

Wider Impacts of COVID-19

Joint Strategic Needs Assessment

Executive Summary

The purpose of this needs assessment was to understand both the direct and in-direct impacts of COVID-19 within Lewisham, as well as seeking to identify any impact on health inequalities. The overall number of cases, deaths and vaccine uptake are summarised, followed by analysis of a variety of data and indicators to understand 'knock-on' effects of COVID-19, for example waiting lists for treatment and uptake of preventative measures such as (other than COVID-19) vaccines and cancer screening.

Whilst the older population and those with certain underlying health conditions were widely seen to be more vulnerable to the COVID-19 virus itself, further inequalities were seen, in that characteristics including but not exclusive to a person's ethnicity, living conditions or the type of work they did, impacted how likely they were to contract COVID-19 and how likely they were to become seriously ill. This is well summarised in ['The Unequal Pandemic: Health Inequalities'](#). It was notable that Lewisham's population saw a higher age-standardised COVID-19 mortality rate than both the regional and national average. This age-standardisation is important, particularly for an area like Lewisham which has a younger population bias. Data sources analysed also found that the diagnosed prevalence rate of Long COVID is higher in Lewisham than the national average.

The wider impacts of COVID-19 have been felt right through the entire population. Issues in difficulty accessing healthcare both during lockdowns and subsequent delays and extended waiting lists have been extensive. However, those who were already in poorer health have been disproportionately impacted by this. Delays in accessing healthcare are continuing and waiting times and targets are frequently not meeting operational standards.

Key findings to note include issues with the below:

- Cancer screening
- Immunisations
- Hospital Treatment Waiting Times:
- Two Week Wait Cancer Referrals:
- Child and Adolescent Mental Health Service

Although this needs assessment has strived to understand the breadth of effects of COVID-19, it is highly likely some of the wider impacts of the pandemic will not be fully understood for years to come. Some services now appear to have activity levels similar to before COVID-19 (such as surgery and Sexual Health), however in cases where services were temporarily halted or reduced, it is not clear how backlogs are being caught up with. Mental health is another key area that will need to be monitored closely post-pandemic. Further attention needs to be given to the areas outlined above. Fuller understanding of waiting lists and any disproportionate impact this has between residents is required to increase awareness of the wider impacts of COVID-19 on the population and healthcare system. Additional promotion of all preventative healthcare including screening and immunisations is needed to bring levels back to that seen pre-pandemic.

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Background

Even at the beginning of the COVID-19 pandemic the wide reach, both directly and in-directly of the virus quickly became apparent in a variety of areas. Therefore, this joint strategic needs assessment was prioritized to attempt to gain as much understanding of the impact and whether these impacts had disproportionately affected different groups of the population.

Data sources used were from a combination of local and national data from the UK Health Security Agency and Office for Health Inequalities and Disparities. This was crucial to benchmark data where possible to understand if other areas experienced COVID-19 differently to Lewisham. This was then complimented by a combination of service specific data, Hospital Episode Statistics and data from Lewisham’s Population Health Management System.

Introduction

The COVID-19 pandemic has had a profound impact across the world. For Lewisham we want to understand not only the way resident’s health was directly impacted by COVID-19, through the number of cases and deaths but how the widely reported disproportionate impact on certain population groups has affected health inequalities within the borough.

This latter focus is due to the existing health inequalities whereby in Lewisham, if you are a baby boy born in a household that falls within the least deprived areas in the borough you can expect to live just over 7 years longer than a fellow boy born in a household within the most deprived areas¹. This difference in health status (in this case life expectancy at birth) based on deprivation is a stark example of the health inequalities that were present in Lewisham, even prior to COVID-19.

From early in the pandemic, research conducted nationally and in London has drawn attention to a wide range of population groups who have been disproportionately affected by COVID-19. Within London, the GLA has reported that:

“The pandemic has widened existing inequalities and created and exposed newly vulnerable groups. The reasons why particular groups have been more vulnerable to COVID largely relate to the socio-economic and structural inequalities they experience”²

The same document also defines who has been ‘Directly vulnerable’ and ‘Indirectly vulnerable’ to COVID-19.

Directly vulnerable

This includes groups who are more susceptible to contracting COVID-19; more likely to get severe disease requiring hospitalisation; and more likely to die from the disease.

Indirectly vulnerable

This includes groups who are vulnerable to the impacts of the policies used to control COVID-19 and the resulting recession - such as those in insecure housing, recently unemployed, and those with other medical conditions who have missed out on treatment or diagnosis.

These also represent a public health concern due to the knock-on implications for physical and mental health, homelessness, and poverty.

Vulnerability in terms of poor health can be seen as clinical vulnerability but also social and economic vulnerability, which in turn impacts on health and wellbeing (the so called ‘social determinants of health’); the two are closely related. The impacts of the pandemic have been

¹ [Lewisham Health Inequalities Toolkit - 2022](#)

² *Wider Impacts of COVID-19 – Overview of regional responses and resources available*, GLA, May 2021

caused by the disease itself but also the policies which have been used to control its spread. This JSNA topic assessment aims to examine the impact on both vulnerabilities.

Bambra et al. (2021)³ have also summarised that COVID-19 outcomes are worse in less advantaged groups and communities. They have described it as a ‘Syndemic Pandemic’, whereby health problems and inequalities that were already present then exacerbate the prognosis and burden of disease of the pandemic disease itself, in this case COVID-19. They have then presented this graphically in Figure 1 (below).

Figure 1: Pathways to Inequalities in COVID-19

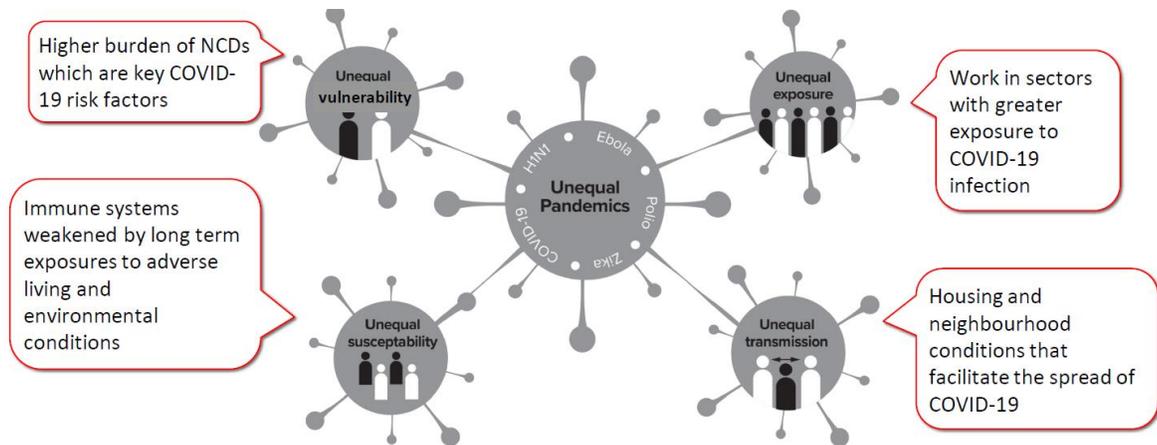


Figure 1 (above) highlights the complex compounding factors that mean certain groups are more vulnerable to COVID-19, as well as poorer health outcomes overall.

COVID-19 Direct Impact Section

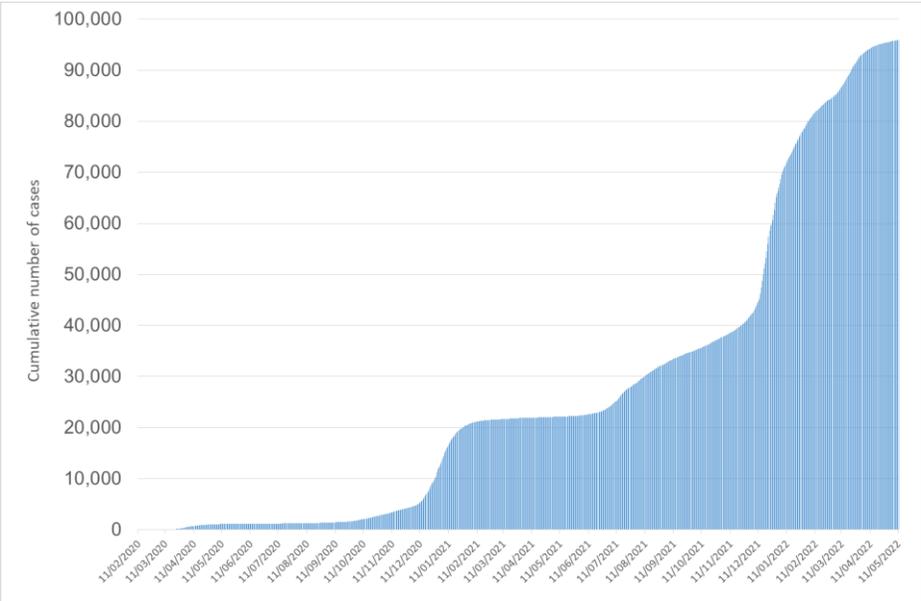
COVID-19 Cases

As at 31/03/22⁴ there were 92,787 confirmed cases of COVID-19 within Lewisham residents. From the 31/01/22 the national methodology used to count COVID-19 cases changed from reporting the number of people who have tested positive for COVID-19 to the number of episodes (instances) of COVID-19. This later methodology allows us to have better understanding of people who became re-infected with COVID-19 since the start of the pandemic. It is important to acknowledge this is a count of the number of reported cases, with the true number likely to be higher.

³ [The Unequal Pandemic: COVID-19 and Health Inequalities](#)

⁴ Measured until this date, as it was the last day of universal free testing

Figure 2: Number of Confirmed COVID-19 Cases within Lewisham residents up to 31/03/22



(Source: data.gov.uk, accessed 13/05/22)

55% of confirmed cases in Lewisham were female, 45% were male (no other gender options were available for reporting). 73,220 confirmed episodes stated their ethnicity. Of this group who stated their ethnicity 32,413 (44.3%) were from a White British ethnic group. 5,264 were from a Black African ethnic group (7.2%).

Table 1: Confirmed COVID-19 episodes of Lewisham residents by ethnicity

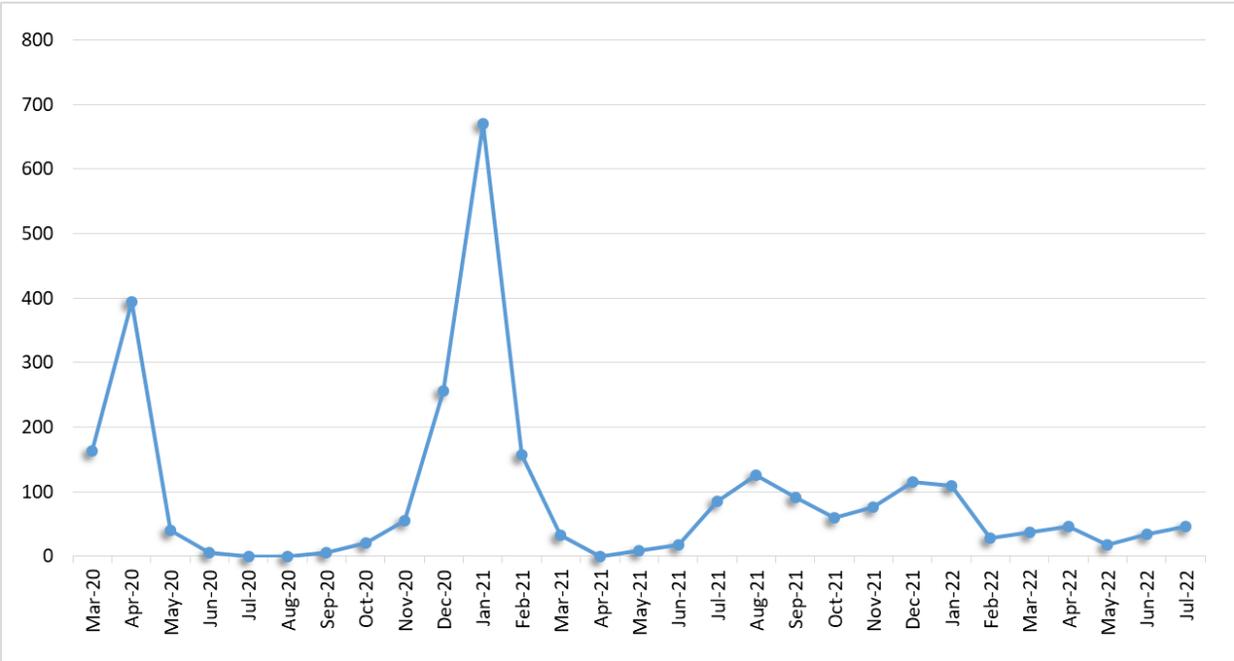
Ethnicity	Number of confirmed COVID-19 episodes	% of COVID-19 episodes
White British	32,413	44.3%
Black Caribbean	6,354	8.7%
Black African	5,264	7.2%
Asian	5,309	7.2%
Mixed	4,401	6.0%

(Source: UKHSA)

COVID-19 Hospital Admissions

Figure 3 (below) shows COVID-19 admissions by month throughout the pandemic. The ‘second wave’ of COVID-19 accounted for more hospital admissions by month than the first wave. Despite the extremely high COVID-19 infection rate in December 2021 and January 2022, this did not translate into hospital admissions in the same way as previous infection peaks.

Figure 3: Monthly Hospital Admissions from COVID-19, University Hospital Lewisham



(Source: NHS Digital/Hospital Episode Statistics)

Table 2: Hospital admissions (into University Hospital Lewisham) due to COVID-19 broken down by ethnicity

Broad Ethnicity	2020/21		2021/22	
	Number of Admissions	%	Number of Admissions	%
White	757	52.2%	279	43.7%
Other	144	9.9%	44	6.9%
Asian	108	7.4%	52	8.2%
Black African	119	8.2%	42	6.6%
Black Caribbean	163	11.2%	134	21.0%
Black Other	98	6.8%	61	9.6%
Mixed	61	4.2%	26	4.1%
Total	1,450	100%	638	100%

(Source: Hospital Episode Statistics Database, 2022)

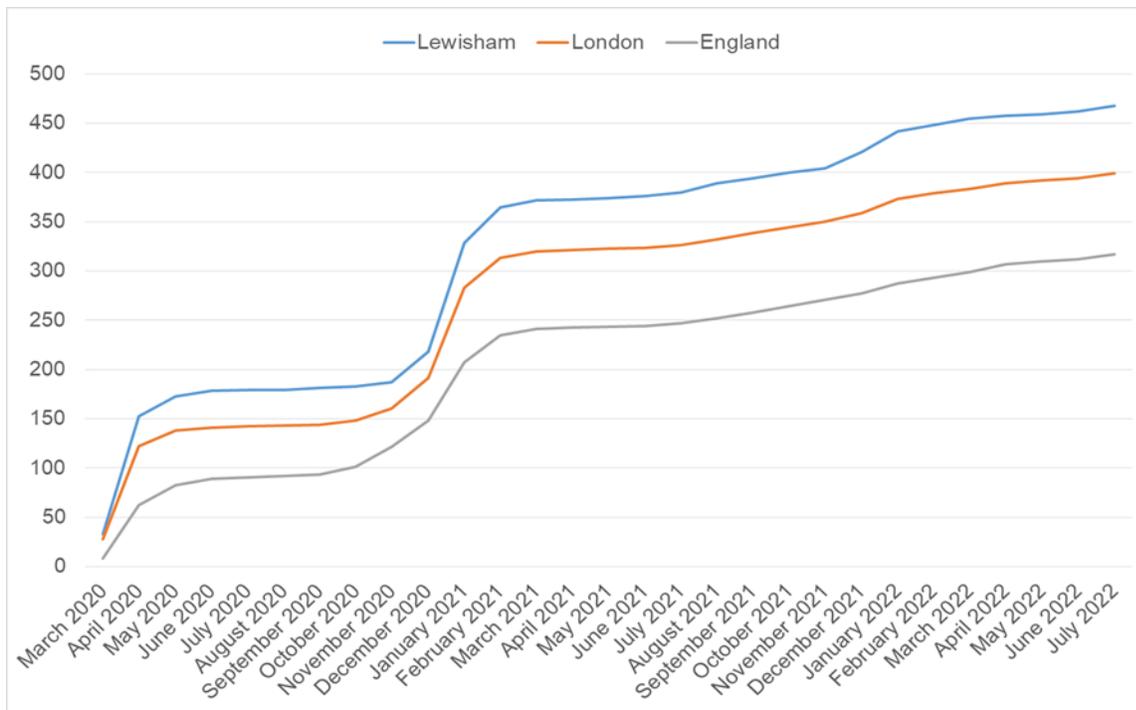
Over half of COVID-19 hospital admissions in 2020/21 were people from a White ethnic group. This is approximately in-line with the estimated proportion of the population from this ethnic group who live within the borough, however residents from a White ethnic group have an older population profile.

COVID-19 Deaths

There are a number of sources of data on deaths related to COVID-19. Some definitions encompass where COVID-19 is mentioned in cause of death, whilst others count COVID-19 as sole cause of death. Hence different total figures and/or rates can be quoted. Figures quoted by the data.gov.uk⁵ site, state up to 07/11/2022, 722 Lewisham residents had died within 28 days of being identified as a COVID-19 case by a positive test. Up to the same date 780 Lewisham resident's death certificate mentioned COVID-19 as one of the causes of death.

To give these figures context with other areas, OHID have calculated cumulative age-standardised COVID-19 Mortality Rate per 100,000 population for local authorities, regions and England. This data is presented in Figure 4 (below) for the time period March 2020 - July 2022) and shows the total number of COVID-19 deaths comparable to the population size and accounts for differences in the age of populations. This age-standardization is important, particularly for an area like Lewisham which has a younger population bias. Lewisham's population saw a higher age-standardised COVID-19 mortality rate than both the regional and national average. This illustrates a health inequality for Lewisham's residents.

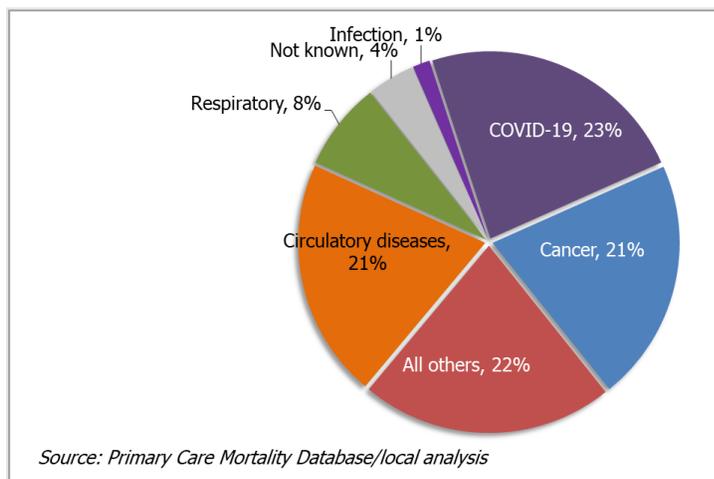
Figure 4: Cumulative age-standardised COVID-19 Mortality Rate per 100,000 population (March 2020 - July 2022)



(Source: CHIME Tool, OHID)

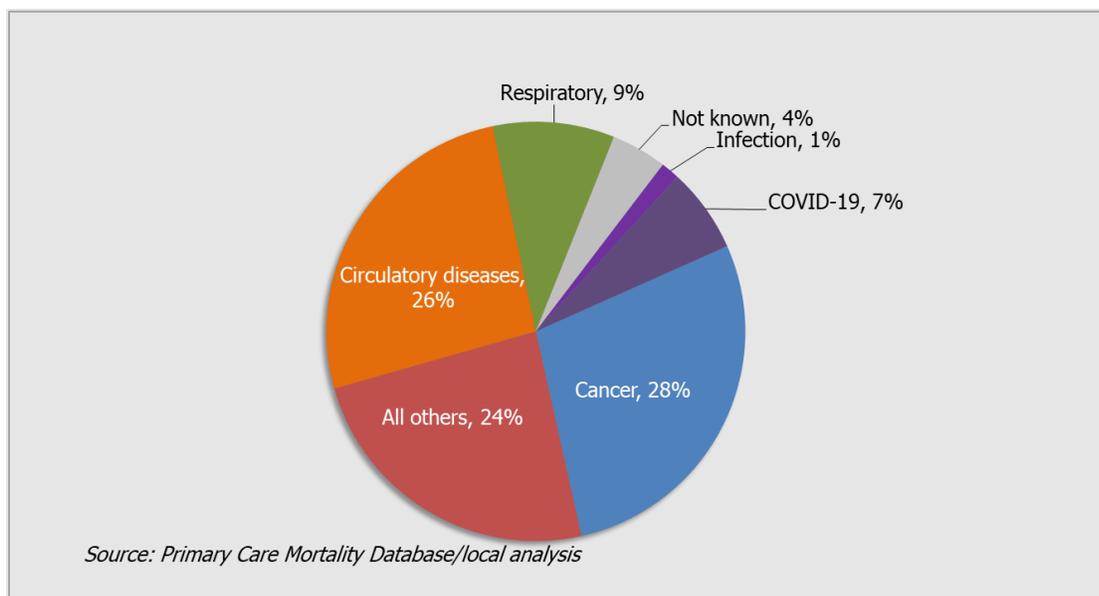
⁵ Accessed 11/11/22

Figure 5: Proportion (%) of Deaths of Lewisham residents of all ages by underlying cause of death, 2020/21



It is also important to consider COVID-19 deaths in context of all deaths during the pandemic. There were 2,341 deaths recorded in Lewisham in the financial year 2020/21, an increase from 1,874 in 2019/20. Figure 5 (above), shows the underlying cause of death by proportion for these Lewisham residents. 547 (23%) were due to COVID-19 and 490 (21%) due to cancer. Pre-pandemic cancer was the biggest cause of death, (538 of the total 1,874 deaths in 2019/20).

Figure 6: Proportion (%) of Deaths of Lewisham residents of all ages by underlying cause of death, 2021/22



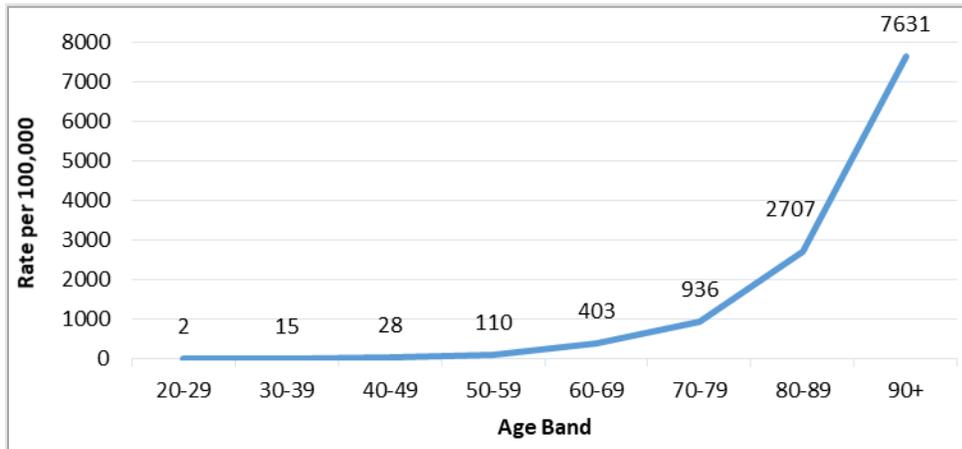
In 2021/22 there were 1,257 deaths in Lewisham. Figure 6 (above) illustrates that 82 (7%) of deaths were due to COVID-19, and 354 (28%) due to cancer. Meaning that cancer was once again the most common cause of death. Both the number of deaths due to COVID-19 and the total number of deaths in Lewisham in the second year of the pandemic were significantly

reduced. The total number of deaths was lower than pre-pandemic years which is typically closer to 2,000.

COVID-19 Deaths by Characteristic

Age

Figure 7: Crude COVID-19 Death Rate per 100,000 population by Age Band (01/01/20 - 08/04/22)

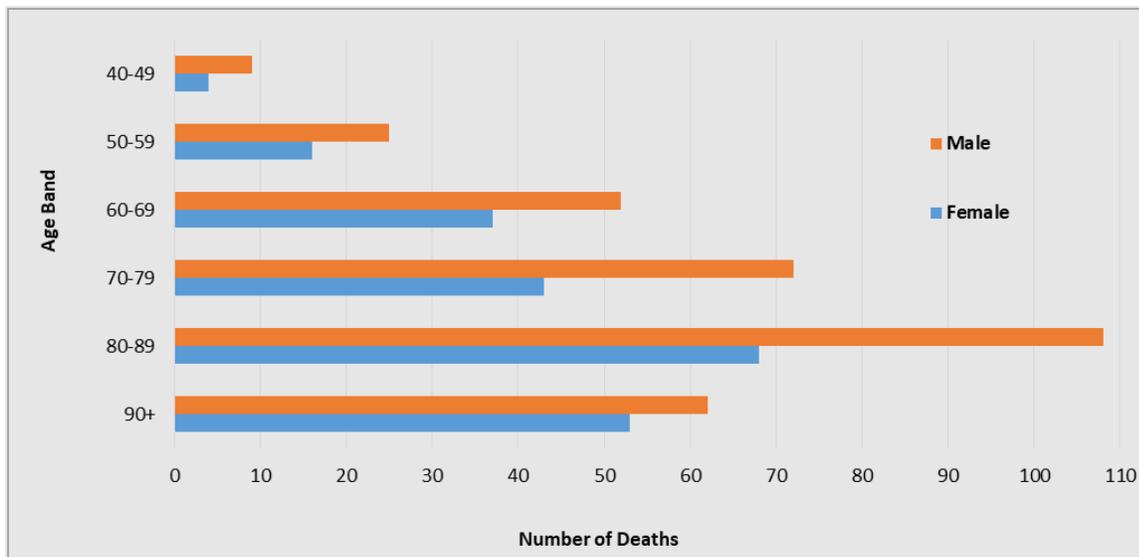


(Source: Local Analysis of Lewisham Registry Office data)

Figure 7 (above) shows COVID-19 as a death rate locally, per 100,000 population for adults by 10 year age band. The death rate increases noticeably as age increased. When looking at all COVID-19 deaths (up to 08/04/22) we see that 96% were to residents aged 50+.

Gender

Figure 8: Lewisham COVID-19 Deaths by Gender (01/01/20 - 08/04/22)



(Source: Local Analysis of Lewisham Registry Office data)

Figure 8 (above) shows the number of COVID-19 deaths by gender and age band for Lewisham residents. The number of deaths for residents aged 20-39 are too small to report on and there were no deaths in residents younger than 20. In all age groups reported, there is a clear bias towards male residents dying from COVID-19, even in the two oldest age categories, where female residents are much more numerous than male. This graph was originally presented as a rate, however due to the relatively small population size of the oldest age groups, rates appeared distorted and thus the actual numbers are presented here.

Ethnicity

In England, Death Registration certificates do not record ethnicity of the deceased. However from the end of May 2020 Lewisham Registry Office asked (on a voluntary basis) those registering a death if they would provide this information. Almost 95% of respondents did so.

For the time period that the Registry Office have recorded and shared information⁶, 2,875 deaths were registered. 537 (18.7%) were due to COVID-19. Ethnicity information was provided for 526 of the 537 (98.0%). Of the 2,338 non COVID-19 deaths, ethnicity information was provided for 2,185 (93.0%).

Table 3: Deaths by Broad Ethnic Group

Ethnic Group	% of <u>COVID-19</u> Deaths where ethnicity was recorded	% of <u>non-COVID-19</u> Deaths where ethnicity was recorded
White	66.9	70.9
Asian	7.2	4.3
Black	23.2	21.6
Mixed	1.0	1.7
Other	1.7	1.3

(Source: Local Analysis of Lewisham Registry Office data)

Table 3, (above) presents data on the ethnicity of Lewisham residents who died between 30/05/20 - 23/03/22, broken down by whether the death was or was not COVID-19 related. Whilst White residents comprised the majority of COVID-19 deaths, this is also true for non-COVID-19 deaths. This group are also the largest in terms of population size and have an older population profile⁷.

Table 4: Proportion of Deaths within each Broad Ethnic Group which were due to COVID-19

Ethnic Group	<i>Number of <u>COVID-19</u> Deaths</i>	<i>Number of <u>non-COVID-19</u> Deaths</i>	<i>% of deaths within each broad ethnic group which was due to COVID-19</i>
White	352	1,550	18.5
Asian	38	95	28.6
Black	122	473	20.5
Mixed	5	38	11.6
Other	9	29	23.7

(Source: Local Analysis of Lewisham Registry Office data)

⁶ 30/05/20 - 25/03/22

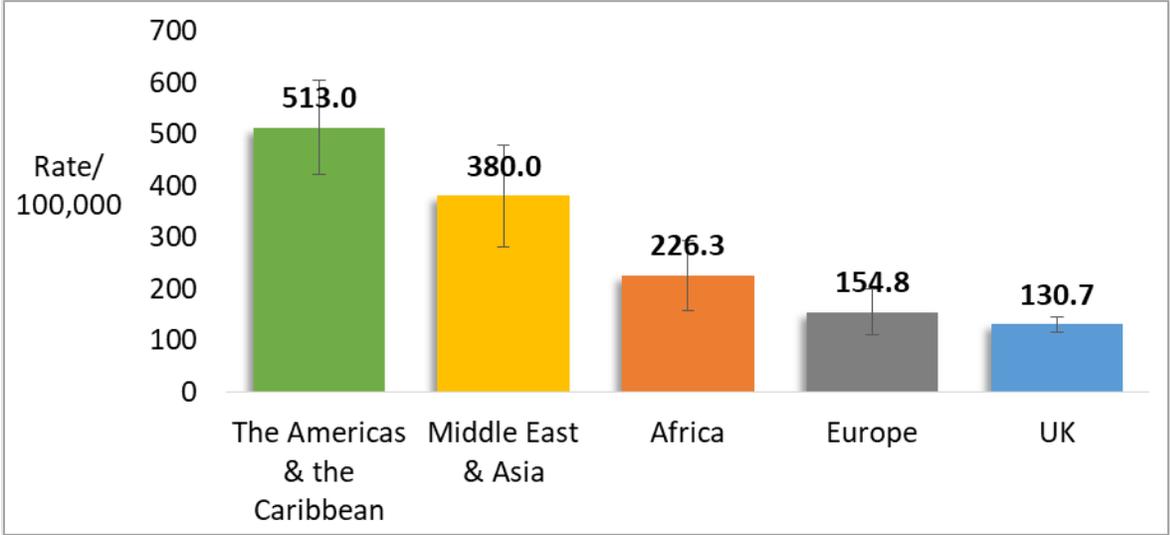
⁷ To provide some context about Lewisham's population profile: Overall just under a quarter of Lewisham residents are aged 0-19 (GLA 2020, Population Projections), with these younger residents having a greater ethnic diversity (GLA 2016 Round Ethnic Group Population Projections).

When we consider what proportion of deaths within an ethnic group were due to COVID-19 (as presented in Table 4 above), Asian residents appear much more likely to have died due to COVID-19. However, it should be noted that this population group is relatively small in Lewisham and the total number of deaths in this group is less than 150.

Country of Birth

Unlike ethnicity, Country of Birth is a required field in completion of a death registration.

Figure 9: COVID-19 Crude Death Rate by Country of Birth, all ages (01/01/20 - 08/04/22)



(Source: Local Analysis of Lewisham Registry Office data)

Analysis of COVID-19 deaths by Country of Birth registered in Lewisham found 48% of such deaths were to non-UK born residents, whereas in the 2011 Census just 34% of the population of Lewisham was non-UK born. Figure 10, (above) highlights that people born in the 'Middle East & Asia' and the 'Americas & the Caribbean' had a significantly higher COVID-19 death rate than people born in Europe and the UK.

Deprivation

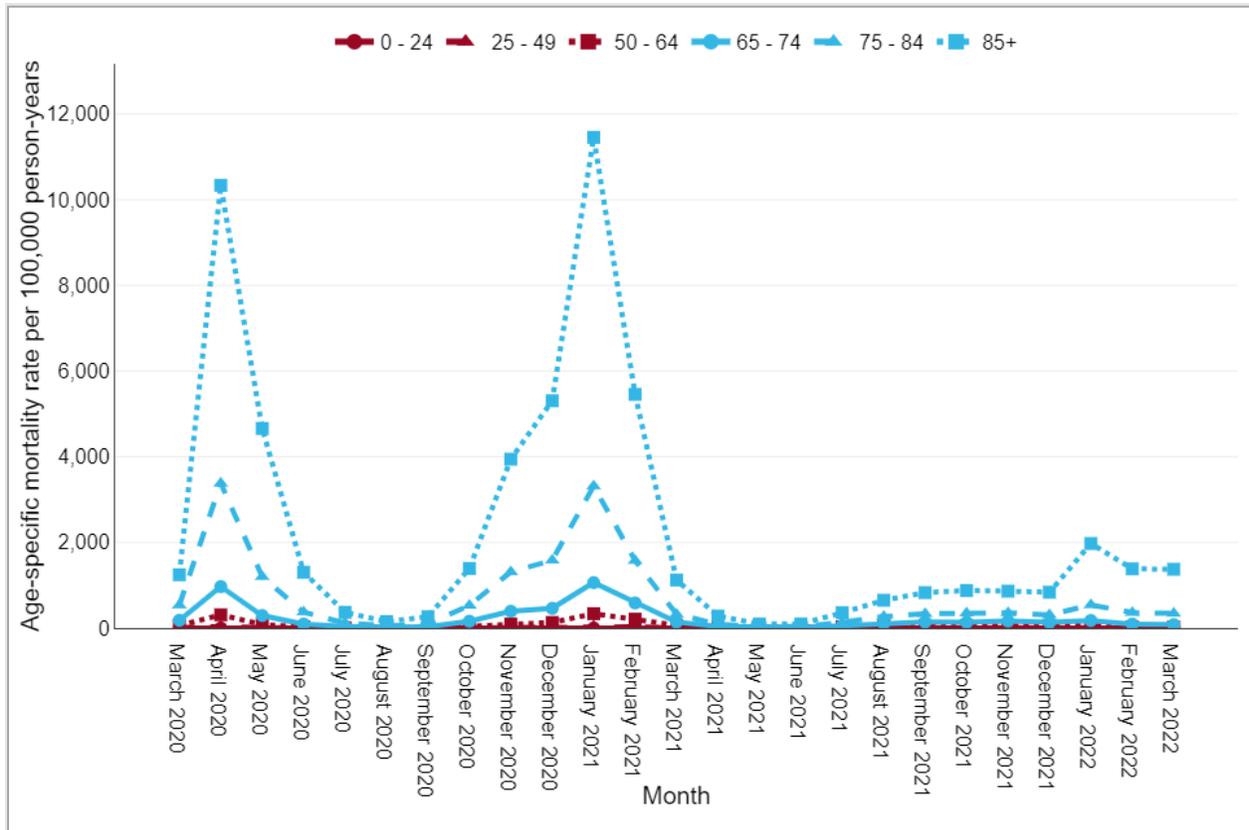
Analysis was conducted to understand both the number of deaths and death rates by deprivation quintile, based on the resident postcode of the deceased. However, this was problematic for two reasons. Due to a relatively high number of COVID-19 deaths of care home residents, bias could potentially be seen to the areas they are located. This is particularly relevant to Lewisham, due to a clustering of nursing/care home in the Catford area. Also, the number of COVID-19 related deaths were so much lower in the least deprived areas of the borough that comparison was not easily made due to the drastically different confidence intervals. Therefore, we defer to national analysis (see relevant section below).

National Analysis

Age

Due to the factors described above it is important to look at figures which have been standardised for age⁸. OHID have produced this analysis at a national level. Figure 11 clearly shows how older age groups but particularly those aged 85 and older had much higher death rates due to COVID-19. These link to during and just after peaks in infection rates.

Figure 10: Monthly age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in England by age-group, March 20 to March 22



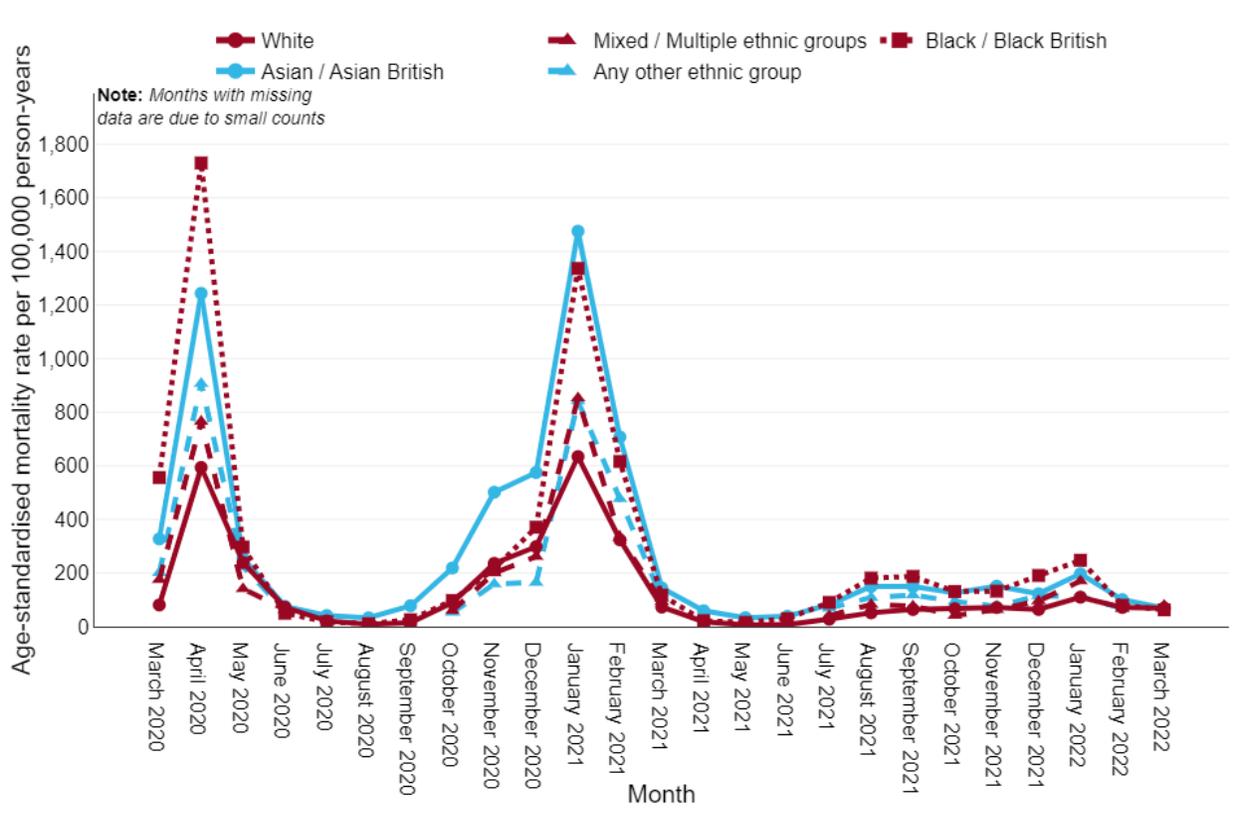
(Source: OHID, CHIME Tool)

Ethnicity

Figure 11 (below) shows that across the course of the pandemic all ethnic groups other than White saw higher death rates per 100,000 population due to COVID-19. For example in April 2020, at the peak of the first wave the Black/Black British population had a COVID-19 mortality rate of 1,729.0 per 100,000 population, whilst the White population's mortality rate was 593.8 per 100,000 population. At the peak of the second wave in January 2021, it was then the Asian population who had the highest COVID-19 mortality rate at 1,475.0 per 100,000 population, whilst the Black population saw their COVID-19 mortality rate at 1,336.4 per 100,000. Both figures were more than twice the rate of the White population at 633.9 in the same month.

⁸ Age standardization is a technique used to allow statistical populations to be compared when the age profiles of the populations are quite different.

Figure 11: Monthly age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in England by ethnic group, March 20 to March 22

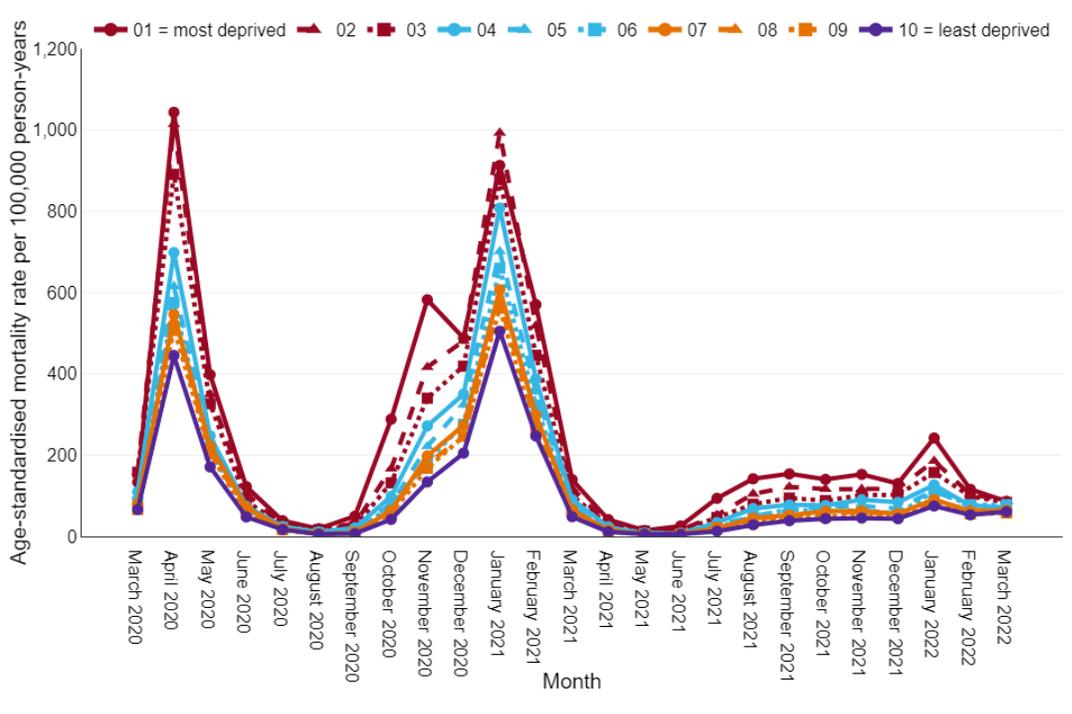


(Source: OHID, CHIME Tool)

Deprivation

Figure 12 (below) shows that people from the more deprived areas of England (1 is the most deprived, 10 the least), had a higher death rate due to COVID-19 than from the less deprived areas. This was true during the entire pandemic, however at the peaks (April 2020 and January 2021), this was more pronounced.

Figure 12: Monthly age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in England by deprivation decile, March 20 to March 22



(Source: OHID, CHIME Tool)

Table 5: Age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in England by most and least deprived areas for April 2020 and Jan 2021

Month	People living in Decile 1 (most deprived areas of England)	People living in Decile 10 (least deprived areas of England)
April 2020	1,043.6	445.2
January 2021	913.0	504.8

The age-standardised COVID-19 death rate is significantly higher in the most deprived areas of the country compared to the lowest. These differences are most notably seen within the peaks of the deaths/COVID-19 infection rates. Residents of more deprived areas seeing higher mortality, poorer health and shorter life expectancy has long been established, however this illustrates how COVID-19 exacerbated long standing health inequalities.

Furthermore, analysis by OHID⁹ of national COVID-19 hospital admission data found that up to January 2022 for people living in the most deprived areas of England, the admission rate was 3.0 times the rate compared to the least deprived and the COVID-19 mortality rate up to March 2022 was 2.6 times higher. This trend was seen for all age groups to varying extents. The greatest difference in mortality rates between levels of deprivation were seen in the age group 50 - 64.

⁹ [OHID, CHIME Tool](#)

Life Expectancy after COVID-19

Even before the COVID-19 pandemic, increases in life expectancy in England had stalled¹⁰, however COVID-19 has meant that every region within England has now seen a fall in life expectancy. For male and female life expectancy at birth, figures are now below even 2018 figures for London and England.

Table 6: Life Expectancy at Birth

	Male				Female			
	2018	2019	2020	2021	2018	2019	2020	2021
Lewisham	79.0	79.7	77.7	-	83.5	83.7	82.4	-
London	80.7	81.3	79.0	79.5	84.5	85.0	83.5	83.8
England	79.6	80.0	78.7	78.7	83.2	83.6	82.6	82.8

(Source: OHID, Chime Tool)

Lewisham COVID-19 Specific Services

[One Health Lewisham](#) (OHL) is the GP federation of all the General Practices in Lewisham. They provide primary care and community services to local residents, therefore were responsible for many aspects of COVID-19 services.

OHL COVID-19 Services

Between March 2020 and March 2022, OHL provided COVID-19 related services in response to the pandemic and responded rapidly throughout the pandemic to ensure the needs of Lewisham patients and the system that supports patients were met. Although a large proportion of the COVID-19 services were specific to the illness, OHL also pivoted existing services to support the COVID-19 efforts and operated in a COVID-19 safe manner (e.g., remote health checks, GPEA cold hub, cancer care e-hub).

COVID-19 Remote Monitoring

OHL use Doctaly Assist (digital partner) to remotely monitor patients on the oximetry@home pathway during their acute phase of COVID-19. Helping to keep patients at home safely by monitoring their oxygen saturations, and highlighting any deterioration early, reducing pressures on the wider system (A&E/NHS 111/GP etc.). OHL have reviewed just over 22,000 patients during the time this service has been live, and are seen as an exemplar service for SEL.

Covid-19 Hot Hubs and Taxis

The service would see COVID-19 positive, or suspected COVID-19 positive patients in a face-to-face capacity. OHL developed localised guidance for all Lewisham GP practices to follow, and set up a bespoke clinic with relevant Infection Prevention Control to ensure patients were able to be seen safely in the community, without burdening A&E, but also reducing the risk of spread of COVID-19 to staff/patients at GP practices.

OHL also provided a bespoke COVID-19 taxi service, used to transport suspected patients to appointments at the Hot Hub to reduce the risk of wider spread to the borough. OHL further provided a similar 'hot home visit' service, for those housebound patients with confirmed or suspected COVID-19, so they could still access home visiting support.

¹⁰ [Health Equity in England: The Marmot Review 10 Years On](#)

Community Phlebotomy Service

OHL provided a phlebotomy service specifically designed for at risk shielding patients, Care Home residents and housebound patients. This involved a dedicated clinic in a 'cold site' for at risk, shielding patients who can safely travel or be transported to our clinic as well as a home visiting service for patients who cannot safely travel to our clinic.

COVID-19 Personal Protective Equipment (PPE)

OHL managed PPE stock to support practices with PPE requests. As well as coordinated scrubs for practices via 'for the love of scrubs'.

Care Home Support

OHL provided varied aspects of support to care homes during the pandemic. This included support in coordinating the vaccination campaigns delivered by the Primary Care Networks (PCNs). They also provided support to ensure residents had their treatment and escalation plans up to date – achieving almost 100% coverage. Care Home staff were supported in training to take patient PCR swabs.

For a period, OHL supported a COVID-19 positive discharge pathway to a care home. This enabled hospital patients who were fit for discharge but with a concurrent positive COVID-19 swab and requiring a care home bed be discharged back to a care home. Rather than the alternative of remaining in hospital until safe to return to a general care home ward.

Social Prescribing

OHL leveraged its social prescribing service to identify at risk patients during peak COVID-19 waves to proactively ensure they had the appropriate and available support to them (e.g., food delivery options, befriending support etc).

Staff PCR Testing

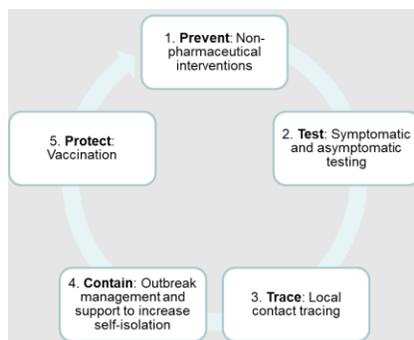
OHL deployed a local staff COVID-19 test centre, based at Marvels Lane, when there were challenges/delays with the central test sites. This was a service made available to staff and household contacts of local staff (care home, primary care, wider community staff) to ensure testing was rapid. This enabled staff to isolate quickly as needed, but also return to work quickly ensuring resilience in the health and care services of Lewisham.

Please note that Long COVID is addressed in a separate section of the report.

Lewisham COVID-19 Local Outbreak Management Plan (LOMP)

The Lewisham Public Health Team developed the COVID-19 Local Outbreak Management Plan (LOMP) at the start of the pandemic and continue to review and develop it. This document outlines the Lewisham approach of:

- a. Prevent
- b. Test
- c. Trace
- d. Contain
- e. Protect
- f. Surveillance
- g. COVID-19 Community Champions
- h. Surge planning



Of particular note was PCR testing was available at 3 fixed sites within the borough and a mobile testing unit visited Catford several times a week. Numerous locations later offering supervised LFD tests, including many pharmacies. Further details of the local approach are outlined in the summary LOMP appended to this report (Appendix A).

Long COVID

Long COVID is a broad term to describe the signs and symptoms that continue or develop after initial acute COVID 19 infection. As an informal term, it encompasses the National Institute of Clinical Excellence (NICE) clinical case definitions of 'ongoing symptomatic COVID-19' (4 to 12 weeks) and 'post COVID-19 syndrome' (symptoms lasting 12 weeks or more that cannot be explained by an alternative diagnosis.¹¹⁾

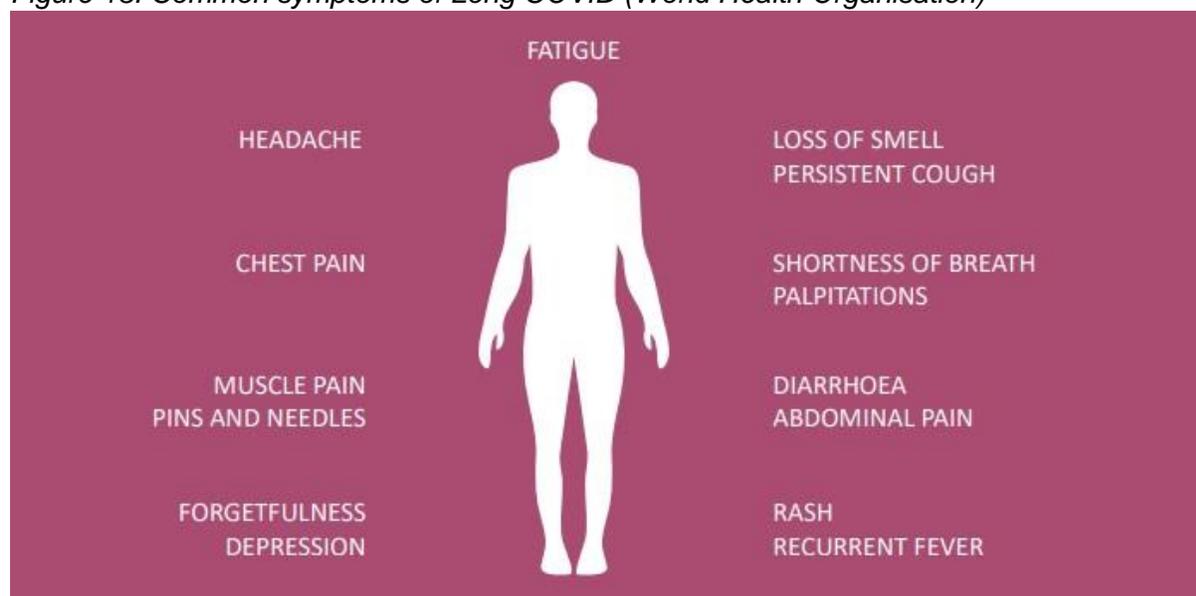
The first cases of Long COVID were reported in May 2020¹² and since then, over 50 Long COVID symptoms have been described¹³. Though wide-ranging and highly variable, common symptoms include fatigue, shortness of breath, cough, smell or taste dysfunction, cognitive impairment, and muscle pain. The cause of Long COVID is, as yet, poorly understood and the subject of major international research.

¹¹ [Scenario: Managing long-term effects | Management | Coronavirus - COVID 19 | CKS | NICE](#)

¹² [Why we need to keep using the patient made term "Long Covid"](#) Perego E, Callard F, Stras L, Melville-Johannesson B, Pope R, Alwan N (1 October 2020 BMJ)

¹³ [Characterizing long COVID in an international cohort: 7 months of symptoms and their impact](#) Davis HE, Assaf GS, McCorkell L, Wei H, Low RJ, Re'em Y, et al. (July 2021. EClinicalMedicine. 38: 101019.

Figure 13: Common symptoms of Long COVID (World Health Organisation)



Facts and Figures

National data on the scale of Long COVID comes from 2 sources:

- i) Office of National Statistics (ONS) self-reported Long COVID surveys
- ii) GP records where Long COVID has been coded.

ONS Survey

ONS figures as of 1 May 2022 show that an estimated 2 million people in the UK (3.1% of the population) were experiencing self-reported Long COVID symptoms. This number is increasing: a rise of 10% from the previous month and almost double the just over 1 million who self-reported Long COVID in May 2021. This poses a huge challenge to health and social care, especially as 71% of Long COVID sufferers report limitation to their day-to-day activities. The wider societal and economic impact is also potentially vast.

GP Record Data

An analysis of 58 million patient records in England (96% of the population) between 1 February 2020 and 17 March 2022 recorded Long COVID for 162,881 people. This represented 0.28% of the population, with the overall rate of Long COVID being 287.6 per 100,000 people.

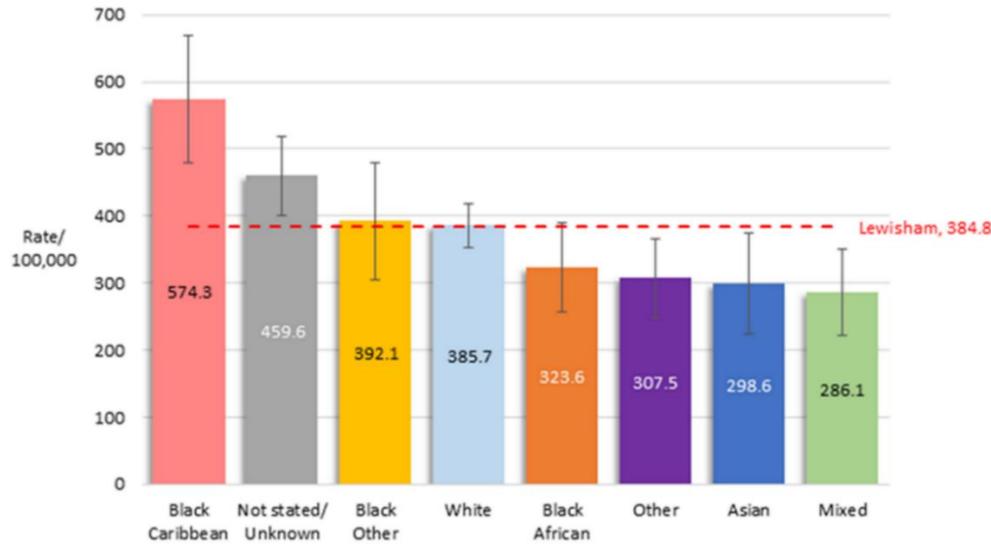
Long COVID in Lewisham

Locally records from the Population Health Management System show that between May 2020 and May 2022, 1,332 people in Lewisham have been given a diagnostic code for Long COVID. This equates to 0.38% of registered patients, higher than the England prevalence rate of 0.28%. This figure also means the rate of Long COVID in Lewisham is 384.4 per 100,000 population, significantly higher than the 287.6 per 100,000 rate in England.

The peak age of those with Long COVID in Lewisham is 40-49 (24.7% of the total), followed closely by 50-59 (22.1% and 30-39 age group (21.2%)). The predominance in the working-age population group correlates with ONS and national GP record data. Long COVID was much lower for those aged under 18 in Lewisham (1.65% vs 8.8% nationally). In terms of gender there

were more than twice as many females with Long COVID than males (67.7% vs 32.3%). This was an even greater sex imbalance than seen in national GP record data (61.9 vs 38.1% female: male).

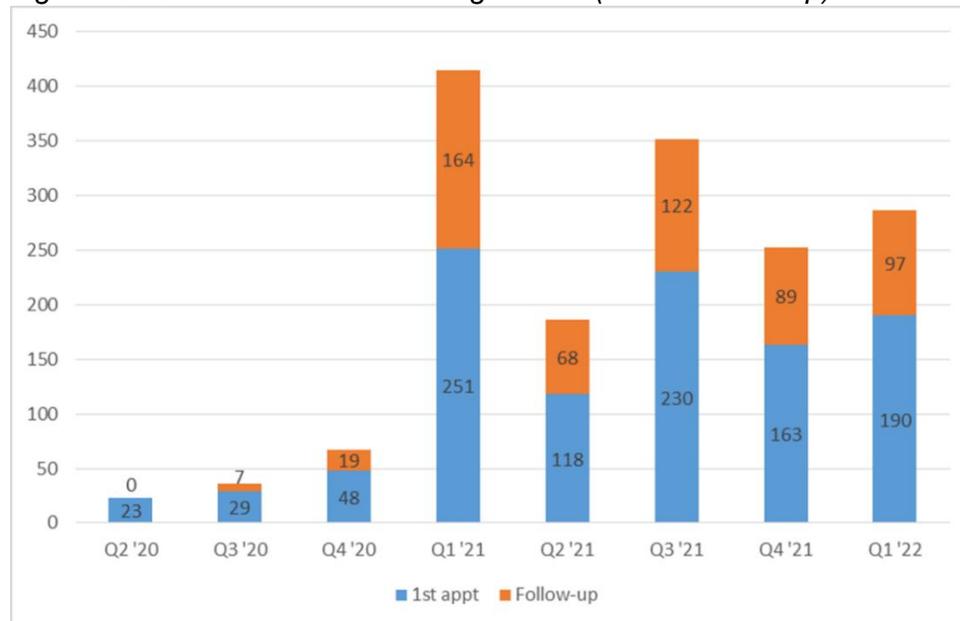
Figure 14: Long COVID - cases per 100,000 registered population in Lewisham by ethnic group



(Source: Lewisham Population Health Management System (Spring 2022))

The ethnic group most diagnosed with Long COVID in Lewisham is Black Caribbean. The rate was significantly higher than those from a White or Black African ethnic group.

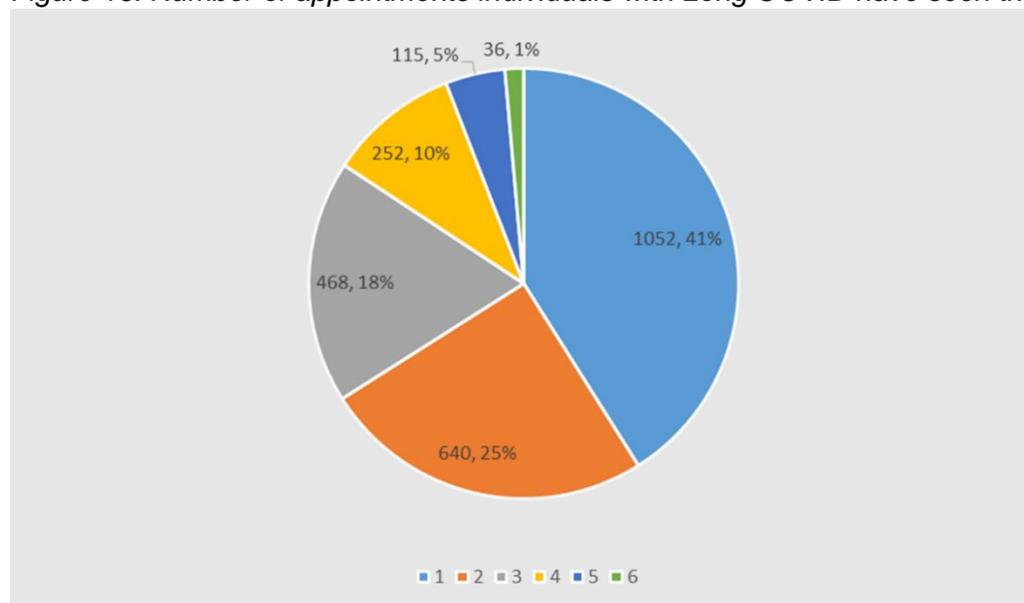
Figure 15: GP consultations for Long COVID (initial & follow up) in Lewisham



(Source: Lewisham Population Health Management System (Spring 2022))

There were 2,553 GP consultations from May 2020 - May 2022 where Long COVID was the main reason for the consultation (to provide context there were 41.6 million consultations in that time period). The peak of Long COVID consultations was in Q1 of 2021.

Figure 16: Number of appointments individuals with Long COVID have seen their GP for



(Source: Lewisham Population Health Management System (Spring 2022))

There remains a significant proportion of patients (34%) who are seeing their GP at least 3+ times due to ongoing Long COVID symptoms. 36 people have seen their GP 6 times with Long COVID issues.

Local Action taken to address impacts of Long COVID

Until the end of 2020 Long COVID clinics were run in secondary care by the respiratory medicine team at University Hospital Lewisham. The One Health Lewisham Long COVID clinic had a soft launch in January 2021 before launching fully in March of that year, running two mornings a week. Until June 2022 it was led by a GP, working with a Band 8d Advanced Care Practitioner (ACP), a physiotherapist, a clinical psychologist and an administrator. An occupational therapist was attached to the clinic but recalled back to UHL at the end of 2021 during the third wave of COVID (Omicron). As of late June 2022, the GP has left the clinic and not been replaced, with the ACP now leading the clinic. The physiotherapist is also on sick leave with no replacement. Recruitment to the clinic has been highlighted as a problem. Referrals to the clinic are via GP (no self-referral route). At the time the needs assessment work was carried out, no formal audit of waiting times had been conducted.

Recommendations

Whilst no best practice model currently exists of how to run a Long COVID service, it is considered that the local service would benefit from:

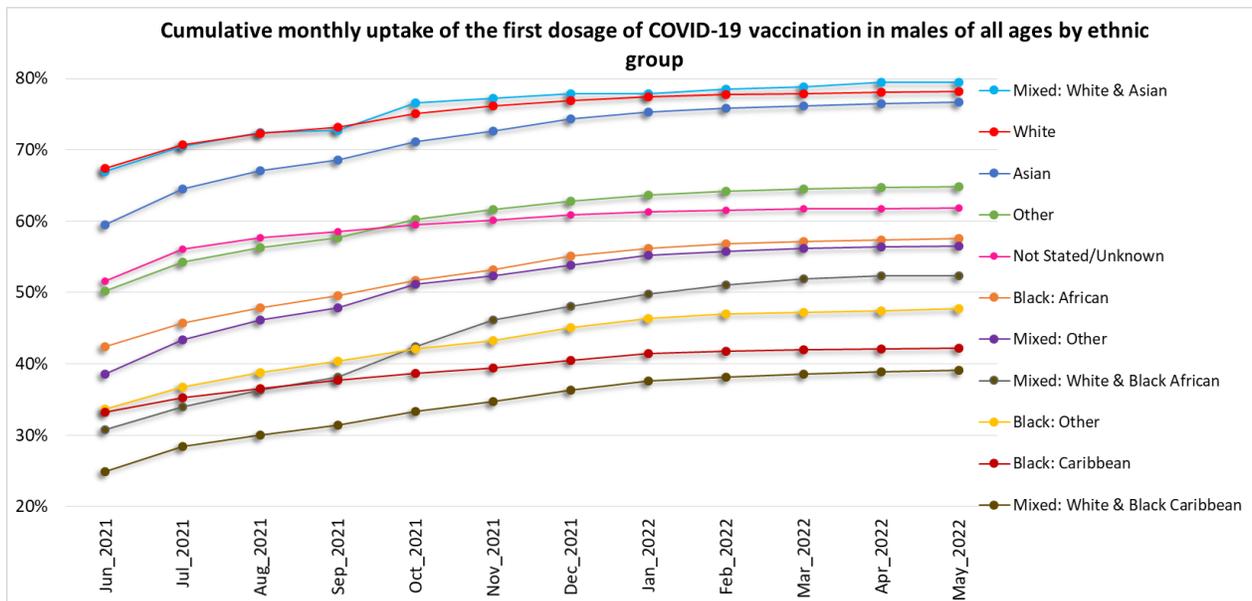
- Better resourcing, latest information was that an Advanced Practitioner rather than a Doctor was leading the team
- The Long COVID clinic would also enormously benefit from better coding and auditing processes

COVID-19 Vaccinations

Over 205,400 first dose COVID-19 vaccines have been given to a Lewisham resident aged 12 and over¹⁴ since the start of the vaccine programme. However, this total figure masks huge variations in uptake between age, gender and ethnic groups. Due to these variations, there is a risk of any health inequalities persisting for years if the virus continues to circulate, as well as any restrictions regarding it, for example related to travel or hospital admissions.

Figure 17, (below) shows 1st dose COVID-19 vaccination uptake for males by ethnic group. This highlights large differences. Men from White and Asian ethnic groups had uptake of at or near 80%. However, for men from a Black Other, Black Caribbean or White & Black Caribbean background, uptake was all below 50%. A similar pattern was seen for women by ethnic group, however % uptake was higher across all groups.

Figure 17: Cumulative monthly uptake of 1st dose COVID-19 vaccination in males (all ages) by ethnic group

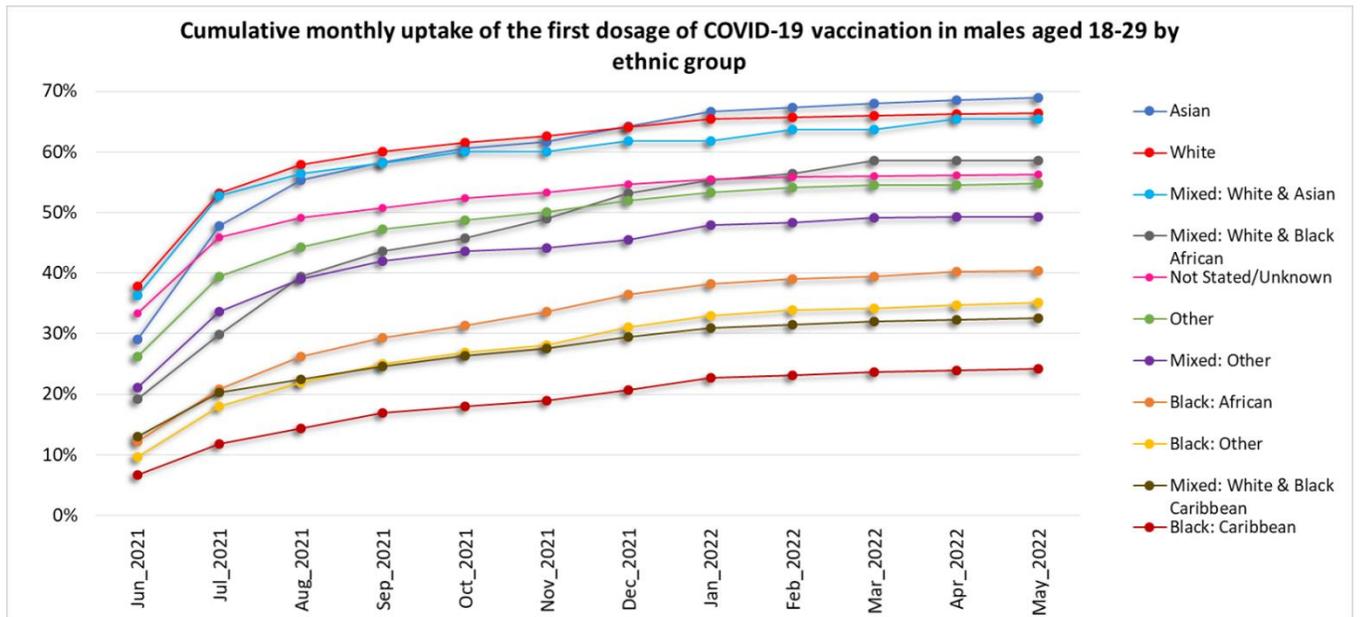


(Source: Lewisham Population Health Intelligence System (Cerner))

Difference in uptake of vaccine by age was noted throughout the roll-out programme, however when age and ethnicity and gender were all considered, the impact on 1st dose uptake was compounded. Figure 19 (below), shows that for males from a Black Caribbean ethnic group, aged between 18-29, less than 1 in 4 had received a 1st dose of COVID-19 vaccine.

¹⁴ Source: data.gov.uk (as of 10/06/22)

Figure 18: Cumulative monthly uptake of 1st dose COVID-19 vaccination in males (aged 18-29) by ethnic group



(Source: Lewisham Population Health Intelligence System (Cerner))

Impact on Wider Health System

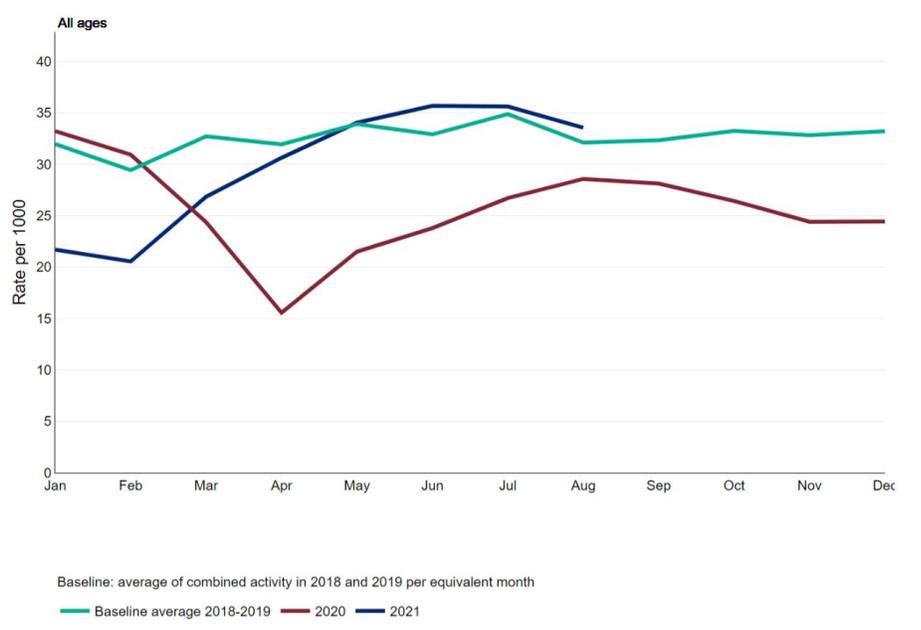
COVID-19 has directly impacted the health system through primary care appointments, hospital admissions, intensive care treatment and delivery of a mass vaccination programme. In terms of the wider impact of the pandemic, the following section looks at how others areas of health care were impacted by the pandemic.

Access to care

A&E Attendances

As a frontline service for serious health issues, comparing A&E attendance below and during the earlier stages of the pandemic aids understanding of changes seen.

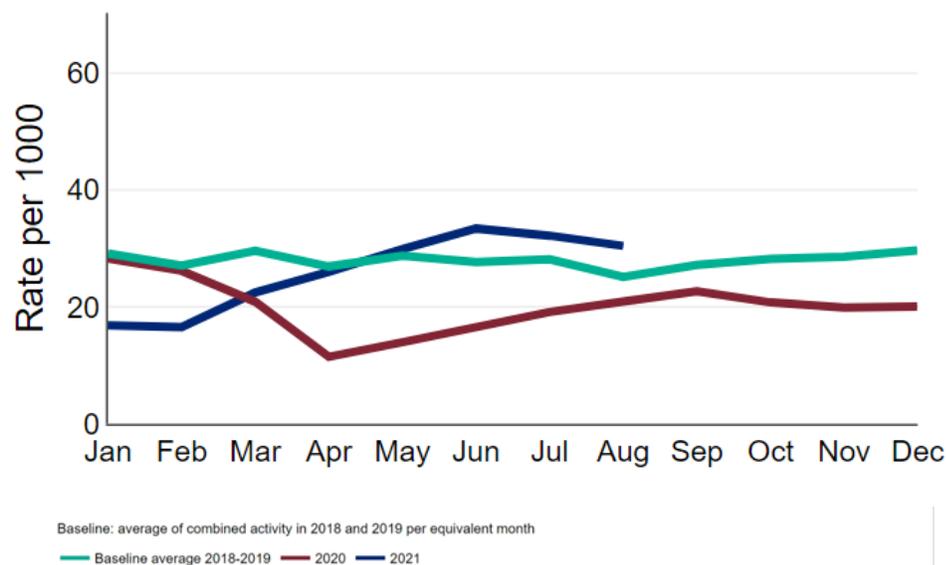
Figure 19: Monthly trend in A&E attendances compared to baseline - England



Source: Hospital Episode Statistics (HES), accessed via OHID

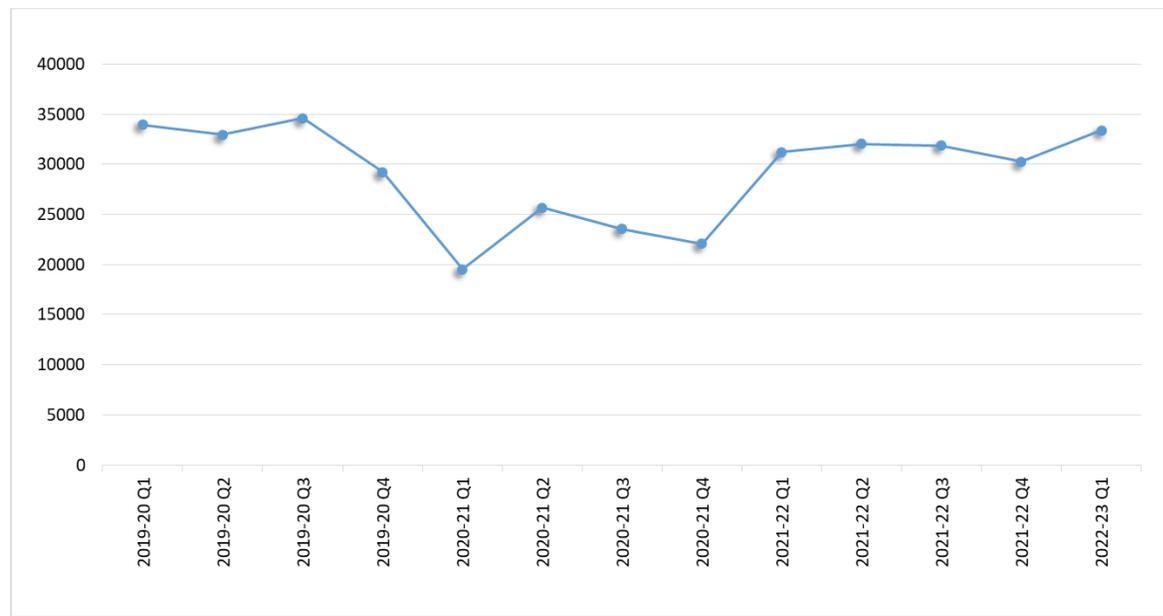
National data (Figure 19 above) shows that A&E attendances were markedly down in 2020, particularly at the start of the first wave of COVID-19, although they did recover in 2021, and by May 2021 levels were similar to those seen in 2018-19 (baseline green line in graph). This pattern was seen across all age groups. There were slight differences nationally by ethnic group, with people from a Black African ethnic group seeing a higher A&E attendance rate in the summer of 2021 than the baseline year (Figure 20 below).

Figure 20: Monthly trend in A&E attendances compared to baseline for people from a Black African ethnic group - England



(Source: OHID)

Figure 21: Quarterly A&E Attendances from All Conditions - University Hospital Lewisham



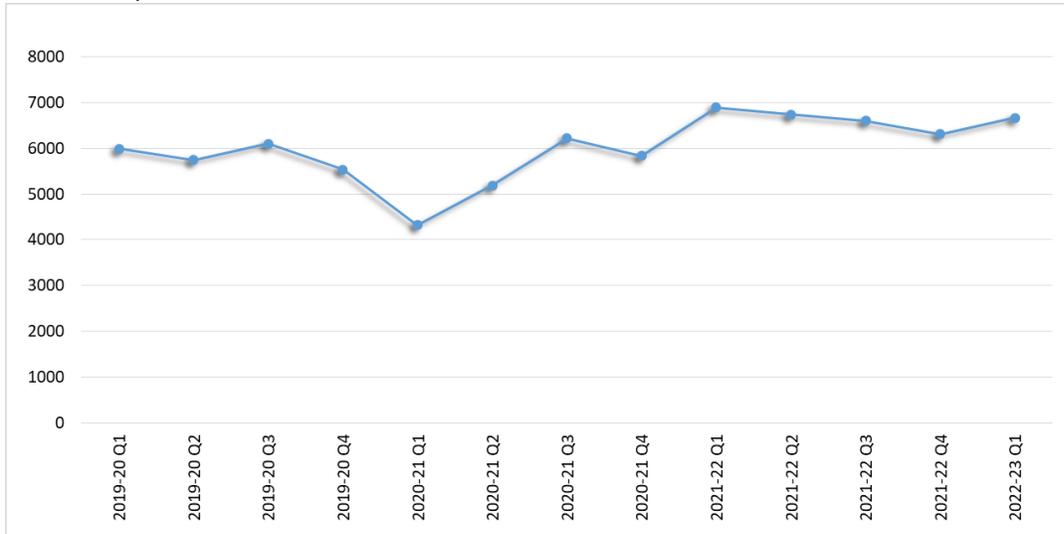
(Source: NHS Digital/Hospital Episode Statistics)

Locally, at UHL, A&E attendance figures followed the general pattern of the national trend (data presented in Quarters rather than by month in other Figures). The lowest number of attendances were in Quarter 1 2020/21, at the start of the pandemic, higher numbers of attendances were seen in Quarter 2 and Quarter 3 of 2020/21 before a second dip in Quarter 4 of 2020/21. By the first quarter of 2021/22 the number of attendances had broadly returned to level seen below the-pandemic.

Hospital Admissions

Emergency Admissions

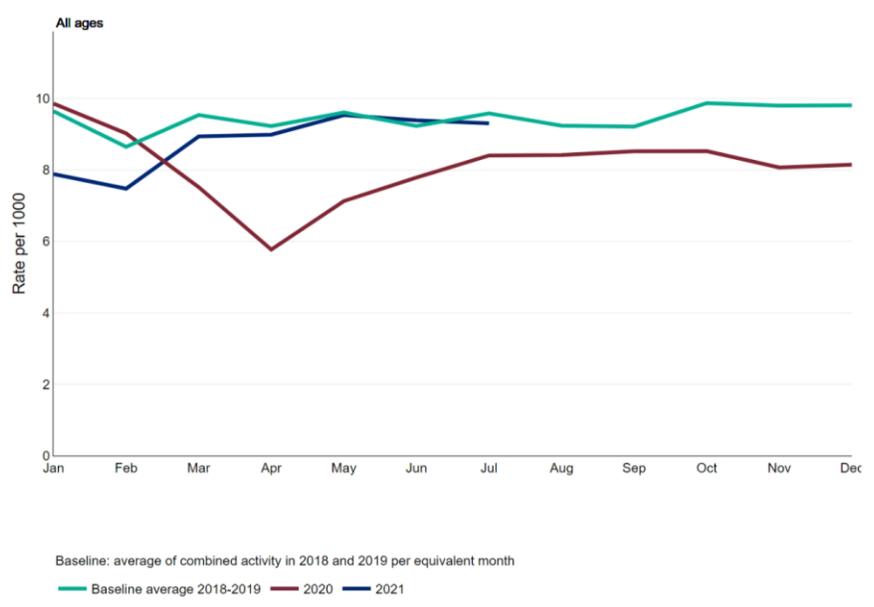
Figure 22: Quarterly emergency hospital admissions – University Hospital Lewisham (all conditions)



(Source: NHS Digital/Hospital Episode Statistics)

Figure 22 (above) shows emergency hospital admissions across UHL by quarter, before and during the pandemic. A similar pattern to that seen locally for A&E attendances (Figure 21) is presented, whereby there is a marked dip during the first COVID-19 wave, before levels rose, before falling again in the second wave. At the national level, there was also a similar pattern between A&E attendances and emergency admissions (Figure 23 below).

Figure 23: Monthly trend in emergency hospital admissions (all cause) compared to baseline - England



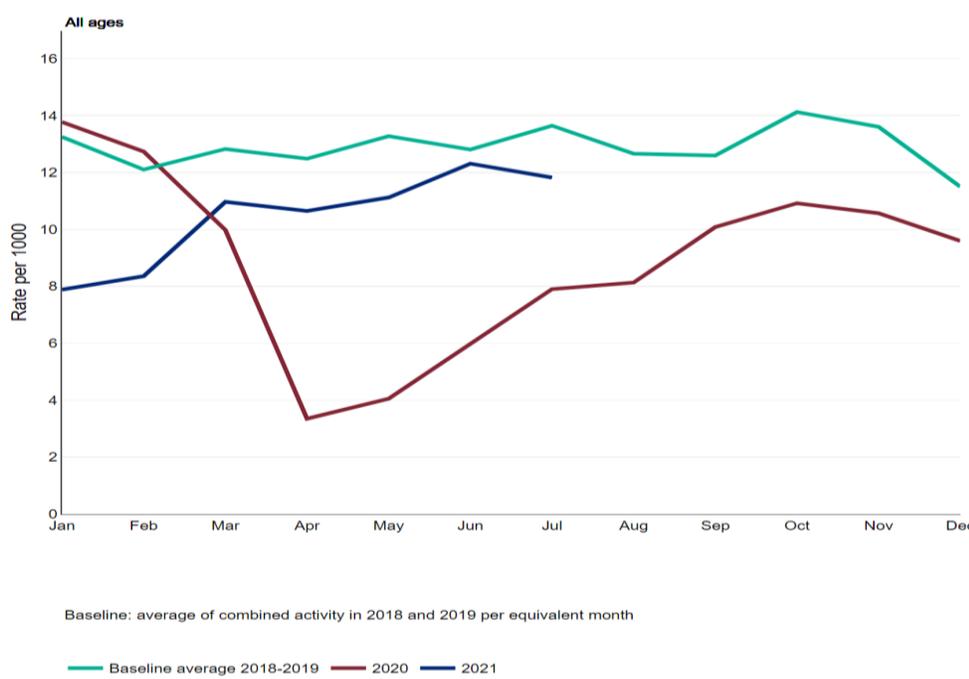
(Source: Hospital Episode Statistics (HES), accessed via OHID)

The national data also showed that people living in more deprived areas had a higher Emergency Hospital Admission rate before the pandemic, therefore saw a bigger % decrease in admission levels in first COVID wave.

Elective (Planned) Admissions

In 2020, nationally the rate of planned hospital admissions followed a similar pattern to A&E attendances and emergency admissions. However in 2021, whilst the emergency figures came closer to the baseline average illustrated (2018-19), elective hospital admissions were slower to recover.

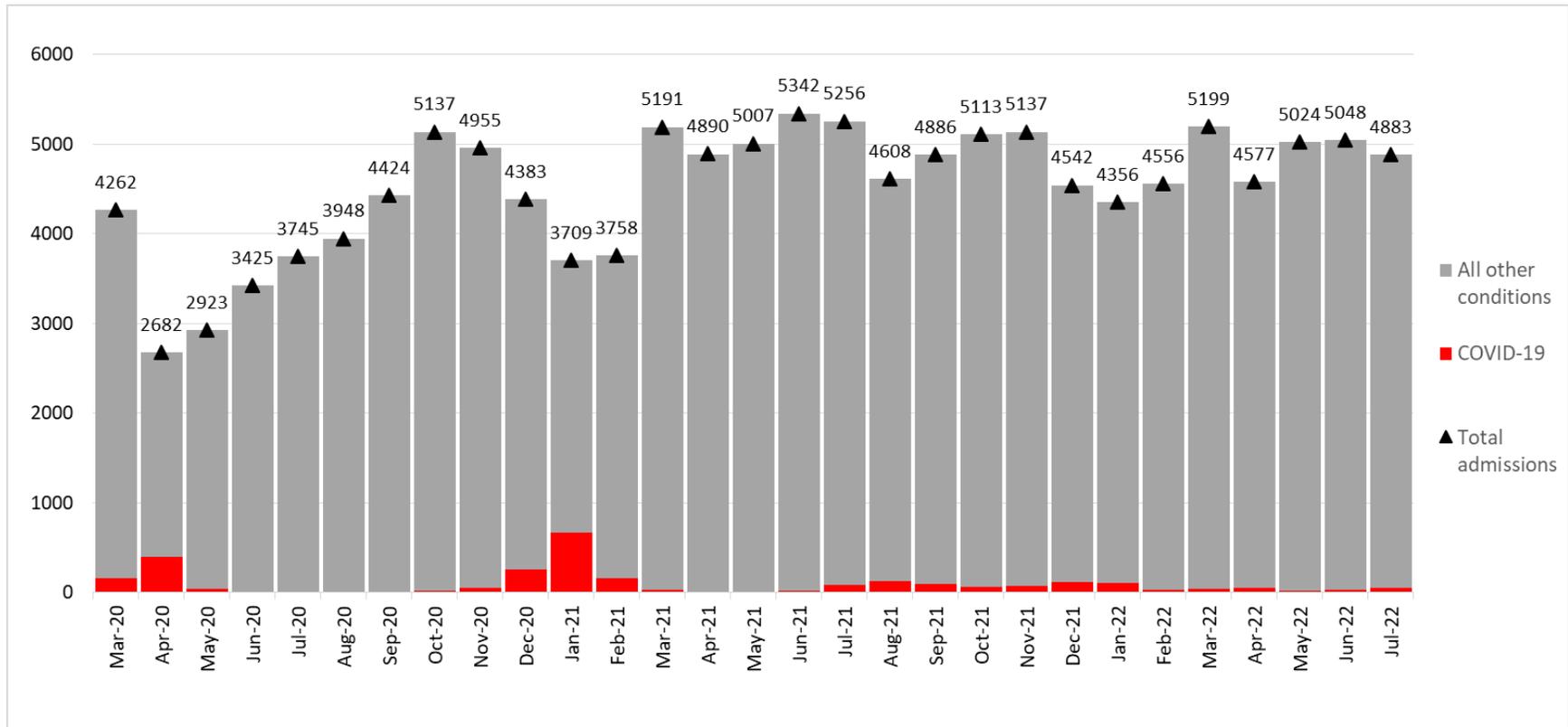
Figure 24: Monthly trend in elective hospital admissions (all cause) compared to baseline - England



(Source: Hospital Episode Statistics (HES), accessed via OHID)

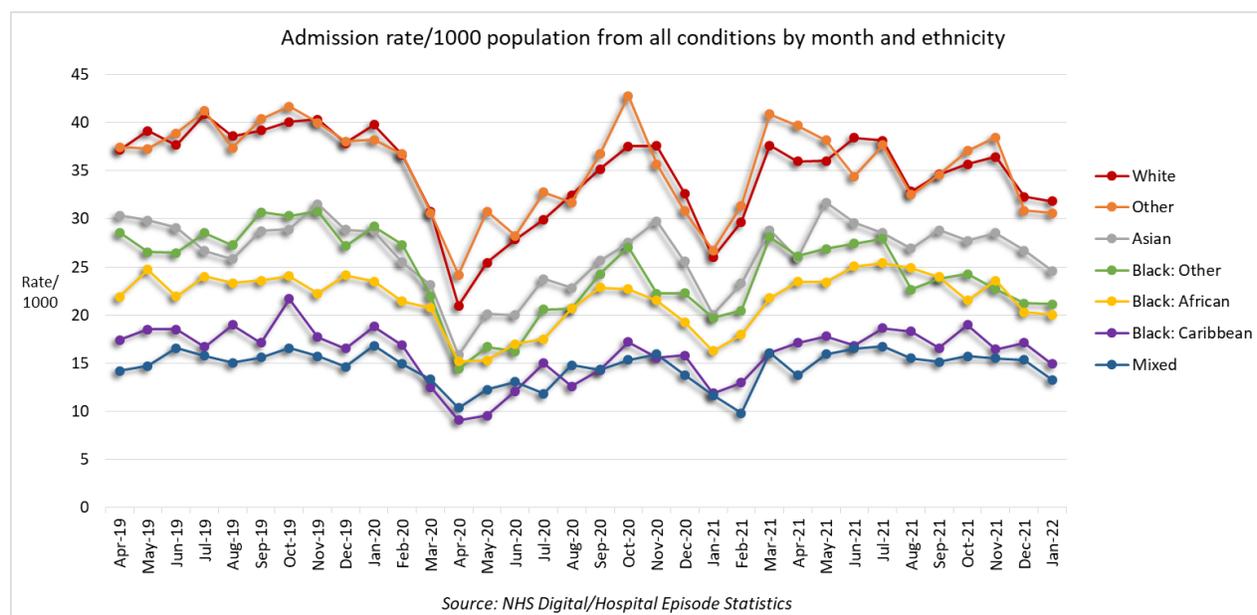
For all UHL hospital admissions (as shown in Figure 25 below), the biggest monthly drop is between March 2020 and April 2020, due to the 1st COVID-19 wave, with admissions falling more than a third between the two months. Monthly hospital admissions levels did not return to the March 2020 levels until August 2020, but then dropped again in December 2020 – February 2021. Locally the number of COVID-19 hospital admissions was actually higher at the peak of the 2nd wave in January 2021 than the first wave.

Figure 25: Monthly Hospital admissions - University Hospital Lewisham



(Source: NHS Digital/Hospital Episode Statistics)

Figure 26: Hospital Admission Rates per 1,000 population by ethnic group for all conditions by month¹⁵



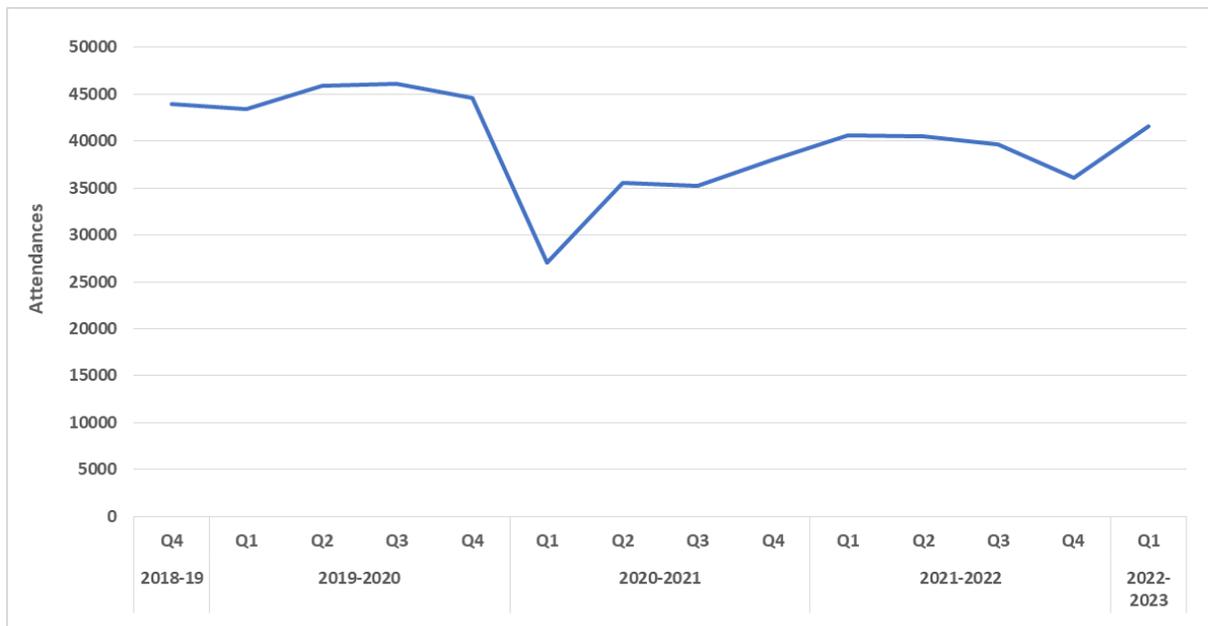
For Lewisham this dataset has also been analysed by ethnic group, with data provided up to January 2022. Before and during the pandemic the hospital admission rate, due to any condition has been highest for those from a White and Other ethnic group. (It should be noted that the Other ethnic group has a relatively small population size in Lewisham). Whilst all ethnic groups saw a decrease in the hospital admission rate in April 2020, this decrease was steepest for those from a White ethnic group. Whilst hospital admission rates generally increased from their lowest rates during the rest of 2020, all ethnic groups subsequently saw a further sharp drop in January 2021.

¹⁵ This data is being presented as a rate due to different ethnic groups having very different population sizes. Please note that the rate could only be calculated using ethnicity of the resident population (as it was not possible to get ethnicity data for all the registered population which HES uses).

Outpatient Attendances

Having an overall view of hospital activity during the COVID-19 pandemic, and comparing with baselines is crucial in attempting to understand the wider impact. As well as reduced numbers of admission and surgeries taking place there was also a significant decline in out-patient appointments. Figure 27 (below) shows out-patient attendances at UHL between 2019 and June 2022. As seen in other areas, the most significant drop was in Quarter 1 2020/21 (the first lockdown) with attendances increasing/plateauing in Quarter 2 & 3 of that financial year. What is noticeable is that even by Quarter 1 of 2022/23 attendances remain lower than the five quarters preceding COVID-19. Further information is needed to understand if this is because there are not enough clinics running to offer the same number of appointments as in 2019, or whether lower activity in other areas of the health system due to the pandemic, has meant that issues are not being diagnosed and treated as they would have previously been.

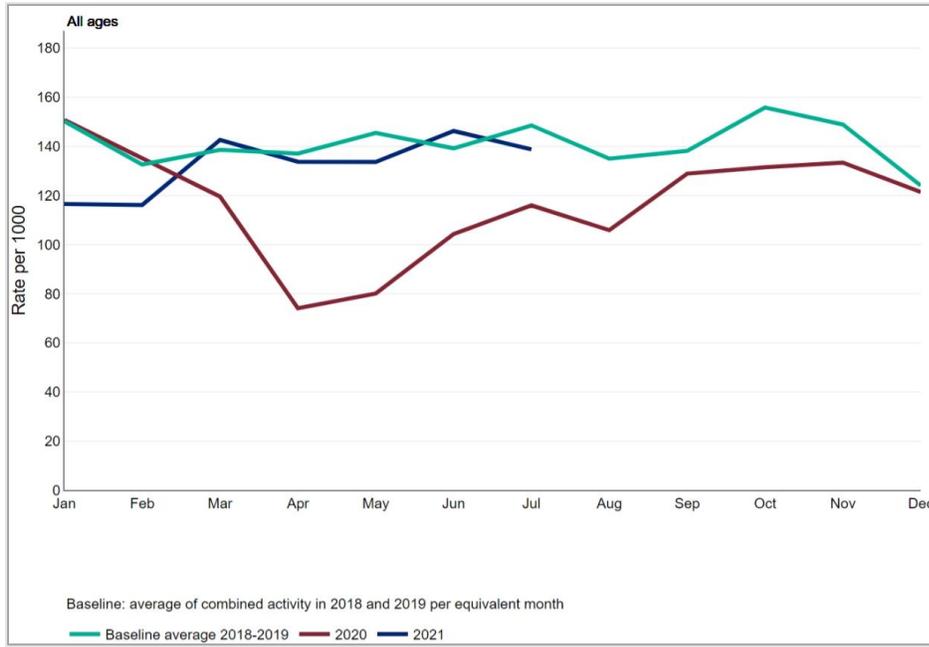
Figure 27: Quarterly trend in UHL outpatient attendances



(Source: NHS Digital/Hospital Episode Statistics)

For available national data, as with all hospital activity, out-patient attendances dropped steeply in 2020 but recovered more sharply at the start of 2021.

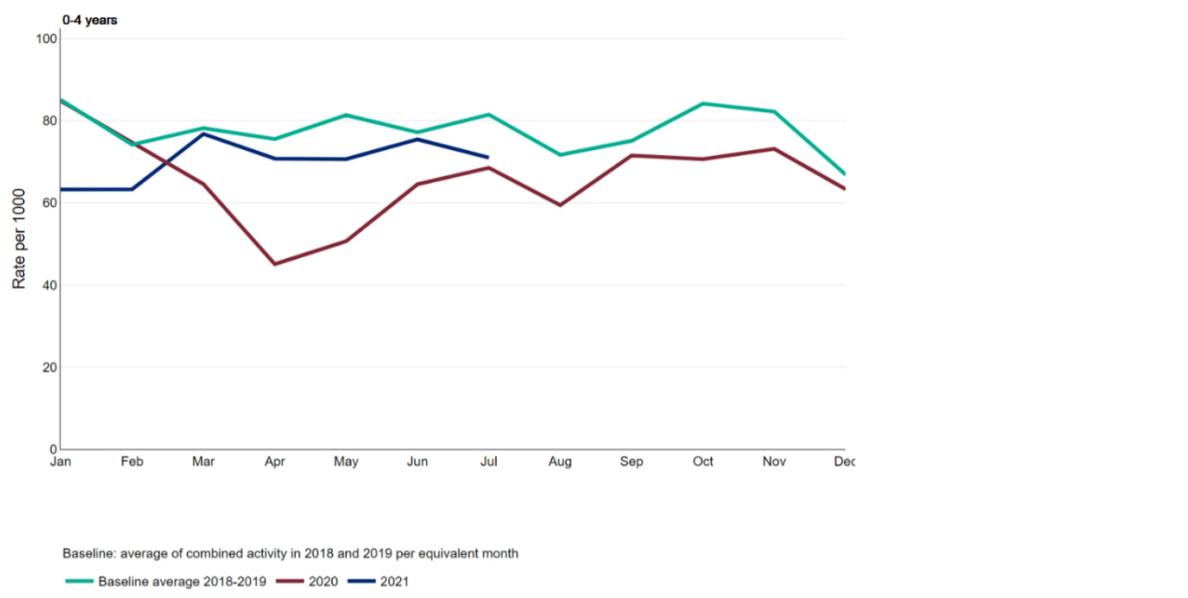
Figure 28: Monthly trend in hospital outpatient attendances compared to baseline - England



(Source: Hospital Episode Statistics (HES), accessed via OHID)

However for young children, aged 0-4, rates had not returned to pre-pandemic levels by the summer of 2021.

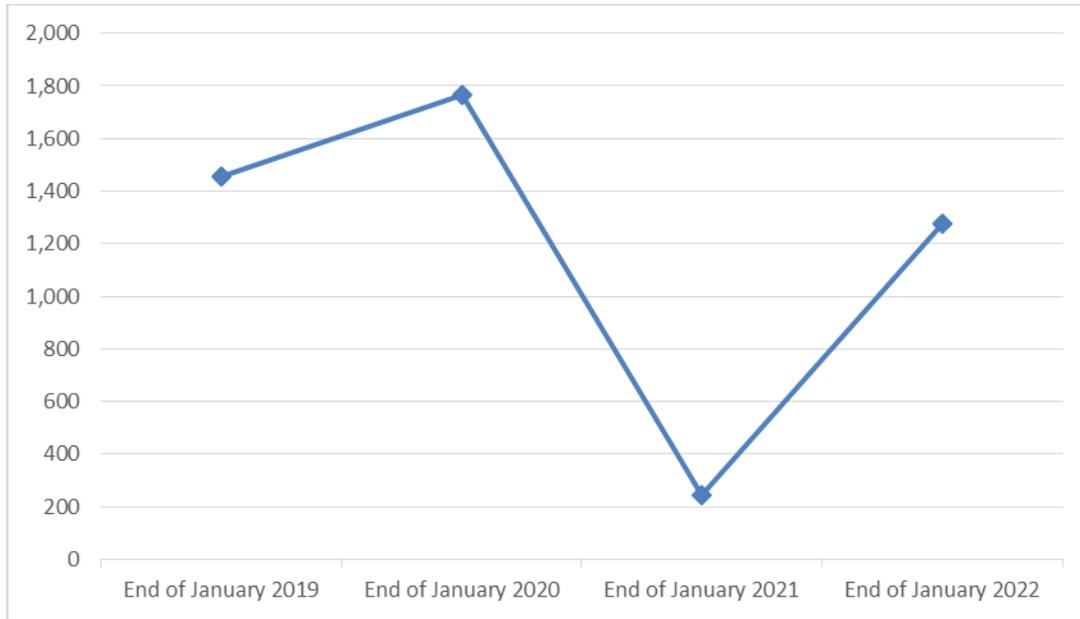
Figure 29: Monthly trend in hospital outpatient attendance compared to baseline - England (0-4-year-olds)



(Source: Hospital Episode Statistics (HES), accessed via OHID)

Total Admissions

Figure 30: Number of Patients Admitted for Treatment within LGT in January of each year - 2019-2022 (all conditions)



(Source: NHS Digital)

Figure 30 (above) presents the data in a different way (and for the entire LGT Trust, rather than just UHL), comparing the number of people who were admitted into LGT in the same month (in this case January), over a four-year period. This highlights how much the high COVID-19 infection rate of December 2020 and January 2021 impacted health services locally, with the number of people starting treatment at 250, a fraction of what it was any other year presented.

Waiting lists data

To understand how the pandemic may have impacted waiting times for different areas of health care, a number of sources of information have been analysed.

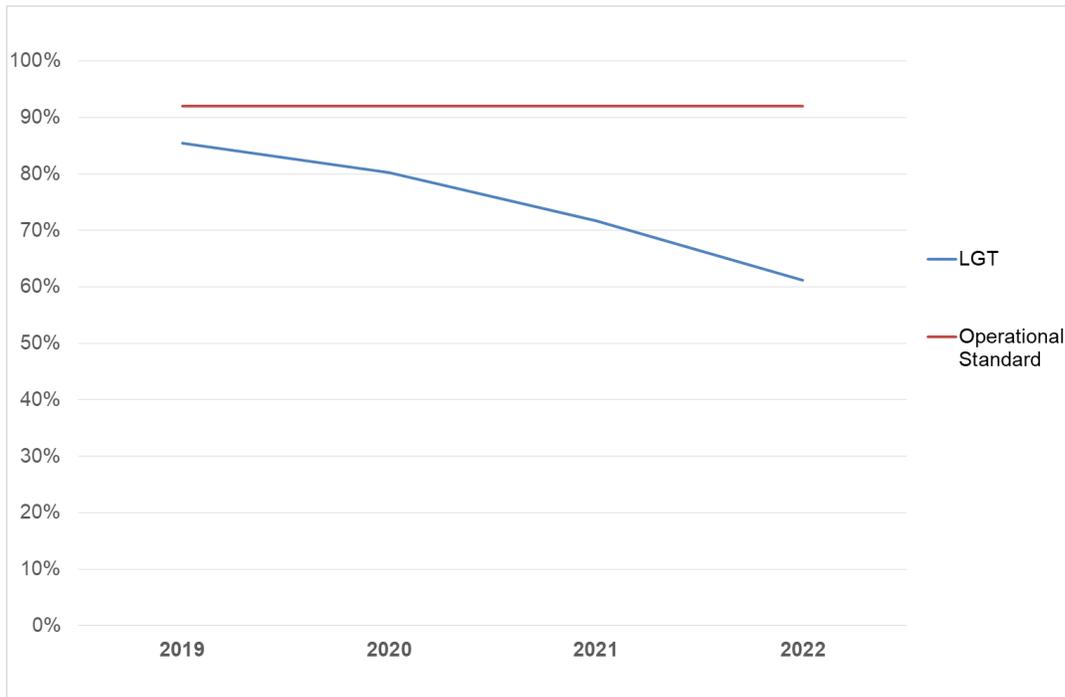
Referral to Treatment Waiting Times

The maximum waiting time for non-urgent, consultant-led NHS treatments should be 18 weeks¹⁶. The NHS Digital produced 'Consultant led Referral to Treatment Waiting Times' report is published to monitor whether NHS Trusts meet this target. As such the report provides trust wide data for LGT, rather than figures for Lewisham residents or those registered with a Lewisham GP. However, we are able to look at the data over time and see what appears to be a cumulative impact on the 18 week waiting times. At the end of January 2022, 61.2% of patients were waiting (to start treatment) within 18 weeks¹⁷. As Figure 31 (below) highlights, there has been a continued decrease since the pandemic.

¹⁶ [Guide to NHS waiting times in England - NHS \(www.nhs.uk\)](https://www.nhs.uk)

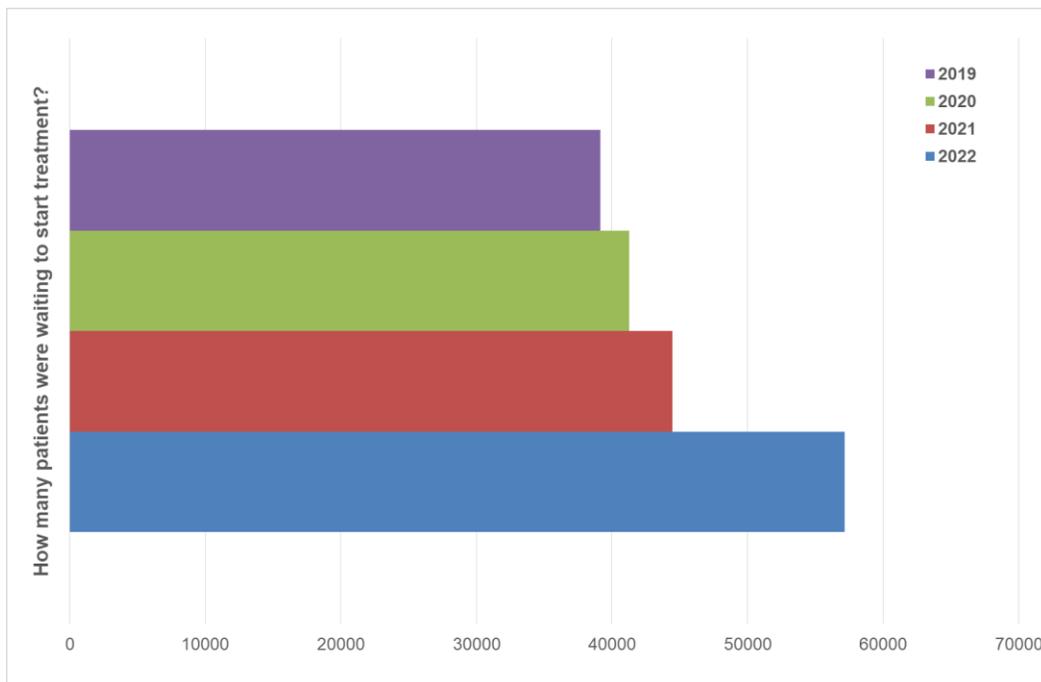
¹⁷ The NHS operational standard is 92%

Figure 31: Proportion of Patients waiting to start treatment within 18 weeks in LGT in January of each year - 2019-2022 (all conditions)



(Source: NHS Digital)

Figure 32: Patients Waiting to Start Treatment in LGT in January of each year 2019-2022

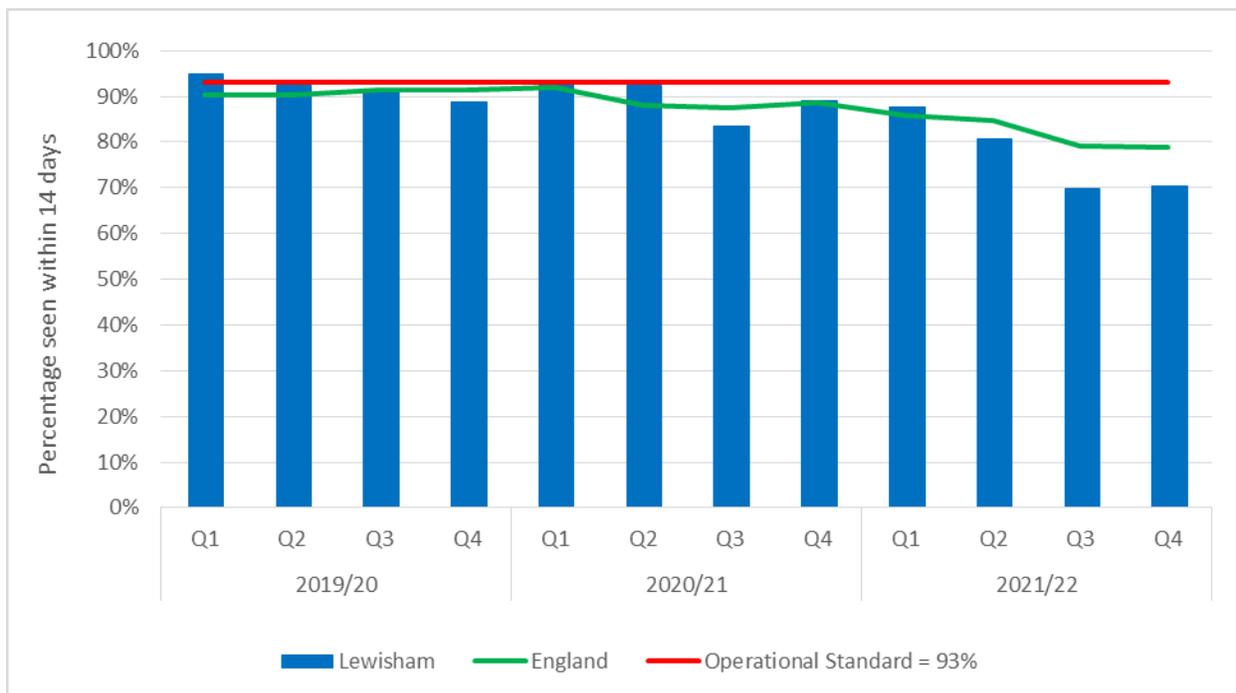


(Source: NHS Digital)

Cancer Waiting Lists

Data around cancer waiting times is recorded separately to the data previously presented. Figure 33 below shows LGT's Two Week Wait from GP Urgent Cancer Referral to First Consultant Appointment, from 2019/20 to 2021/22. Since the beginning of the pandemic both the local and national figures have fallen notably below the Operational Standard, however Lewisham saw a particular drop in Q3 and Q4 of the 2021/22 financial year. However this drop for LGT was not also seen in other London Trusts (Guy's and St Thomas's, Kings and UCL all saw performance of over 80% in Q3 2021/22, with only Guy's and St Thomas' dropping to similar levels to LGT in Q4 2021/22).

Figure 33: Two Week Wait From GP Urgent Referral to First Consultant Appointment - All Cancers (LGT 2019-2022)



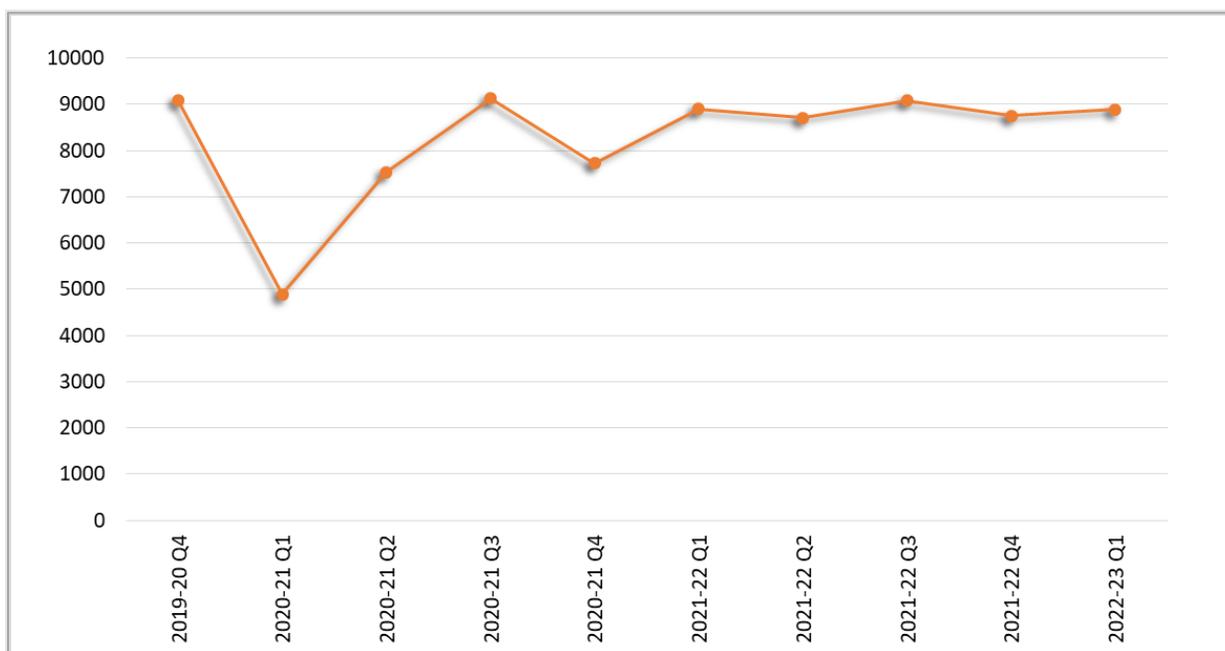
(Source: [NHS Digital](#))

The LGT Cancer Service commented that pressures, particularly for referrals of cancers where there were consistently very high volumes of Two Week Wait Referrals meant that meeting the overall target of 93% was very challenging. For example, for Breast cancer, in the 12 months to April 2022 there were on average over 500 people a month on the Two Week Wait Referral pathway. From Jan-March 2022, less than half of those referred were able to be seen within the two week timescale, hence skewing the overall average. Measures have now been taken to increase capacity, including contracting external services. When discussed whether the burden of COVID-19 was contributing to this, it was seen as a possibility, with the intense work pressures of the pandemic meaning that staff could not continue working additional shifts.

Surgery

The Hospital Episode Statistics database allows us to see how many people admitted to hospital had a 'procedure' by financial quarter. This is being taken as a proxy measure to understand any delays to surgery due to the pandemic. Whilst there was a large drop in the number of procedures undertaken in Quarter 1 of 2020/21, which was the first full quarter of the pandemic, figures did increase in both Quarter 2 and 3, before dipping again in Quarter 4. Since Quarter 1 2021/22 there has been a slight decrease each quarter in the number of procedures completed. What has not been seen in this timeframe is additional procedures to compensate for those not performed at the start of the pandemic.

Figure 34: All admissions that involved a procedure, UHL - Quarterly Trend data



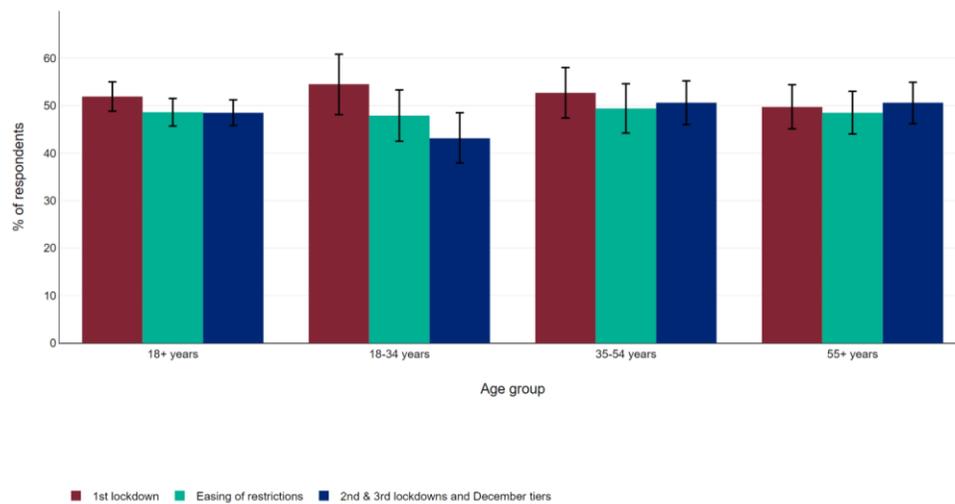
(Source: NHS Digital/Hospital Episode Statistics)

Delays in Diagnosis

Throughout the COVID-19 pandemic there has been concern that people were not accessing healthcare for non-COVID-19 related health issues and the impact this may have long-term on health. One national source of information around this area, is a You Gov Survey, as presented by OHID¹⁸. It found that the proportion of respondents who have not sought advice for a worsening health condition was highest in the 1st lockdown, particularly for younger adults (Figure 35). Marginal differences were seen between males and females, however these were not statistically significant (Figure 36).

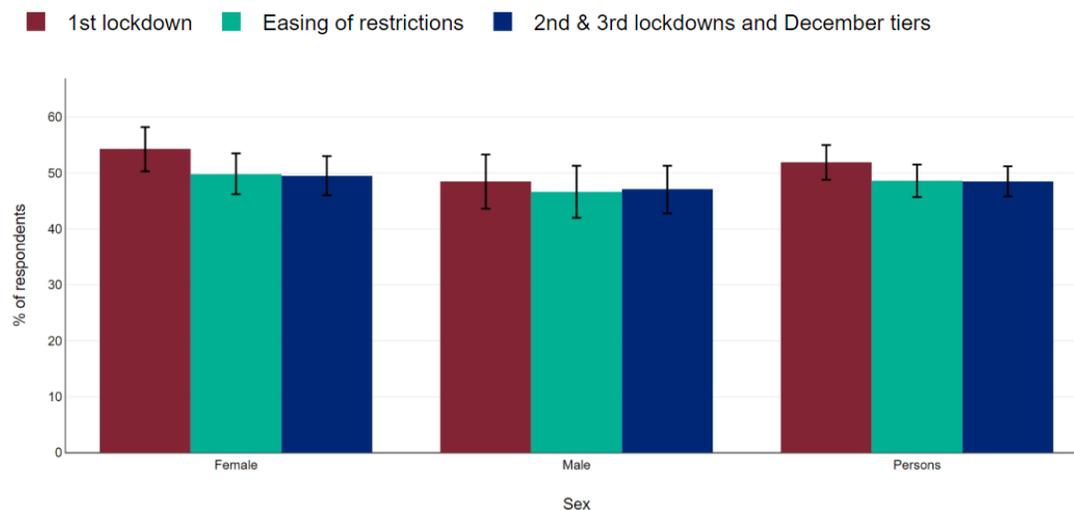
¹⁸ It should be noted that due to the survey nature of this data, there are confidence intervals.

Figure 35: Proportion of respondents who have not sought advice for a worsening health condition in England by age group: survey data up to 26/01/2021



(Source: OHID, presenting YouGov survey results)

Figure 36: Proportion of respondents who have not sought advice for a worsening health condition in England by sex: survey data up to 26/01/2021



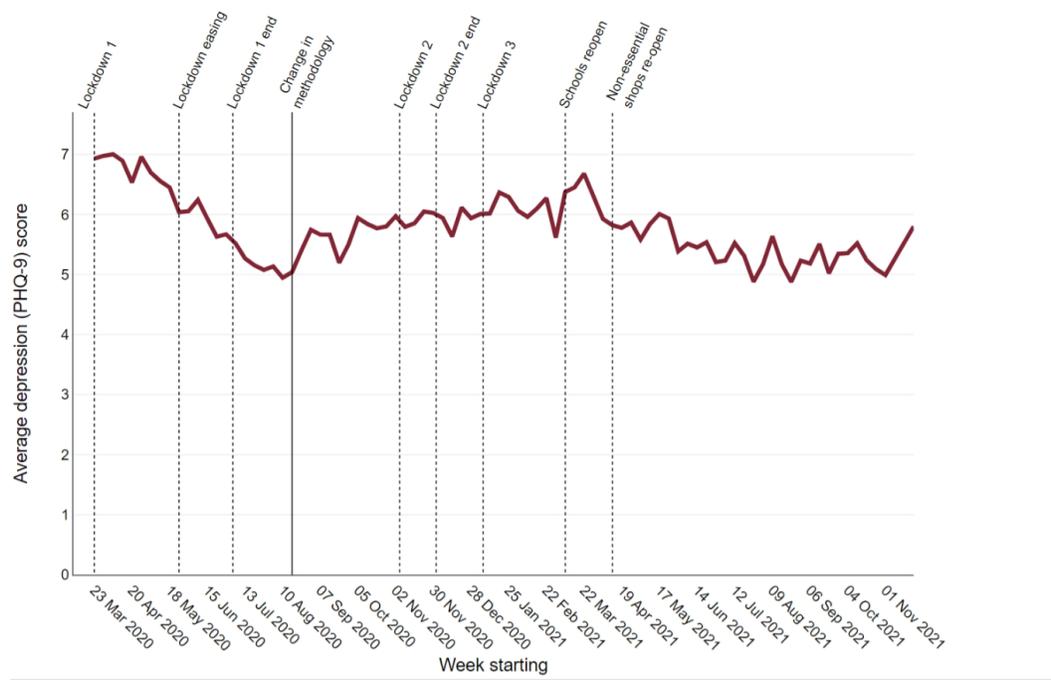
(Source: OHID, presenting YouGov survey results)

Mental Health

Mental health is an aspect of health particularly impacted through lockdowns and restrictions that were in place throughout the pandemic. Local indicators for Lewisham do not yet cover the entire time period we wish to analysis, hence data presented on depression in the charts below is taken from the UCL COVID-19 Social Study and gives data for the UK. It looks at responses to the PHQ-9 (patient health questionnaire 9), a self-reported panel of 9 questions used for identifying, and measuring the severity of depression. It is widely used in health care and in population health research. An individual score of >5 is considered to be 'mild' depression, and >10 'moderate' depression. These graphs show average population scores taken from a large

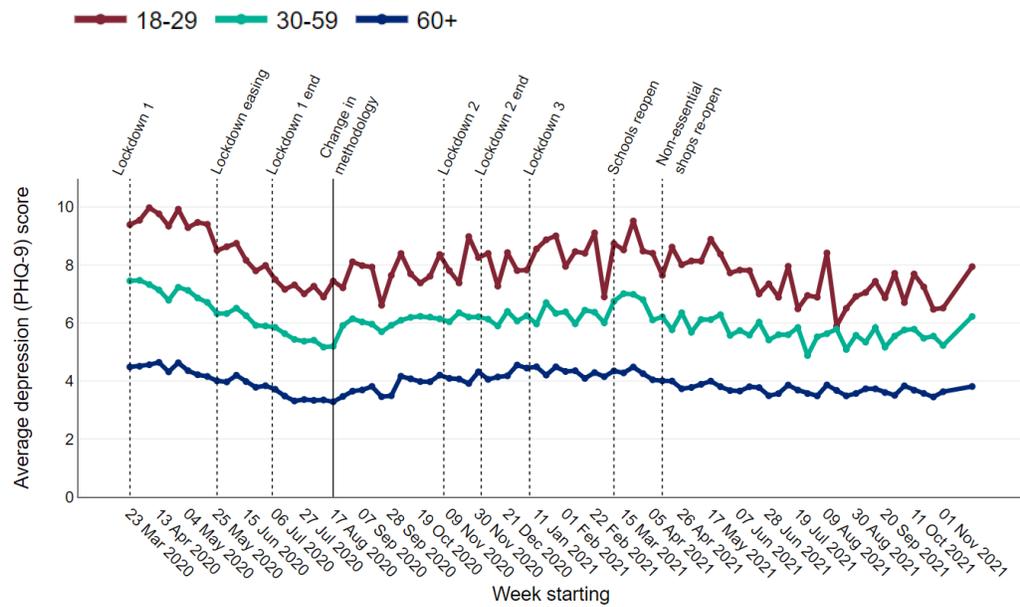
panel study, weighted to the national population. Figure 37 shows that average depression scores were highest at the start of the 1st lockdown but continued to fluctuate throughout the course of the pandemic. Noting that a score of above 5 is considered mild depression, this would indicate that the mental health of the majority of respondents was impacted.

Figure 37: Trend in average depression (PHQ-9) score for all respondents in United Kingdom



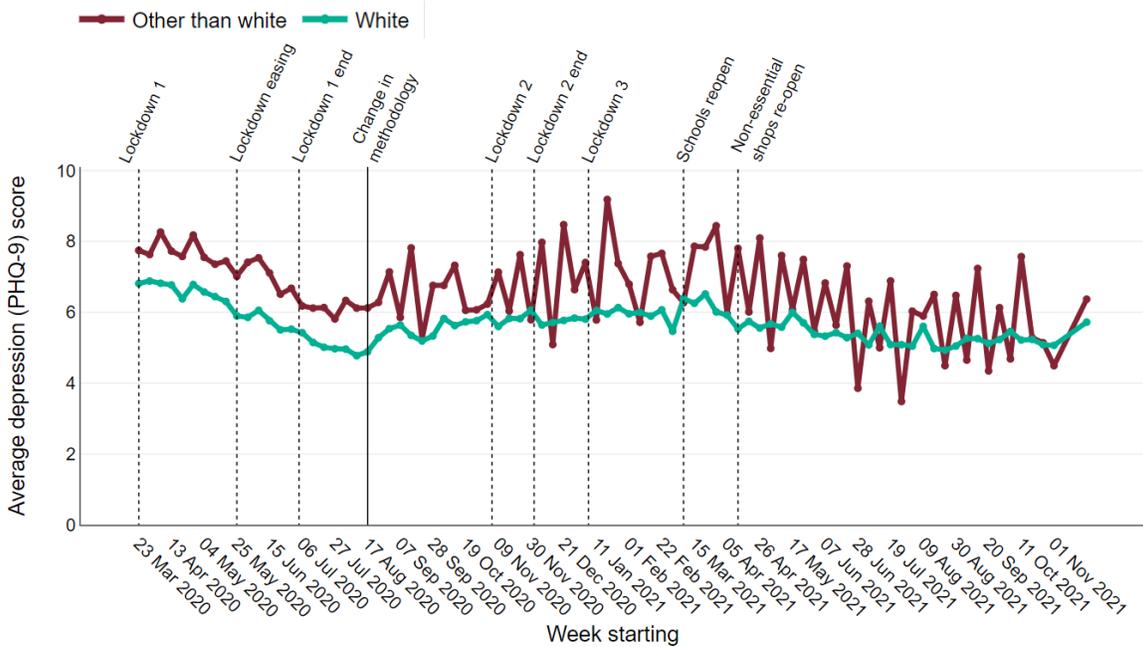
(Source: OHID)

Figure 38: Trend in average depression (PHQ-9) score in UK, by age group



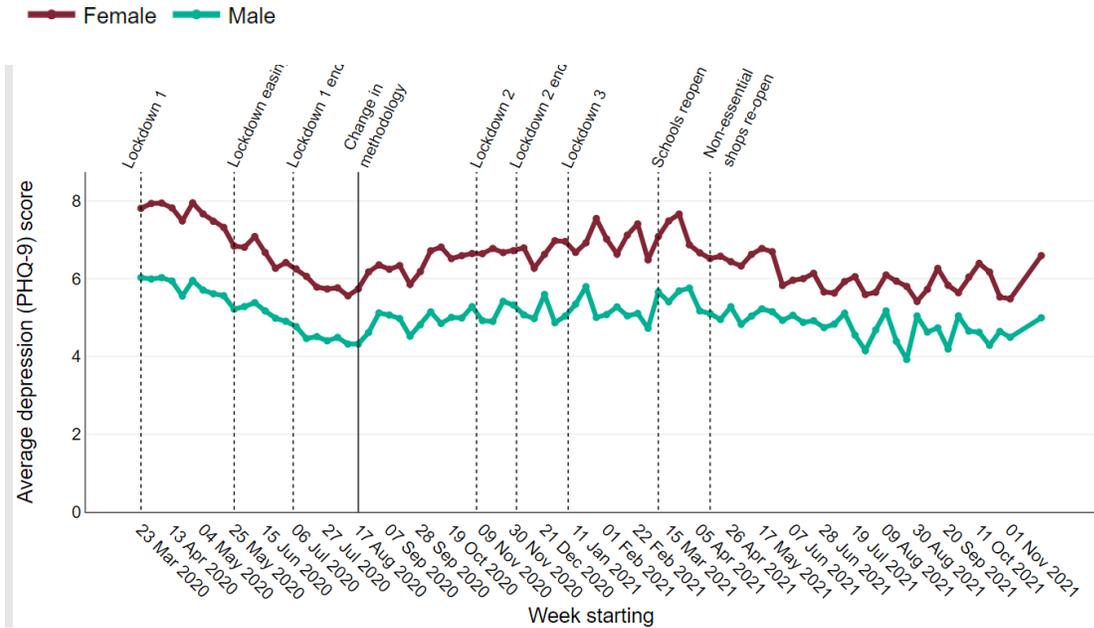
(Source: OHID)

Figure 39: Trend in average depression (PHQ-9) score in UK, by ethnicity



(Source: OHID)

Figure 40: Trend in average depression (PHQ-9) score in UK, by gender



(Source: OHID)

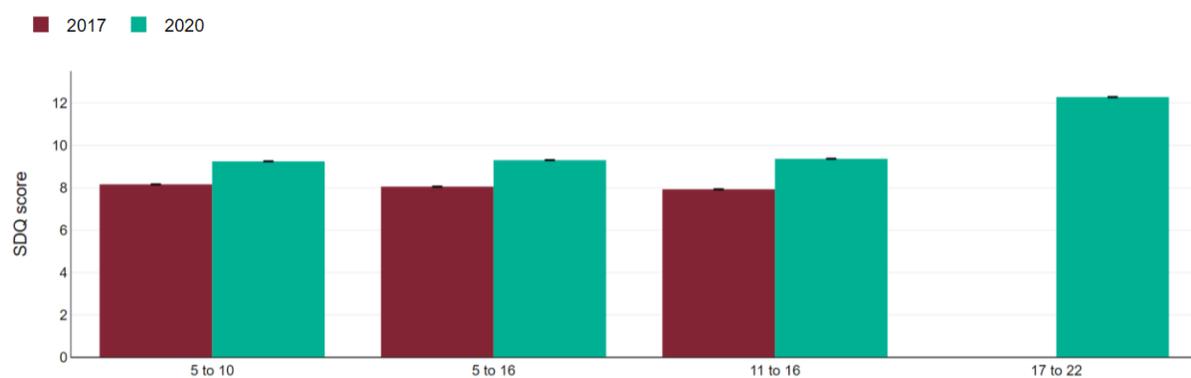
When we look at the same dataset by characteristic we can see that young adults had the highest reported scores (Figure 38), throughout the pandemic. Whilst those from an ethnic group other than White predominantly had higher scores than those from a White ethnic group, particularly within the first year of the pandemic (Figure 39). Females were consistently seen to have higher reported scores than males (Figure 40). Data from the same source on anxiety

showed the same patterns. Whilst this data presentation does not show pre-pandemic levels, it does highlight inequalities between genders, ethnicities and age groups in both depression and anxiety levels.

Young People’s Mental Health

Figure 41 (below) presents data from the NHS Mental Health Survey for Children and Young People. This began in 2017, where over 3,500 children took part in a survey, with parents also contributing for younger age groups. This group was then followed up in 2020. Instead of the PHQ-9 measure used in Figures 37 - 40 above, this survey used ‘The Strengths and Difficulties Questionnaire’, which is a brief screening questionnaire used to detect child mental health difficulties¹⁹, lower scores indicate better mental health. Average scores increased significantly (indicating poorer mental health) for all age groups followed up. For the additional older age group added in 2020, scores were significantly higher than their younger peers.

Figure 41: Trend in mental health and young people survey in England



(Source: OHID)

Waiting times for the Lewisham Child and Adolescent Mental Health Service (CAMHS)

Analysis conducted locally has found that the total number of referrals into Lewisham CAMHS in 2021/22 of 1,956 was a 40.42% (or 563 additional referrals) increase on the previous year (2020/21). This includes all referrals received by SLaM, Lewisham’s CAMHS provider including those subsequently rejected.

The acceptance rate of referrals was very similar in both 2021/22 (72.4%) and 2020/21 (68.9%), indicating that the additional referrals in the later year were broadly as appropriate as the previous year.

Whilst waiting times for those accepted for treatment remained steady over the first 3 quarters of 2021/22, they did begin to rise in quarter 4, with 90 children and young people waiting between 39 and 51 weeks and 7 waiting 52+ weeks as at the end March 2022. This compares to 26 and 2 respectively for the end of March 2021. The average number of weeks wait from referral to first contact stood at 11 weeks at the end of March 2022, compared to 16 weeks at the end of March 2021. However, the average number of weeks wait from the first to second contact has increased to 32 weeks as at the end of March 2022, from 21 weeks in March 2021.

¹⁹ [GOSH](#)

The increase in referral rates and the proportion of referrals being accepted over the year, has resulted in larger caseloads. The increase in demand for services coupled with challenges around recruitment and retention of staff that is being felt nationally, is contributing to longer waiting times.

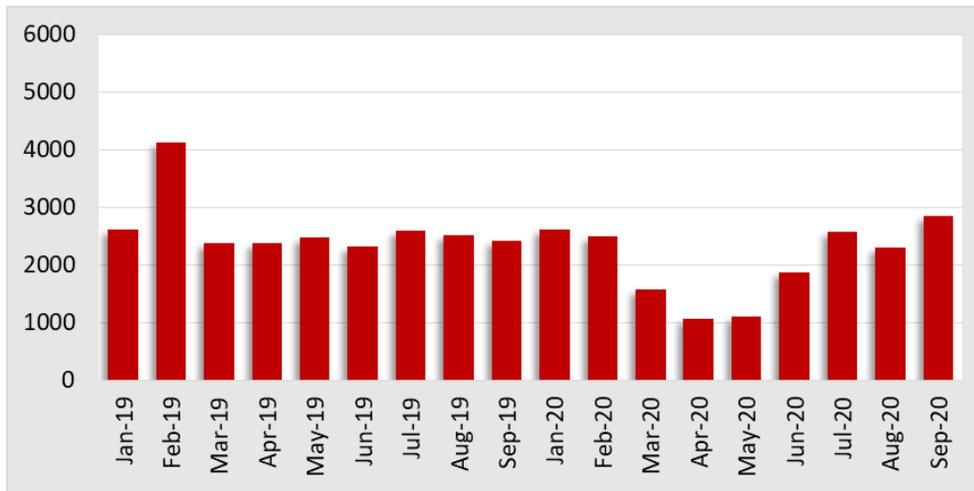
The service have taken a variety of steps to mitigate the additional stresses and caseload, including recruitment, use of locums and Saturday clinics.

Sexual Health

Due to data availability this section focuses on the first six months of the pandemic.

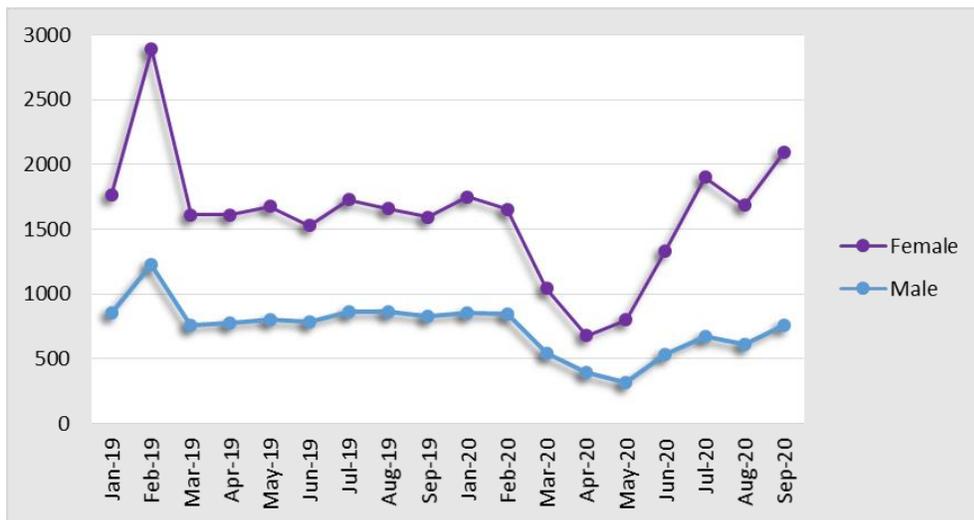
Reductions in the use of Sexual and Reproductive Health services were observed in the period of the 1st national lockdown. By July 2020, activity had largely resumed to pre-COVID levels and by September 2020 activity exceeded that of September 2019.

Figure 42: Number of Sexual Health Service Users in Lewisham



(Source: ISHT backing data)

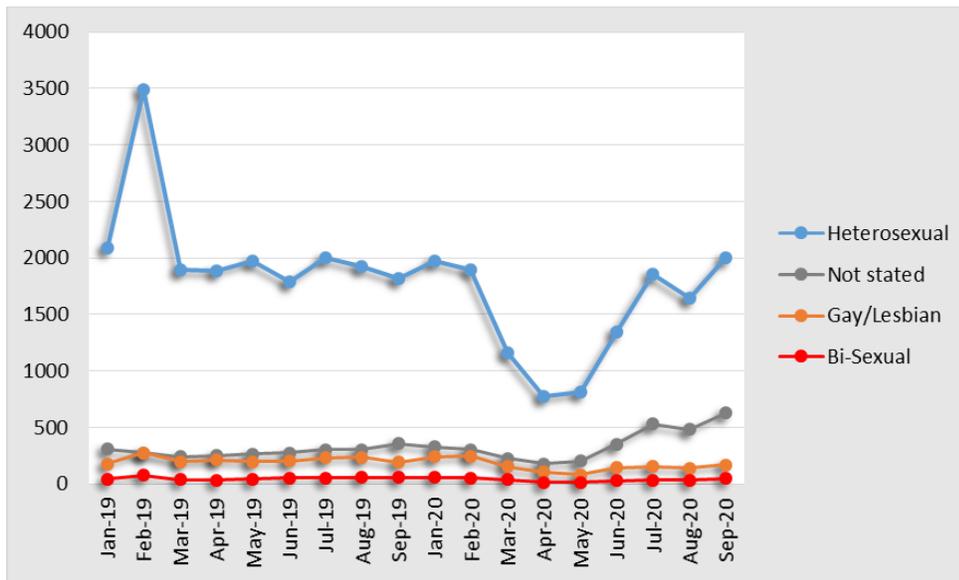
Figure 43: Sexual Health Service users by gender



(Source: ISHT backing data)

As per historical patterns of use of Sexual and Reproductive Health services, female use exceeded that of males during the period of the 1st lockdown and subsequent months. Service activity recovered faster in females and has generally exceeded pre-COVID levels. Male service activity remains lower than pre-COVID levels. This may reflect demand for contraception which is not being met by other services, such as the E-service or GPs.

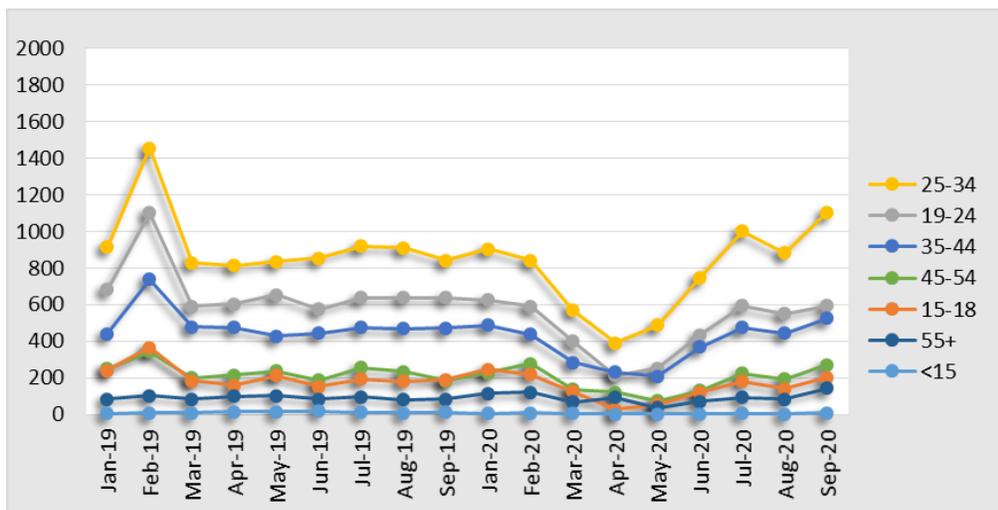
Figure 44: Sexual Health Service users by sexual orientation



(Source: ISHT backing data)

The most frequently stated sexual orientation among service users is heterosexual, with not stated being the second most frequently applied category pre-and post-lockdown. Service use by all groups reduced in March and April 2020 before resuming. Activity for all groups had largely resumed to pre-pandemic levels by September 2020. There has been an increase in 'not stated' category that is not balanced by a drop in other categories.

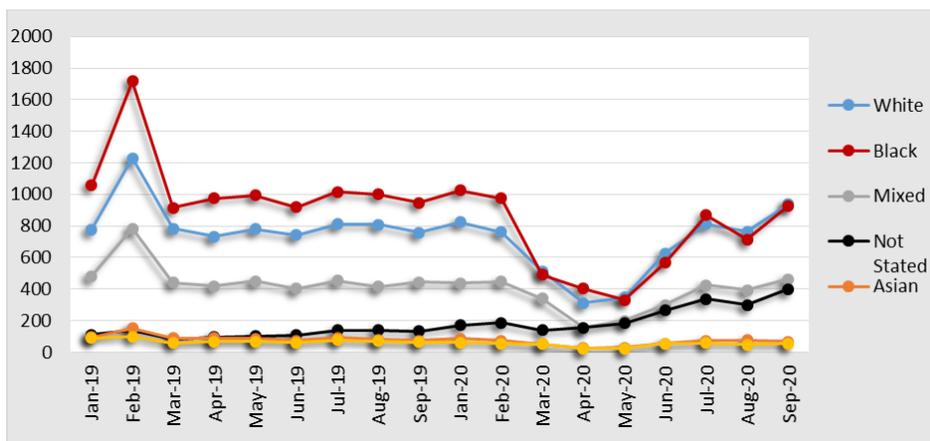
Figure 45: Sexual Health Service users by age band



(Source: ISHT backing data)

As Figure 45 (above) highlights, residents 25-34 years of age remained the highest users of Sexual Health services during lockdown. All age group's service use followed a similar pattern, with a sharp drop-in service activity in March and April, which began to recover in May. By September 2020 service use by residents aged 25-34 years of age generally exceeded pre-lockdown activity levels.

Figure 46: Sexual Health Service users by ethnicity

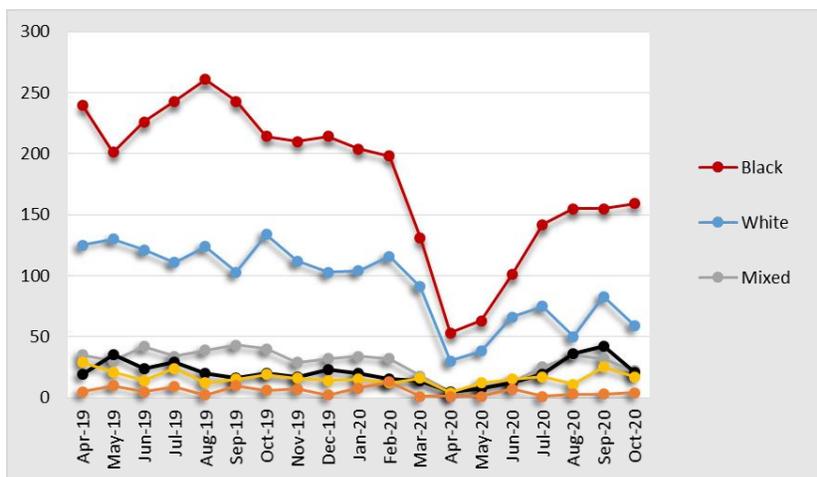


(Source: ISHT backing data)

For Figure 46 (above), ethnicity categories have been combined to enable clearer presentation of data. For reference Black people recorded as being of African or Caribbean ethnicity are similar in number within this dataset. In Lewisham, people of Black ethnicity were the highest users of sexual and reproductive health services in 2019. By September 2020, service use by people of Black ethnicity has resumed more slowly and unlike use by other groups was yet to return to pre-lockdown levels.

A noticeable increase in 'ethnicity not stated' was observed between May and September 2020. It is not known if this is universal, or if particular group(s) are disinclined to report their ethnicity or if healthcare professionals' inclination to ask someone their ethnicity or to record a presumed ethnicity varies between ethnic groups.

Figure 47: Emergency Hormonal Contraception provision by ethnicity



(Source: Local database)

People of Black ethnicity were the highest users of Emergency Hormonal Contraception (EHC) before the pandemic and during the first six months of COVID-19. People of Black ethnicity’s use has resumed more quickly than that of people of other ethnicities. This suggests a particular unmet contraceptive need for people of Black ethnicity, echoing the findings of the 2019 Lambeth, Southwark and Lewisham contraceptive needs assessment. EHC is ordinarily available in pharmacy, GP and Specialist Sexual Health Services. During the pandemic telephone triage and consultation was introduced in all types of setting, with in-person pick up of medication. Whilst EHC activity reduced substantially in all settings, in the first wave of the pandemic, pharmacy accounts for the largest share of activity and saw the greatest reduction. This was considered to be due to the following:

- Changes in sexual behaviour
- Perceived reductions in pharmacy availability
- Changes in pharmacy access, e.g. queuing outside.

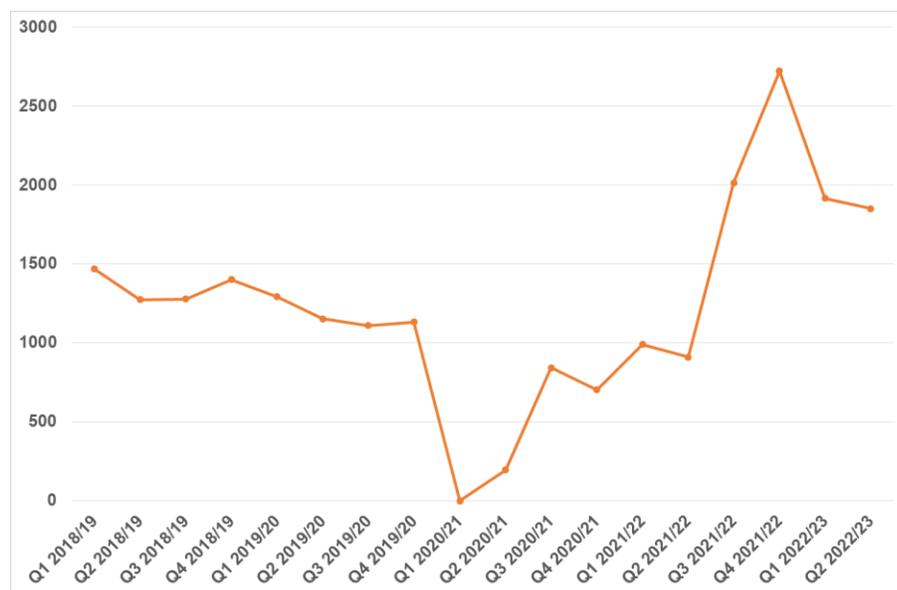
Subsequently EHC activity in pharmacy recovered more slowly than activity in GP (overall contraception activity in GP was approaching 2019 levels by September 2020).

Preventative Services

The [NHS Health Check](#) is a service for adults aged 40 to 74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. The check is not offered to people who have already been diagnosed with the listed conditions or certain others including high blood pressure. If eligible, a person should be invited for a health check every five years.

Since 2018, the NHS Health Check programme has been commissioned through the local GP Federation One Health Lewisham. Figure 48 (below) illustrates the number of NHS Health Checks that were received in Lewisham by quarter. (Typically, any analysis of NHS Health Check data would also consider the number of appointments that were offered and calculate the % uptake but due to changes in the service and health checks only being conducted opportunistically at certain points of the pandemic, these figures are not included).

Figure 48: Number of NHS Health Checks Received by Quarter - Lewisham



(Source: NHS Health Check Database/OHL)

From September 2019, delivery of the statutory NHS Health Checks programme in Lewisham has been overseen by One Health Lewisham (OHL), the local GP federation. Pre-pandemic, between 1,000 and 1,500 NHS Health Checks were received each quarter in Lewisham. In the first full quarter of the pandemic (2020/21), NHS Health Checks were paused, with a small number being conducted opportunistically in Quarter 2 2020/21. Since then, figures have improved and since Quarter 3 2021/22 have been higher than before COVID-19. However, without the full context of how many appointments have been offered, to understand what % of the eligible population are being offered this preventative service it is difficult to establish whether this is an area for concern and whether there is unmet need in terms of the cardiovascular health issues that the programme is designed to identify. Given the short timeframe of OHL overseeing the programme before the start of the pandemic it is not possible to assess if and how uptake has changed with a new provider.

Immunisations uptake

Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases. Lewisham has historically not achieved most of its immunisation targets. Therefore, it is crucial to understand if and how immunisation has been impacted throughout the pandemic. Uptake of the key vaccine MMR2 by the age of 5, decreased throughout the course of the pandemic. Uptake increased in Quarter 2, 2021/22, however it still falls below the England average and below herd immunity level (Figure 49 below). A similar pattern is seen for core vaccines for children by 1 year of age (Figure 50 below), however uptake dipped below the London average in Quarter 3 2021/22.

Figure 49: % uptake of the Measles, Mumps and Rubella (MMR2) vaccine at 5 years

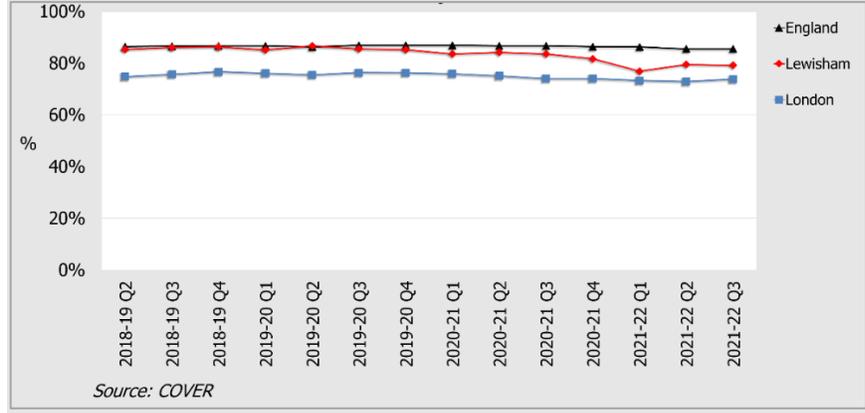
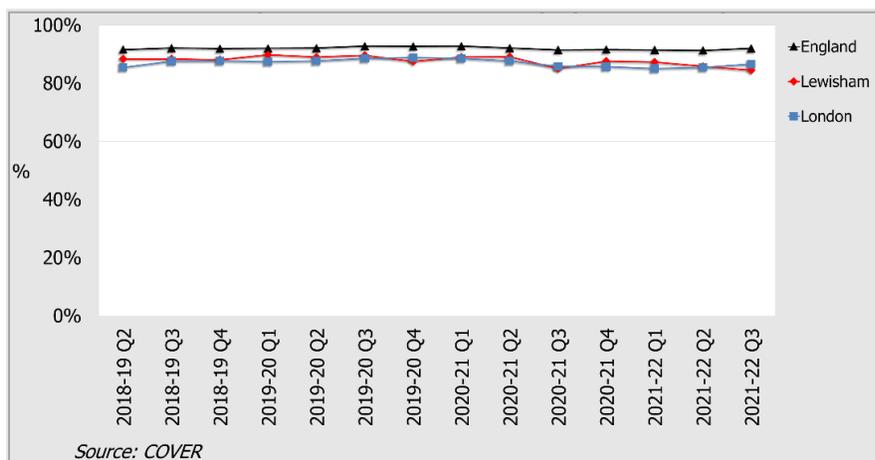


Figure 50: % uptake of the core vaccines by 1 year of age

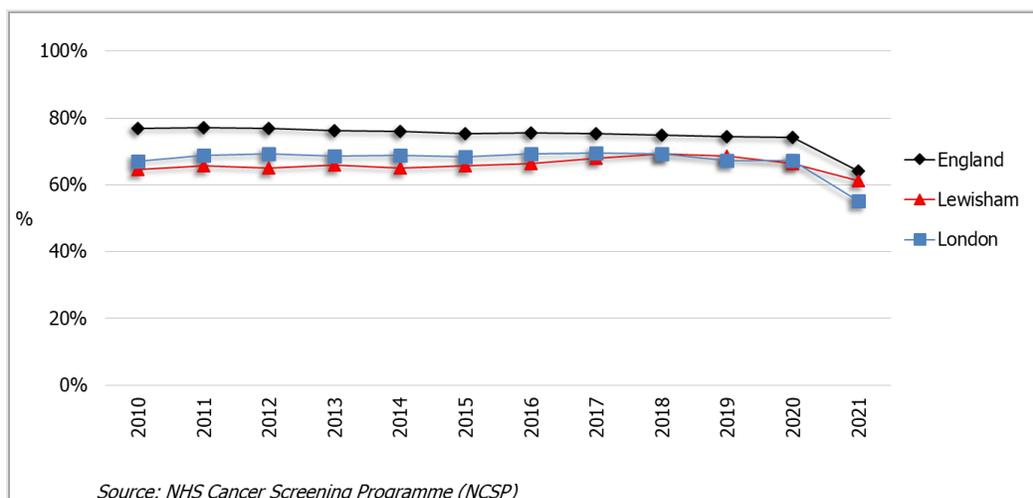


Cancer screening

Cancer screening supports early detection of cancer and is estimated to save thousands of lives in England each year. Improvements in screening uptake and coverage mean more cancers are detected earlier, at more treatable stages. Hence it is important to understand any changes in screening levels through the pandemic.

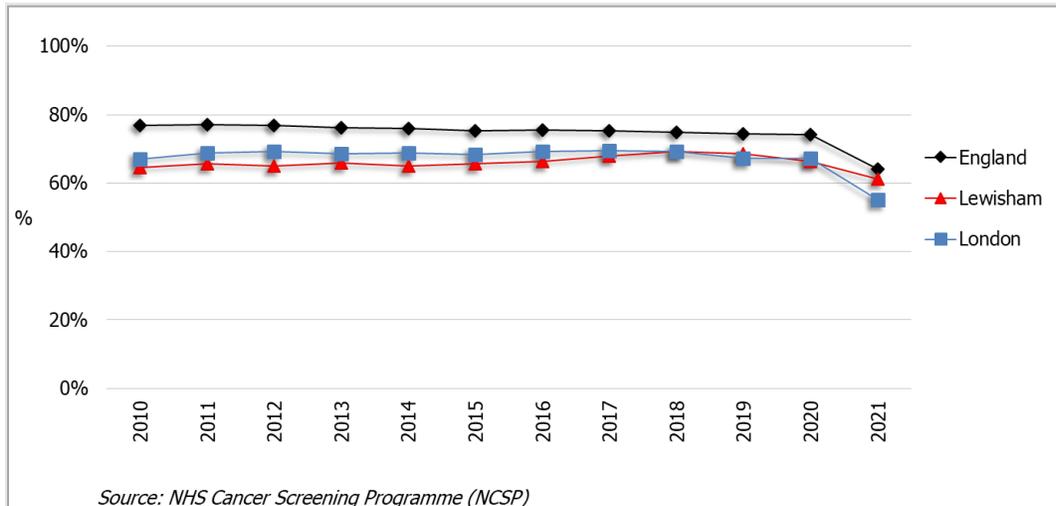
Whilst Lewisham’s under 75 cancer mortality rate is now in line with England, it does remain above the London average. Prior to the pandemic, cancer screening coverage in Lewisham was significantly lower than the England average for breast, bowel and cervical cancers. Figure 51 (below) shows that although there was a notable decrease in breast cancer screening uptake in Lewisham, it was not as steep as the London decrease (Lewisham’s coverage was in fact better than London in 2021). The England average also saw a steeper decrease in coverage, however remained higher than the Lewisham figure.

Figure 51: Breast cancer screening: trends in coverage of women aged 53-70 years screened in the last 3 year period



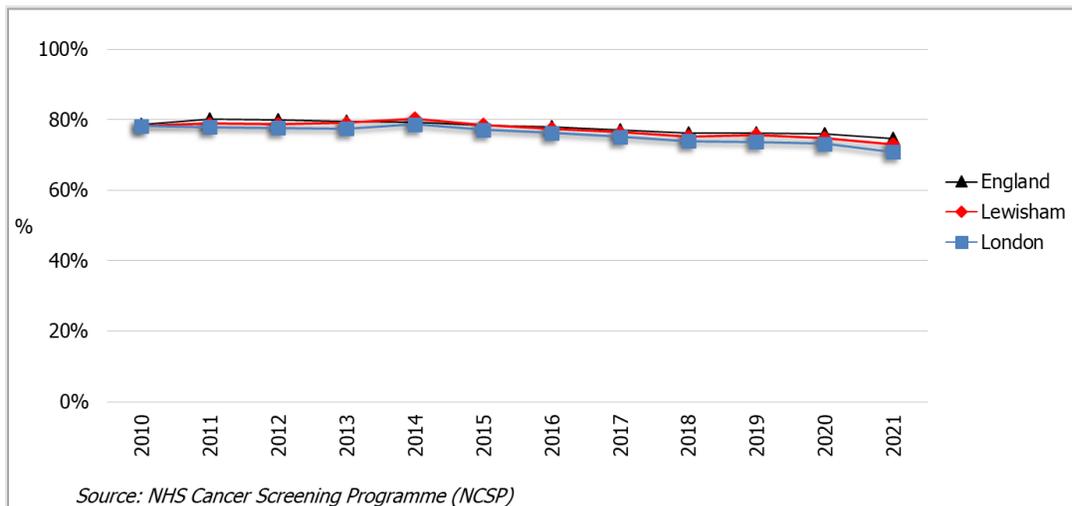
A similar pattern is shown for cervical cancer screening (Figure 52 below). Coverage in Lewisham dropped less in Lewisham than across London, however remains below the national average.

Figure 52: Cervical cancer screening: annual trends in coverage of women aged 25-49 years screened adequately in the last 3.5 years



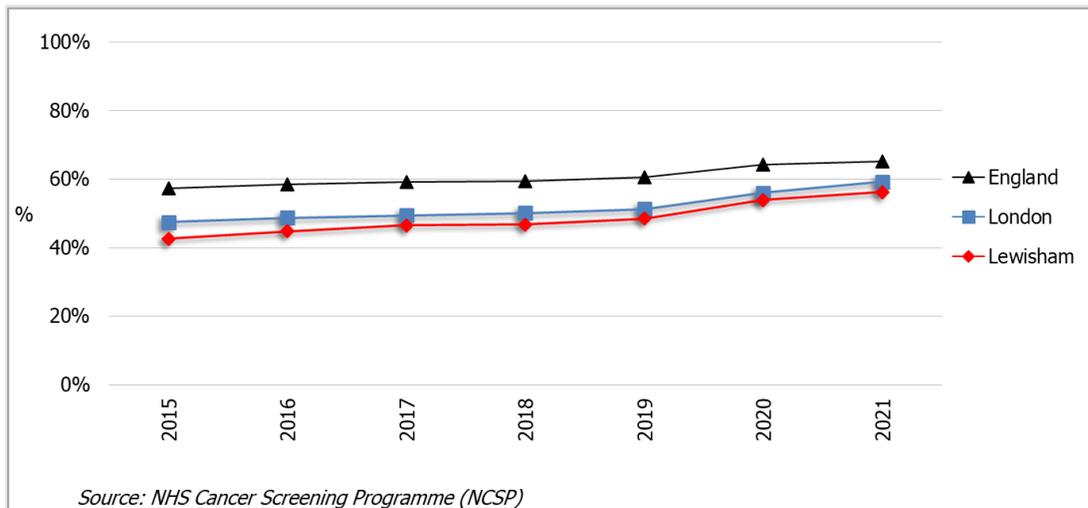
For cervical cancer screening in women aged 50-64 the decrease was much smaller, however this can partly be explained in the lesser frequency of screening requirement, 5.5 years, compared to 3.5 years for younger women (Figure 53 below).

Figure 53: Cervical cancer screening: annual trends in coverage of women aged 50-64 years screened adequately in the last 5.5 years. Annual trends



As illustrated by Figure 54 (below), bowel cancer screening has increased in Lewisham, London and England in 2021. Whilst Lewisham remains statistically lower than the England average the gap has closed from 12% lower in 2019 to 9% lower in 2021.

Figure 54: Bowel cancer screening uptake (2.5 year coverage) in persons aged 60-74. Annual trends



Immunisation and Screening Summary

With the exception of bowel cancer screening, uptake of screening, immunisations and NHS Health Checks declined during the pandemic. For all indicators where benchmarking is available Lewisham's performance was below the England level. Emphasising as seen elsewhere that health inequalities seen before the pandemic have persisted and in some cases intensified as uptake has not yet returned to pre-pandemic levels.

Other Services

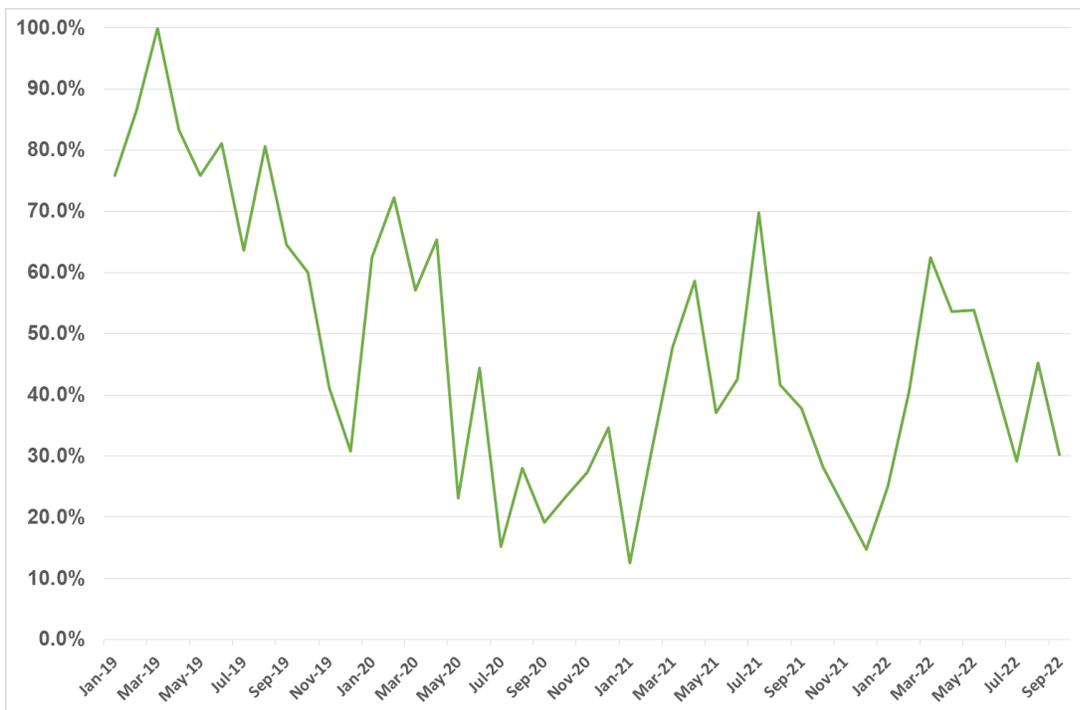
Delays in processing and implementation of Education, Health and Care Plans for children with support needs

An education, health and care (EHC) plan is for children and young people aged up to 25 who need additional support as they have been assessed to have additional needs. The usual timeline for the assessment to decide whether a plan will be put in place is 20 weeks. During the pandemic there were a number of issues which increased the length of time for plans being issued. These issues, as well as issues that the Special Education Needs Service faced overall are detailed below:

- Staffing capacity across education, social care and health. Either due to illness or being redirected to work specifically within the COVID-19 response team. This delayed the completion of EHC plans.
- Staffing capacity was further impacted as officers moved away from London during the pandemic and there were difficulties attracting/maintaining staff. This also created additional expense with the reliance on agency staff (whom were also in short supply). The number of staff available to work in the different areas of the EHC process remains a HUGE challenge across education, health and social care.

- Due to lockdowns children and young people have not been physically seen and had thorough assessments during the pandemic and the information gathered is usually from the parental perspective, which does not provide a rounded EHC plan for a young person, it also does not provide a wealth of information.
- Although a large number of children were not at school, demand for EHC plans remained constant during the pandemic as Special Educational Needs Coordinators (SENCOs) had more time to complete the request and/or parents realised the gaps while home educating their child.
- Students not receiving the provision that is stated within the young person's EHC plan, this was not the case from all services as some teams thought creatively about what and how strategies could be provided, this resulted in complaints from parents.
- Statutory transitions were a challenge as children had not had the same preparation for the next phases in their learning, an increase in behaviour's that challenge and pupils demonstrating that they are not ready for the next phase of school.
- Now the demand for EHC plans has increased whilst schools are continuing to go back to normal, due to the gaps in learning, impact on mental health, students out of practice of learning and different routines and boundaries.

Figure 55: Percentage of EHC Plans issued under 20 weeks (excluding exceptions)²⁰



(Source: Lewisham Council)

As shown in Figure 55 above, although there was variation in the percentage of EHC Plans issued under 20 weeks month on month in the year before the start of the COVID-19 pandemic, there was an overall downward trend since. Between April 2020 and December 2020, less than half of EHC plans were issued within 20 weeks. Figures were also very low at the end of 2021.

²⁰ Exceptions include parent not attending agreed meeting etc.

Health Inequalities Section

Defining Health Inequalities

Health inequalities are avoidable and unjustified differences in health and wellbeing of groups of individuals, so are not inevitable or immutable.²¹ The greatest drivers of overall health (both positive and negative) and health inequalities are not related to the health service but are driven by social and economic factors. This section discusses the interaction between health inequalities and COVID-19.

The GLA have described how the pandemic has widened existing inequalities, citing where there was already a large overlap between those who already experienced health and social inequality who have been disproportionately affected both directly and indirectly by the pandemic²². The pandemic has also created and exposed newly vulnerable groups by highlighting their vulnerability or exposing people who were previously economically secure to threats of economic insecurity, with knock on health impacts. The reasons why particular groups have been more vulnerable to COVID largely relate to the socio economic and structural inequalities they experience. Even where it is a particular health condition or comorbidity that increases vulnerability to COVID e.g. diabetes, many of these are also patterned by socio economic factors and/or are preventable (key risk factors include poor diet, physical inactivity, smoking, alcohol and drug use, poor sexual health, poor air quality).

Also relevant to the COVID-19 pandemic and health inequalities is the concept of Intersectionality. This is the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups²³. It is deemed important in the context of the pandemic as some population groups have multiple vulnerabilities which increase their risk of being seriously affected by COVID e.g. people from Black, Asian and Minority Ethnic Groups have higher prevalence of some comorbidities e.g. diabetes; are more likely to live in overcrowded and/or intergenerational households; have poorer socio- economic circumstances and work in high risk professions these put them at high risk of both the direct and indirect impacts from the pandemic. Some of these factors increased the risk of catching COVID-19, whilst others mean the consequences of becoming COVID-19 positive were more severe.

The following sections outline the impact of COVID-19 on the population by a number of protected and other characteristics:

Age

Local analysis has shown that COVID-19 has widened age inequality, disproportionality affecting those of older age groups – both directly and indirectly, with the highest number of deaths from COVID-19 being in over 80s, as well as a significantly higher rate of non-COVID related deaths in this population compared to previous years. There are a number of reasons that could contribute to this including difficulty or fear of accessing healthcare services during the pandemic.

²¹ Lewisham Health Inequalities Toolkit - Feb 2022

²² GLA Vulnerable Report (see introduction for full reference)

²³ <https://www.merriam-webster.com/dictionary/intersectionality>

However, the wider impact of COVID-19, including lockdowns will have disproportionately impacted other age groups in a number of ways. One strong example is sexual health services, which are more frequently used by young people. Lockdowns significantly impacted on young women's ability to access contraception, particularly those with vulnerabilities such as language barriers, mental health concerns or learning disabilities, which may have disproportionately affected their ability to obtain contraception, as they may not have been able to access their usual professional care support.²⁴

Closure of smaller clinics and poor transport connections may have affected young people accessing services, if they were reliant on public transport. Young people may have returned to their family homes during lockdown and may not have wished to access postal STI tests due to lack of privacy.

Geography

Nationally published data shows that regional inequalities in COVID-19 mortality are greater than those seen previously for all-cause mortality. London had the highest COVID-19 mortality rates, but the lowest baseline all-cause mortality rates. People living in urban areas had increased odds of contracting COVID-19, likely due to reduced ability to maintain adequate social distancing. Population density, deprivation and other factors associated with urban areas such as an ethnically diverse population may also be associated with higher mortality from COVID-19.

ONS published data stated that death rates in London were 3-times higher than in the region with the lowest rates during the pandemic. This level of inequality between regions is much greater than the inequality between all-cause mortality rates prior to the pandemic.

Ethnicity

As shown above, nationally published data has highlighted that death rates from COVID-19 were higher in Black, Asian and Minority ethnic groups, with black ethnic groups at the highest risk of death. Furthermore pregnant women from Black, Asian and Minority ethnic groups had an increased risk of needing hospital admission or dying due to COVID-19. Black, Asian and Minority ethnic group populations were also more likely to live in poverty including child poverty, more likely to become unemployed, and had an increased risk of abuse and neglect during the pandemic compared to other ethnicities.

Areas of health inequalities:

Unemployment

The impact of the COVID-19 pandemic has widened existing health inequalities, affecting those on lower incomes disproportionately. They have been more likely to be made redundant, lose income, more likely to catch and die from COVID-19 and less able to support their children's home schooling.

Between October and December 2020 young black people were three times more likely to be unemployed compared to young white people²⁵. Over a third of low income families with

²⁴ [The Faculty of Sexual and Reproductive Healthcare](#)

²⁵ [ONS](#)

children increased their spending during 2020, while 40% of high income families without children reduced theirs²⁶.

Children and Education

Children were the least likely to become seriously unwell with COVID-19, and there were fewer deaths in under 15s between March and May 2020 compared to previous periods of the same length²⁷ – this is likely due to lockdown and social distancing reducing the risk of accidents, usually the leading cause of death in this age group.

However, school closures and isolation have had a huge impact on children’s education, health and well-being. Children from disadvantaged backgrounds were disproportionately affected due to having more limited access to learning resources, online education, space and private tutoring²⁸.

Parents and caregivers of young children also reported being more anxious, stressed and depressed, particularly those who faced financial difficulties, which may have had an impact on their ability to provide home schooling. Increased financial hardship can impact mental and emotional wellbeing, and deterioration in these can increase child maltreatment, domestic abuse and neglect. The risk of this was heightened due to reduced health visiting services and limited face to face contact.

These factors have led to negative impacts on children’s physical, social and emotional development, affecting their future progress and widening the existing socio-economic gap.

Nutrition

Low-income families are most likely to have poor diets and experience worse health outcomes. The pandemic has exacerbated this further due to increased unemployment, reduced household income, increased food prices and school closures. Families with children have been significantly affected by the pandemic with 38% of households needing support from a food bank during April 2020, 89% more than in the previous year²⁹.

Physical activity

Children and Young people had a decreased level of activity during the pandemic, which disproportionately affected boys aged 9-11 and black, asian and minority ethnic groups. More deprived families are more likely to rely on school playgrounds and facilities for exercise and less likely to have access to resources, space and equipment to support physical and mental wellbeing.³⁰

²⁶ [BMJ](#)

²⁷ [ONS](#)

²⁸ [Darmody et al.](#)

²⁹ [Trussell Trust](#)

³⁰ [Sport England](#)

Local Views

This section of the JSNA has taken work from the Voices of Lewisham publication that was conducted by Lewisham Council. 'Voices of Lewisham' is an engagement platform for residents and stakeholders in the borough to share their experiences of living through the COVID-19 pandemic. The platform was created to:

- Capture and profile insights and lived experiences of residents and stakeholders (since lockdown) that are now part of the borough's story;
- Reflect on the journey that we have all been on and consider what type of place Lewisham should become in the future;
- Inform and influence what happens next as a community, building on a new understanding of what is possible when we work together;
- Capitalise on the community spirit, innovation and collaboration that has formed through the pandemic;
- Bring together disparate strands of existing insight from vulnerable residents, third sector, local businesses, grassroots community groups, staff engagement and other data sources;
- Recognise the range of different experiences – acknowledge inequalities – we're not trying to boil feedback down into one common approach.

Information was taken from first-hand accounts, conversations, personal experiences and group discussions. As part of the process, the project analysed a wide range of existing data sources such as the 1,700 emails that residents have sent to the Council's COVID-19 response inbox (between March – August 2020), learning from the various interactions with the 11,200 residents that were supported by Lewisham's 'shielding' programme, as well as the outcomes of dozens of reports, surveys, engagement exercises and discrete pieces of research.

To ensure the diversity of Voices of Lewisham, those involved included: residents, the private sector, voluntary organisations, community groups, the faith sector, academia and public bodies.

Below outlines the reports main conclusions:

1. We need to better understand the scope and scale of vulnerability across the borough

"Covid-19 only exacerbated the challenges that were already there".

(Shielding resident)

The traditional understanding of vulnerability is becoming broader. For example it is not just those who are out of work that have become vulnerable, it is also those who are in work but may still need a variety of support from financial to emotional. The opportunity exists to re-imagine how we understand vulnerability so that we can better utilise our collective skills and knowledge assets to prevent the escalation of risk and need.

2. We need to rethink our approach to data and evidence

The COVID-19 pandemic has revealed that it is not possible to fully promote equity and fairness without the knowledge and understanding of the communities that we serve. There seems to be genuine scope to look at the approach to collection and evaluation of data from a partnership perspective. The payback for getting this right could mean avoiding needless duplication, better targeted effort, mitigated risk and increased public trust. In one workshop, it was suggested that a community sector data sharing agreement should be developed

3. The pandemic has created real scope for innovation, but care needs to be taken not to leave the most vulnerable behind

The COVID-19 crisis has created real scope for innovation in the development and application of digital solutions, with many services being provided online. The opportunity exists to look at this issue strategically in order to mainstream learning and sustain momentum. However, the evidence informing this report suggests that existing efforts to address digital exclusion (i.e.: literacy, accessibility and affordability) must continue in order to ensure that the most vulnerable are not left behind.

4. There are significant reserves of resilience in the community as well as an appetite to further harness this social energy

Evidence drawn from across all streams of activity, informing the Voices of Lewisham project, has heralded the way in which the borough's diverse community has come together during the pandemic. Networks and supportive relationships have been established.

5. The local economy has been hit hard and it may take a while before it recovers

Businesses in the borough have been hit hard. Lewisham businesses are more likely to be high-footfall businesses and small/micro which are least likely to be able to absorb the knocks and shocks of economic disruption.

6. There is a genuine appetite for exploring new ways of collaborating and working together

The wide-range of individuals, communities, groups and representatives and agencies involved in the Voices of Lewisham work have highlighted a genuine desire to connect with others, continue the dialogue and be more actively involved in the decisions that affect them and their communities.

7. The need to communicate the language of recovery in a way that everyone can understand

The project has highlighted the important role that communication can play in anticipating public anxiety, increasing public assurance messages and building public trust.

8. The importance of public service at a time of crisis and the opportunity to redefine this for a new age

The pandemic had underlined the importance of trusted public institutions in providing guidance and leadership in times of crisis. Covid witnessed a redefining of the public service delivery model as something that residents do for each other, not just something that public institutions are expected to do for them.

9. This is a unique opportunity to turn our experience of Covid-19 into a repository of knowledge for ourselves and others

Recommendation that the resources made available for the Voices of Lewisham work should form the basis of a knowledge repository and that partners be invited to submit additional sources of evidence as appropriate.

10. The need to recognise the differential impacts of COVID-19 on residents as consumers, customers and citizens with a view to revisiting how these experiences might redefine Lewisham as a place

The pandemic has provided individuals with varied and unique range experiences.

11. There are things we do not know about the impacts of the pandemic on longer terms physical and mental wellbeing

Many aspects including impact on mental health and childhood development yet to be seen.

Conclusion

This needs assessment has considered both the direct and indirect impacts of COVID-19. Whilst the older population and those with certain underlying health conditions were widely seen to be more vulnerable to the virus itself, there were also health inequalities present in that characteristics including but not exclusive to a person's ethnicity, living conditions or what type of work they did, impacted how likely they were to contract COVID-19 and how likely they were to become seriously ill. This is well summarised in 'The Unequal Pandemic: Health Inequalities'. Due to features of Lewisham's demography, including its relative deprivation and pre-existing health inequalities, the borough was positioned to experience a disproportionate impact of the pandemic. Lewisham's higher cumulative mortality rate due to COVID-19, even when accounting for differences in age is evidence of the reality of this.

At the same time, the wider impacts of COVID-19 have been felt right through the entire population. Service use data illustrates there have been issues in accessing healthcare and as described in the health inequalities section, those who were already in poorer health have been disproportionately impacted by this. Delays in accessing relevant healthcare are continuing and waiting times and targets are not meeting operational standards.

Whilst there have been some positives in terms of improvements and efficiencies in use of technology during the pandemic, it is likely some of the wider impacts of COVID-19 will not be fully understood for years to come as we wait to see whether uptake of preventative healthcare including NHS Health Checks, immunisations and cancer screening improves. Mental health is another key area that will need to be monitored closely post-pandemic. The current cost of living crisis is also throwing extra light on inequalities in income and food security, which again is in severe danger of compounding the health inequalities that already existed prior to COVID-19 and were indeed widen by it.