


COVID-19: Lewisham system recovery plan

Lewisham

NHS

working together

Lewisham Health and Care Partnership

DRAFT

as at 7th September 2020



Contents

1. INTRODUCTION AND CONTEXT

1. Executive Summary

Following the initial emergency response to the COVID pandemic, all health and care systems are developing borough-level COVID 'recovery' plans as part of wider system and Council plans for recovery. This Lewisham health and care system plan forms the Health and Wellbeing workstream of Lewisham Council's recovery plan. It also forms part of the South East London CCG's COVID recovery plan, which will incorporate plans covering health and care in Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley.

This document sets out our plans for the next 18 months. It includes how we will:

- **protect local people** and the key workers that support them by mitigating and managing any further waves of COVID-19, learning from our experiences since March of this year.
- **re-start key services and manage existing and new need for support** arising from the lock down period.
- **work with local communities to "build back better"** and ensure everyone in Lewisham can live safely and well.

The impact of COVID-19 on Lewisham has left scars which must be acknowledged and healed. We are proud of the diversity of our borough but we know that COVID-19 has disproportionately harmed those from Black, Asian and Minority Ethnic (BAME) communities, older people, those living in the most deprived areas of the borough and in care homes. It has highlighted existing inequalities and too often made these worse.

There have been 1340 confirmed cases of COVID-19 in Lewisham residents (to 31 August) and 293 deaths associated with COVID-19 in Lewisham (to 14 August). As well as the tragic toll of the disease, the lockdown has affected both mental health and wider determinants of health and wellbeing, including access to vital services, our local economy, and the education of our children and young people. The full extent of this impact on the population of Lewisham and the inequalities that are created or exacerbated will only begin to emerge over the coming months and years.

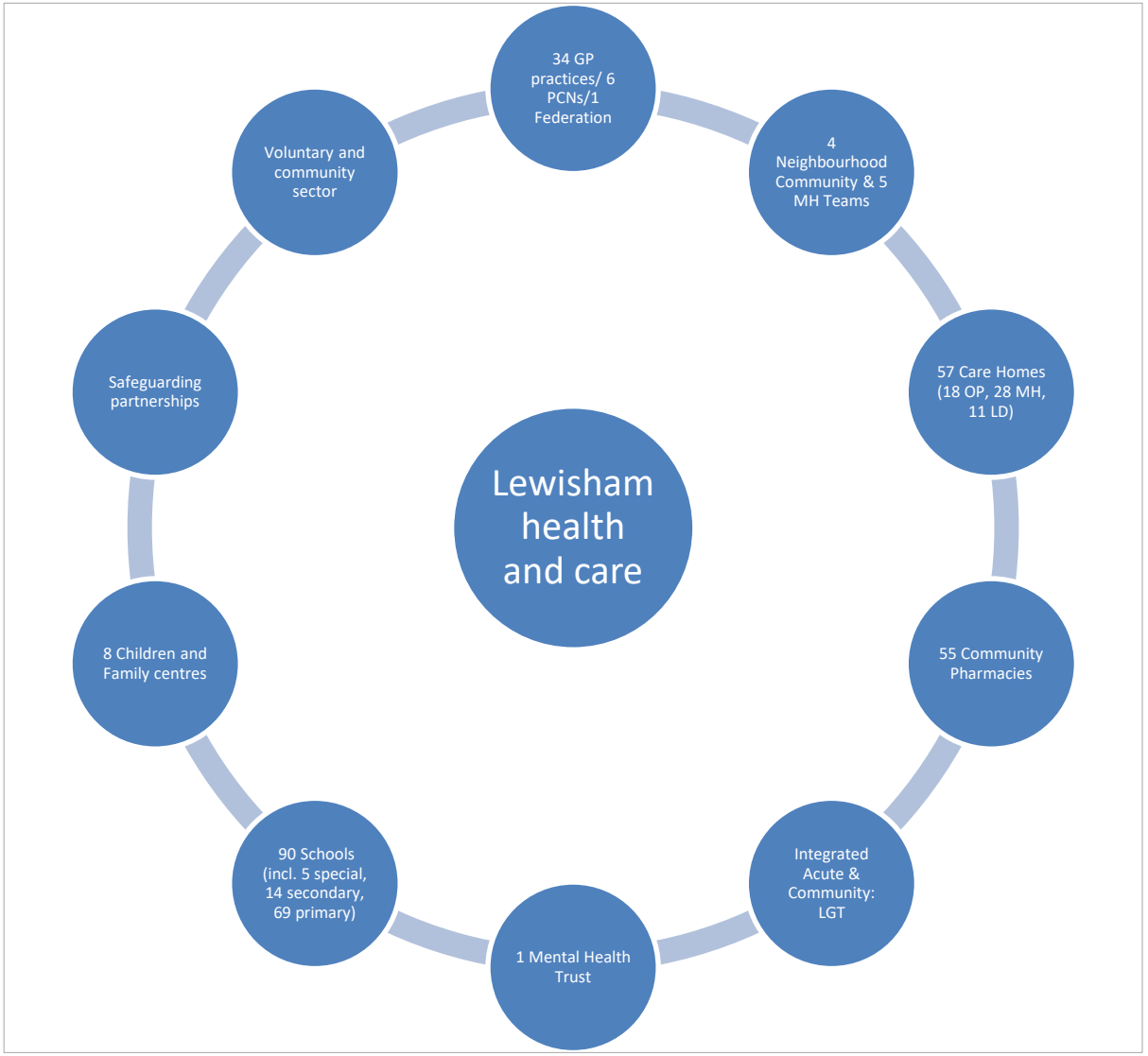
Our ambition for our recovery is to create a strong, sustainable and accessible health and care system which supports people of all ages: to maintain and improve their physical and mental wellbeing, to live independently and well, and to provide access to high quality care whenever they need it. To achieve this we need to deliver care in our communities which is proactive, joined up, cost-effective, and helps to prevent ill-health and promote wellbeing. And we need to tackle the wider causes of inequality.

1. Context – the Lewisham Health and Care System

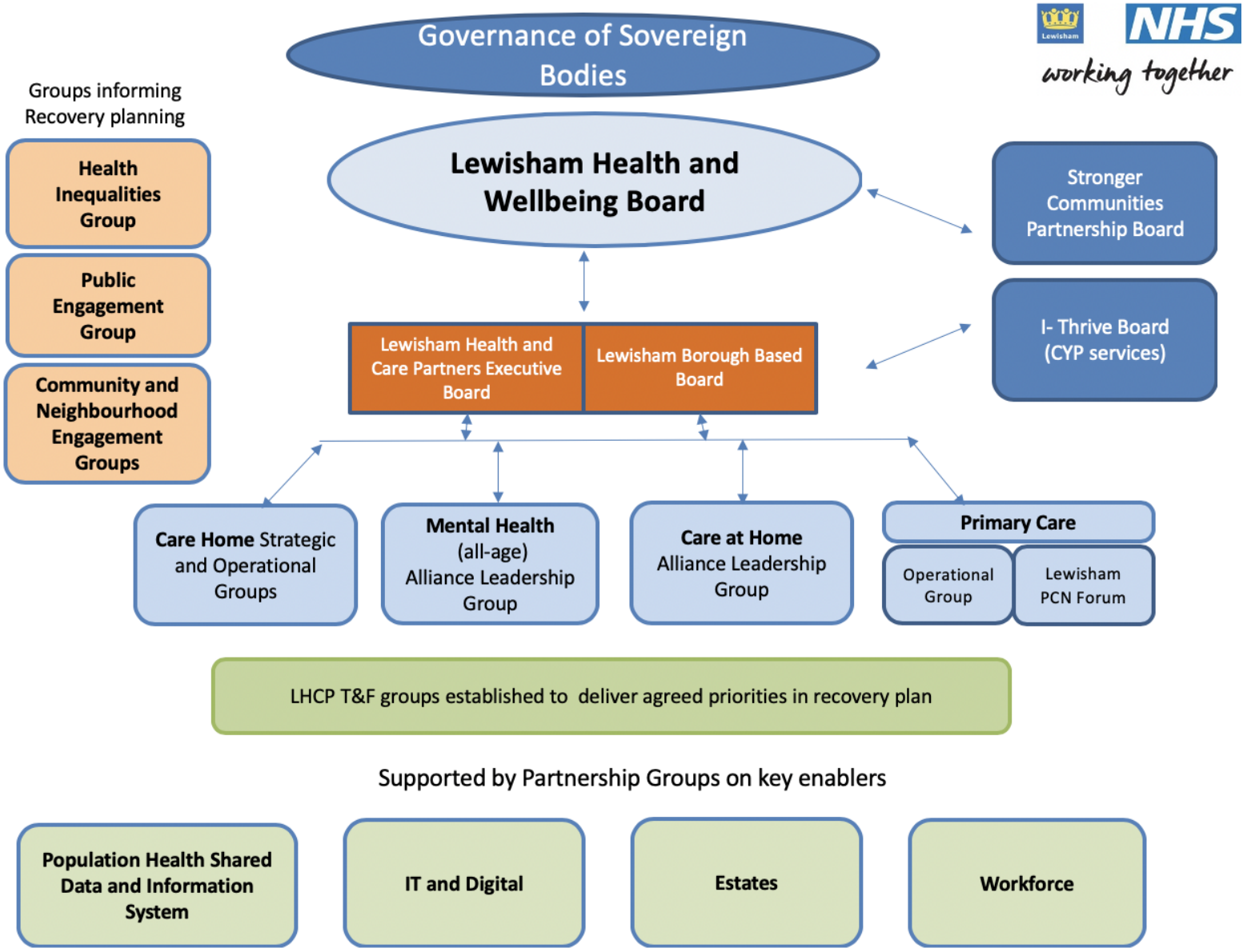
In Lewisham, health and care is delivered and supported by a range of organisations and partners across the Borough.

Lewisham has a strong history of partnership working. Our response to COVID-19 has shown the value of these relationships and of the joint working of our health and care services, with our voluntary and community sector, and with the communities we serve.

These established relationships have meant that we were able to identify activity to meet risks quickly and mobilise resources effectively, sometimes within a matter of days, minimising the impact which may have otherwise been a great deal worse.



1. Context – Lewisham Health and Care Boards



1. Context – Lewisham Health and Care Partners (LHCP)

Lewisham Health and Care Partners (LHCP) include Lewisham and Greenwich NHS Trust (LGT); London Borough of Lewisham (LBL); NHS South East London Clinical Commissioning Group (CCG); One Health Lewisham (Pan-Lewisham GP Federation); South London and Maudsley NHS Foundation Trust (SLaM); Primary Care Network Leads and Lewisham's Local Medical Committee. Discussions are taking place to secure strategic input from the voluntary and community sector given the important role of the VCSE in maintaining and improving health and wellbeing.

The Partners meet regularly at the LHCP Executive Board to provide shared system wide leadership, set the strategic direction for integration and transformation and oversee the changes required for health and care across Lewisham. Lewisham's existing joint commissioning arrangements for children and adults are governed by section 75 agreements. The Local Authority and CCG are seeking to further strengthen these commissioning arrangements as part of the place based system and governance.

Alongside Lewisham's integrated commissioning arrangements, the borough has two alliance leadership groups for Care at Home and Mental Health. The former brings together local health and care organisations to develop integrated provider arrangements to deliver care and support for adults in their own homes, improving the co-ordination, quality and accessibility of that care and support. Similarly, the Mental Health Alliance Leadership Group seeks to provide working age adults with a personalised approach to their treatment, care and support needs, based on the identification of assets and strengths, and facilitating the achievement of personal goals. The group's remit will be expanded to include Children's Mental Health and Older Adult Mental Health.

Lewisham's Health and Care Partners report into the borough's statutory Health and Wellbeing Board. Alongside a requirement to publish joint health and wellbeing strategies, the Board is also required to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing health and wellbeing.

2. POPULATION HEALTH

2. Population health: context #1 - population

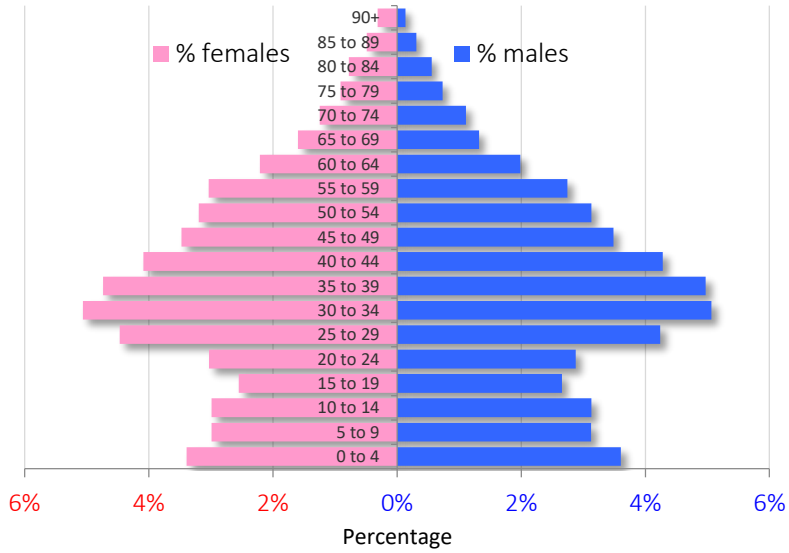
Lewisham has a population of more than **305,800 people**

Lewisham is **densely populated** and has the 6th highest rate of household overcrowding in London. Nearly 10% of households in the borough are classed as overcrowded.

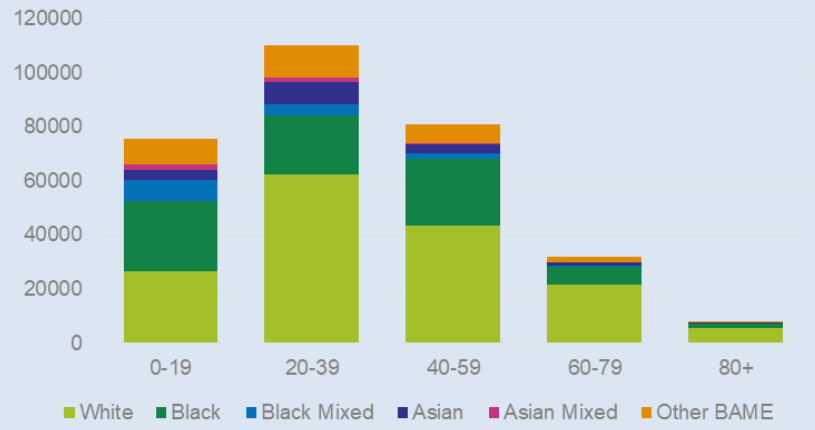
The borough has a **relatively young population** profile.
Residents aged 0-19 make up nearly 25% of the total population
About 70% of the borough's population is of working age (16-64)
Whilst older residents, aged 65+, make up about 10%

Lewisham has an **ethnically diverse population**.
46% of the total population are of BAME heritage
This differs with age. **Over 65% of Lewisham residents age 0-19 are from BAME heritage.**

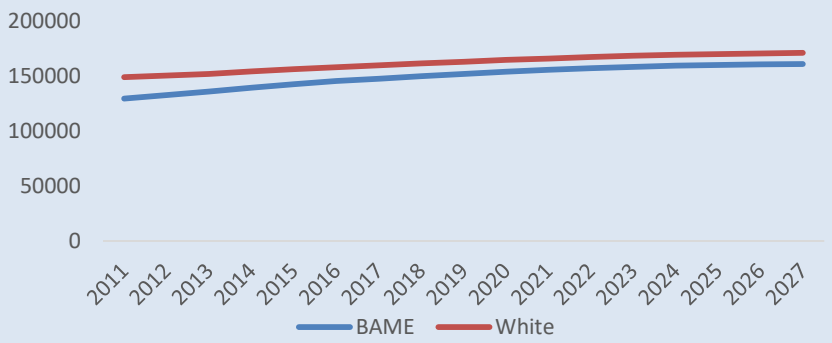
Population pyramid: annual percentage of females and males in Lewisham by 5 year age band, 2020



Lewisham ethnicity distribution by age group



Ethnicity projections for Lewisham by 2027



2. Population health: context #2 – health risks

Life Expectancy	There are big variations in life expectancy throughout the borough: men in Crofton Park ward can expect to live for 6 years longer than those in New Cross ward, and women in Perry Vale ward can be expected to live 8.5 years more than women in New Cross ward.
Cardiovascular and respiratory diseases	The rate of premature death from **cardiovascular and respiratory diseases** in Lewisham are higher than the average for London and England.
Smoking and Obesity (adults)	**Smoking and obesity** contribute significantly to **premature mortality and morbidity** in Lewisham. These health risks are also strongly linked with poor COVID-19 outcomes. Lewisham has a higher proportion of **smokers** and higher levels of **adult obesity** than most areas in London.
Diabetes	**Diabetes** is also a known risk factor for COVID-19 outcomes. Nearly **1 in 10 people** in Lewisham are estimated to have diabetes (T1 & T2, including those currently undiagnosed). **58%** of our population with **type 2 diabetes** are estimated to be of **ethnic minority origin.**
Obesity (children)	**The prevalence of obesity** in Yr 6 children in Lewisham is above the England average. Obese children may be at risk of more severe symptoms of COVID-19 should they catch the disease, although further research into the link between obesity in children and COVID-19 outcomes is required.
Asthma (children)	The rate of hospital admissions for **asthma in children** aged 18 and under is significantly higher than the average for London and England. Children with severe or poorly managed asthma may be at risk of more severe complications as a result of COVID-19 infection.
Low Income Households	Nearly a quarter of Lewisham's children (23%) live in **low income households** and over 12,000 children claim free school meals (as at 28 August 2020). There is a known link between deprivation and the risk of COVID-19 infection.
Further information and analysis on the link between health status, comorbidities and the impact of COVID-19 on the Lewisham population can be found on slide 15	

2. Population health: impact of COVID-19 – direct impact on health

Number of cases	There have been **1340 confirmed cases of COVID-19** in Lewisham residents (up to 31st August).
Number of deaths	There have been **293 deaths associated with COVID-19** in Lewisham (up to 14th August).
Demographic analysis of deaths registered in Lewisham up to 16th July confirms that mortality from COVID-19 impacts population groups in Lewisham disproportionately, matching some of the patterns that have been identified nationally and internationally:	
Mortality	**Men and women aged 50 and above** have an increased risk of mortality. The gender difference in mortality risk increases with age with the rate of death considerably higher **in males aged 80+** than females.
BAME	**Lewisham residents born in the Americas & the Caribbean or the Middle East & Asia** have a significantly higher death rate than people born in either the UK or Europe.
Deprivation	The updated analysis shows **no significant difference in the rate of death from COVID-19 between those living in the most deprived areas** of Lewisham compared to **those living in the least deprived areas**
Care Homes	22% of deaths from COVID-19 were to **residents who normally live in care homes.**
This analysis has been updated to incorporate COVID-19 associated deaths registered in the latter part of the initial wave of the outbreak, the analysis now include all deaths associated with COVID-19, in Lewisham residents, registered in Lewisham (from 20th March to 16th July).	
Lewisham Public Health Team are creating a demographic profile of the entire cohort of residents who were diagnosed with COVID-19. Partners in SEL ICS & Kings Health Partnership are working on more granular analysis of the cohort of people in Lewisham who received hospital treatment for COVID-19. This analysis will include a breakdown by ethnicity, previous health status/risk factors. This analysis is due for completion in September 2020.	

2. Population health: impact of COVID-19 - inequalities and the wider determinants of health

- **As well as the direct impacts of the disease on physical health, the lockdown imposed as a result of COVID-19 has also had an impact on mental health and the wider determinants of health** such as socio-economic factors and education and developmental impacts for children and young people.

- **The full extent of this impact on the population of Lewisham and the inequalities that are created or exacerbated, will only begin to emerge** over the coming months and years.

- **Lewisham is working in partnership with public health teams across South East London and colleagues in Kings Health Partnership** on an in depth analysis of COVID-19 needs and inequalities across SEL. An evidence review of interventions known to effectively tackle the inequalities identified is also being undertaken. This will provide a detailed profile of the holistic impact of COVID-19 on each borough and a menu of options for each borough, to incorporate into their recovery plan, that will transform the health and inequalities of their population over the next 3 – 5 years.

- **Birmingham City Council and Lewisham Council are launching ground-breaking work into the health inequalities of African & Caribbean communities**. The programme, which will conclude in Dec 2021, consists of a series of reviews which aim to explore in-depth the inequalities experienced by these ethnic groups and their drivers. The review topics include; children and young people, mental health and wellbeing and chronic health, amongst others. The aim is to find approaches to break the decades of inequality in sustainable ways that will lead to better futures for local citizens.

- **The following slide highlights some of the early indicators of the wider impact of COVID-19 on our population**.

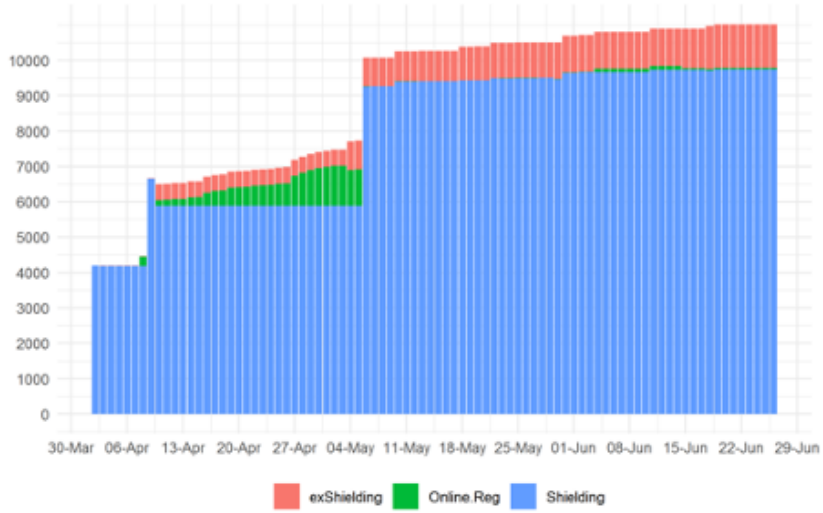
2. Population health: impact of COVID-19 - inequalities and the wider determinants of health #1

- **Lewisham's claimant count is now 19,300** (August 2020), up from 12,800 (April 2020) and 8,400 (March 2020) pre-lockdown.
- **Government data reveals that 36,200 jobs within Lewisham were furloughed** (43.2% of all in-borough jobs).

Table: Lewisham Shielding list over time

The increase in number of shielders in May was due to the second release of central data by NHS digital.

The additional 3,000 vulnerable people identified locally are not shown in this table.



- **Lewisham has seen a significant increase in food insecurity in the months since the onset of COVID-19**. More than 12,100 requests for food have been made and more than 11,100 food packages have been delivered (as of 28 August 2020).
- **Children and Young People: As of the 2020 Spring Census (16 January 2020) there were 6,856 children and young people claiming Free School Meals.** As at 30 August 2020 there are more than 12,000 children and young people registered for Free School Meals. This means that a significantly higher number of Lewisham CYP have access to food through their schools supporting those families affected by unemployment or loss of earnings.
- **Almost 10,000 people were shielding in Lewisham and being supported by the Shielding Team** - the geographic spread of shielders broadly follows patterns of deprivation. The Community Hub (Lewisham Local) delivered support to over 15,000 people. The majority of support provided was food packages (See Case study 3, slide 22).
- **A wider cohort of approximately 3,000 vulnerable people and not known to services were identified using population and Council data.** This group were then prioritised for a welfare call and referred to other support if required.

2. Population health: Health and Wellbeing Strategy

Lewisham will ensure that its new Health and Wellbeing strategy addresses the impact of COVID-19 and that actions are prioritised within short, medium, and long-term plans.

In March 2020, the Health and Wellbeing Board agreed to the development of a new strategy for the period 2021-26. In developing a new strategy, Lewisham will consider the wider contributory factors to health and wellbeing such as housing, education and employment. It will also seek to encourage individuals to take greater control and responsibility for their own health and care and reflect the need to address health inequalities, particularly in Black, Asian and Minority Ethnic (BAME) groups.

Alongside addressing the impact of COVID-19, the strategy will continue to focus on the following:

- **Quality of Life** – too many people live with preventable ill health or die too early in Lewisham. Health inequalities persist and the wider contributory factors to a person's quality of life and overall wellbeing require focused attention to enable all people in Lewisham to live well for longer.

- **Quality of Health, Care and Support** – People's experience of health, care and support is variable and could be improved. The system needs to evolve from a provider-focused one. The individual needs to be empowered to be in control of their own health and wellbeing through accessible information and local support, available closer to home.

- **Sustainability** – there are increasing levels of demand - population growth, age, complexity of need – and the financial resources are limited. The local health and wellbeing system must be forward looking and adaptable to such competing pressures.

Demand for services has been disrupted by COVID-19. It will take time to understand fully what this means in terms of impact on our local system. However, as part of our response planning we have considered the recent Public Health England review of disparities in risks and outcomes for COVID-19 – please see the following slide for details.

Managing Population Health & Tackling Inequalities - Addressing the impact of COVID-19

As part of our response planning we have considered the recent Public Health England review of disparities in risks and outcomes for COVID-19. The PHE analysis has looked into effects of age, sex, deprivation, region and ethnicity, but it does not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences. Continuing to improve the holistic management of long-term conditions in Lewisham is a key priority for our partnership, as (working with VCSE colleagues) is addressing the broader socio-economic determinants of health and wellbeing, including inequalities exacerbated by the effects of the COVID-19 outbreak. However, as an area with a diverse population and a diverse workforce, we recognise our shared responsibility to address emerging disparities in risks and outcomes specifically in our immediate and future plans

	Age and Gender	Deprivation	Ethnicity	Occupation	Health Factors/Co-morbidities
Risk Factors	• Those 80 or over were seventy times more likely to die than those under 40 • Males had a statistically significantly higher rate of death (9.9 deaths per 100,000) compared to females	COVID-19 has had a proportionally higher impact in the most deprived areas when compared to all deaths. Some groups are particularly at high risk • Migrants • Those with Nil recourse to public funds • Homeless • Children and Young people (impact of education	The risk of dying is higher for those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups	• Caring occupations including social care and nursing auxiliaries and assistants • Those employed driving private and public vehicles including taxi and minicab drivers and chauffeurs • Security guards and related occupations; including those in care homes	• Hypertension • Cardiovascular diseases • Diabetes mellitus • Obesity • Smoking • COPD • Chronic kidney disease
Potential Impact on Lewisham Population	• Lewisham has a relatively young population with less than 5% of residents aged 80 + • About 700 older clients are in nursing and residential settings, • COVID-19 has caused, or been attributed to 22% of all deaths occurring in care homes in Lewisham since March 2020 • The proportion of males:females in the population is relatively evenly balanced (49.5% : 50.5% respectively). However the proportion of men in the older age group is much smaller. Of those aged 80+ in Lewisham, only 39% are male.	• In Lewisham 25% of the population live in the most deprived area in London, with none living in the least deprived area • Lewisham is the seventh most deprived of all London boroughs • Children live in low income households and over 12,000 children claim free school meals • There are more than 2,300 families living in Temporary Accommodation and over 150 rough sleepers in Lewisham • Nearly one in five Lewisham residents hold a foreign passport (this provides an indication of the proportion of migrants within the population) • The council have 62 active cases involving people with nil recourse to public funds	• 46% of Lewisham population are of BAME heritage • As a proportion, people of BAME heritage (Men and Women) represent 53% of all those employed in the 'Human Health and Social Work sector' in Lewisham • Approximately of 54% of Women employed in the 'Human Health and Social work' sector are also of BAME heritage	• Lewisham residents are working in sectors that are more likely to be exposed to risk of COVID-19 infection • It is estimated that more than 60% of Lewisham residents of working age are employed in "public-facing" roles • 18% of Lewisham residents work in the "Human Health & Social Work" sector (compared to 10% in London)	• High levels of smoking and obesity and rates of premature death from cardiovascular and respiratory diseases • Nearly 10% of people in Lewisham are estimated to have diabetes (T1 & T2, including those currently undiagnosed) • High proportion of population with type 2 diabetes are estimated to be of ethnic minority origin
Areas to be reflected within delivery plans	• Integrated support to our vulnerable and frail population • Agree risk stratification process to identify the cohort of people who would respond most effectively to anticipatory care or integrated care following an acute admission • Support to CYP and families specifically around MH and emotional wellbeing	• Working with partners to address wider determinants of health and wellbeing including housing, education, employment • Review of Health and Wellbeing Strategy to reflect wider contributory factors to health and wellbeing	• Understand and address health inequalities for BAME and other vulnerable residents as exacerbated by COVID-19 Action plan in place to support the work agreed in 2019 and updated in March 2020	• Shared programme to develop health and care workforce, especially BAME staff • Establish a new partnership relationship with local Domiciliary care providers • Care Home support and implementation	• Continued investment in prevention to support population health and wellbeing • Improved LTC self management and care • Continued focus on: Mental Health, Respiratory, Diabetes, and Frailty • Cross borough work on Cancer

3. COVID-19

WHAT CHANGED?

3. COVID 19 - key developments timeline summary

The situation changed extremely quickly and locally staff and residents responded equally swiftly. Below is a timeline of some of the activity during the early stages of the pandemic.

16th March	•Staff with underlying conditions or caring responsibilities advised to work from home; Council partners with Lewisham Local (Community volunteer-led hub) established a process to support Lewisham's vulnerable residents
17th March	•Staff asked to self-isolate if they or family members showing any symptoms of COVID
20th March	• Schools closed. They continued to provide care and schooling to vulnerable children, or children of key workers.
23rd March	• COVID helpline and email address launched for Lewisham residents; Critical service areas identified and prioritised; Govt. announced stringent measures to prevent further spread.
27th March	•First delivery of PPE; Emergency distribution hub established; Additional PPE sourced by local staff for care homes and home care agencies
31st March	•Staff redeployed to most urgent service areas
1st April	•Over 120 staff signed up to internal volunteering programme
3rd April	• COVID centres (Hot Hubs) opened
2nd May	• 1st Mobile Testing Unit in place

Throughout NHS guidance was implemented locally to change the way services were delivered with 'hot' and 'cold' sites, infection control measures, technology solutions for virtual service provision, and to stand down non-critical services, while increasing capacity for critical services.

3. COVID-19 – how did we respond? #1

Strong local leadership	The response to COVID-19 was swift and effective, emergency leadership structures were put in place quickly, supported by coordinated communications across partners and with the local population
Use of data	The existing Lewisham population health data system, and other health data was used to identify additional potentially vulnerable people among local residents quickly, and offer support through the shielding team and Lewisham Local (see case study). It also enabled staff to analyse the emerging trends on a day to day basis to provide care for the expected COVID-recovery patients needing further support.
Patient behaviour	*Risks:* Attendances at general practice and at A&E and for elective surgery decreased sharply. The outcome of this is a high risk in terms of unmet need and likely exacerbation of conditions for our local population. Lewisham Health and Care Partners are increasing communications to encourage people to attend services. Individual services such as child immunisations are boosting capacity in order to mitigate this impact of COVID. *Opportunity:* The decrease in emergency attendances together with the redesign of a hospital 'flow centre' helped to get people quickly out of hospital *(see case study*). We were also able to make some progress with internal changes in our emergency departments. This has meant that we have seen a significant improvement in achieving the 4-hour target for patients to be seen in ED. We now need to sustain this to cope with any future waves, and with winter pressures.
Community Health Services	Community health services continued to provide a similar level of caseload, but with a different emphasis, providing home-based swab tests, while other patients started to self-monitor (e.g. blood glucose levels) to avoid face to face contact.
A volunteer force	A volunteer force of over 2,000 people was mobilised quickly to support the most vulnerable in our community with practical and emotional support. Social prescribing link workers played a key role in supporting vulnerable people through the COVID crisis, providing holistic wellbeing support and signposting to critical services. They will continue to support people through recovery using a proactive approach to identifying people
Digital First	Laptops were issued to General Practice and to other staff to enable remote working where possible, and reduce face to face contact while continuing to deliver healthcare services. A further 1,000 laptops were distributed to children and young people (provided by DfE) after it was recognised that some local families were being disadvantaged by the move to digital for healthcare and education. New technology was introduced to support remote assessments and reviews for users of social care services in the community and in care homes. **Care leavers:** Through the local Independent Visitor Service contact with care leavers has significantly improved during the pandemic. Changes in social work practice has provided increased flexibility, offered at a convenient time through the use of digital tools, this approach has been welcomed by our young people who have previously been difficult to engage. As we go forward we will look in depth at how the use of technology impacts on those who don't have digital access, particularly how it affects those in temporary accommodation, those without access to broadband, and those who lack physical or mental dexterity.

3. COVID-19 – how did we respond? #2

Testing	Staff Testing for COVID-19 has been co-ordinated jointly with the Council and CCG, initially to provide access to antigen testing for key workers in primary care, pharmacy and care homes, and then connecting with the south east London team as the programme has been rolled out for instance with blanket testing in care homes. An initiative during June and July has seen antibody testing provided to staff in the CCG, primary care, pharmacy and care homes, with phlebotomy carried out by One Health Lewisham and laboratory analysis by LGT.
Local Outbreak Management	A cross-sector COVID-19 Health Protection Board has been established to oversee the implementation of Lewisham's COVID-19 Local Outbreak Control Plan. Plans for the management of COVID-19 outbreaks in a range of health and non-healthcare settings have been agreed, these include pathways to increase testing capacity and mutual aid agreements to support contact tracing for outbreaks in complex settings.
Establishment of COVID Centres	2 COVID Centres were rapidly established in the north and south of Lewisham, to manage patients with suspected COVID.
Personal Protective Equipment	Distribution of PPE locally to GPs was coordinated by the GP Federation, staff in the Council and CCG coordinated supplies of PPE to Care Homes and Domiciliary Care agencies until the national supply of PPE became effectively mobilised.
Referrals to Children's Mental Health Services reduced	Referrals to front line services such as MASH, CAMHS, Athena (for domestic abuse) and the Young People's Health and Wellbeing Service have reduced during the pandemic, largely due to reduced face to face contact with key referral sources such as primary care (GPs) and schools. CAMHS referrals have dropped by 50% during COVID-19 (approx. 130 referrals a month in 19/20, compared to 65 per month in 20/21). It is not known whether there is an increase in need and the full impact is unlikely to be recognised, however the use of the crisis line has increased. *(see case study)*
Infection Prevention and Control in non-healthcare settings	The Public Health Team have become the central point of contact for enquiries relating to COVID-19 infection prevention and control guidance in non-healthcare settings. The team have worked across sectors providing advice and support to care homes, mental health settings and supported housing providers as well as schools and early years settings.
Mental Health in ED	Emergency Department walk-in triage was extended to 24/7. As a result of this initiative 36% of patients were diverted from a bay in majors and did not require a full psychiatric assessment.
Service changes and additional support	The SEND travel assistance programme has been able to assist with the delivery of food parcels to shielded / vulnerable families. A task force was established quickly to risk assess all supported housing and provide COVID-safe accommodation for symptomatic people. Dormitory-based night shelters were closed and 210 rough sleepers accommodated safely in self-contained accommodation such as student housing.

3. COVID 19 – impact on services

Demand on services changed during COVID for some service types. Below are highlights of some of the changes in health and care service delivery.

- **Community health services** continued with adjustments in place to ensure people continued to receive support.
- **Referrals to MASH** and adult safeguarding board reduced. CAMHS referrals reduced by 50% during COVID. There is likely to be significant unmet need coming out of COVID.
- **Domestic Abuse**: teams increased publicity in supermarkets and pharmacies to reach people who rarely left their homes.
- Use of the **Children and Young People's mental health** crisis line increased. (See case study 4)
- **IAPT** services moved from 70% face to face, to 70% virtual.
- **ED Mental Health** liaison expanded their triage function to 24/7 which resulted in 36% of patients being diverted from a bay in majors and not requiring a full psychiatric assessment.
- **COVID Centres** had 601 patients booked in between 9/4-29/5.
- Over 85% of **Primary Care appointments** were delivered virtually.

- **Social Care information and Advice** line contacts reduced by a third and as a consequence demand for social care assessments also reduced.
- Building-based **Day Care services** have been suspended and support and activities have been provided in people's homes.
- **Continuing HealthCare** assessments and checklists were suspended.
- Long Term Placement numbers dropped by 20%.
- **College placements** for young adults with a disability ceased, so more care at home was provided.
- **Domiciliary care** packages reduced in the early days of COVID by 14 %. Providers continued to be paid on planned activity to ensure they could flex quickly to meet demand if needed.
- **A&E attendance** reduced significantly. Attendance is now rising to pre-COVID levels again.

TABLE: Primary care appointments
source: SEL PCN SITREP Dashboard wc 0405

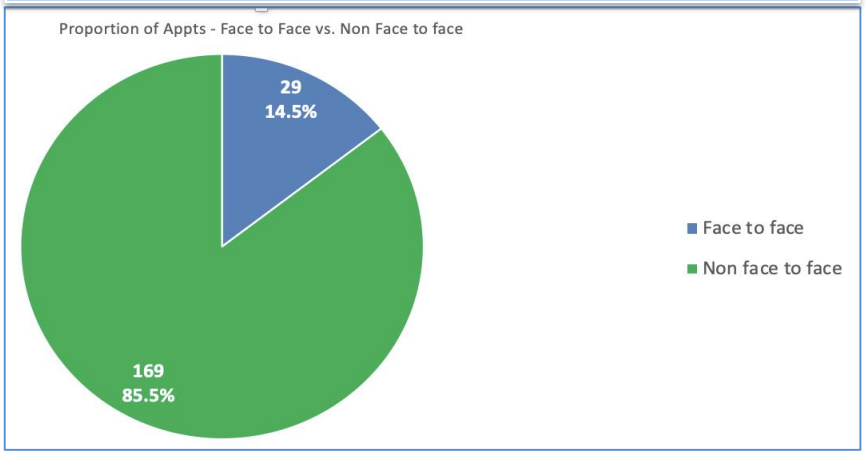
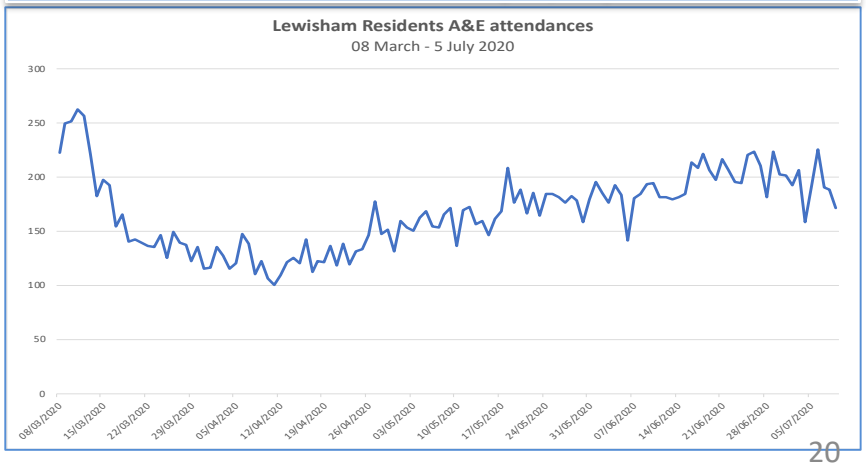


TABLE: Lewisham Residents A&E attendances
Source: LGT COVID19 Borough Reporting



3. COVID-19 - case studies 1 & 2

Case study 1 – COVID Centres

GPs across Lewisham working in partnership with One Health Lewisham came together *to redesign two medical centres into COVID-19 community assessment centres, more commonly referred to as Hot Hubs, for caring solely for patients with suspected COVID-19.*

This reconfiguration went from a design on paper to implementation within a matter of weeks. This was something that primary care had never had to do before and embodied the strong sense of working together to best support patients.

Patient access and staff safety was managed through effective new remote capabilities set up for Practices, including system VPN access and Remote working activities such as phone and video triage. If the clinician determined that a patient with suspected COVID-19 symptoms still needed to see a GP face-to-face, then they would be referred to a COVID centre for a rapid assessment that same day.

To help facilitate the movement of patients to and from the COVID centre (or Hospital), a group of local black cab drivers were enlisted to undertake the transport duties. PPE was supplied and cabs were modified to ensure safety for driver and passengers along with the cabbies being taught to 'deep-clean' their vehicle between journeys.

The centres used effective triaging, PPE and robust cleaning resources in a safe way *to ensure patients and primary care teams were protected and the risk of spreading the disease was minimised.*

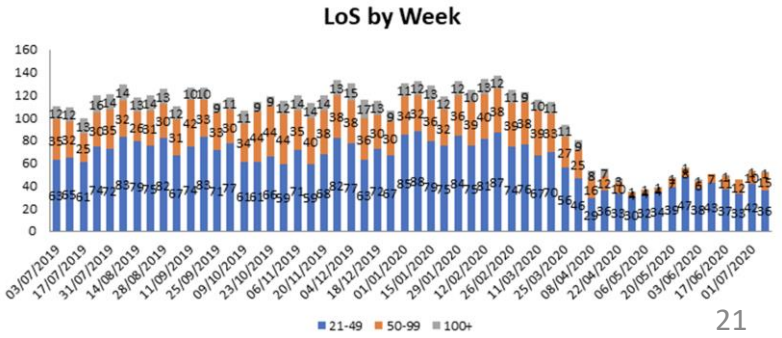
The work identified key areas of learning:

- *The need for fast **decision-making**. Decisions had to be made often in the space of a day, considering all the options.*
- *Understanding the demand for the service - **data** was collected and interpreted quickly to ensure demand did not outstrip provision.*
- *The importance of effective **staff communication**: as events and services developed rapidly, **One Health Lewisham** began publishing regular news-updates to keep all primary care colleagues informed, updated, engaged and confident in the new systems and procedures.*
- *Bringing the **community** together – Working collaboratively with support from the community hugely contributed to the success of the COVID centres. This was apparent at **One Health Lewisham**, where healthcare colleagues worked together to effectively run the clinic and the community donated money and scrubs - for example through 'For the Love of Scrubs'. Members of the community also volunteered at the new centre.*

Case study 2 – Hospital Flow Centre

- Pre-COVID the hospital had on average over 100 stranded patients with over 21days length of stay. By bringing in additional staff and focusing on purely medical reasons for inpatient stay, the flow centre was able to dramatically reduce stranded patients over the COVID period.
- Reasons to stay in hospital were restricted to medical reasons, such as
  - ✓ Physiology - NEWS2 >/= 3 (unless AF &/or COPD)
  - ✓ Therapy - oxygen therapy/ NIV (Treatment)
  - ✓ Therapy - intravenous fluids
  - ✓ Therapy - i.v. medication > b.d.
  - ✓ Iatrogenic - lower limb surgery within 48hrs
  - ✓ Iatrogenic - thorax-abdominal/pelvic surgery with 72 hrs
  - ✓ Iatrogenic - an invasive procedure within 24hrs
  - ✓ Function - Diminished level of consciousness where recovery realistic
  - ✓ Function - Acute impairment in excess of home/community care provision
  - ✓ Function - Last hours of life

The trust the public and families showed in our judgement was magnified through public opinion of the NHS during the crisis and this helped public acceptance of the need for patients to leave hospital quickly. The flow process is now being redefined and redesigned to work more closely with social care and therapies.



3. COVID-19 - case study 3 – Lewisham Local

Community Hub ("Lewisham Local") to support the most vulnerable

Lewisham's response to COVID-19 included the swift mobilisation of a community response. This response was formed of two key elements: a shielding team to identify those most at risk and a Community Hub to deliver support.
Given that people who are shielding have serious underlying health conditions placing them at very high risk of severe illness, the role of the Council's shielding function and the delivery of food and other essential welfare services provided by the Community Hub has been critical in maintaining the health and wellbeing of residents.
The Community Hub was established in mid-March to identify and address additional support needs arising from the COVID-19 crisis.
The Hub is a partnership between the Council and four key delivery partners, Lewisham Local, Lewisham and Southwark Age UK, Voluntary Services Lewisham and the Food Bank. Many other local voluntary and community services support this delivery. The service works closely with the social prescribers based in primary care.

Clear links have been seen between areas of deprivation and use of the community hub ("Lewisham Local") service.

In addition to the PHE-identified 'shielding' population, a wider cohort of approx. 3,000 vulnerable people who are over 70, living alone and not known to services were identified and prioritised for an initial welfare call and where appropriate referral onto other services using the Lewisham Population Health and Council data systems.

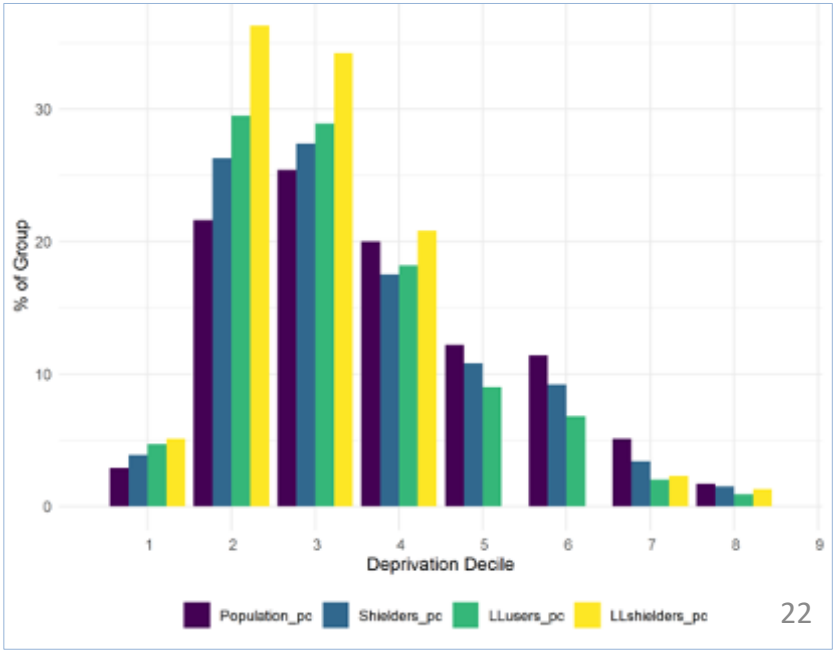
To 28 August**, 5,299** individual adults had been referred to the community hub and an estimated **15,000** people had been helped including children and other adults within the households.
14,058 help request referrals were made to Lewisham Local:

- 11,574 food requests
- 1,391 befriending requests
- 493 practical assistance requests
- 600 food bank walk-ins

2,470 - Total volunteers were registered with hub partners.

Lewisham already has high levels of food insecurity with estimates suggesting that up to one in four (24%) adults and one in six (17%) parents have children living in low or very low food security. The co-ordination of food provision and delivery by the Hub has played a critical role in mitigating the negative impact of food insecurity and poor malnutrition on some of the most vulnerable residents.

Table: Comparison of users of Lewisham Local (Community Hub) and Shielders with general population by deprivation



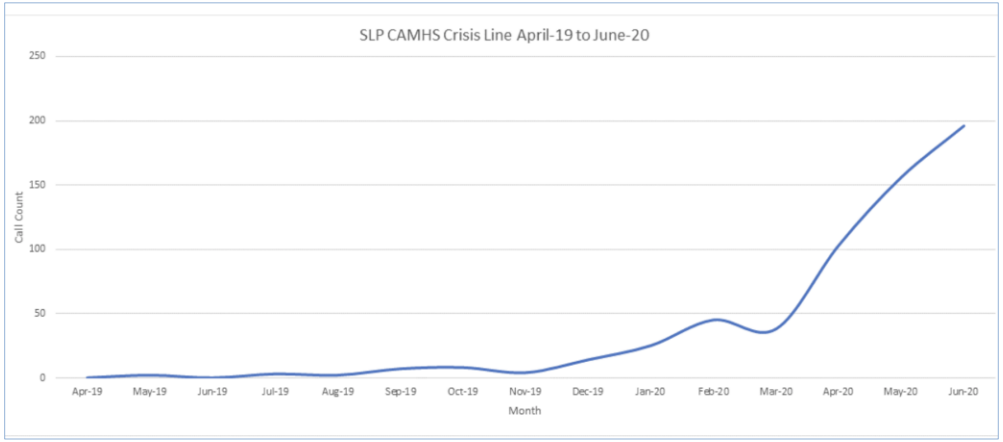
3. COVID-19 - case study 4 – Children and young people's mental health

(1) Crisis Mental Health line

In March 2020 NHS E/I requested every area provide a 24/7, single point of access for urgent mental health support available to the public as a priority during the Covid-19 pandemic. A South London wide CYP crisis line for all CYP was launched on 30th March'20, Monday to Friday 5pm-10pm and weekends (incl. bank holidays) 9am - 9pm. By May 2020 the opening hours were extended to 11pm, 7 days a week, to deal with additional demand.

The line can be accessed by phone by children and young people from anywhere during these times. It is always staffed by two CYP mental health practitioners from nursing, occupational therapy, and psychology backgrounds, as well as a support worker, all of whom have extensive CAMHS expertise.

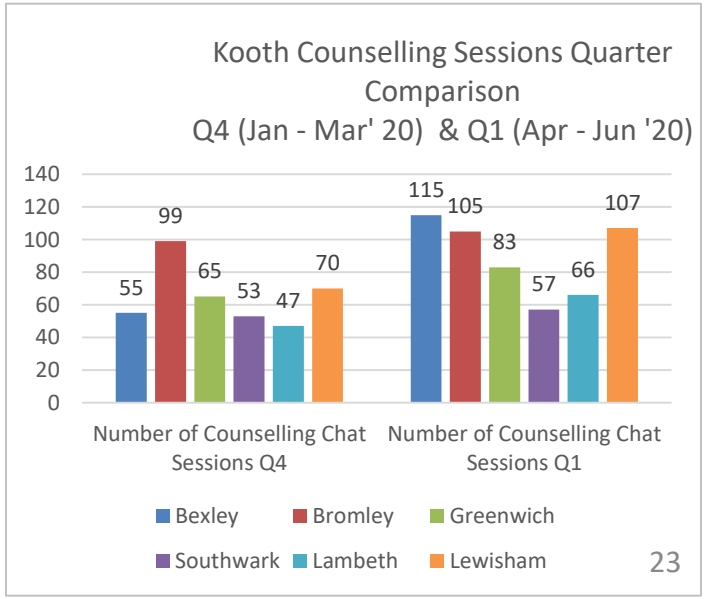
The new CYP crisis line service was communicated widely to professionals and CYP and families. Soft communications went out to the public. As awareness of the line and Covid-19 issues continue, numbers are expected to increase.



(2) Online counselling

Kooth.com is an online counselling service, offering free and confidential sessions and forums to young people aged 10 – 19 and up to 25 years of age (for targeted groups), across the six SE London boroughs. It is a well-established service.

During March-July '20 the service did not see any significant change in referrals. This may be due to the lack of interface between CYP and schools or GPs. However, the service did see an increase in counselling sessions delivered between Jan-Mar '20 and Apr-Jun '20 for those CYP already registered with the service.



3. Working together: learning from COVID-19 first wave

There is learning to be taken from our experience of the pandemic first wave, and we are working with residents and staff to recognise where things have worked well and not so well for them. Below are some initial highlights from organisational perspectives.

Strong local leadership	The local GOLD/SILVER command emergency planning structures were put in place quickly and supported place-based system coordinated communication, data gathering, operational planning and delivery, and key decision-making. Although roles and structures needed some clarification initially, particularly in light of the new CCG SEL structural changes, this was quickly resolved.
Organisational behaviours and culture	During the pandemic providers worked collaboratively with willingness and flexibility to deliver existing services differently, and to move quickly to establish new services. These behaviours were the result of an absolute commitment to the 'common good', and enabled by the removal of financial and bureaucratic constraints. Organisational silo working almost disappeared overnight. Access to digital means (such as MS teams) have made interagency meetings more accessible and easier to plan, especially where a range of agencies are required to attend. Partner agencies have successfully attended statutory social care meetings in a virtual capacity. We will build on the good relationships and behaviours which came out of our joint response to COVID-19 and continue to operate virtually where this is beneficial to joint working.
Collaborative working across provider organisations	Joint working with other partners across SEL (acute) and the independent/private sector (acute and MH) ensured that patients most in need were able to receive support.
Additional funding and removal of organisational requirements	Additional funding and quick decision-making enabled enhanced services to be established in days. The acceptance of common sense decisions over fully developed business cases and requirement for multiple sign-offs led to quick implementation and flexibility, some of which may prove to have been wrong, but much of which was extremely effective, for example, the addition of therapy staff in the hospital 'flow centre' which enabled much quicker discharges to take place.
Removal of national regulation	The removal of some regulations, such as patient choice on care homes, has meant that hospital length of stay was able to reduce to manageable levels. (see case study)
Digital first	COVID-19 prompted an incredibly fast and widespread move to use of digital solutions to reduce face to face contact where possible and continue to deliver services safely. This change was remarkable in its adoption across primary, secondary and acute services. Some Mental Health services moved from 70% face to face interaction, to 70% digital (IAPT). During Mar-June, Primary Care in Lewisham have moved to 85% of appointments delivered virtually. Safeguarding boards developed and delivered a range of online training to the large number of new volunteers. However, this move to digital has disadvantaged some people and we are working with local people to understand how to mitigate this.
Voluntary sector and volunteers	Voluntary organisations in Lewisham collaborated in an unprecedented way to serve residents, particularly those who are most vulnerable to the health, social and economic impacts of coronavirus. A volunteer force of over 2,000 people was mobilised quickly to support the most vulnerable in our community with practical and emotional support.
Staff and residents responded well to change at pace	Staff and residents responded well to change at pace with a common goal and shared purpose. Staff have shown resilience and resourcefulness, understanding that the priority lies with serving patients and residents more than ever at this time. Staff have positively and quickly developed virtual ways of communicating across the organisation and beyond to support critical services. The need to respond quickly meant that a culture of empowering and encouraging new ideas and contributions and working in a positive and constructive way arose. Staff were able to deliver flexibly and quickly, feeling supported in their decisions and actions.

4. PLANNING FOR RECOVERY

PROTECT, RE-START AND BUILD BACK BETTER

4. **Protect:** Protecting residents from a 2nd wave

A cross-sector COVID-19 Health Protection Board has been established to oversee our Local Outbreak Control Plan.

In Lewisham our partnership response to COVID-19 was swift with emergency structures put in place quickly, supported by coordinated communications across partners and with the local population.

In planning to mitigate and manage any second wave, we will explicitly build on the accomplishments and the lessons of the first, including:

- **Continue with existing robust infection control practices** which are now embedded in all aspects of activity, including educational establishments in readiness for secondary school reopening in September.
- **Target services to those most in need** quickly, using population health data. This information continues to be built on and refined.
- **Continue with collaboration between health and care providers** which was developed during the first wave of COVID-19 and build on this to ensure that those most in need receive relevant care and support.
- **Enable safe access to key services through use of digital for consultations and patient support and providing safe face-to-face services** supported by PPE, training and effective use of sites including designated shielding and isolation areas.
- **Consultant Connect provides access for GPs to specialist input** reducing the need for patients to be seen at the hospital. The number of specialist conditions offered by this service has increased exponentially in the last few months.
- **Support for staff to work remotely where possible.** Laptops and telephone solutions are in place and continue to be supported.
- **Extra critical care capacity available as required** to support any second wave and winter plans.
- **The 2nd COVID Centre which was set up for the first wave of COVID** to be reinstated if needed.
- **The infrastructure to support shielded people will be maintained** to allow the service to restart in the event of a second peak. A shadow team of volunteers are "on call" for swift redeployment.
- **Ensure effective mental health services are available** including co-producing support on offer with local BAME groups.
- **Improving the support available in the community** to prevent unnecessary hospital attendances and improving the discharge process for those leaving hospital will be a priority to ensure that hospitals have capacity for those needing acute treatment.

Winter plans

The recovery plan is being aligned with winter plans, including a strong focus on increasing the uptake of flu vaccinations, planning for increased staffing levels, and extra PPE to ensure care homes in particular are well supported.

Services will continue to provide digital access, and segregated areas with strong infection control processes in place where face to face hospital or surgery appointments are needed.

4. **Re-start:** Re-starting key services

In line with the NHS England letter of 31st July setting out requirements for re-starting NHS services, and as part of our recovery plan, system partners are working to re-start services which were stood down or reduced due to COVID. This includes:

- **Restoring full operation for all cancer services** including a focus on unmet need and health inequalities, and managing demand, reducing the number of patients waiting for diagnostics and/or treatment
- **Recovering the maximum elective activity** possible between now and winter, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals Ensuring overnight electives and outpatient/daycase procedures get back on track. MRI/CT and endoscopy procedures to be back to last year's levels by October. Achieving good performance on outpatient and follow up appointments
- **Reviewing Learning Disability day opportunities** to ensure people's needs are being met
- **Social care assessments** to be carried out on all patients who were discharged as urgent hospital discharges during the height of the pandemic to ensure their care is appropriate to their need
- **Resuming NHS Continuing Healthcare** assessments from 1 September 2020
- **Restoring activity to usual levels where clinically appropriate in primary care and community services**, including offering face to face, remote triage and video, online and telephone consultations
- **Addressing the backlog** of childhood immunisations and cervical screening
- **Re-starting medication reviews** in care homes and in support of GP practices
- **Expanding and improving mental health services** and services for people with a learning disability and/or autism
- **Reducing the number of children**, young people and adults within a specialist inpatient setting
- **Practices should ensure that everybody with a Learning Disability** is identified on their register and receives an annual health check and has screening and flu vaccinations arranged
- **Expanding Mental Health Services** to meet Long Term Plan priorities

Tackling fundamental challenges including support for our staff, action on inequalities and prevention:

- **Recognising the crucial role that health and care staff have played** in managing the response to COVID
- **Keeping staff safe, healthy and well** and offering staff flexible working.
- **Addressing systemic inequality** that is experienced by some of our staff, including BAME staff.
- **Increasing the scale and pace of progress of reducing health inequalities**, and regularly assessing progress.

4. Build Back Better: our priorities #1

LHCP have identified a number of key priorities for 20-21 and beyond which are reflected in our recovery plan. Whilst many of these build on pre-existing priorities, some have an increased focus as the result of learning from COVID-19 as set out below.

COVID-recovery plans will be aligned with Winter planning including for 2nd wave of COVID-19. This will include a focus on flu vaccination uptake, particularly for those most at risk, including older people, BAME and those with co-morbidities.

Inequalities

- **Addressing inequalities has always been emphasised throughout LHCP's work.** However issues around inequalities and disparities have come into stark focus both as a result of the emergence of an understanding of populations most likely to suffer from COVID-19, the profile of deprivation being linked to higher numbers of BAME people, and the rising racial tensions following the killing of George Floyd in the USA in May.
- **We will continue to review and address inequalities and disparities in risks and outcomes**, with a specific focus on the BAME population. For example the case management approach taken by the shielding team and community hub has rightly delivered to proportionately more people from BAME backgrounds, reflecting local racial inequalities. The shielding service has been overwhelmingly positively received and some residents reported it as 'life changing'. This model will be reviewed to see how it can be adapted for future use.
- **In addition, priorities have been developed to support the BAME workforce**, including mentoring, career enhancement opportunities and practical support

Care Homes

- **Care homes reported issues early on in the COVID response, with the focus nationally being primarily on acute care.** We have built on existing systems to support care homes locally including primary care coordinated support through the local GP Federation, and through LIMOS (Lewisham Integrated Medicines Optimisation Service). A workplan is in place to safeguard care home residents and staff from COVID, and a comprehensive action plan has been developed.
- **The vulnerability of the local market especially in light of the impact of COVID remains a major concern**, voluntary closures are likely. Lewisham will work proactively to support vulnerable care homes and ensure the safety of residents.
- **A strategic oversight group has been established to track delivery of further actions to strengthen the support to the care market.** One action is to secure additional local infection prevention and control resources by October 2020.

Prevention

Many of our prevention services such as sexual health, substance misuse, Health Visitor, NHS health checks and immunisations were reduced or put on hold during COVID. A priority will be to get these back up and running particularly with a focus on addressing inequalities as part of their delivery.

4. Build Back Better : our priorities #2

Planned Care

- **Following the reduction or stopping of some services during the peak of COVID-19**, LHCP are rightly eager to ensure that planned care restarts as soon as is safe and practicable.
- **Cancer screening programmes are now re-starting**, with patients now actively being invited for cervical screening other programmes to follow such as bowel and breast.
- **Bowel sample testing did not stop during COVID-19.**
- **There are about 5,500 outstanding Endoscopy appointments across SEL**, a proactive plan has been put in place to re-start this, with the expectation that the backlog will be cleared in 6-8 weeks.
- **In primary care, priorities are to refocus on proactive planned care including immunisations**, cancer screening, LTC management, postnatal checks, SMI/LD/NHS Health checks.
- **Implementation of RAS and the rollout of DXS systems also continue to be priorities** for Primary Care going forward.
- **Establish community services for dermatology, cardiac diagnostics and anti-coagulant initiation** to improve access to these services and reduce health inequalities.

Building Community Resilience

- **We will adopt an asset based approach to our service delivery ensuring that we focus on an individual's strengths, knowledge and skills.** This aims to give individuals more control and a greater voice in the development of their care and support plan in order to achieve improved health and care outcomes.
- **We will ensure that the learning from the BAME MH Health inequalities pilots is used to co-produce interventions** that make efficient use of digital **access**, face to face support, mutual aid, peer support and other approaches that improve community resilience leading to increased levels of self care and self management.
- **The burden on unpaid carers during COVID lockdown has been exacerbated, and work during September is taking place to identify new carers**, and offer them carer assessments and support.

Children, Young People and Families

- **A programme of catch-up immunisations has been put in place and screening and weight management programmes will commence in September.** Referrals to MASH, CAMHS, Domestic Abuse and YP Mental Health and Wellbeing services reduced during COVID-19, but calls to the CYP Mental Health crisis line increased exponentially.
- **The Mental Health Support Teams in Schools are directly supporting Lewisham schools during lockdown** and helping young people and families prepare for the return to school in September.

4. Build Back Better : our priorities #3

LHCP will also use the learning from COVID-19 to review workplans for the areas set out below which were identified pre-COVID as priorities for system transformation and reprioritise activity as necessary. LHCP will continue to work together to deliver integrated community based care at a neighbourhood level continuing its work on prevention, early intervention, care at home and end of life care. It will also continue to develop an effective interface and pathways between community based care and secondary provision particularly for admission avoidance and hospital discharge. The partnership will continue to reflect on the learning and practices that have developed following COVID-19 and incorporate this into future developments.

FRAILTY

A dashboard for Frailty was in development to stratify the local population into cohorts of mild, moderate and severe and map against other conditions, service and IMD information. This will continue to be used to provide more responsive anticipatory care. We will review the activity that we identified to address the Right Care Frailty recommendations and reprioritise where necessary.

MENTAL HEALTH

The Mental Health Leadership Group will continue to focus on transforming Front Door & Rapid Crisis Response ; Community Support; and Rehabilitation & Complex Care. In particular there will be a continued focus on addressing inequalities and improving outcomes, particularly for BAME communities. The group will now also focus on the mental health of CYP and Older Adults.

RESPIRATORY

Priority actions include commissioning integrated respiratory community hubs, review of Lung Education Exercise Programme (LEEP), and delivery of multi-disciplinary team working with primary care, community and social care for Respiratory patients. Current plans are being reviewed in light of emerging data and evidence from COVID-19 and plans amended accordingly.

DIABETES

Following an analysis of the data, pre-COVID the following areas of focus were identified :

- Patients with undiagnosed diabetics
- Patients at risk of developing diabetes
- Patients that had gestational diabetes with no 3 and/or 15 month check
- Patients not in range for 1, 2 or all 3 of the treatment targets

Given the impact of COVID 19 on this cohort of patients, the partnership group will review formerly agreed proposals for change to see if where activity needs to be re-prioritised or enhanced.

CHILDREN AND YOUNG PEOPLE

Implementation of the i-Thrive model across early help and emotional health services remains a priority for 20/21, this approach aims to develop a common language and enable access to services, creating improved family resilience.

All LHCP's work will continue to be supported by Lewisham's data and information management system which is providing the population level data and information necessary to inform and validate the improvement and transformation decisions being taken across Lewisham's health and care system. Lewisham is enhancing the local analytical capability to identify further areas for improvement.

4. Build Back Better : wider Council priorities

A number of wider council priorities will be supporting the delivery of the health and care specific priorities set out earlier. The Council's own recovery plan will focus on the Council and the Borough respectively and will be underpinned by the following anchoring principles:

- Tackling widening social, economic and health inequalities
- Protecting and empowering our most vulnerable residents
- Ensuring the Council's continued resilience, stability and sustainability
- Enabling residents to make the most of Lewisham the place
- Collaborating and working together with our communities and partnership across the borough

Recovery will be staggered over three phases:

1. Easing Lockdown : Spring/Summer
2. Transition : Autumn/Winter
3. Reinvention : Autumn/Winter onwards

Phase One

- The immediate focus of recovery is managing a coordinated easing of lockdown to ensure Council services remain safe for residents and for staff.
- To date, the Council has focused on implementing robust and consistent social distancing measures in Council sites that are still in use, and to provide practical and wellbeing support for staff. A review has been carried out of non-critical services to assess capacity, anticipated impact on demand and working arrangements as lockdown eases. Active Council buildings have undergone a thorough risk assessment and adaptation to ensure that critical workers who are sometimes or always required in the office can work in a safe environment, compliant with government guidance.
- The Council is also focused on ensuring that both critical and non-critical services that have been running at a reduced operation during lockdown are gradually and safely reopened where it is appropriate to following a thorough COVID-specific risk assessment and in accordance with the aims and principles of our recovery approach.

Phase Two

- The Council has conducted an internal, interim review of the response to COVID-19 so far and identified a number of lessons learned which will inform and shape ongoing recovery development as well as inform its response to future waves of COVID-19.
- Phase Two will build on and embed the lessons learned from response. There will also need to be an extensive borough-wide impact assessment with residents, members, partners and local businesses in order to build an evidence base to inform policy and decision making.
- This phase will focus on inequalities, analysing the various impacts of COVID-19 on those with protected characteristics to ensure that Council services and local partnerships are working to shared objectives and are fit to tackle inequalities in a post-COVID Lewisham.
- Phase Two will also focus on stabilising the Council's finances and service delivery for the short term, while beginning to plan for the longer term sustainability and stability of the organisation.

Phase Three

- The findings from the assessment and consultation stages of Phase Two will inform a longer term phase of service redesign according to the anchoring principles as set out above.

4. Build Back Better: engagement with partners and residents

Experience of COVID

Healthwatch Lewisham undertook a survey to understand the impact of COVID-19 on the local population. The findings are taken from a total of 1,030 responses from the public. 95% of responses were made online, but phone and written responses were also encouraged.

Accessing Services: There remains a considerable reluctance by residents to access services because of the fear of catching COVID-19 or not wanting to be a burden on the NHS. 20% of respondents had been unaware that their GP practice was open during lockdown.

Digital services: Residents were predominantly happy with their experience of using GP services and the availability of phone consultations. They had positive experiences with phone consultations finding them to be "quick" and "informative". However, respondents strongly feel there is a continued need for face to face appointments. It was felt that the main limitation of using a tablet, computer or smartphone is the digital exclusion for those who cannot use or afford to use the technology. Services need to ensure that there is still equity of access for residents who cannot engage with the digital offer.

Information: Respondents felt the best sources to keep themselves safe were the daily national briefings, news and the NHS and government websites. The 4 main topics which respondents wanted to receive further information and guidance around were COVID-19 testing, mental health self-help tips, dental services, and any changes to local healthcare services they access.

Impact of COVID: The COVID-19 outbreak and lockdown has had a substantial emotional impact on residents, with residents' experiencing issues such as bereavement, financial worries, isolation and anxiety. There is greater need for a wide provision of mental health support services to be included in services' recovery plans.

Next steps: Patients felt that up to date coronavirus figures, the availability of a vaccine, clear information from services about infection control measures and provision of PPE for staff would encourage them to access services.

Next steps

A communications and engagement plan has been developed with partners to support the borough's recovery plans. This includes:

- Reflecting on what we know from previous engagement work
- Understanding further what partners have learned from people's experiences of receiving care during the pandemic and the impact this has had on them
- Identifying gaps in knowledge and implementing plans to address this
- Considering how this intelligence will inform our recovery planning going forward
- Working collaboratively across partners in a coordinated way, using our collective engagement resources for the good of our residents

Given the disproportionate effect that COVID-19 has had on older people and those from the BAME community – alongside the disproportionate impact it has had on men, lower paid workers, people with long term conditions, people with learning disability and/or autism and people with mental health needs – we will engage proactively and work with people from these communities and groups in particular to understand the impact that the virus has had in Lewisham. This information will inform how recovery planning can address these issues, as well as supporting how people can help shape our plans. It will build on pre-pandemic work to address health inequalities including the 2018 BAME Mental Health Summit and the BAME mental health insight co-production work which followed.

We are mapping intelligence gathered by partner organisations such as local authorities, acute, community and mental health trusts, Healthwatch organisations and voluntary and community sector organisations. This insight is informing our plans and engagement activity around recovery planning.

Over the coming months we are building on the conversations that have taken place to date with partners including elected members and the Lewisham Public Reference Group.

Robust engagement and clear communications are vital to ensure our plans are well informed and that all local stakeholders including patients are aware of their required roles to support its success. These can be coordinated at local, SEL and national levels and build on a better understanding of what's worked well from the Healthwatch survey.

4. Build Back Better: engagement with partners and residents

Responding to mental health needs

Mental health summit

In June 2020 we took part in a mental health summit organised by South London and Maudsley NHS Foundation Trust and attended (virtually) by over 1,000 people including staff from partner organisations and a significant number of service users and residents. All partners agreed to the following six actions:

Six actions we will take on COVID-19 mental health prevention

1. **To create a mental health prevention taskforce that will have representatives from across organisations and boroughs** and that will oversee a twelve-month prevention programme.
2. **To develop a programme of mental health community capacity building across South London** – which will work with schools, faith and community groups to stay well. Making sure we reach out and listen to as many communities as possible across our four boroughs, including those for whom English is not a first language to help shape this work.
3. **To create a package of digital mental wellbeing courses for all residents across South London** through the South London and Maudsley NHS Foundation Trust Recovery College
4. **To support and share the South East London Free Your Mind mental health campaign** with all our residents and communities
5. **To work together on tracking the levels of psychological distress** in our communities as a result of COVID-19
6. **To host a Mental Health Prevention follow-up summit in October to report back on progress and further challenges as a result of COVID-19.** Using the priorities you have shared with us today, and from our listening campaign with local communities, we will publish our shared action and implementation plan in full.

Free Your Mind campaign
22 June – 22 August 2020

www.nhsfreeyourmind.co.uk
#FREEYOURMIND

We developed the **Free Your Mind** mental health and wellbeing awareness campaign to reach and engage with south east London residents during COVID-19, informing them of the digital resources and services available to them and give them a nudge to think about their mental wellbeing.

5. PLANNING FOR RECOVERY

INFRASTRUCTURE

5. Planning for Recovery: infrastructure #1

Whole system demand and capacity planning

- **During the COVID-19 pandemic the SEL system has worked collaboratively** to understand and plan for expected demand.
- **We are now building from this work to develop a SEL demand and capacity model**, that will support both scenario planning related to recovery and a potential second wave, plus future strategic and operational planning across our system.
- **Our demand and capacity modelling will be utilised to underpin our service strategies and plans** and will help us identify, understand and address capacity gaps in a consistent and systematic way.
- **This will include securing plans to address gaps**, inclusive of an agreed approach to demonstrably maximising productivity and efficiency and pathway transformation opportunities and a collaborative utilisation of available resource on a system rather than organisational basis, to secure our objective of equity of access and outcome.

Market fragility and development

- **The vulnerability of the local care homes market especially in light of the impact of COVID-19 remains a major concern**, voluntary closures are likely. Lewisham will work proactively to support vulnerable care homes and ensure the safety of residents.

Workforce

- **COVID has fostered greater collaboration and flexibility in how we utilise our existing work force** within and across organisations, successfully integrated new entrants and returners to the workforce and enabled highly effective sharing of services such as staff testing.
- **Our priorities of valuing and investing in our people and working collaboratively to improve working lives, workloads and wellbeing are more critical than ever.** Our workforce plans include a focus on:
  - **Staff health and wellbeing** as we recover from the pandemic – with a specific focus on the psychological impact of the pandemic and ensuring embedded safety and learning cultures.
  - **At risk and vulnerable staff**, including clear risk assessments and support for BAME staff
  - **Optimising innovative workforce models** that support flexibility and resilience across staff groups - multi disciplinary team working, integrated workforce development and fellowship/employer models that embed integrated working in the delivery of care, development of non clinical workforce and volunteer models.
  - **A refreshed workforce strategy** that builds from our LTP response and incorporates learning from Covid and the workforce implications of our planning for recovery. This will include a re-appraisal of supply pipeline risks and growth programmes risks spanning this year and next.

5. Planning for Recovery: infrastructure #2

Digital

- **Our objective is a digital strategy that drives our population health management and care pathway transformation**, maximising the opportunities offered by digital. Our strategy will include understanding and mitigating the digital barriers experienced by some user groups and ensuring that alternatives are in place.
- **The COVID pandemic has seen a rapid digitalisation** – we are committed to building from this to secure our LTP objective of securing ubiquitous access to digital care services.
- **Our objective is a virtual by default model** - converting primary care and outpatients to virtual wherever appropriate, securing digitally augmented integrated primary and unscheduled care pathways, extending digital solutions to a wider range of care pathways, including mental health, diagnostics, care home support and self care approaches
- **This will be underpinned by work to secure collaboration and system leadership for digital transformation** and accelerating digital maturity, enhanced capacity and capability to support system transformation, agreed long term funding, interoperability, and access to patient records and data services to deploy Population Health Management solutions to identify the areas of greatest health need and match services to meet them whilst also supporting our wider pathway transformation objectives.

Estates

- **LHCP partners aim to utilise existing estates more intensively to support a wide range of community-based health and care services, as well as providing flexible and adaptable spaces to support health and wellbeing.** LHCP is also committed to releasing inappropriate estate where possible, withdrawing from property which is at the end of its useful life, and from leasehold property where public freehold estate is available. These project priorities are articulated in more detail in the STP London and South East Estate Strategy and in provider (SLaM, LGT and NHS Property Services) plans. Health and Care estate development will also form part of the One Public Estate plans.
- **To support current health and care estate development, a number of potential funding sources have already been made available to various Lewisham projects**, including NHS England's Estate & Technology Transformation Fund (ETTF), Department of Health Wave 4 fund, One Public Estate funding and funding contributions from CIL and S106. Further funding will be required as progress is made on estate development in Lewisham
- **Capacity in general in buildings has been reduced by the need to incorporate infection control approaches.** SLaM report a reduction of 10% capacity in bed based provision. However, many other services have moved to incorporate digital consultations, reducing footfall at buildings and this is likely to continue. Zoning for infection control and triage needs to be reviewed in preparation for winter and a possible 2nd wave of COVID. Consideration will be given to how services can adapt to reflect the changed need for building bases.
- **Workforce considerations will include virtual working where possible, protection of at-risk groups, infection control and PPE.**

6. PLANNING FOR RECOVERY

FINANCE

6. Planning for Recovery: finance #1

Financial context pre-COVID

- **Pre COVID ICS partners across the NHS and local authorities had been working to establish agreed financial plans** for 2020/21.
- **These plans included significant savings programmes for the year**, including the assumed impact of our pathway transformation and productivity improvement programmes, required to support the delivery of 2020/21 budgets and financial targets.
- **The plans also included a number of agreed investments**, including targeted NHS investment in our out of hospital care system across primary care, community and mental health services, alongside investment in acute services to support underlying demand and improvements in access. For local authorities plans reflected the very significant pressure that social care and other budgets have been under for a number of years.
- **Our plans included a continued commitment to pooled and delegated budgets across health and care** to support integrated out of hospital service provision and to incentivise the development of integrated models of care, risk and gain share approaches.

Financial context - COVID

- **The pandemic resulted in significant changes to the funding and payments regime for months 1-4 of 2020/21.** Block payments to cover core costs were implemented nationally, alongside mechanisms to recover additional covid related costs. As part of these new arrangements discharge costs were borne by the NHS on behalf of the system.
- **Guidance is now expected for the rest of 2020/21 and as a system we will work to implement the national guidance** with a key priority of providing financial certainty and stability across the system and to ensuring agreed system approaches to the management of risks or funding shortfalls. This will ensure that we are able to secure best value from available resource and support a funding approach that puts the needs and care of our residents at its centre.

20/21 and 21/22 financial plans

While the overall implications of the funding regime for 2020/21 are unclear at this point it is clear that we face a very challenging financial position across both the health and care sector:

- **We have experienced an Increased year to date run rate associated with managing the pandemic** – this means that in underlying terms we are spending more money than we expect to have available to us on a recurrent basis
- **Our 2020/21 plans are on hold or delayed** – resulting in efficiency programmes and the expected return on investment also being delayed during this year, meaning a bigger resulting financial challenge to address going forward
- **Recovery will require investment in some areas and/or result in increased inefficiencies** – to meet national / regional requirements (critical care, infection prevention and control), meet increased demand (mental health, waiting list backlogs) or to support on going delivery of benefits seen in the pandemic response (discharge, hubs for vulnerable people) – we will need to understand these requirements and reflect them in our financial plans.

6. Planning for Recovery: finance #2

Key Local Issues / Challenges

There are a number of key local issues / challenges which need to be addressed as part of the local borough based recovery plan and these include:

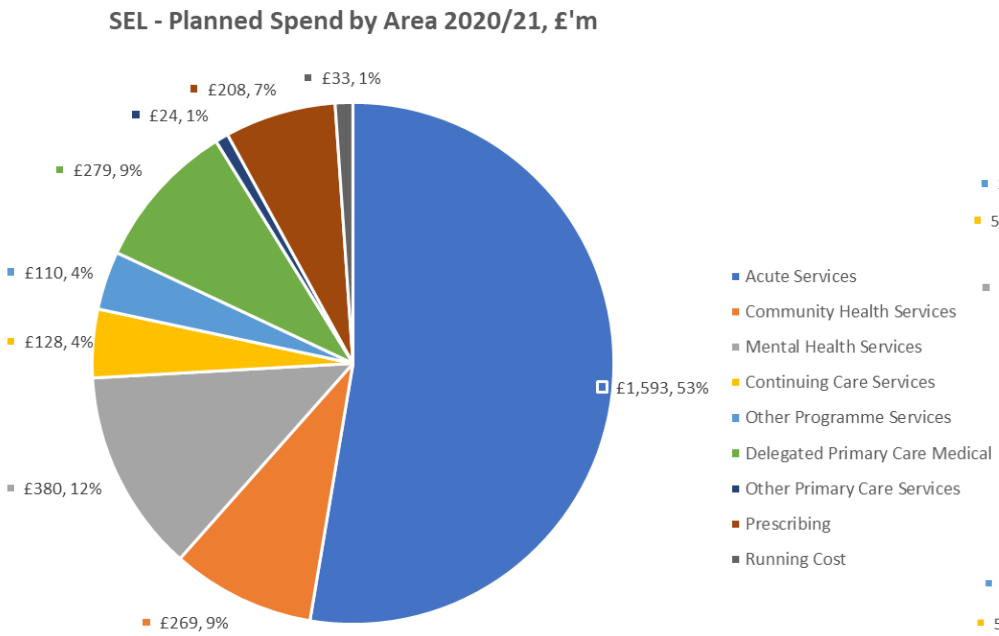
- **Hospital Discharge Scheme** – this has been put in place since mid March to allow early facilitated discharge of residents and avoidance of admission to acute settings during the pandemic with no assessments being undertaken, both financial or CHC. This arrangement is underpinned by the existing Section 75 agreement plus the addition of a new schedule which will be signed by both parties. When this scheme ends, in terms of recovery, there will need to be an agreed plan across health and social care for assessing all clients within the required timeframe.
- **Out of Hospital Schemes / Other Transformation Schemes** – Lewisham is working on a number of transformation schemes, in particular to ensure more clients are treated in the community at home. The challenge around delivery of any of these schemes will be the need to work as a system to deliver the changes without any additional finances. The out of hospital agenda including our care homes has become vitally important during the COVID crisis. As a borough, if investment funds became available, we will align any funding with our priority schemes.

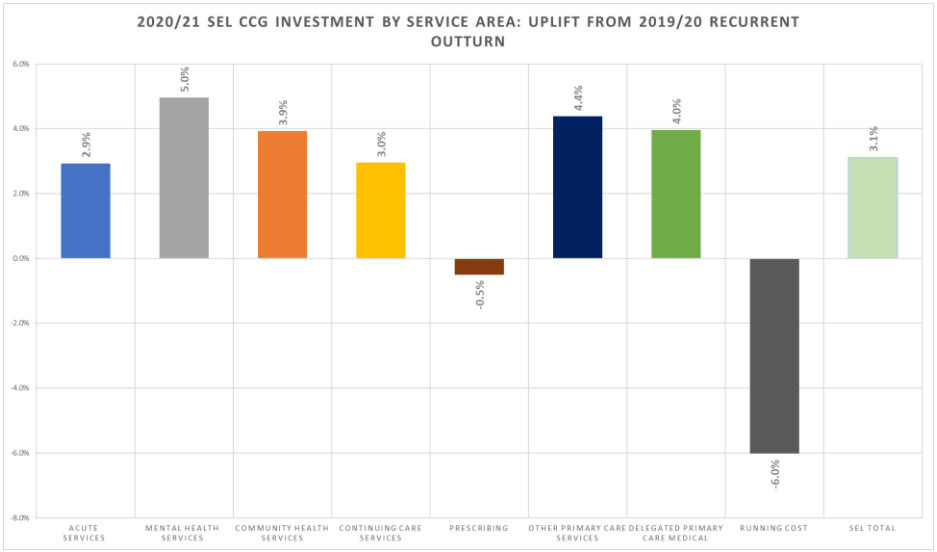
20/21 and 21/22 financial plans

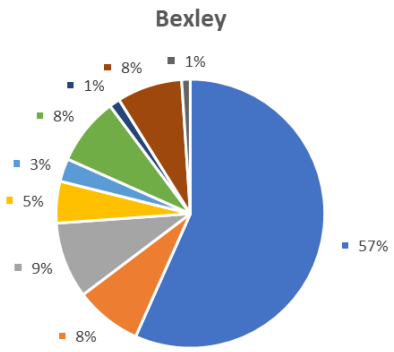
NHS – the chart below summarised the planned allocation of resource/investment by area related to CCG commissioned services, which reflected increased investment agreed across the system and which was aligned to the national Long Term Plan funding uplifts. The chart excludes non CCG sources of funding for SEL providers, noting these are significant for areas like specialised services.

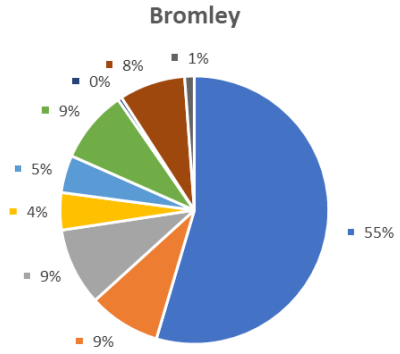
- The chart below is provided to illustrate our planned investment for 2020/21, to support expected demand and to support our service and investment priorities for the year.
- The COVID impact we have seen year to date, the financial implications of our recovery plans for the rest of the year plus the NHS funding regime for months 5-12 will result in a balance of spend/investment that differs to that planned
- It will however be important to understand these differences as we plan for the future and reassess out investment priorities whilst seeking to remain true to the overall objective set out in our Long Term Plan response of shifting investment to community based care and from treatment to prevention.

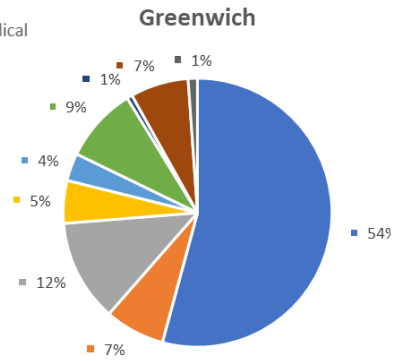
6. Planning for Recovery: finance #3

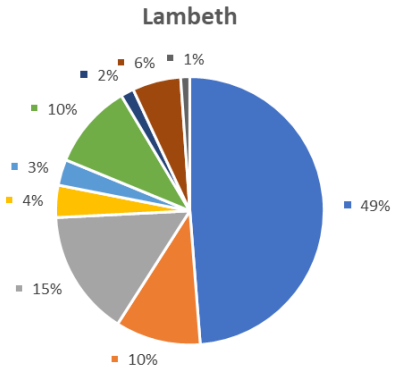


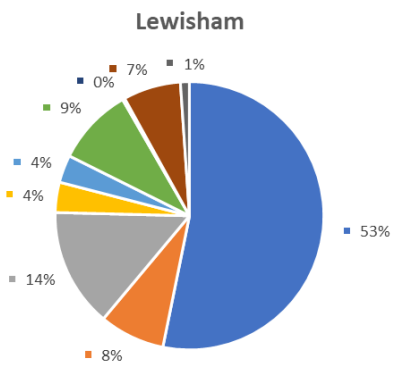


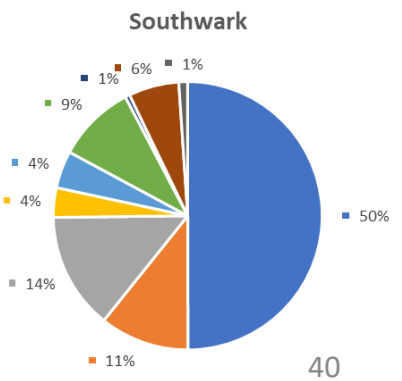












6. Planning for Recovery: finance #4

Principles

Whilst recognising the financial uncertainty that we are currently operating under we are committed as a system to managing our financial challenges and future investments in line with the following principled approach:

- Commitment to our existing strategic investment plan – differentiated by area of investment to support agreed strategic priorities and the development of community based care.
- Recognition that we will need to transition back towards our existing strategic plan as in the short term (20/21 and 21/22) there will be additional recovery priorities that we will need to fund
- Commitment to work collaboratively and with collective responsibility across system partners to ensure that we make ends meet over this period
- Commitment to securing demonstrable best value and to maximising available efficiencies to secure the lowest possible run rate - at organisation and system level
- Commitment to ensuring that the recovery commitments we make are cost neutral overall e.g. they can be managed within the total resource available to the system, recognising that this may require stringent prioritisation
- Commitment to ensuring that there are no adverse consequences of our recovery (and wider) actions - where there is either an intended or unintended consequence by organisation we will collectively work to mitigate the risk for that organisation

Funding recovery

- We will need to review our recovery commitments for the reminder of 2020/21 in the context of the national funding approach and the above principles, with a focus on ensuring that we can fund prioritised recovery commitments whilst also seeking to reduce our run rate wherever possible.
- For 2021/22 we will need to adopt a systematic approach to our financial planning that also reflects our principles, takes due account of our pre COVID strategic investment plans and our identified recovery priorities. We are developing a planned approach for doing so and will develop this further over the coming weeks as national guidance and our own recovery implementation plans provide greater certainty in terms of the ask and available resources. Our work will include a collective review of:
    - The investments and savings that we had planned for 2020/21 - to determine those that remain important (strategically or as a vital component of our planned recovery) and those that we would deprioritise as not feasible/no longer a priority in the current circumstances - this will give us a *'carry forward' proposition* as a first step
    - Our original 2021/22 LTP commitments, our recovery commitments and requirements and the scope for new savings for 2021/22 - this will give us a 'new requirement' proposition as a second step

6. Planning for Recovery: finance #5

- An assessment of the carry forward and new funding requirements against available resource and in the context of our pre COVID investment strategy.
- The development of options for managing the expected gap between aspiration and available resource to support an agreed within borough and system wide prioritisation to enable us to set plans that match available resources.

Ensuring our financial planning and investment approaches support integrated delivery and optimised utilisation of available resource

- As a system we are clear that we need to move away from the pre COVID funding regime if we are to support our objectives of downstream strategic investment shifts, the development of our prevention and community based care offer, integrated service delivery underpinned by genuinely pooled budgets, system approaches to risk and gain share to incentivise innovation and financial sustainability plus collective responsibility for managing the system finances. This will include our Long Term Plan commitment to move away from the Payment by Results funding model.
- There are a number of key pathways or service areas that we will need to work through to determine approaches that best meet these objectives.
    - Doing so will secure a system proof of concept in terms of demonstrating our principles and ensuring a collective agreement on the way forward for these areas that embed the benefits seen during the pandemic whilst also providing a sustainable funding approach for recovery/the future.
    - Potential areas that we will will consider are: discharge, Continuing Health Care, community services 2 hour rapid response/48 hour discharge models, shielding/vulnerable hubs, urgent and emergency new access models and digital by default. All will require agreed resourcing and resourcing shifts, alongside securing appropriate system incentives and risk/gain share approaches, to secure a sustainable financial delivery model

6. Planning for Recovery: finance Local Authority

The Council's finances have been severely affected by the ongoing pandemic. The cost of the Council's response to COVID-19, after government funding confirmed to date, is £25m: £15m on the tax base and £10m on lost income and additional expenditure. The ongoing impact of economic recession (including Brexit) is still to be determined but it is anticipated that demand for benefit will increase going forwards. The Council's current Medium Term Financial Strategy estimates a shortfall of more than £40m over the next three years.

The key challenges that impact on the demand for Council services are as follows:

- **Population growth** – particularly affecting people-based services such as adult and children's social care;
- **Ageing population** –affecting care for the very elderly but also impacting on care for younger adults and children with disabilities who are living longer as a result of improvements in medical care;
- **Impact of reducing preventative services** – reductions in budgets for preventative services such as early years, the youth service and aspects of adult social care provision are likely to affect demand for more acute services;
- **Impact of government policy** including children at risk, children involved in crime, adults with drug and alcohol problems, adults in residential accommodation and so on;
- **Household growth;**
- **Regulations and standards**

Officers are assessing the scale and nature of the challenge, identifying opportunities to capture positives from the crisis, and considering how these options may contribute to future cuts. This work is ongoing and includes reviewing progress with agreed cuts of £16.6m, the impact of COVID-19 on service delivery and budgets, and the continuing need for £19.0m of service pressures funded in 20/21.

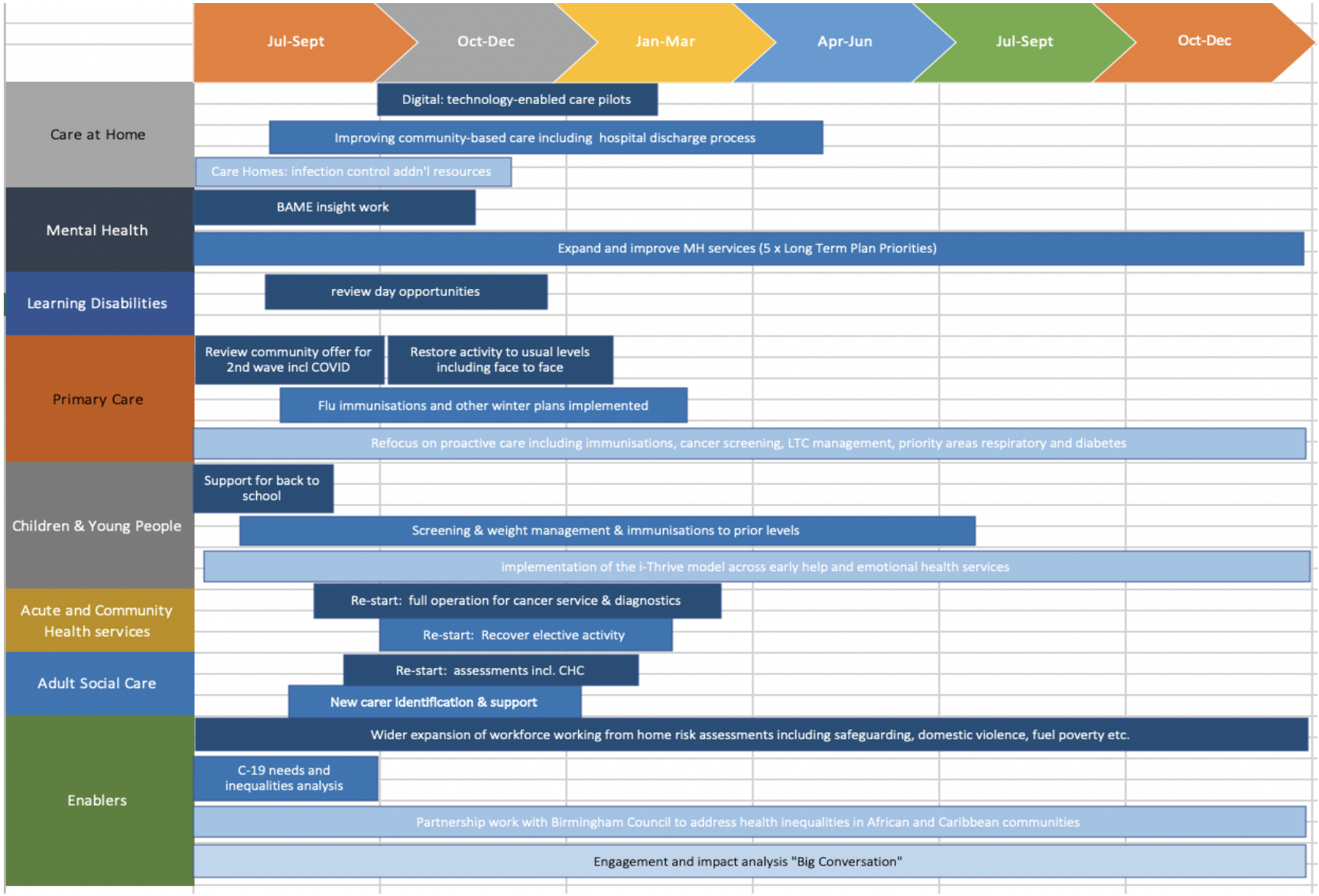
The Council priority will always be to protect the most vulnerable people in our communities and this period has brought considerable challenges for many of our residents and businesses. Although funding received by government to date has gone some way in alleviating the financial pressures being experienced, this still leaves a significant budget gap. While the Council has sufficient reserves to meet these financial commitments at present, without further investment the Council will be faced with some difficult choices.

Officers are intending to bring forward a financial stabilisation report with a budget update and medium term plan in the autumn.

7. DELIVERY

HIGH LEVEL MILESTONES

7. How will we deliver this: milestones for delivery



APPENDICES

SUPPLEMENTARY INFORMATION

APPENDIX: Input to development - Stakeholder groups

July

- Lewisham Health and Care Recovery Task & Finish Group – 8th
- Lewisham Health and Care Recovery Task & Finish Group – 15th
- Care at Home Group – 16th
- Mental Health Alliance Leadership Group – 27th
- Primary Care Operational Group - 30th

Aug

- GP Divisional Members Meeting – 3rd
- Healthwatch meeting with primary care - 6th
- Care at Home Provider Alliance Leadership Group – 13th
- LBL Executive Management Team – 14th
- Health and Social Care Leaders Forum – 14th
- Mental Health Alliance Leadership Group – 24th
- Joint Borough Based Board and Lewisham Health and Care Partners Executive Board – 25th

Sept

- Lewisham Public Engagement Forum – TBC
- Council EMT – 2nd
- Health and Wellbeing Board – 3rd
- Early Help and Prevention Board – 9th
- Mayor and Cabinet – 16th
- Patient Reference Group – 18th
- Mental Health Alliance Leadership Group – 21st
- Joint Borough Based Board and Lewisham Health and Care Partners Executive Board – 22nd
- Healthier Communities Select Committee - 23rd
- Primary Care Operational Group – 24th

* Please note that these dates may change and are subject to agenda planning discussions

APPENDIX: Partnership structure – board details

Group	Remit
Lewisham Health and Wellbeing Board	The role of the Health and Wellbeing Board is to carry out statutory functions set out under the Health and Social Care Act 2012. These functions include: promoting collaborative working amongst the various agencies whose role it is to advance health and wellbeing in the borough. As part of this the Board oversees the development of joint strategic needs assessments and informs the development of strategy. The Board also offers its opinion on how effectively the Council is performing its functions with regard to promoting health and wellbeing in the borough.
COVID-19 Health Protection Board	The COVID-19 Health Protection Board will report to HWBB to ensure that services can continue to operate as normally as possible, see link for outbreak plan https://lewisham.gov.uk/myservices/coronavirus-covid-19/health/the-lewisham-covid19-outbreak-prevention-and-control-plan
Lewisham Health and Care Partners Executive Board	This board provides system oversight and delivery of Lewisham's vision for health and care and sets the priorities for system transformation. This board works closely with the Lewisham Borough Based Board which is made up of CCG and Council commissioners.
Lewisham Borough Based Board	Borough (place) based boards (BBB) are prime committees of the SEL CCG governing body, bringing together the CCG in the borough and the local authority. The BBB is accountable for delegated functions and local delivery as well as helping to shape the priorities and work across SEL.
I-Thrive (CYP) Board	The iThrive Board brings together agencies in Lewisham to improve outcomes for children, young people and their families.
Stronger Communities Partnership Board	This board provides a partnership forum to develop joint actions between the local authority and statutory partners and the Voluntary and Community Sector.
Care at Home Alliance Leadership Group	This group is responsible for the development and implementation of integrated health and care (except MH) for adults in their own homes.
Mental Health Alliance Leadership Group	The group oversees the development and implementation of integrated provider arrangements to improve outcomes for people and which enables individuals and their families to take control of their recovery, wellbeing and overall life
Care Home Strategic Group	This group supports the partnership work with Lewisham Care Homes and their vulnerable residents and ensures delivery of the associated action plan.
The Lewisham Health inequalities group	This group provides oversight of the development of the health inequalities action on behalf of the Health and Wellbeing Board.
Lewisham Public Reference Group	Working closely with the CCG, the PRG members act as a mediating voice between the public and the CCG. They do this by meeting regularly and giving their opinion and views to make valuable contributions to help shape health services for people in Lewisham.

APPENDIX: LHCP – ways of working

The Lewisham Health and Care Partner Executive Board have agreed some key principles, behaviours and approaches which underpin their work

Principles

We have agreed to work together in good faith and will operate in accordance with the following principles to achieve our vision:

- **Equal voice** and status around the table irrespective of organisational size.
- **Openness and transparency** in relation to the sharing of information and data.
- **Fair and proportionate** distribution of risk and reward in relation to new ways of working.
- **Consideration** of the needs of the health and care system when taking decisions in our own organisations .

Shared behaviours

We are committed to working together to achieve our vision and will adopt the following behaviours:

- **Collaborative and constructive**: Partners will support the development of a whole system approach by engaging in collaborative and constructive dialogue.
- **Consensual:** Partners will seek to achieve consensus so far as is possible when making recommendations and taking decisions, while respecting each other's views and statutory accountabilities.
- **Supportive:** Partners commit to a supportive approach, sharing learning and expertise and thereby maximising transformation resources.

Shared Approaches

We will ensure our work:

- **Is population based** – ensuring that the health and care needs of the whole population are met.
- **Expands and strengthens primary and community care** – providing most care at home or near to people's homes.
- **Promotes health and wellbeing** – providing easy access to information and advice and the support, activities and opportunities available in neighbourhoods to improve and maintain health and wellbeing.
- **Provides a co-ordinated response to the specific needs of the individual** – providing holistic, personalised and integrated care that gives individuals control of their care, enabling them to be independent and make informed choices.
- **Is developed in partnership with patients, service users, carers and wider communities** – involving them in the design and development of services and pathways, listening to their experiences and seeking their feedback at an early stage.
- **Takes a whole system approach** - ensuring it contributes to the overall safety, sustainability and provision of high quality care; managing effectively our shared resource and delivering value to the whole system.
- **Is evidence based and outcome focused** – using the evidence available across health, social care and public health, taking account of patient and user experience, to identify and adopt best practice, develop new ways of working and identify and address inequalities.
- Actively and energetically seeks to **identify and rectify inequalities.**
- **Builds up from communities** to boroughs to sub-region, with integration at neighbourhood and primary care network levels.

APPENDIX: Evidence base for the impact of COVID-19

Those experiencing deprivation are more at risk from covid-19.
A PHE review of disparities in covid has found that after age the greatest risk factor for dying with covid-19 was among those living in more socioeconomically deprived areas *PHE: Covid-19 Disparities in Risks and Outcomes.*
People facing the greatest deprivation are experiencing a higher risk of exposure to COVID-19 and existing poor health puts them at risk of more severe outcomes if they contract the virus. *The Health Foundation: Will COVID-19 be a watershed moment for health inequalities?*

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. *Public Health England: Beyond the data: Understanding the impact of COVID-19 on BAME groups.*
ONS data shows the risk of a COVID-19-related death for males and females of Black ethnicity is 1.9 times more likely than those of White ethnicity. *ONS: Covid related Deaths by Ethnic Group, England and Wales (March-April 2020).*

Men working in the lowest skilled occupations had the highest rate of death involving COVID-19.
Among men, a number of occupations were found to have raised rates of death involving COVID-19, including taxi drivers and chauffeurs, bus and coach drivers , chefs and sales and retail assistants.
Men and women working in social care, including care workers and home carers, had significantly raised rates of death however health care workers were not found to have higher rates of death involving COVID-19. ONS "Coronavirus (COVID-19) related deaths by occupation, England and Wales .

The largest disparity in deaths and outcomes found was by age.
People who were 80 or older were seventy times more likely to die than those under 40. COVID-19 diagnosis rates increased with age for both males and females and these disparities exist after taking ethnicity, deprivation and region into account. *PHE: Covid-19 Disparities in Risks and Outcomes.*

Smoking is associated with increased severity of disease and death in COVID-19 patients. *WHO: Smoking & Covid 19.*
Compared to former and never smokers, current smokers were at greater risk of severe complications and higher mortality rate. *PLOS ONE: Prevalence, Severity and Mortality associated with COPD and Smoking in patients with COVID-19.* Smoking is known to impair the immune system and increase risk of respiratory tract infections all of which increase the risk of contraction and death. *The Lancet: Tobacco smoking and COVID-19 infection.*
Smoking was considered an additional risk factor for those with severe mental illness due to the high numbers in this population group**.** *JAMA: Addressing the COVID-19 Pandemic in Populations With Serious Mental Illness.*

People experiencing homelessness are vulnerable to infection and severe disease. *Medrxiv: COVID-19 and homelessness in England: a modelling study of the COVID-19 pandemic among people experiencing homelessness.*
Homeless population are at risk from multiple health conditions and access to health services has worsened for this group due to constraints of lockdown and the need to socially distance. *Groundswell: Monitoring the Impact of Covid.* Additionally those placed in emergency housing are at greatest risk due to overcrowding, small spaces and sharing facilities with strangers. *KCL: The coronavirus response shows we can solve the UK's housing crisis.*

Those with substance use disorders are vulnerable to contract the infection due to existing health conditions and high risk behaviours.
SUD is associated with a range of health issues such as cardio-respiratory emerging evidence suggests this could heightened their risk for COVID-19 which can be further exacerbated by high risk behavior such as sharing of cigarettes, alcohol and needles increasing the chance of outbreak in this community. *NCBI: Covid 19 and Addiction.*

People and places with the lowest incomes are the most vulnerable to job loss and employment impacts.
Employment has been impacted heavily by lockdown measures, particularly for those in lower socioeconomic positions, research shows that nearly 50 percent of all the jobs at risk are in occupations earning less than £10 per hour. *McKinskey & Company: COVID-19 in the United Kingdom: Assessing jobs at risk and the impact on people and places*
Unemployment is bad for health and wellbeing, as it is associated with an increased risk of mortality and morbidity an increase due to economic impacts from covid-19 could further impact population health and health inequalities. *PHE: Health Matters: Health and Work.*

School closures may widen existing educational inequalities. *The Health Foundation: Emerging evidence on health inequalities and COVID-19: May 2020*
School closures in the UK are more likely to negatively impact those from lower socioeconomic background with pupils from better-off families spending longer on home learning and having better access to more individualised resources. *Institute for Fiscal Studies: Learning during the lockdown: real-time data on children's experiences during home learning.*
We may also see these closure having a negative impact on nutrition for children, as many families rely on free school meals as source of this. *UNESCO: Adverse consequences of school closures.*

Lockdown has forced people to spend more time at home in environments sometimes unsuitable to their health.
Housing conditions are the worst for Britain's 5.5 million private rented sector households, those in rented accommodation are more likely to be younger and in lower socioeconomic positions.
Additionally evidence suggests small homes can impact health in many ways through lack of access to green space and exercise space as well as lack of light and ventilation. The increased time spent in homes unsuitable for health could be having an increased impact on population health, particularly for the more deprived. *SMF: Homes, health, and COVID-19: how poor housing adds to the hardship of the coronavirus crisis* & UCL: Coronavirus pandemic puts the spotlight on poor housing quality in England.

UK domestic abuse charities have reported a 25% increase in calls made to its helpline since lockdown. *NCBI: The socio-economic implications of the coronavirus pandemic (COVID-19): A review*
Domestic abuse services have experienced challenges in providing support within the current government guidelines with many forced to reduce or withdraw support that they are able to offer women and children – largely due to staff shortages and challenges in adapting to remote delivery. *Women's Aid: The Impact of Covid-19 on Domestic Abuse Support.*
This is further impacted by an increase in pressure on associated risk factors such as unemployment and financial security with added stress potentially causing an increase in drinking at home; a risk factor in domestic violence. *NCBI: An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives*

Increase in stress, anxiety and fear during the crisis will impact individual's mental health.
Many of the impacts from the pandemic won't be physical but will be economic or social. The increase in risk is likely to be impacted by factors including socioeconomic inequalities, poverty, debt, unemployment, food insecurity, social isolation, physical distancing, and physical inactivity, all of which would also be expected to increase the risk of relapse in individuals with a mental disorder. The Lancet: Addressing the public mental health challenge of COVID-19. & Mental Health Foundation: The COVID-19 pandemic, financial inequality and mental health.
Furthermore the inequality in the fallout from covid-19 means that the mental health consequences may also be unequally felt, impacting the most deprived and further entrenching the inequalities of mental health. Mental Health Foundation: The COVID-19 pandemic, financial inequality and mental health.

APPENDICES

SYSTEM PLANS

Lewisham Primary Care Recovery Plan #1

- *The following areas have been identified as priorities for the local primary care recovery plan and will be linked to other national and local recovery plans.*

Priority area	Description	Considerations
Planned care	*Need to ensure community and acute services pathways including outpatient referrals (especially cancer 2WW) and diagnostics are fully functioning so patients are appropriately managed and that pressure does not fall back on primary care – this may involve new models of service delivery i.e. virtual clinics, telephone/video appointments, patient initiated follow ups.* *Also need to take advantage of the current situation to accelerate the national/London/SEL ICS vision for community based care, with services moving into the community. This will both support pressures on acute services (i.e. long waiting lists) and respond to public feedback in regard to anxieties about accessing hospital services.*	*Will need close working with community/acute providers on this* *This will include joint work with neighbouring boroughs where appropriate.* *There is an opportunity to build on initiatives already underway e.g. PCN first contact physio service, dermatology/diabetes PCN pilots* *Need to ensure sufficient resources follow any work moved into the community.*
Proactive care	*Refocus on proactive care including immunisations, cancer screening, LTC management, postnatal checks, SMI/LD/NHS Health checks, diabetes prevention etc* *We will need to consider a preventative and early intervention model of service (including virtual models) which empowers and builds the capacity of local services and communities to support people earlier around existing and new needs we expect to emerge – we will need to consider what proactive care interventions we might want to end / amplify / let go / re-start and which population cohorts and pathways we want to prioritise.* *We will need to have specific focus on our Care Home residents and patients who have been shielding.*	*There is likely to be an increased need for benefits and employment support as well as people dealing with trauma and need for crisis prevention – will need to consider the on going role of local social prescribing resource to help support these needs.* *Working with our PCNs, practices, federation and wider stakeholders we will need to consider the implications of the PCN DES Care Homes and Anticipatory Care specifications to support maximum impact.*

Lewisham Primary Care Recovery Plan #2

Priority area	Description	Considerations
Covid community management	*Need clear plans for the on-going community offer for suspected COVID cases and those who are discharged from specialist care.* *This will need to include the future of COVID Centres and approach to dealing with a potential 2nd wave of COVID, including adequate funding, PPE and access to estates.*	*Any support with demand modelling would greatly enhance ability for local planning.* *Need to consider the on going impact on GPEA capacity if we continue to divert resource to support COVID centres- with current funding streams it is not possible to provide both COVID centres and a full GPEA service.* *Need to link with acute/community respiratory services to ensure a joined up and complementary approach.*
Winter planning	*Need to ensure robust plans in place to manage winter pressures and potential overlap with suspected COVID cases.* *This will include a specific focus on an enhanced flu campaign – an initial flu plan has been drafted and is currently being peer reviewed across SEL.*	*Need to ensure whole system approach to this for maximum impact.*
Urgent and emergency care	*Need to consider primary care input to support inappropriate demand at front door of A&E including the co-located GPEA service and interfaces with NHS 111 to ensure only patients requiring emergency care are seen at ED.* *Need to consider interface between OHL GP home visiting service and CARRS and how these all relate to the wider community based care developments. Also need to be clear on function of ACU going forward and how primary care best make use of this.*	*Agreement on a SEL position on management of unregistered patients presenting at A&E/NHS 111 would be useful.* *Need to progress the integration of Digital First and Digital by Default models in the UCC and GPEA to support patient flows and redirection of patients to the most appropriate setting.*
Evaluation and iteration	*Impact of interventions need to be continually monitored and evaluated and then iterated as required.* *Through clinical effectiveness models, there needs to be focus and support for ongoing Quality Improvement (QI) in primary care.*	*Evaluation and Quality Improvement in primary care could be supported at a SEL level.*

Lewisham Primary Care enablers

Priority area	Description	Considerations
Communications and engagement	*Robust engagement and clear communications will be vital to ensure the plan is well informed and that all local stakeholders (including patients) are aware of their required roles to support its success.* *Need to build on work already undertaken by local Healthwatch especially in addressing misconceptions/concerns that patients have about access to primary care services.*	*Communications could be best coordinated at both a borough and SEL level for consistency and maximum impact.* *It is essential that communications does not become purely top-down. An effective strategy needs to include bottom up development of ideas – for example through Communities of Practice/networks of primary care nurses & GPs, informing colleagues across SEL of what is being achieved locally to share best practice.*
Workforce	*Need to ensure a continued focus on the health and wellbeing of primary care staff (including mental health) to support on going service delivery in challenging circumstances.* *Specific focus to be given to risk assessment for BAME staff.* *Work will continue on our local primary care WRES action plan as informed by the primary care WRES survey undertaken in 2019.*	*Need to consider what role the local CEPN Training Hub can best play to support training in new ways of working and also recruitment and retention.* *Also need to consider any opportunities that staff engaged through the PCN ARR scheme may be able to play in recovery and beyond. Social PCN prescribers have already made a significant contribution and now need to maximise impact of clinical pharmacists and also new first contact physio roles to support recovery efforts.*
Estates	*Will need to consider any enhancements/developments to primary care estate to support new ways of working. This could include adaptations to support social distancing/IPC (i.e. Perspex screens at reception, hot and cold zoning of premises, hub working) but also the design of any new developments to take into account the shift to digital access.*	*Coordination of approach across SEL would be beneficial to ensure consistency.* *Increased remote working in primary care and community services can free up estate for use by PCN ARRS and GP Federation staff (it is projected that there will be approx 90-110 additional staff by 2023)*
Finance	*Will need to consider options to resource the delivery of the plan both in terms of local resource that can be redirected/refocussed and also any available external funding at a SEL level and wider.*	*Would be helpful if the SEL central team could map any potential external funding sources to support local planning i.e. GP Forward view, PCN development, ETTF, improvement grant, ICT capital, COVID funds*
Contracts / incentives	*Will need to consider how any local/national contracts and incentives can best support delivery of the plan i.e. PCN DES / QOF / PMS premium.*	*Need absolute clarity on expectations for delivery of national schemes and the level of local discretion available.*

Lewisham Primary Care enablers

Priority area. We need to	Description	Considerations
Digital	• *IT & Innovation will form a significant part of the framework for the Recovery Plan and integrated working as a concept. Digital First and Digital by Default should be at the heart of our plans and of our future primary care service offer .* • *We need to maximise and build upon the current momentum with shift to digital services both from patients and practices (i.e. remote working / telephone, electronic and video consultations / SMS) to support improvements in access and efficiency.* • *However, need to ensure no patient groups are disadvantaged through digital exclusion and the benefits of face to face consultations not lost.* • *Support the integration of clinical systems e.g. for virtual clinics / MDTs and ensure appropriate technical support to those systems.* • *Ensure practices have access to the right hardware/software solutions to best support their patients and work efficiently (i.e. webcams, multimedia monitors, iBoards, DXS, WIFI, DOCMAN, SMS, telephony, practice websites)* • *Support patients to seamlessly register with GP practices digitally* • *Continue the digitisation of patient records to improve efficiency, reduce bureaucracy and maximise available estate* • *Continue support and focus for our local online consultation programme through the Ask NHS GP APP and widening the suite of tools available to all practices to include systems such as eConsult/AccurX (video and SMS) based on patient and practice requirements – also to support rapid integration with the national NHS APP to enhance patient experience and mitigate against potential confusion with multiple systems/access points* • *Ensure best long term use of the digital tools made available to primary care in response to COVID – i.e. laptops, RAS tokens, UC telephony*	*We would support continued coordination of the digital work stream at a SEL level with local autonomy in light of individual borough positions – this has worked well to date.* *A local borough ICT group is being formed asap with all health and care partners to support a joined up approach to this. A joined up approach is essential to developing, funding and delivering gold standard IT solutions across Lewisham and the wider SEL footprint.* *Building on the initial work undertaken with Healthwatch, we will need to engage with patients to establish their appetite for digital interactions and identify and try and mitigate any ''digital exclusion' issues. This could include establishing a non-digital point of access for digitally excluded patients – i.e. an "analogue hub"*

Lewisham Primary Care leadership

- ***The newly reformed Lewisham Primary Care Operational Group (PCOG) has taken on the role of the local "primary care recovery cell".*** *This group is already part of established governance structures and its membership includes many of the key stakeholders who will contribute to the development and delivery of the primary care recovery plan (i.e. public health, LMC, Healthwatch, SEL Primary Care Team). The group formally meets on a regular monthly basis but it is envisage that much work will be undertaken via email correspondence due to the required timescales involved.*

- ***The Borough Based Board (BBB) and Lewisham Health and Care Partners groups will act as the local oversight mechanism for the primary care recovery plan and to ensure alignment with wider community recovery plans.*** *The Primary Care Operational Group reports directly to the Borough Based Board.*

- ***The Lewisham PCN Forum will be used to ensure engagement and leadership from a primary care provider perspective – this forum has representation from all 6 Lewisham PCNs, the borough wide Lewisham GP Federation and the Lewisham LMC.*** *There will also be PCN/OHL engagement at the Lewisham Health and Care Partners (LHCP) group.*

- ***The Lewisham LMC will also be engaged separately through the now monthly liaison meetings.***

- **As highlighted, the strategic Lewisham IT Group will:**

    - **Coordinate a joined up approach** to digital strategy across the borough
    - **Assess which technology platforms** we should aim to end / amplify / let go / re-start in the longer term in line with new models of care
    - **Develop solutions** to digital / system connectivity issues

- ***Creation of sub groups / Task and Finish (T&F) Groups will be considered to ensure specific work steams are progressed and outcomes delivered.*** *A joint T&F group with LGT and primary care is already being convened to consider specific interface issues related to both planned and unplanned care.*

- ***The local membership is to be engaged and a local membership meeting took place in August.***

Lewisham Council Recovery Plan summary

The overarching strategic aims of recovery are:

- To be prepared and resilient for further COVID-19 demands
- To work to secure the Council's financial stability
- To reinvent and refocus service delivery in order to better serve residents' needs
- To maintain a more agile way of working
- To retain and embed streamlined processes and stop practices that don't add value
- To aim higher and deliver better outcomes for our residents
- To understand and respond to direct and indirect impacts of COVID-19 on our communities, services, local economy and the Council
- To strengthen and embed our connection with residents in order to support sustainable renewal, based on local strengths and identified needs
- To lobby for, influence and shape any new national standards and statutory duties
- To work in partnership to develop an ambitious long term vision for Lewisham the place
- To harness community spirit, strengthening community networks and promoting culture

Key focus of the borough's recovery will be on:

- **Community Development and Resilience -** harness community spirit and capture goodwill, creativity and innovation.
- **Inclusive Economic Recovery -** support and promote a sustainable and thriving local economy and place
- **Health and Wellbeing –** tackling health inequalities and promoting good public health and wellbeing
- **Cultural Recovery –** Borough of Culture will be delivered in 2022 increased emphasis on tackling inequality and being strengthened by our diversity
- **Green Recovery –** continuing to take action on the climate emergency
- **Education and achievement (our young people) –** to work across the system, promoting the mental health and wellbeing of children and young people.

A focus on tackling racial inequalities will be woven through every element of our recovery. The Mayor, as leader of the borough, will take a lead on ensuring that recovery activity is coordinated and designed to effect long term and sustainable change for Black and minority ethnic communities in the borough.

Wider System Plans: Acute Care

Key changes made as part of COVID response:

- Routine elective surgery and routine diagnostic activity was stood down across all providers for around 13 weeks – backlogs have therefore increased significantly. Additional infection prevention and control measures were introduced including COVID protected pathways, additional PPE for staff and patients and additional cleaning / air changes between patients.
- Digital by default, in particular the use of telephone/video for outpatient appointments.
- Significant surge capacity for critical care opened, including the use of theatres and recovery areas, with very successful networked approaches to critical care provision across the three SEL providers.

Key elements of recovery plan:

- **Restarting activity** via a phased approach, with additional precautions in place, such as patients isolating before admission, to ensure patient and staff safety.
- **Redesigning services,** in line with infection prevention and control guidelines – e.g. spacing in Emergency Departments – and in response to evaluation of new ways of working introduced in the response phase. Key initiatives include:
  - Urgent and Emergency pathway transformation schemes driven through the system wide Help Us Help You programmes, including Same Day Emergency Care
  - Building from the rapid expansion of virtual by default models during the pandemic to drive our outpatient transformation programme at pace and scale.
- **Establishing a programme of work** to be progressed via the Acute Provider Collaborative, including:
  - **Elective surgery** – orthopaedics, urology and ophthalmology as initial priorities, to be followed by ENT, general surgery and gynaecology.
  - **Specialised services** – critical care as a top priority.
  - **Clinical support** – pathology (GSTT/KCH only) and endoscopy as initial priorities, to be followed by radiology/imaging and pharmacy.

Borough interfaces

- Ensuring **effective and timely access to swabbing** for patients ahead of admission.
- Three **diagnostic community hubs** will be established in SEL by April 2023. Locations are to be determined but likely to include Queen Mary's Sidcup with plans to develop from April 2021.
- **Maintaining discharge arrangements** to ensure that patients do not spend longer than necessary in hospital.
- **Supporting virtual by default** access to acute services and referral support to primary care e.g. using Consultant Connect.

Ways of working:

- To ensure the safe and effective recovery of clinical services post COVID-19 and to address the ongoing variation within the acute system in terms of access and outcome, SEL's three acute providers have formed an Acute Provider Collaborative (APC), a mutually beneficial model of collaboration between the three Trust Boards, enabled through transparent governance and decision making.
- To support delivery the APC will continue to work in collaboration with other organisations / partnerships across SEL via both informal discussions, borough partnerships and ICS arrangements, for example through the SEL ICS Recovery Leadership Group.

Wider System Plans: Adult Community Health services

Key changes made as part of COVID response:

- Radical restructuring of community services to shift resources to frontline admission avoidance/early discharge/multiagency flow processes via single point of contact – integrated discharge processes, palliative care end End of Life policies and procedures
- Introduction of virtual clinics across community services and step up of digital approach
- Introduction of borough-based demand and capacity modelling to inform workforce plans and specific service developments (eg, intermediate care).
- Weekly cross-community provider meetings to share good practice, jointly problem solve and take sector approach where sensible to do so

Key elements of recovery plan:

- The priorities for adult community services are:
  - Address health inequalities focusing on shielded and vulnerable people
  - Keep people at home (including admission avoidance)
  - Support discharge home quickly and safely
  - Focus on the last years of life (including supporting care homes)
- SEL is an early accelerator site for 2 hour rapid response and 2 day reablement and we will be implementing our plans to secure this as part of recovery
- These priorities will be enabled through: a digital first approach; building the workforce (including taking a cross-provider approach to workforce development); measuring progress (including community, social and acute care indicators); and responding to ongoing COVID infections.

Borough specific aspects of recovery plans

- Community services a key element of borough plans with embedded joint local working across primary care, community, social care and mental health
- Developing borough-based integrated delivery plans for each of the four priorities
- Taking a borough approach to the modelling/ forecasting of demand and capacity, based on acute, community and social care activity.
- Developing local plans for the support of care homes

Ways of working:

The priorities will be:

- Delivered in partnership with primary and social care, hospices and the voluntary sector
- Informed by proactive engagement with referrers, patients and families
- Led by clinicians, with advice from social care professionals
- Underpinned by the principles of 'Home First' and 'Right Care, Right Time, Right Place'
- Informed by population data and demand and capacity modelling.

Mechanisms to support these ways of working include: an agreed core offer for SEL residents for community services to support the delivery of equal access and equal outcomes; multiagency steering group for each priority, chaired by providers; multiagency dashboard to measure progress across sectors; joint working across the four community providers including active working towards a SEL formal community provider collaborative; cross provider approach to workforce development (staff passport in first instance) and shared use of some services (eg, intermediate care beds) to enable infection control and specialisation; shared learning (eg, roll out of: GSTT @Home service; Bromley Healthcare's e-scheduling, etc.).

Wider System Plans: Mental Health

Key changes made as part of COVID response:

- Fully operationalised pre-admission testing for all people, regardless of age, requiring non-elective care
- Fast-tracked discharges to free up ward capacity for use by tertiary Acute partners to support system surge
- New and innovative all-age Crisis Assessment Centres opened to alleviate pressure on Acute emergency departments and provide a targeted mental offer in a calm environment. Working to develop and strengthen this model with acute partners to deliver a best in class 'mind and body' offer
- Routine MH elective care continued throughout our Covid-19 response due to service type (therapies) and the ability to mobilise technology at pace to support staff and service users to access the necessary technology for meaningful digital contact. 70%+ of all elective community contacts (in the main IAPT services) are now via on-line virtual or telephone consultation
- Increased Home Treatment Team service capacity to support patients post-discharge
- 24 hour all age Crisis Lines established including a dedicated out of hours specialist CAMHS line

Key elements of recovery plan:

- Maximising system resources to keep our communities safe, well and thriving
- Improving our front door and crisis offer for mental health
- Delivering a best in class integrated offer across Housing, Welfare, Education and Employment opportunities
- Delivering our Primary Care Network Offer for Mental Health ambitions (a population health based system with multidisciplinary support wrapped around the individual based on their needs)
- Reducing health inequalities across our communities
- Pharmacy and prescribing with a focus on supporting individuals in our communities experiencing psychosis or schizophrenia

Any borough specific aspects of recovery plans

- In taking forward the work of Black Thrive and Lambeth Alliance, commenced pre—Covid-19, Lambeth is focussing on a review of ethnicity data to support further our understanding of the impact on BAME communities. There will be shared learning here for other Boroughs
- Data sharing across partners in Lewisham is supporting the build of a population health model that is delivering results in reducing waiting times and referrals to secondary care, underpinned by rapid decision making

Ways of working:

- There was an SEL System Summit on 2 June jointly hosted between NHS and Local Authority partners to address how we can work together to protect our communities' mental health as result of Covid-19. This supports our planning for targeted and culturally appropriate support services / offers as a system recognising the disproportionate impact of Covid-19 on our BAME communities
- The South London Partnership is already sharing resources to deliver a three provider collaborative approach across Mental Health provision in South London. working closely with ICS partners. As a recognised best practice model this offers us the opportunity to deliver our existing plans at greater pace to improve patient care whilst supporting our staff in the best way possible.