physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength’.[158] Although deconditioning can occur in all age groups, in older adults it can occur more rapidly and be more severe. Many of the conditions in the section below may have increased in prevalence over the course of the pandemic, however, more recent survey data is not available. It is also challenging to attribute deconditioning and associated conditions to the pandemic specifically.

Frailty

Frailty describes someone's overall resilience and ability to recover quickly from health problems. It mainly occurs in older patients and is linked to the ageing process, however frailty can occur in younger adults who experience multiple health conditions and there is emerging evidence that frailty risk increases in people who are obese, particularly where there are other unhealthy behaviours such as inactivity, poor diet and smoking.[159] This section of the report refers to frailty in older adults.

Older adults with frailty are characterised by having reduced muscle strength and mass, fatigue, arthritis, poor eyesight or hearing, and reduced mobility. Older people with frailty are also more sensitive to medicines due to changes in the way in which their bodies process them, making older people more susceptible to side effects. People living with frailty are at greater risk of disability and admission to hospital or care homes.[160]

In England, the NHS measures frailty using the electronic Frailty Index (eFI). This index includes 36 factors such as heart conditions, respiratory conditions, kidney disease, diabetes, arthritis and osteoporosis, weight loss, urinary incontinence, hearing and vision problems, mobility problems, polypharmacy, falls, foot problems, and social vulnerability.[161]

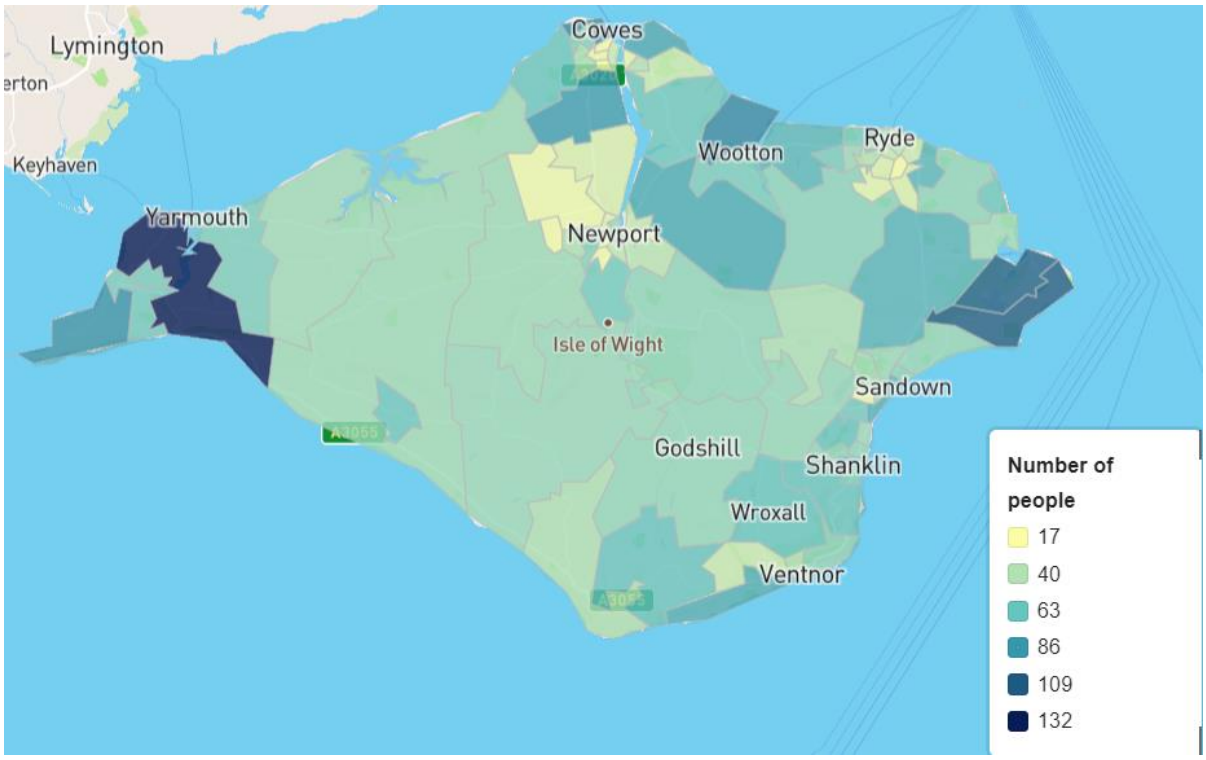
National figures for people recorded as living with moderate and severe frailty are not published by the NHS, however a number of studies have estimated the proportion of people living with frailty in England. These studies use different sources of data, and the prevalence estimates vary between them.

Figure 24: Estimates of frailty prevalence

	Year	Age	Prevalence	Source
English Longitudinal Study of Ageing[162]	2020	50+	8.1%	Survey
Clegg *et al*[163]	2016	65+	15% moderate or severe	eFI
Seymour[164]	2018	65+	9% moderate or severe	eFI
Fogg *et al*[165]	2022	65+	12% moderate or severe	eFI

Applying the proportions of people experiencing frailty observed by Fogg *et al*., to the population of the Island suggests that there are around 4,594 people on the Isle of Wight with moderate or severe frailty. There are small areas across the Island where residents with frailty are concentrated, with particularly high numbers around Freshwater Yar to the west and Bembridge to the east.

Figure 25: Estimated people with severe or moderate frailty on the Isle of Wight, 65+



Source: Fogg et al (2022) | BMC Geriatrics applied to ONS population estimates[166]

Aside from increasing age, a number of risk factors have also been linked to developing frailty through the English Longitudinal Study of Ageing. These included: obesity, deprivation, being female, poor lower body strength, smoking, higher levels of pain (e.g. from pre-existing conditions such as arthritis), loneliness and sedentary lifestyle.[167]

Due to the unclear definitions of frailty and the challenges in recruiting and retaining participants for studies into older people there is a limited amount of research available for interventions to slow or reduce frailty. Some systemic reviews have been conducted of international research and relating to the more limited frailty definition of sarcopenia. [168,169] These studies suggested that physical activity and nutrition interventions can play a role in reducing frailty. Those interventions which were supervised (including virtual or phone supervision) and included both resistance and balance training were the most successful interventions, and there was some evidence to suggest that deterioration had been reduced for up to 12 months after intervention.[170]

Reduced mobility

Closely linked to frailty is reduced mobility. Many older people suffer from reduced mobility, meaning that they are unable to walk as far or for as long, or complete household chores. This could be due to a number of factors including health conditions such as heart disease or stroke, or chronic pain caused by conditions such as arthritis. It may also be impacted by more psychological factors such as the fear of falling and a loss of confidence.

The Living in Britain Survey 2001 measured reduced mobility through the numbers of people aged 65 and over unable to manage at least one activity on their own: going out of doors and walking down the road, getting up and down stairs, getting around the house on the level, getting to the toilet, and getting in and out of bed. This demonstrated that reduced mobility increased with age, and that women had greater levels of reduced mobility than men. Unfortunately, no more recent data is available and there may have been a change in behaviours since the social distancing restrictions of the pandemic.

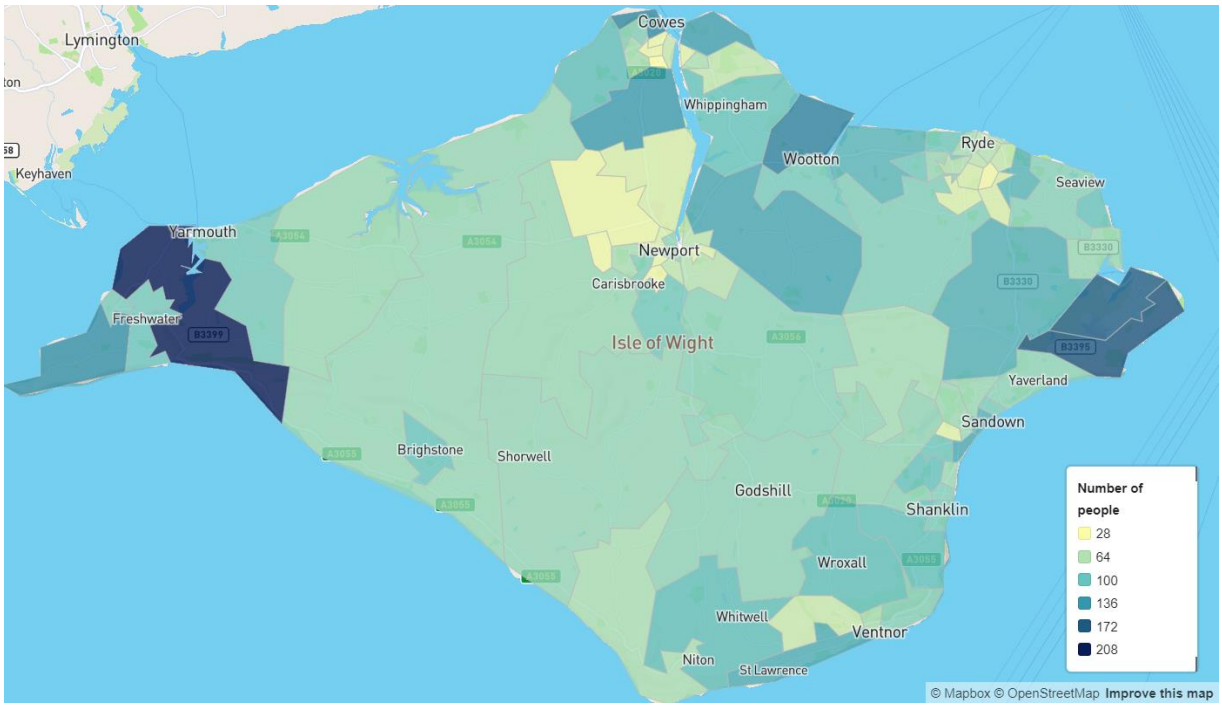
Figure 26: Proportion of those aged 65+ with reduced mobility

Age band	Men	Women
65-69	8%	9%
70-74	10%	16%
75-79	12%	21%
80-84	18%	29%
85+	35%	50%

Source: Living in Britain Survey, 2001

Applying these proportions to the population on the Isle of Wight suggest that there are a little over 7,400 older people with reduced mobility resident on the Island.

Figure 27: Estimated people with reduced mobility on the Isle of Wight, 65+



Source: Living in Britain, 2001, applied to ONS population estimates

Incontinence

This section focuses on urinary incontinence (UI) rather than faecal incontinence (FI) as there is a higher prevalence of UI, and FI appears to be more clearly linked to medical conditions (e.g. bowel cancer or medications) or loss of capacity with dementia. Both UI and FI are linked to people needing increased levels of social care including more domiciliary care and entry into care homes.

A widely accepted definition of UI is: *'involuntary loss of urine in sufficient amount or frequency to constitute a social and /or health problem'.* However, this definition is subjective there are a number of different types of UI (stress, urge, mixed, functional and overflow). There is still a significant knowledge gap around incontinence, however this condition could have the third most serious impact on quality of life after stroke and dementia. Research also suggests that UI is a predicting factor for moving into a care home and some psychological conditions such as social isolation.[171]

Prevalence can be difficult to measure for a number of reasons. For example, a lack of reporting due to embarrassment or because people believe it to be a normal part of ageing and therefore it cannot be cured or reduced. These factors have led to large underreporting, especially in medical records, and therefore much of the data about prevalence is from survey data.

The Health Survey for England[172], which is conducted annually to estimate the proportions of the population with particular conditions, includes questions about both urinary and faecal incontinence. This study only asked respondents aged 65 and over about incontinence.

Figure 28: Urinary incontinence prevalence estimates

Age group	Men	Women	Total
65-69	14%	21%	17%
70-74	20%	26%	23%
75-79	27%	32%	30%
80-84	23%	30%	27%
85-89	29%	37%	34%
90+	48%	51%	50%
All ages	**21%**	**28%**	**25%**

Source: Health Survey for England 2016 | NHS Digital[173], weighted results

Applying these proportions to populations on the Isle of Wight suggests that nearly 10,500 people over the aged of 65 experience UI. As with frailty there are also pockets across the Island where the proportion of the population is older and we would expect numbers of people experiencing UI is estimated to be higher, again concentrated in Freshwater Yar and Bembridge.

Figure 29: Estimated people experiencing UI on the Isle of Wight, 65+

Source: Health Survey for England 2016 | NHS Digital[174], applied to ONS population estimates

The proportion of people who seek help for UI is very low, for example, of those surveyed in GP waiting rooms only 47% of those with severe or moderate incontinence report this to a doctor, which could be even lower for those who aren't attending the doctor for other health reasons.[175] This is consistent with other estimates from a postal survey in the UK which reported that 40% of men and 45% of women contacted health services about UI.[176]

There are a number of factors which increase the risk of urinary incontinence including obesity, diabetes and smoking, and preventing these risk factors from developing would also reduce the prevalence of UI.[177] The NHS recommends a number of these factors to prevent UI, including: controlling weight by eating healthily and taking regular exercise, avoiding or cutting down on alcohol and caffeine, stopping smoking, and keeping fit (in particular carrying out pelvic floor muscle exercises).

Sensory Impairment - Hearing

Age-related hearing loss is the gradual loss of hearing in both ears and is common in older people. Estimates suggest that around 71% of people aged 70 and over have hearing loss.[178] Hearing loss is associated with an increase in other chronic health conditions such as diabetes, stroke, sight loss and falls.[179] There is also evidence that hearing loss is associated with dementia and an increased rate of cognitive decline. Additionally, it can also lead to social isolation and impact on mental health.

As age-related hearing loss is a gradual decline in hearing this is another condition which is not always reported or recorded in medical records. Data used in the NHS hearing loss data tool was first published in 1995 and shows the increase in hearing loss in older age groups.[180]

Figure 30: Estimated proportions experiencing hearing loss

Age band	Some hearing loss, >25dBHL	Severe hearing loss, >65dBHL
18-30	1.8%	0.0%
31-40	2.8%	0.7%
41-50	8.2%	0.3%
51-60	18.9%	0.9%
61-70	36.8%	2.3%
71-80	60.3%	4.0%
80 +	93.4%	22.3%

Source: Davis 1995

When applied to the population of the Isle of Wight this suggests that around 3,700 people experience severe hearing loss whilst over 29,660 people aged over 65 experience some hearing loss. Again, those areas with higher proportions of older people in the population are those areas with higher prevalence.

Figure 31: Estimated people experiencing severe hearing loss on the Isle of Wight, 65+

Source: Davis 1995 applied to ONS population estimates

Sensory Impairment – Sight

Sight impairment is another condition which increases with age. There are a number of main causes of sight loss including: age related macular degeneration, cataracts, glaucoma and diabetic complications. Diabetic sight loss is the one of the most

common causes of avoidable sight loss and other risk factors for sight loss including smoking, learning disabilities and stroke. Overall, it is estimated that around 50% of sight loss is preventable or avoidable.[181] Someone with sight loss is at greater risk of experiencing falls, reduced mobility, social isolation, dementia and depression.

Very slight differences have been noted between men and women, with women showing slightly increased risk of sight impairment in all age groups.[182] Studies have reported that people from Asian ethnic groups have a higher risk of cataracts, people from Black ethnic groups have greater risk of glaucoma, whilst both of these ethnic groups have greater risk of diabetic sight loss.[183]

Moderate or severe sight loss for those aged between 65 and 74 has been estimated as 5.6%, whilst for those aged 75 and over it is 12.4%.[184] Applying these proportions to the Isle of Wight population suggests that over 3,500 people are experiencing sight loss, with an increase in prevalence in those areas with a higher proportion of older people.

Figure 32: Estimated people experiencing moderate or severe sight loss on the Isle of Wight, 65+

Source: RNIB, 2006, applied to ONS population estimates

Dementia

Dementia is a collection of symptoms which include memory loss, mood changes, and problems with reasoning, perception and communication. It is not an inevitable part of growing old and is caused by diseases of the brain, most commonly Alzheimer's but also vascular dementia, mixed dementia (both Alzheimer's and vascular), Lewy body dementia, and a number of rarer conditions.

There are a number of risk factors for developing dementia:

- Age: as age increases so does the risk of developing dementia
- Sex: Women are more likely to develop dementia than men, in part because of longer life expectancy but there are also possible links between hormone changes during the menopause and the development of dementia
- Ethnicity: Some research has suggested that people from Black African, Black Caribbean and South Asian ethnic groups are more likely to develop dementia than those from white ethnic groups
- Cognitive reserve: if someone has left education early, had employment with less complexity and experienced social isolation they are less likely to have a cognitive reserve from keeping their brain active and are more likely to develop dementia
- Health conditions: certain conditions such as cardiovascular disease, high blood pressure, obesity and Type 2 diabetes are linked to increased rates of dementia
- Lifestyle factors: including not smoking, maintaining a healthy diet including only moderate alcohol consumption, regular exercise, mental and social activity are protective factors against developing dementia
- Physical environment: research suggests living in areas of greater deprivation, with lower access to services and employment increase the risk of dementia. Higher level of air pollution has also been linked to increased rates of dementia.[185]

As outlined above the risk of dementia increases with age, and a higher rate is shown in women, increasing to almost half of women aged 95 and above.

Figure 33: National prevalence of dementia, 65+

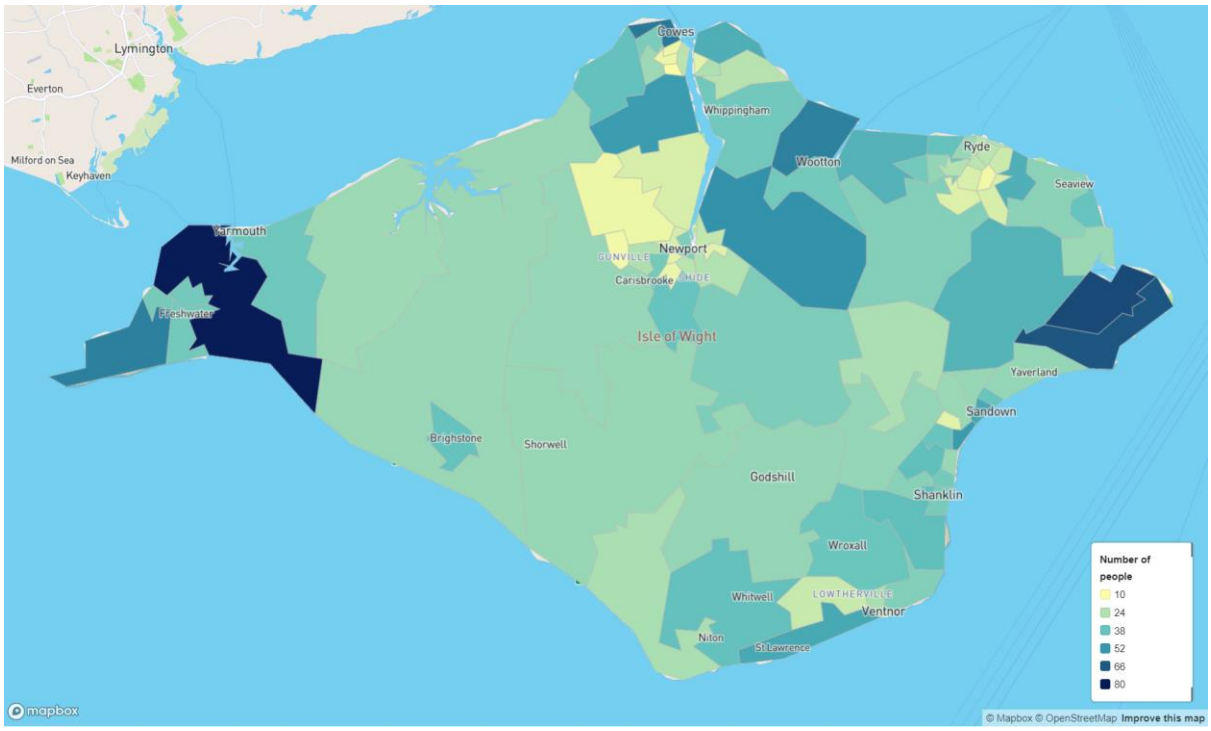
Age band	Men	Women
65-69	1.5%	1.8%
70-74	3.1%	3.0%
75-79	5.3%	6.6%
80-84	10.3%	11.7%
85-89	15.1%	20.2%
90-94	22.6%	33.0%
95+	28.8%	44.2%

Source: Dementia UK Update, 2014 | Alzheimer's Society[186]

A diagnosis of dementia is important for dementia patients and their families. An early diagnosis may mean that the progress of dementia can be slowed in some cases and also allows people to get the right support and plan for the future. However, not all cases of dementia are diagnosed. On the Isle of Wight there were 1,649 cases of dementia recorded in 2020, however, when applying the survey

figures to local population estimates the number of cases of dementia on the Island is estimated to be much higher at around 2,814.[187]

Figure 34: Estimated number of people with dementia, 65+



Source: Dementia UK 2014, applied to ONS population estimates[188]

An estimated diagnosis rate for dementia is calculated by OHID which suggests that nationally 62.0% of dementia cases were diagnosed in 2021, down from 67.4% in 2020.[189] A decrease was also reported on the Isle of Wight (57.7% down from 60.6%).[190] This is likely to be due to the impact of the pandemic and challenges facing patients accessing care. People living in areas with higher deprivation have lower rates of dementia diagnosis compared with areas of lower deprivation, however this difference is not significant.

Rates of emergency hospitalisation have remained stable in England between 2016 and 2019, whilst on the Isle of Wight there has been a slight decrease (from 2,401 to 2,138 per 100,000 people). Hospitalisation rates for dementia on the Island remained significantly lower than those recorded for England.[191] The rate of mortality for people with dementia has also remained stable both nationally and on the Isle of Wight between 2016 and 2019.[192]

Falls

People are at increased risk of falling as they get older, and at increased risk of these falls causing more serious injury, including bone fracture. Falls are one of the most common reasons for hospital stays in older adults and falls and fear of falling can result in loss of confidence and activity in older people. There are many risk factors for falling including medical conditions (e.g. Parkinson's), the effect of

medicines or combinations of medicines, physiological changes (such as poor eyesight and the loss of muscle strength), environmental hazards (rugs, slippery surfaces, poor fitting shoes and low light levels) and lifestyle (for example physical inactivity or alcohol).[193]

However, falls can be prevented and NICE guidelines set out a number of actions that can be taken to reduce the risk of falling.[194] These include physical activity and strength and balance exercises, assessing hazards at home, eyesight testing and medication review. In addition, maintaining a healthy diet, reducing alcohol and keeping hydrated can also assist in reducing falls and improving outcomes if a fall happens.[195]

Falls are not well reported or recorded in medical records and therefore estimated numbers of people experiencing one or more falls in the previous 12 months has been calculated using data from the Health Survey for England.[196] This demonstrates that risk of falling increases with age and that women have a higher risk of experiencing a fall than men.

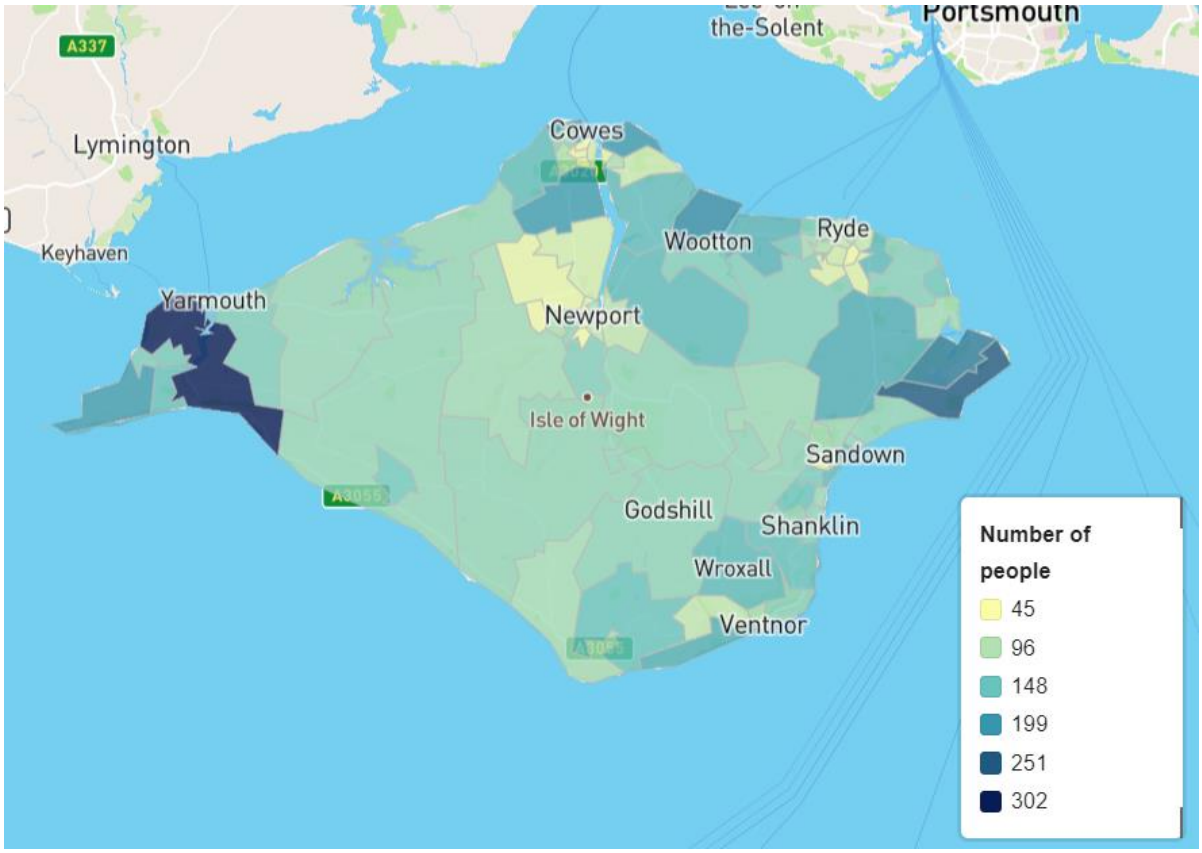
Figure 35: People experiencing one or more falls in the previous 12 months, 65+

Age band	Men	Women
65-69	18%	23%
70-74	20%	27%
75-79	19%	27%
80-84	31%	34%
85+	43%	43%

Source: Health Survey for England, 2005 | NHS Digital[197]

Across the Isle of Wight, the number of people experiencing a fall in the previous 12 months is estimated to be just over 10,800. Those areas with a higher proportion of older people have higher numbers experiencing falls.

Figure 36: People who experienced a fall in previous 12 months, 65+



Source: Health Survey for England, 2005, applied to ONS population estimates

In 2020/21, the rate of emergency hospitalisations after falls in England for those aged 65 and over was 2,023 per 100,000. This rate increases to 5,174 for those aged 80 and over. On the Isle of Wight, the rates are statistically significantly lower at 1,319 and 3,288 respectively.[198,199] Nationally and locally, women show a higher rate of admissions than men. This difference between men and women is significant at England and the Isle of Wight level.[200] Nationally, areas of higher deprivation have higher rates of admissions for falls, however this may be related to the locations of care homes and therefore a higher population of the most vulnerable older people. It is not possible to examine patterns by deprivation on the Isle of Wight due to the relatively small number of admissions involved.[201]

The rate of hip fractures has been declining in England and on the Isle of Wight since 2013/14 and rates on the Isle of Wight are lower than those recorded nationally but not statistically significantly so (for those aged 80 and over the rates are 1,426 for England and 1,248 for the Isle of Wight in 2020/21). Women also have significantly higher rates than men on the Isle of Wight and England. There is no clear link between deprivation and hip fracture rates.[202]

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