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HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 16 November 2021
Time	9.00 am
Venue	Council Chamber, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services in advance of the meeting. 2. CONTACT OFFICER for this Agenda is Constitutional Services Tel. 0161 770 5151 or email constitutional.services@oldham.gov.uk. 3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 11 November 2021. 4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming. Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held. Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences. MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD IS AS FOLLOWS: Councillors M Bashforth (Chair), Birch, Chauhan, Leach, Moores and Sykes

Item No

1 Apologies For Absence

2 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

5 Minutes of Previous Meeting (Pages 1 - 6)

The Minutes of the meeting of the Health and Wellbeing Board held on 14th September 2021 are attached for approval.

6 Oldham Safeguarding Children Partnership Annual Report (Pages 7 - 36)

7 Developing a Health Inequalities Plan for Oldham (Pages 37 - 40)

8 Supporting patients with Long COVID, Chronic Pain and Fatigue (Pages 41 - 88)

9 Date of Next Meeting

The next meeting of the Health and Wellbeing Board will be on Tuesday 25th January 2022 at 2.00pm.

HEALTH AND WELL BEING BOARD
14/09/2021 at 3.00 pm

Present: Councillor M Bashforth (Chair)
Councillors Chauhan and Moores

Harry Catherall	Chief Executive OMBC
Donna Cezair	CEO, FCHO
Gerard Jones	Managing Director Children and Young People
Stuart Lockwood	OCLL
Dr. John Patterson	Clinical Commissioning Group
Katrina Stephens	Director of Public Health
Tamoor Tariq	Oldham Healthwatch
Mark Warren	Director, Adult Social Care

Also in Attendance:

Sarah Whittle	Neighbourhoods
Christine Wood	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Birch, Leach and Sykes, Superintendent Rachael Harrison, Dr Keith Jeffery, Claire Smith, Laura Windsor-Welch.

The Chair introduced Harry Catherall, recently appointed Chief Executive of Oldham Council, and advised of a new member to the Board, Superintendent, Rachael Harrison who would be replacing Chief Superintendent, Chris Allsop.

2 **DECLARATIONS OF INTEREST**

Tamoor Tariq declared an interest by virtue of being an Elected Member of Bury Council and Bury Health and Wellbeing Board.

Councillor Chauhan declare an interest by virtue of his employment as a Local General Practitioner in Oldham.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING HELD ON 22ND JUNE 2021**

RESOLVED that the minutes of the meeting held on 22nd June 2021 be approved as a correct record.

In relation to item 7 of the minutes of 22nd June 2021, the Board was advised that national guidance regarding Pharmaceutical Needs Assessments (PNA) had still not been published and that it would not be possible to bring forward the timeline for completing the PNA.

In relation to item 8 of the minutes of 22nd June 2021, it was suggested that an action plan would be appropriate to address issues that had been raised within the report. It was agreed that the issues raised within the report would form part of an action plan to be addressed by the Health and Social Care Portfolio Holder.

6 **OLDHAM SAFEGUARDING ADULTS BOARD: 2020/21 ANNUAL REPORT AND STRATEGIC PLAN 2021-2024**

Consideration was given to the Oldham Safeguarding Annual Report 2020/21 and the 2021-24 Strategic Plan. The Board was reminded that the Oldham Adult Safeguarding Board (OSAB) was a statutory partnership set up to safeguarding adults at risk of experiencing abuse, neglect, or exploitation. As part of the statutory duties, the Board was required to produce an Annual Report setting out future ambitions and actions to help keep people safe in Oldham.

The Board was advised that, during the previous eighteen months, the OSAB had introduced a series of measures designed to remodel adult safeguarding arrangements across Oldham. The new arrangements were designed to strengthen and improve multi-agency working through a combination of new safeguarding structures, greater alignment with the Children's Safeguarding Partnership and integrated safeguarding structures across Community Health and Social Care.

The Board was reminded that the role of the OSAB was to assure itself that organisations and agencies across Oldham were working together to protect and enable adults to live safely. This meant helping people to make decisions about the risks they faced in their own lives as well as protecting those who lacked the capacity to make these decisions.

The Board was advised that the three main statutory duties of the OSAB were to:

- Produce a Strategic Plan setting out the changes the Board wanted to achieve and how organisations would work together.
- Publish an Annual Report setting out safeguarding concerns it had dealt with in the last year as well as plans to keep people safe in the future.
- Undertake a Safeguarding Adult Review in line with Section 44 of the Care Act where it believed someone had experienced harm as a result of abuse, neglect or exploitation.

The Annual Report provided information on the number and type of safeguarding concerns reported in Oldham, along with actions taken to adopt learning from the Safeguarding Adult Reviews. Central to this had been the collection and sharing of first-hand experiences by adults 'at risk' and family members who had experience of safeguarding issues and services in Oldham.

It was reported that a total of 2038 safeguarding referrals had been made in 2020/21. Of these, 408 had become the subject

of a formal safeguarding enquiry. Data had shown that the number of referrals had doubled in the previous two years. The report acknowledged that this may be due to a combination of improvements in the recording data, Covid-19 campaigns designed to encourage people to report safeguarding concerns and lockdown restrictions which had seen an increase in reports of domestic and financial abuse. Whilst the number of overall referrals had increased, the number of serious safeguarding enquires remained relatively consistent during the previous four years.

It was further reported that nine Safeguarding Adult Reviews had been completed in 2020/21, which was consistent with the previous year. The main types of abuse had been self-neglect, acts of omission and domestic abuse which could include psychological abuse, violence, physical abuse and financial abuse.

The Board was advised that the OSAB Strategic Plan had been shaped by the Government's new legislative programme, learning from Covid-19 and the correlation between Oldham's demographic profile and local safeguarding trends. Factors such as levels of poverty, the numbers of people living with mental health issues, homelessness and alcohol related deaths disproportionately impacted on adults with care and support needs and were key factors within Oldham's Safeguarding Adults Reviews.

As a result of the above, the Strategy had set out a challenging programme of work, designed to prevent and reduce future safeguarding incidents and implement an effective 'all age' safeguarding offer. This work would take place within far-reaching changes proposed in the Health and Care Bill, including the creation of Integrated Care Systems (ICSs), new legislative requirements within the Mental Health Act White Paper and the introduction of the Liberty Protection Safeguards. The strategy recognised that changes of this scale and complexity needed integration that looked beyond the NHS and social care, to fully involve the wider statutory, voluntary and community sectors as equal contributors.

It was reported that the strategy was designed to focus on action and the 2021/22 Annual Plan on a Page set out the Board's work programme for the current year. The one-page summary was being actively promoted and shared across agencies to highlight the aims of the Board and promote the wide range of resources and information available through the Board's website and fortnightly joint Children's and Adults Safeguarding bulletins.

In terms of the evaluation of the strategy, it was noted that assurance relied on insight gained from Oldham's multi-agency safeguarding data and quality assurance processes. However, during 2020/21, OSAB recognised that data sets used for the reporting of adult safeguarding incidents by partners, required improvement.

As such it was highlighted that prevalence data needed to consider wider data sets and for example to consider activity across primary care and GP practice.
The Board was advised that the above comments would be conveyed to the Safeguarding Board with a suggestion that the report be updated to reflect the above comments.

RESOLVED that the Safeguarding Adults Board 2019/20 Annual Report and 2021-24 Strategic Plan be approved, subject to the amendments in relation to prevalence data and benchmarking.

7 **GREATER MANCHESTER INTEGRATED COMMISSIONING SYSTEM**

The Board considered a report providing an update on the NHS White Paper entitled 'Integration and Innovation: Working Together to Improve Health and Social Care for All' and the associated plans being put in place in Oldham and Greater Manchester.

The Board was reminded that, since the publication in February 2021 of the White Paper, colleagues across Greater Manchester (GM) and Oldham had been planning the transition of a Greater Manchester Integrated Care System (GM ICS) on 1st April 2022.

The Board was advised that an ICS Design Framework had been published by NHSE in June 2021, which had provided further information about the changes. On 6th July 2021, the Health and Care Bill for this White Paper had been introduced to Parliament and received its second reading in Parliament on the 14th July 2021. This had outlined that ICS's would be included in the creation of a statutory Integrated Care Partnership (ICP), which would be a joint committee, and an Integrated Care Board (ICB) (previously referred to as the ICS NHS body/board). The NHS Confederation had produced its own briefing note on the Health and Care Bill here.

It was reported that in GM, under the Devolution Agreement, we had been working as "more than an ICS" for the last five years – with strong working partnerships between health and social care and the voluntary sector, and that the creation of a statutory Integrated Care Partnership and Integrated Care Board would formalise these arrangements. The new statutory nature of an ICS would allow for building on the ambitious and ground-breaking ways we had been working over the last five years and continue to evolve to deliver even better health and care for the people of Grater Manchester.

It was further reported that the GM ICS would operate on three levels to deliver a new five-year vision and plan:

- Neighbourhood
- Locality
- Greater Manchester

The Board was advised that, whilst duties would transfer to ICS's, it was anticipated that the GM ICS would deliver its functions partly via locality place-based boards and teams within each GM locality, including through neighbourhood structures.

The Board was further advised that a GM Statutory ICS Transition Programme had been established, led by a Board meeting fortnightly, to oversee the transition to the new ICS arrangements. The Board was made up of representatives from all organisations which would become part of the new NHS body, as well as NHS providers and Local Authorities. There were fourteen workstreams, each with a GM system lead. Work was underway to agree the critical path for the next nine months. There was a recognition that GM staff were still managing the COVID-19 response and recovery.

It was reported that the recruitment process of the Chair of the GM ICS had commenced and was due to conclude around the first two weeks of September and the ICS Chief Executive role would commence recruitment early September and conclude at the end of September. The GM Executive Team would take place over the next two to three months. The intention was for the GM ICS, including localities to operate with shadow arrangements ahead of the statutory change on 1st April 2022.

It was further reported that the Oldham transition arrangements would be managed by a Transition Programme Board on behalf of the CCG Governing Body and would therefore oversee the time-limited ICS change programme. Its core purpose would be to oversee at least four key work areas that would work in tandem with the GM approach:

- System/Place-based Governance Accountability and Strategic Planning Functions
- People and Culture
- Finance and Use of Resources
- Provider Collaborative

The Board was advised that, during August, national guidance had been released in respect of the Employment Commitment for those NHS staff impacted by the ICS change. This meant that the majority of Oldham CCG would be covered by an employment commitment to continuity of terms and conditions. his commitment was designed to provide stability and remove uncertainty during this transition. For those not covered by this commitment, the guidance also detailed the support that these individuals would receive during the HR process to be followed. There was an expectation that all CCG employees would 'lift and shift' into the GM ICS on 1st April 2022, with any remaining/ongoing work to determine exact roles and structures continuing after this date.

A discussion took place in which the challenge and massive impact on Oldham was recognised. The importance of the voluntary sector and partnership arrangement being in place was also recognised.

The accountability to residents of Oldham and the need to recruit talented young people to work in the Borough was also highlighted. The Board was reminded that Oldham was the greenest Borough in Greater Manchester and the importance of integrated working was also recognised.

RESOLVED that the report be noted.

8 **DATES OF NEXT MEETINGS**

16th November 2021
14th December 2021 (Development Session)
25th January 2022
22nd March 2022

All meetings commence at 2pm.

The meeting started at 3pm and ended at 4.45pm.

OLDHAM SAFEGUARDING CHILDREN PARTNERSHIP

ANNUAL REPORT

1 April 2020 – 31 March 2021

This report is a public document.

It can be accessed on the website of Oldham Safeguarding Children Partnership: https://www.olscb.org/about/publications/

Approved by Oldham Safeguarding Children Partners on 14 October 2021

Independent Chair: Dr Henri Giller

Report compiled and written by Lisa Morris (OSCP Business Manager)

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Availability and accessibility: if you would like to receive this report in any other format please contact Lisa Morris - address above.

Contents

Message from the Independent Chair

The business year 2020-21 has proven to be a challenging one for the Oldham Safeguarding Children Partnership. In particular, the challenge of Covid-19 has tested the strength of Partnership bonds in what was only the second year of their reformulation.

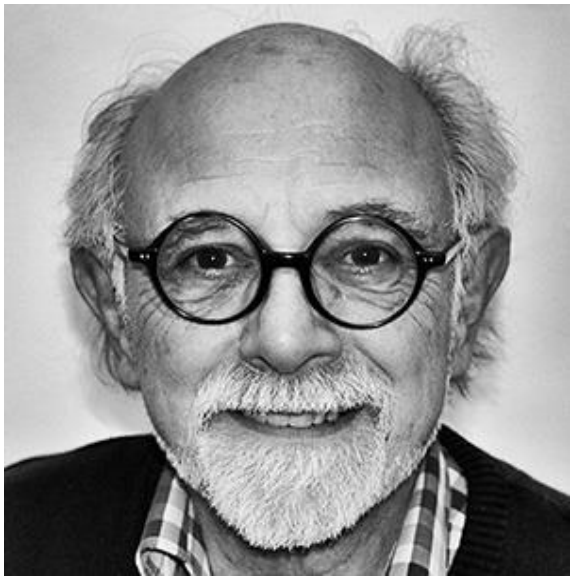
The impact of Covid on children and families in Oldham has been disproportionate due to the levels of poverty and inequality that affect the borough.

The Partnership has responded well to the challenge of the pandemic by:

- Identifying and responding to new levels of safeguarding demand – particularly with respect to harm to infants, increases in levels of domestic abuse affecting children and meeting children's mental health and well-being needs.
- Enhancing the arrangements to enable reflection and learning of good safeguarding practice on a co-ordinated cross-agency basis
- Examining current safeguarding processes and asking how they can better meet the needs of children and young people – the arena of transitioning from children's services to adult services being a particular point of focus in this
- Engaging with children and young people so to ensure that the Partnership identifies and responds to their priorities and concerns.

The legacy of the pandemic is one which has enabled the Partners to re-examine established practice and adapt and refine ways of working which better meet the needs of children and young people of Oldham. The implementation of this learning will be a major theme for the forthcoming year.

The pandemic also underlines the fact that if we are to have an enduring impact on safeguarding need in Oldham, we must systematically address the levels of inequality and poverty that affect children and young people. The Safeguarding Partnership must have a key role in the implementation of the emergent blueprint for change for children and families which seeks to address these issues.



Dr Henri Giller
Independent Chair

Reflections from our Statutory Partners

The impact of the Covid Pandemic in Oldham has been intense, with children missing education, and the increased demand placed on safeguarding services across the borough. The Partnership has had to adapt quickly and accordingly, and I am proud of our response. We swiftly identified emerging areas of safeguarding concern related to the pandemic, including injuries to under two-year-olds, increases in high-risk domestic abuse and the damaging effect of the mental health of our children and young people, and introduced a strong multi-agency plan and response to each. Despite these challenges we have continued forward with our strategic priorities, launching the new complex safeguarding hub, restructuring the Partnership to ensure maximum effectiveness, and introducing a new model of quality assurance in the form of a learning hub. We are well aware of the continued challenges to safeguarding children in Oldham, particularly in the context of such high levels of poverty and deprivation. In this adversity the Safeguarding Partnership is as important as ever, if not more so, and I look forward to further developing our Multi Agency Safeguarding response with you over the coming years.
Gerard Jones - Managing Director, Children's Services

The challenges of the last 12 months are well documented, and we have all lived through the experience of the pandemic in so many ways. I am extremely proud of how the safeguarding partnership has remained strong throughout these difficult months and faced head on the challenges of safeguarding our vulnerable children and young people, supporting families, and focusing on continuous improvement. The activity and outcomes documented in this report are testament to the unwavering focus of the teams across the partnership and to do this against the backdrop of a global pandemic and a fatigued workforce is remarkable. The pressures facing the NHS are immense and it is vital that as services go through the current restoration phase alongside a national restructure that safeguarding practice remains front and centre with everything that we do. This report highlights some of the good practice that we have seen over the last 12 months however the focus on current challenges remains clear as we see the growing complexity of transitions, complex and contextual safeguarding and children and adolescent mental health. The partnership arrangements continue to develop, and the commitment is evident across all our statutory and key partner agencies to meet these challenges and improve outcomes for our children and young people. **Claire Smith – Director of Nursing and Quality, Oldham CCG**

As we have moved out of the lockdown restrictions with a return to more normal levels of social interaction, education, and work, we have seen a significant increase in high-risk Domestic Abuse and also more incidents relating to concern for welfare, both for children and adults. I have been impressed at how the Safeguarding Partnership has picked up on these trends, promptly responding to understand and instigate improvements to better support victims and vulnerable people. The Safeguarding Partnership adapted its own practices to reduce risks during covid, but we are pleased to have growing face to face participation, on-line is often no substitute when developing strategies and dealing with complex issues. There is a greater sense of working together at all levels of safeguarding delivery, which is good for the people who need our help and particularly so for those with circumstances that do not fit defined criteria, for example children transitioning to adults. In relation to the Independent Chair's observations relating to measurement of outcomes of multi-agency practice, great progress has been made which we look forward to building upon, particularly in our plans to develop the Complex Safeguarding offering. Setting effective objectives that are measurable and deliver assurance is essential to our being as a tripartite partnership group. **Chief Superintendent Rachael Harrison, Oldham Police**

Introduction

Safeguarding Partnership

The Oldham Strategic Safeguarding Partnership has been developed by Oldham Council, Greater Manchester Police, and the Oldham Clinical Commissioning Group to ensure that all children and young people in the area get the safeguarding and protection they need in order to help them to thrive.

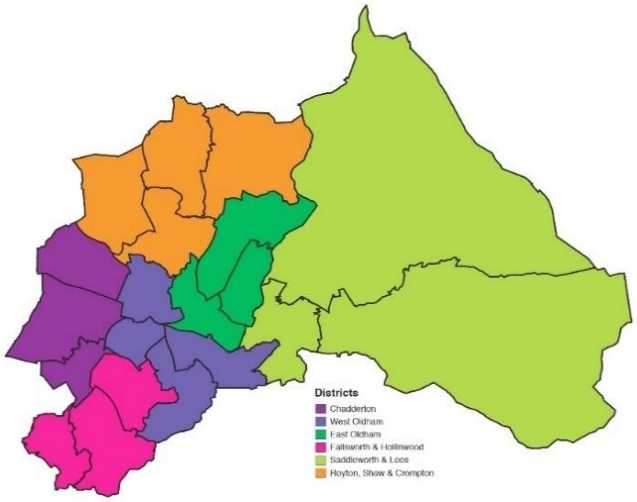
The Partnership provides leadership and accountability for the promotion of children and young peoples' well-being and the prevention and protection from harm.

Partners work together to promote a child-centred approach to safeguarding, listening to children, empowering families and, where needed, providing services that are professional, evidenced-based, and effective. The partners will continuously strive to improve and challenge each other to learn the lessons from daily practice.

Safeguarding is everyone's business, and the Oldham Safeguarding Partnership will provide lead responsibility in demonstrating what this means for all people and professionals living and working in the local community.

Our strategic aims include:

- Excellent practice is the norm across all practitioners in Oldham
- Partner agencies hold one another to account effectively
- There is early identification of new safeguarding issues
- Learning is promoted and embedded
- Information is shared effectively
- The public feel confident that children are protected



Oldham has a population of 224,900 people making it the 6th largest borough in Greater Manchester.

There is a high proportion of Oldham residents under the age of 16 years (22.5%) compared with 15.7% over the age of 65 years.

Oldham has a diverse population with 22.5% of residents and 46% of school pupils from Black and Minority Ethnic (BAME) backgrounds.

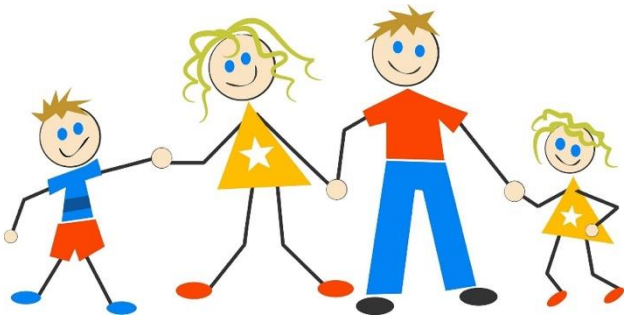
38% of children in Oldham are living in poverty – this is the highest figure in the UK

Oldham is ranked 19th worst out of 317 local authority areas on the indices of deprivation. Five areas within Oldham are ranked amongst the top 1% of the nation's most deprived areas.

Profile of Safeguarding in Oldham

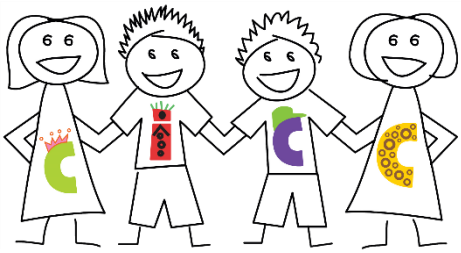
Contacts to MASH — 12,824

Referrals to Targeted Early Help or Children's Social Care — 4,278



1344 S47 enquiries initiated

Of those referred:
696 were under the age of 2 years
2043 were between 3 years and 11 years
1484 were between 12 years and 19 years



448 children on child protection plans as of March 2021

532 children looked after as of March 2021

1258 incidents of children missing from home or care

227 children electively home educated

Safeguarding Priorities for 2020-2021

Recap on the Partnership Development day – March 2020

Governance and structure

A key focus of the Partnership development day in March 2020 was an evaluation of the new arrangements thus far. The feedback from members of the Partnership suggested that the new arrangements had made statutory partners more visible, and communication was strong. However, there was still a feeling that our current model wasn't ambitious enough to support effective learning and that the high number of subgroups was a key factor in this.

With the support of Jane Shuttleworth and the learning from Bexley the Partnership agreed a move towards a "learning hub model" as a mechanism to improve and change partnership practice. The Partnership committed to introducing a new structure with a learning hub at its centre by September 2020, followed by six months of evaluation.

Complex Safeguarding

Partners also considered Oldham's approach to complex safeguarding and reflected on the feedback and learning that had arisen from a complex safeguarding operational development day in February 2020 and the recent Greater Manchester Complex Safeguarding peer review.

Five key areas of focus were identified:

Culture: considering attitudes, language, understanding of exploitation, a shared value base of what we are trying to achieve
Pathways - identification and pathway to intervention, advice, and guidance versus intervention, having clarity of the offer
Practice Model – identifying the 'best' person (as per Relational Model), right service at the right time and the right person, clarity around roles of partners
Skills and Training – through all service areas, valuable induction for all services/new starters
Mapping of Services – understanding what else is out there (e.g., Sports Development, Mentoring Scheme), consider how we measure impact, building and strengthening of professional relationships

Covid 19 Pandemic

In response to the global Covid-19 pandemic the Safeguarding Partnership quickly established weekly assurance meetings with the three statutory safeguarding partners to ensure that children remained visible and that safeguarding concerns continue to be responded to quickly and effectively. This was supported by a twice weekly Partnership Management Team meeting involving senior leaders from across the Partnership to identify and review operational safeguarding concerns and trends arising as a result of the pandemic.

Learning from Case Reviews

During the period 2019-20 the Partnership had concluded four serious case reviews, two multi-agency concise reviews and two rapid reviews. An overview of themes arising from these reviews highlighted recurrent learning points in relation to the following areas of practice:

- Partnership response to domestic abuse and neglect
- Professional challenge and escalation
- Child's lived experience
- Transitions
- Early identification of risk, particularly risks relating to exploitation
- Understanding and responding to children's mental health and emotional wellbeing.

Feedback from children and young people

Representatives from Oldham Youth Voice family were part of the Partnership development day and reflected positively on the progress made over the previous 12 months. They set the Partnership a new challenge for the coming year which focused on embedding children and young people's involvement across all our work.

Priorities for 2020-2021

Following on from the development the Safeguarding Partnership agreed key priority areas of focus for 2020-2021 period:

- Strengthening the governance arrangements for the Partnership
- Complex and Contextual Safeguarding
- Transitional Safeguarding
- Neglect
- Communications

Vulnerable 0–2-year-olds: a sudden increase in the number of serious injuries to children under two years prompted a swift partnership response. Audits of the cases indicated that many of the injuries were occurring as a result of lack of supervision in the home. Recognising that families were experiencing increased pressure during the periods of lockdown with children not in school and the inability to access usual support networks, the Partnership focused on working together to support families by providing funded places for vulnerable 1–2-year-olds in an education setting, delivering key messages to families about accident prevention and supporting increased professional curiosity about family living situations and changes that may increase risk.

Domestic Abuse: Whilst data suggested that the number of domestic abuse incidents had remained consistent during lock down periods the Partnership were very concerned about a sizeable increase in the number of high-risk domestic abuse cases being identified. This suggested that the levels of abuse and coercion were escalating much quicker. In order to support victims and families, additional specialist Independent Domestic Violence Advisor (IDVA) capacity was agreed, and the Domestic Abuse Partnership introduced a series of live, online question and answer sessions with the aim of helping to raise awareness, inform people of the support that is available and answer their questions.

Children's Mental health: Oldham CAMHS saw a large reduction in referrals in Q1 and Q2 as we entered the first COVID-19 lockdown. Despite the reduction in routine referrals there was an increase in crisis referrals. Over Q3 and Q4 the number of referrals increased by 78.6%.

During the pandemic CAMHS continued to see children face to face including those who were testing positive if risk suggested it was needed. The service also developed an online medium to review people as well as run groups and individual therapy. We supported Oldham's mental health ward with some of our nurses being redeployed to work on our wards and the service's emotional wellbeing practitioner offered extra advice and consultation support to schools.

The all-age liaison team in A&E assessed children on the paediatric ward out of hours to try and keep beds free and CAMHS assessed on the ward during work hours and every case was risk assessed on a regular basis to make sure the right level of support was offered especially to vulnerable children.

The increasing concerns regarding children's mental health has prompted a strategic partnership review.

Impact on progress

Unfortunately, some of the Partnership activity has been stalled either as direct or indirect result of the Pandemic.

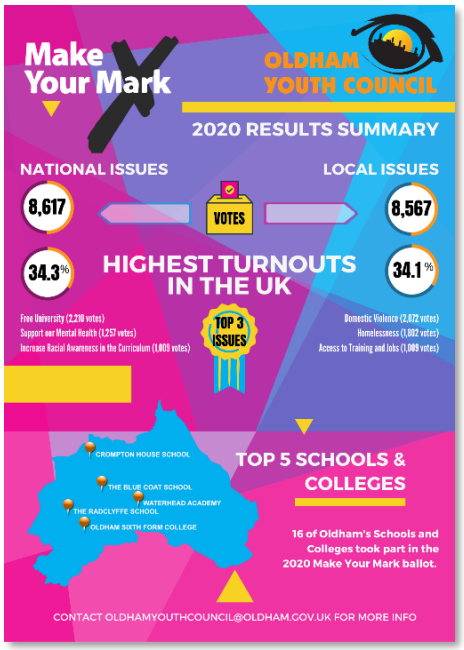
Our Young Person's Safeguarding Forum has been unable to launch I the way that we intended however some consultation work has taken place via online means and we're working closely with Oldham Youth Voice Family to engage more young people in Safeguarding issues.

The commissioning of cultural competency training was halted as the provider was keen for the training to take place face to face. In the interim we shared written briefings with professionals on cultural competency and hope to pick this up as a priority as soon as face to face training resumes.

Voice of children and young people

Make your Mark 2020

Make your mark is the largest annual youth consultation. In 2020 over 8,600 young people from Oldham took part in the consultation which was the highest turn out of young people in the UK.



The national priorities that young people identified were:

- Free university
- Support with mental health
- Increase racial awareness in the curriculum

Locally the following additional priorities were also identified:

- Domestic abuse
- Homelessness
- Access to training and jobs

The findings from the consultation were presented to the Safeguarding Partnership by the Chair of the Youth Council in January 2021.

Work of the Youth Council in 2020/21

Members of the Youth Council are working with members of the partnership around tackling domestic violence with consultation work, development of resources and mapping what support currently exists for children and young people.

Young people are currently planning on how they can further build on the work around mental health and support the work already happening in Oldham to provide support for young people.

The service wants to build on engagement work they are doing ensuring a wider range of children and young people are involved and that they capture the voices, views, and ideas of a diverse range of children and young people.

Covid recovery – the youth council are working with professionals and services to ensure young people are helping to shape how we recover from the Covid pandemic.

Young people want to continue to work with the Local Safeguarding Children Partnership to further embed youth voice and involvement in the work you do.

OLDHAM YOUTH COUNCIL

Activity and Impact

Restructure of the Partnership

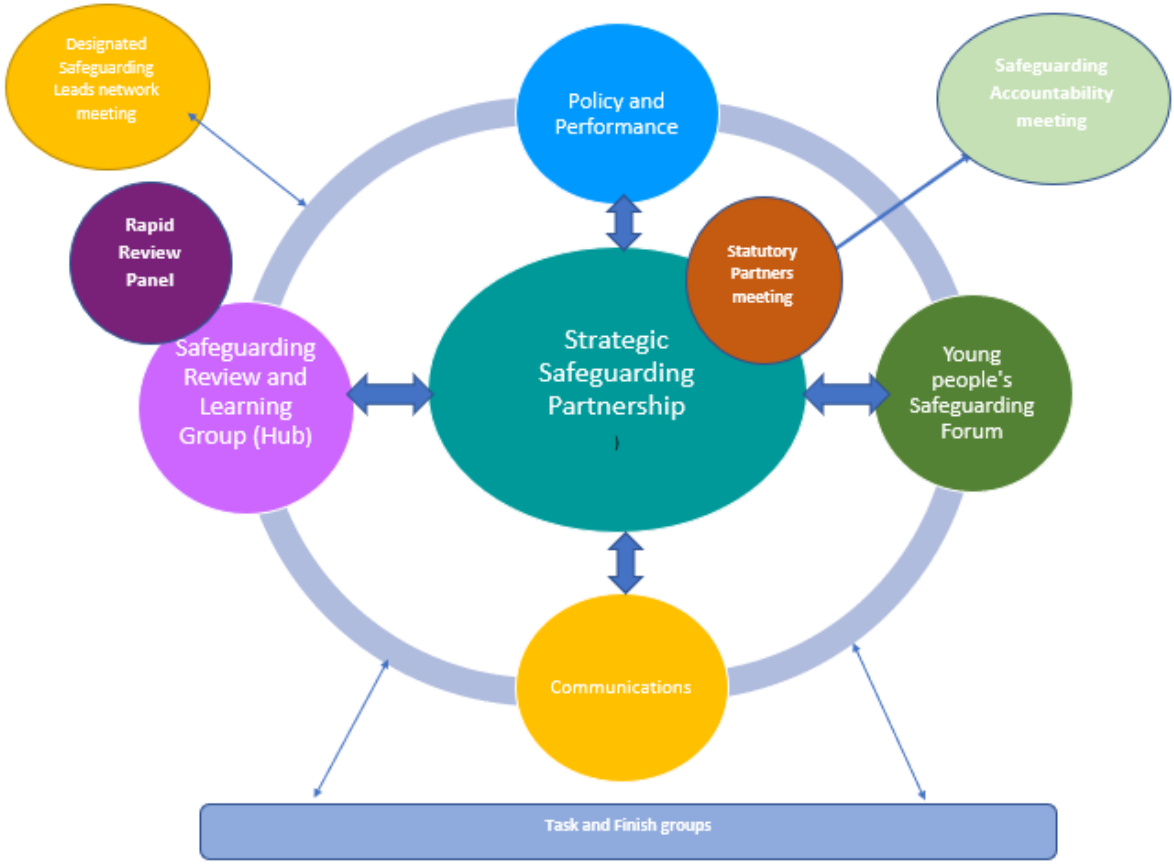
In response to the feedback from partners the structure of the Partnership was reviewed, and a number of subgroups were disbanded. The child safeguarding practice review, learning and improvement and training groups were merged to form the new safeguarding review and learning hub. Thematic subgroups were replaced with time focused task and finish groups where appropriate.

The young people's safeguarding forum is being formalised and is led by the Youth Council and a named link Partnership representative.

A new communication group has been introduced, this is a joint subgroup with the Safeguarding Adult Board with the aim of aligning and joining branding and messages across partners. The three designated statutory partners hold a separate monthly meeting with the Independent Chair to ensure their duties are being met although the Strategic Partnership has retained overall to ensure all relevant agencies are involved in decision making and accountability for safeguarding in Oldham.

In order to ensure clear links to schools and colleges the named education representatives on the Partnership will attend the designated safeguarding leads network on a termly basis.

For the purposes of assurance and scrutiny a safeguarding accountability meeting has been introduced between the designated statutory safeguarding leads, independent chair and the Chief Executive, Accountable Officer, Assistant Chief Constable, Leader of the Council and Lead Member for Children



Complex Safeguarding Hub

Oldham's Complex Safeguarding Hub went live on 1st April 2020. The Complex Safeguarding Hub has functions for Phoenix (Child Sexual Exploitation), Child Criminal Exploitation, Organised Crime and Gangs, Modern Slavery and Trafficking within one service. The Hub combines the three key partners for safeguarding as an integrated service for response, consultation, and intervention. There is also a Clinical Psychologist linked to the Hub to provide consultation and support.

The Oldham Complex Safeguarding Hub will work with any child up to the age of 18 years (or up to the age of 25 years for any young adult currently open to the After Care Service for Oldham) who are open for assessment, intervention or planning to Children's Social Care, where there is an identified high risk of, or current experience of exploitation.

The Hub proposes a Phase 2 development by summer 2021 which incorporates advice and guidance in relation to professionals working with young people and adults where there is increasing concern regarding exploitation.

Youth Now

Youth Now, delivered by Positive Steps, in partnership with Oldham Council, The University of Bedfordshire and Greater Manchester Police is aimed at young people and families identified as at risk of involvement in youth violence.

This project explores the use of family, peer, school, and community interventions as part of Oldham's response to serious youth violence. Through embedded research, the University of Bedfordshire team works alongside practitioners in Oldham to understand how their interventions engage with contextual dynamics of harm, capture, and disseminate this learning, and support the service to identify its impact on the lives of young people and the contexts in which they spend their time.

After the first eighteen months of the project there has been a significant amount of progress made against the outcome measures, in particularly when focusing on community interventions, which are already yielding positive results linked to positive attachment to neighbourhoods. Key to this has been the introduction of the Friday Night Youth Provision in Failsworth. In addition to constructive pursuits young people and their families are supported by the Youth Now Team with targeted support depending upon need. A significant amount of time is spent ensuring young people are attending and engaging in school.

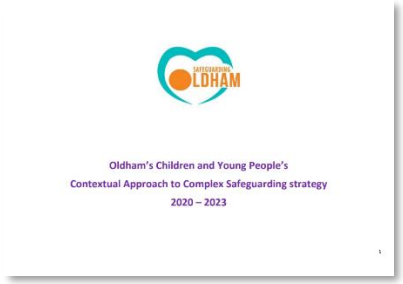
The programme closed in March 2021, although work is continuing through Positive steps within the pilot site areas. Specific resources will be available for the Partnership to use to improve responses to Contextual and Complex Safeguarding.

Oldham's Contextual Approach to Complex Safeguarding Strategy

In March 2021 the Partnership launched its Contextual Approach to Complex Safeguarding strategy 2021-2023. Within the strategy the Partnership recognises the differences in context and influence that children and young people face when vulnerable to exploitation and as such is keen to introduce a Contextual Safeguarding Approach across the Partnership.

Priorities:

- Raise awareness, confidence, and skills to ensure the earliest identification of complex safeguarding, by professionals, carers, and the wider community
- To ensure victims and their families receive good quality support
- Hold perpetrators to account through improved disruption and prosecution and build our knowledge by understanding from perpetrators how they exploit children and adults at risk.



Refreshed Continuum of Need

The Safeguarding Partnership recognises that the earliest possible help and support is likely to engage families to enable change. However, we are also clear regarding our collaborative responsibility to highlight increasing risk or significant unmet need for targeted support or intervention where earliest possible help has not achieved change. In order to assist professionals in making decisions about appropriate support for children, young people, and their families the Continuum of Need was reviewed, refreshed, and relaunched in January 2021.

A series of briefing sessions with professionals were held throughout February and March 2021.

91% of respondents told us that the refreshed continuum of need has assisted them in making decisions about the most appropriate support for children, young people, and families.

91% of respondents told us that the refreshed continuum of need had supported them to evidence the level of need when making a referral to services.

One respondent felt that *"whilst they were able to identify need using the continuum of need, the relevant support services where not always available. This has been compounded be current levels of demand leaving services feeling overwhelmed."*

A strategy for prevention and reduction of neglect in Oldham 2021-2023

We want Oldham to be a borough where the conditions are right for children to be able to

thrive. Experiencing neglect can significantly compromise a child's development, therefore, early identification and timely intervention are extremely important to ensure the safety, wellbeing and development of children and young people. As well as identifying neglect effectively and providing the right support to tackle it, we need to address contributory factors such as parental substance misuse, and domestic abuse, as well as poverty. This strategy sits in the wider context of work across Oldham to tackle the wider determinants of neglect.

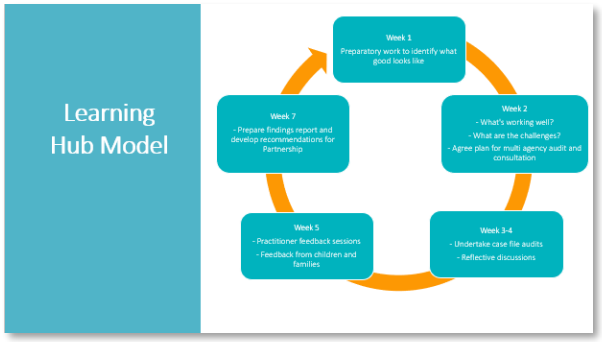
Our ambition:

- Prevention of the causes that lead to child neglect rather than only responding to the symptoms by understanding the scale of neglect in Oldham and how it's affecting our families.
- Protection by ensuring a strong Partnership response with a common understanding of the spectrum of neglect and a recognition of the need to work with families at the earliest opportunity to prevent harm.
- Provision of strengths-based support for families from voluntary and statutory organisations in Oldham
- Participation by providing opportunities for children, young people, and families to share their experiences in order to shape and develop our multi - agency response to neglect.

Learning activity

Learning Hub

The learning hub is a “back to practice” approach which creates a space for professionals from different agencies to have different types of conversations about improving and changing partnership practice.



The model works on cyclic approach to engaging partners at both a strategic and operational level in developing effective multi-agency collaboration. Leading with the establishment of “what good looks like” the model promotes a strength- based approach to improving practice.

Our first learning hub focused on Initial Child Protection Conferences.

Participant packs: Based on statutory guidance, policy, and procedure, and learning from case reviews and inspections Oldham Learning Hub identified “what good looks like” based on the following key points that set out what a good initial child protection conference looks like against the following areas:

- Preparation
- Lived experience/engagement
- Transparency
- Planning and Impact
- Accountability
- Timeliness

Practitioner event: held on 2 December 2020 with a range of multi-agency professionals. Ahead of the event professionals were provided with two documents: What good looks like and Oldham picture. Using the information contained within the document alongside their professional knowledge and experience professionals were asked to consider what’s working well, what are we worried about and what action do we need to take to get to good.

Outcome: Multi-Agency sessions were delivered across the Partnership to support professionals understanding of thresholds, thus ensuring that the right cases are brought to child protection conference.

A set of multi-agency practice standards have been developed in relation to Initial Child Protection Conferences and have supported the development of wider practice standards for other multi-agency safeguarding activity.

A toolkit has been developed to support professionals to reflect the child’s lived experience within reports and assessments.

Easy read tools are being developed to support parents and young people’s understanding of the child protection process.

Contextual Safeguarding plans are being explored for older children where risks relate to exploitation.

Independent Review of non-recent CSE

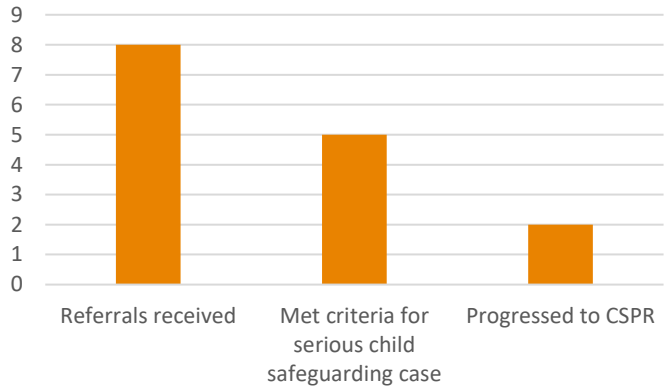
Oldham Safeguarding Partnership, together with the Leader of the Council jointly requested that a review into safeguarding practices in the borough of Oldham be combined into the ongoing independent review work commissioned by the Mayor’s office. The remit of this aspect of the review focuses on historical allegations relating to child sexual exploitation and consider whether the council, with its partner agencies provided an appropriate response to protect children vulnerable to or known to be victims of child sexual exploitation. The outcome of the review is due to be published later in 2021.

Case Reviews

The Safeguarding Partnership has a statutory duty to review serious child safeguarding cases with the aim of identifying learning, improvements in practice and protecting children from harm.

A serious child safeguarding case is one in which,

"abuse or neglect of a child is known or suspected, **and** the child has died or been seriously harmed." (WT 2018)



During the 2020-21 period the Partnership received eight referrals of cases for consideration by the Child Safeguarding Review Panel. Of these, five met the criteria for serious child safeguarding case and two progressed to a further Child Safeguarding Practice Review.

Of the cases that didn't progress to a Child Safeguarding Review the learning identified in the Rapid Review was shared across the Partnership to support practice development.

In three of the cases where the criteria for serious child safeguarding case had not been met the Partnership agreed that multi-agency learning could be obtained from reviewing these cases and thus local learning activity was commenced.

Learning themes identified included:

- Professional curiosity and challenge
- Cultural competency and use of interpreters
- Identifying and assessing neglect
- Stronger pathways and services for transitions
- Importance of holistic chronologies

RR Child E 2020 – his story

RR Child E 2020 was a young baby who sadly died, unexpectedly in 2020.

His family were known to services following concerns around the family's living environment, appropriate supervision, home safety and possible neglect.

The family were not of British heritage and English was not their first language.

Baby was described by professionals as happy and clean with no signs of neglect.

During professional visits to the home, concerns were highlighted regarding baby's sleeping arrangements which were observed to be unsafe. It is unclear how much parents understood the safe sleep messages from health professionals despite the use of interpreters.

The family's living arrangements were sparse and there was cockroach infestation which due to the restrictions of Covid 19 was not managed by the landlord in a timely way. Agency professionals differed in their assessment of the home conditions with some stating that they were neglectful whilst others deemed them basic but suitable.

The siblings within the family were not accessing education and parents were being supported by agencies with the enrolment process.

The children were on a child protection plan for neglect at the time of baby's death, but professionals noted that parents were engaging well and working together with agencies to make the necessary changes.

Training and Communication

Baby Week

As a result of the learning gained from RR Child E 2020 alongside the learning from the national review of sudden and unexpected deaths in infancy, the Partnership delivered a themed week of training to professionals in October 2020.

Four sessions took place over the course of the week focusing on:

- Learning from RR Child E 2020 and messages regarding safe sleep
- Messages from ICON – abusive head trauma
- Emotional wellbeing of babies
- Learning from national review of sudden and unexpected deaths in infancy

In total 78 professionals attended the sessions.

"100% of participants learned something and would recommend the sessions to colleagues"

Key areas of learning that professionals fed back on were:

- Understanding the importance of multi-agency communication
- Consistent delivery of safe sleep advice
- How to use ICON tools with families
- Understanding how babies communicate and the impacts of poor attachment
- Communicating with parents in a meaningful way

Online training and webinars

As a result of the Pandemic the Partnership's usual comprehensive calendar of training was paused. Very quickly the Partnership's training consultant sought to adapt key training sessions to be delivered online via webinar sessions.

Throughout 2020-21 the Partnership has delivered:

58 training opportunities to 1,114 participants

MARAC training evaluation

- 40 evaluations were received out of 64 attendees.
- Of those 51% had worked with a client experiencing domestic abuse since the training.
- Out of these, 95% had completed a DASH risk assessment with the client. Of which 92% resulted in a referral to MARAC.

"It was really beneficial to have the line of questioning role played and was a brilliant example of how the questionaire process plays out, found this very informative."

Information Highway Fridays

Building on good practice from other areas, in January 2021 the Partnership introduced regular lunchtime briefing sessions.

Delivered on a Friday by Partnership professionals the "Information Highway Friday" sessions provide an opportunity for key messages and learning on a range of safeguarding topics to be delivered to a large group of professionals.

To date topics have included:

- Learning from case reviews
- Launch of the neglect strategy
- Refreshed continuum of need
- Learning from adult reviews

Oldham Safeguarding bulletin

In September 2020 the Partnership, together with the Safeguarding Adult's Board launched a children's and adults Safeguarding Bulletin to keep practitioners and managers up to date with resources and training opportunities.

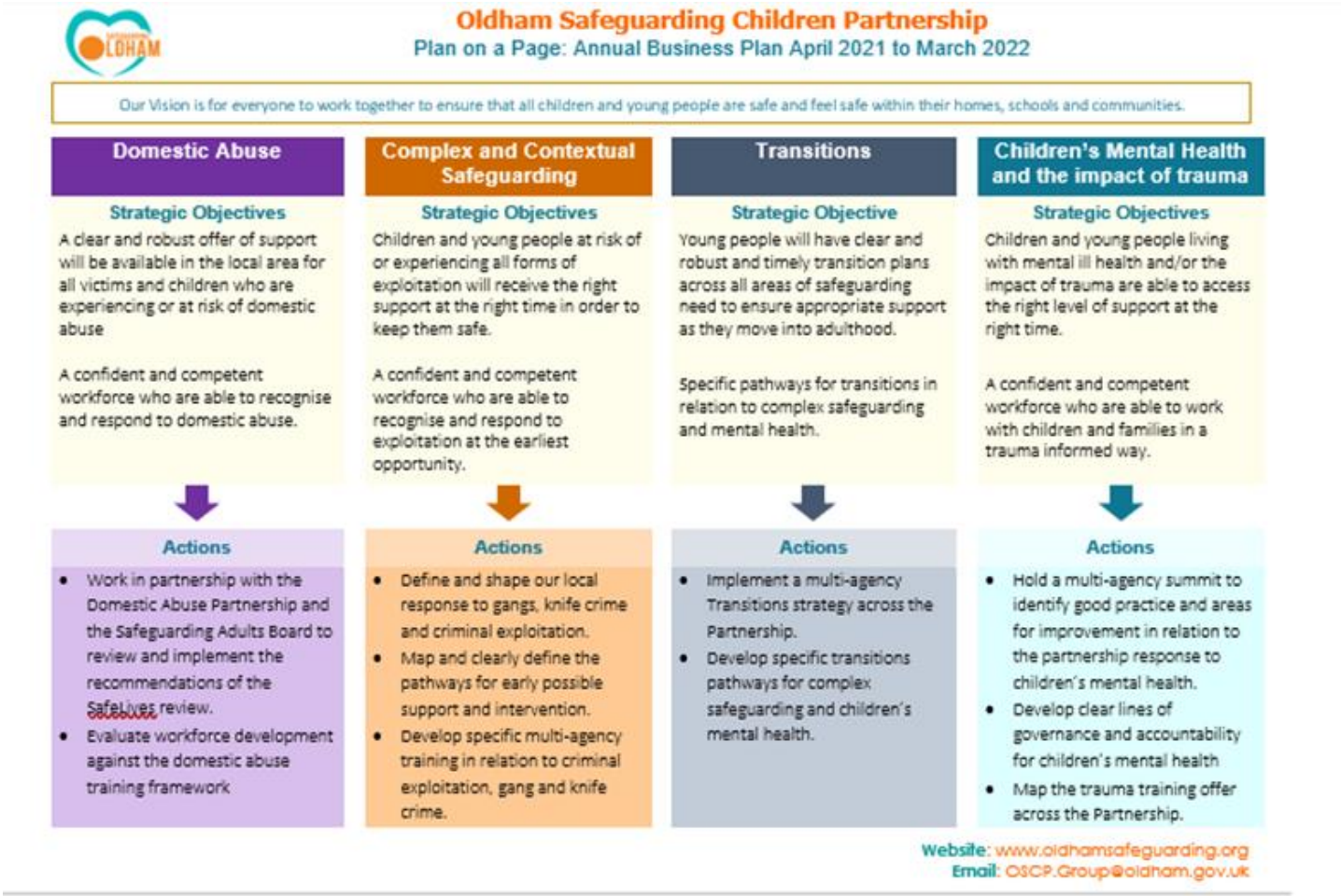
The bulletin goes out to over 260 multi-agency professionals on a fortnightly basis.

Oldham Safeguarding Twitter

In April 2020 we launched our joint Twitter account with Safeguarding Adult Board.

To date we have 391 followers and regularly tweet information about our activities, key messages, and local and national campaigns.

Our plan for 2021-2022



Oldham Safeguarding Children Partnership

Plan on a Page: Annual Business Plan April 2021 to March 2022

Our Vision is for everyone to work together to ensure that all children and young people are safe and feel safe within their homes, schools and communities.

Domestic Abuse

Strategic Objectives

A clear and robust offer of support will be available in the local area for all victims and children who are experiencing or at risk of domestic abuse

A confident and competent workforce who are able to recognise and respond to domestic abuse.

Actions

- Work in partnership with the Domestic Abuse Partnership and the Safeguarding Adults Board to review and implement the recommendations of the SafeLives review.
- Evaluate workforce development against the domestic abuse training framework

Complex and Contextual Safeguarding

Strategic Objectives

Children and young people at risk of or experiencing all forms of exploitation will receive the right support at the right time in order to keep them safe.

A confident and competent workforce who are able to recognise and respond to exploitation at the earliest opportunity.

Actions

- Define and shape our local response to gangs, knife crime and criminal exploitation.
- Map and clearly define the pathways for early possible support and intervention.
- Develop specific multi-agency training in relation to criminal exploitation, gang and knife crime.

Transitions

Strategic Objective

Young people will have clear and robust and timely transition plans across all areas of safeguarding need to ensure appropriate support as they move into adulthood.

Specific pathways for transitions in relation to complex safeguarding and mental health.

Actions

- Implement a multi-agency Transitions strategy across the Partnership.
- Develop specific transitions pathways for complex safeguarding and children's mental health.

Children's Mental Health and the impact of trauma

Strategic Objectives

Children and young people living with mental ill health and/or the impact of trauma are able to access the right level of support at the right time.

A confident and competent workforce who are able to work with children and families in a trauma informed way.

Actions

- Hold a multi-agency summit to identify good practice and areas for improvement in relation to the partnership response to children's mental health.
- Develop clear lines of governance and accountability for children's mental health
- Map the trauma training offer across the Partnership.

Website: www.oldhamsafeguarding.org
Email: OSCP.Group@oldham.gov.uk

An assessment from the Independent Chair

The new safeguarding arrangements, introduced by the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018, require that they include provision for the scrutiny by an independent person of the effectiveness of the arrangements. This section of the report provides the scrutiny of the Independent Chair of the Oldham Partnership of the second working year of the new partnership arrangements. The criteria for scrutiny are those proposed by Sir Alan Wood in his report proposing new safeguarding arrangements (para. 69 Wood report: review of the role and functions of local safeguarding children boards (2016)). These criteria are said to reflect the key strategic issues that need to authorise and underpin effective multi-agency practice.

Determining the physical area of operation covered by the multi-agency arrangements

This issue remained unaltered during the period under review. The issue may need to be revisited during 2022 with the reconfiguration of the NHS into integrated care systems. In particular, the remit and reach of services that will service the Greater Manchester area may require the Oldham Partnership to establish new working arrangements with the newly configured commissioning authority.

Judgement: **Green**

The authorising vision for multi-agency arrangements, the partnership commitment

This issue was re-examined at the partnership development day in March 2020. It was agreed that the vision should be refocussed into one which centred on the partnership being more of a learning hub and from that more effectively implementing change as required from the learning. The period 2020-21 was to be used to test the effectiveness of the learning hub model.

Judgement: Green

The resource framework, e.g., the cost of the multi-agency strategic decision-making body, the cost of agreed initiatives, e.g., joint training, agreed local research, innovation in service design

The Covid pandemic effectively constrained any further consideration of reframing the resource framework in the period under review. Initiatives which commenced in 2019-20 – MASH, enhanced team around the school, improved early help offer, enhancing workforce skills, developing a complex safeguarding team – were all consolidated during 2020-21 and became established elements of the Oldham safeguarding architecture.

It remains to be seen to what extent the learning hub model facilitates a “framework approach” to resourcing across the Partnership and whether this is focussed principally on innovation re core funding.

Judgement: Amber

The method to assess outcomes of multi-agency practice, including how intervention happens if performance falters, and how “independent” external assurance/scrutiny will be utilised.

The assessment of outcomes, particularly in relation to the strategic priorities of the Partnership, has been a real strength of activity in the period under review, despite the impact of Covid. Multiagency audits have been undertaken with respect to neglect of children under two years of age, domestic violence and children’s mental health and have demonstrated the need to enhance policy and practice in these areas. Oldham’s complex safeguarding team has fully participated in the GM complex safeguarding initiative, including participation in the GM peer review process on the way in which the team has been deployed and has engaged with those with safeguarding risk.

The GM safeguarding alliance did not become operational in the period under review. Oldham will engage with the alliance’s proposed programme of

shared learning when it commences in autumn 2021. Meanwhile Oldham has been in discussion with Tameside on a peer review initiative which should enhance the current scrutiny arrangements in relation to effective practice.

Throughout the period of the Covid pandemic the statutory partners and the independent chair have been meeting regularly (initially weekly, latterly monthly) to monitor the impact of the pandemic on safeguarding demand and agency response to it. This has provided a significant opportunity for the partners to share intelligence and perspectives on the impact of the pandemic, develop a risk register to document the safeguarding risks created by the pandemic and the actions taken to mitigate them and evaluate the effectiveness of modified safeguarding work practices and how these might be built into any new normal ways of working.

External review of the working of the Partnership arrangements continues to be led by the independent Chair. This exercise in the evaluation of the Wood strategic criteria is a further iteration of that function.

Judgement: Green

The strategy for information and data sharing, including to allow for identification of vulnerable children in need of early help.

A protocol for information sharing between the statutory partners and between the partnership and key stakeholder organisations was operationalised during this period. This has proven robust and effective and has enabled information to be shared both in the arena of safeguarding need and for the purposes of early help.

The request from Government to report on initiatives in the Borough to combat youth violence demonstrated the need for Partners to share intelligence more readily on critical need issues and on strategies being developed to impact on concerns. Currently there is a resurgence of interest in intelligence-led strategy development and a focus on what effective intervention looks like.

Judgement: Amber

High level oversight of workforce planning, e.g., gaps in skilled areas.

Work force planning continues to be primarily undertaken on a partner- specific basis, with limited consideration of the potential for cross-partner work force development. Active strategies to enhance the quality and quantity of the workforce were significantly interrupted by the Covid pandemic, with the primary emphasis on supporting the workforce, thereby enabling staff to continue to provide support and services for those with significant safeguarding risk. The demands created by Covid undoubtedly affected the capacity of the workforce to engage with the strategic agenda of the Partnership, their priority understandably being to discharge the operational imperative of safeguarding.

Multi-agency training initiatives continued to be provided during this period, with virtual learning being the predominant medium. Training initiatives continued to be focussed on Partnership priorities, with the experience of the past 12 months being assimilated into the Partnership's forward planning for training and workforce development.

Judgement: Amber

A multi-agency communication strategy on protecting children

As with workforce planning, communicating issues relating to safeguarding has hitherto been addressed on a partner-specific basis. The children's partnership in this period commenced a more strategic approach to communicating key safeguarding messages through the Information Highway Friday initiative and the fortnightly safeguarding bulletin (which simultaneously addresses adult safeguarding issues). Both of these initiatives have secured greater awareness of safeguarding issues and have facilitated communication of important safeguarding messages locally.

Judgement: Green

Risk strategy, identifying and adapting to challenges including new events, and establishing a core intelligence capacity.

The Covid pandemic rapidly accelerated the Partnership's understanding and appreciation of risk identification and risk management and the sharing of information and intelligence on these issues. Identification of patterns of safeguarding risk, both on an individual and areal basis, were well documented by the local statutory partners throughout the period and the knowledge and experience gained stored for the development of the next iteration of the local (three year) safeguarding strategy. Strategic risk identification, management and amelioration will be focussed on both priority risk groups and risk settings such as key localities and neighbourhoods, school clusters and estates. Sharing information across the Partnership to facilitate an intelligence-led approach to safeguarding is intended to become a hallmark of the Oldham approach. Key in this will be effective working between the wide variety of Partnerships that operate across the Borough (e.g., Health and Wellbeing, Community Safety etc). Continued efforts will be made to ensure that shared priorities are effectively delivered on and demonstrated to be effective.

Judgement: Amber

The model of local inquiry into incidents

The rapid review arrangements have quickly become established as an effective mechanism for responding to serious child safeguarding incidents. A variety of methods for undertaking review and reflection continue to be trialled and tested and active communication with the National Panel has continued to produce positive outcomes from local decisions and support for local initiatives. The development of local arrangements to date has led to a streamlining of the review process and the avoidance of unnecessary duplication. Key initiatives have been undertaken with respect to the safeguarding needs of those children under two years of age and with respect to youth violence.

The Partnership continues to be challenged to ensure that arrangements are in place to deliver effective practice change where required from practice reviews. This remains a priority for the partners, and one that continues to require audit and evaluation.

Judgement: Green

OLDHAM SAFEGUARDING CHILDREN PARTNERSHIP

STRATEGIC PLAN

2021 - 2024

This Strategic plan is a public document.

It can be accessed on the website of Oldham Safeguarding Children Partnership:

https://www.olscb.org/about/publications/

Approved by OSCP on 18 March 2021

Independent Chair: Dr Henri Giller

Report compiled and written by: Lisa Morris (OSCP Business Manager)

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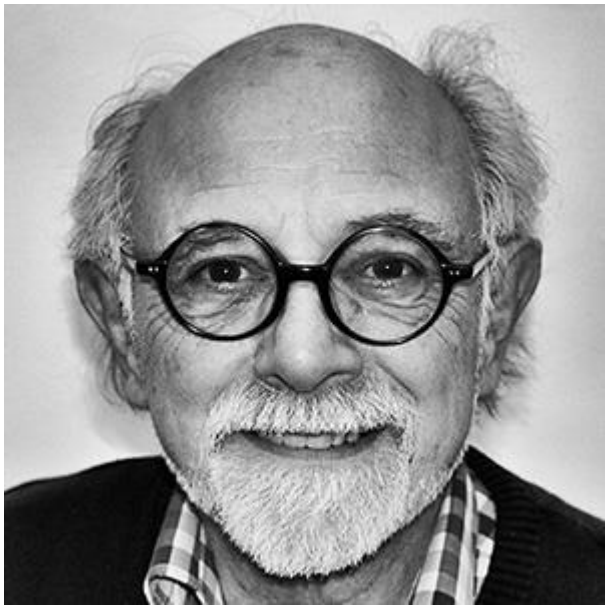
Availability and accessibility: if you would like to receive this report in any other format please contact Lisa Morris - address above.

Foreword



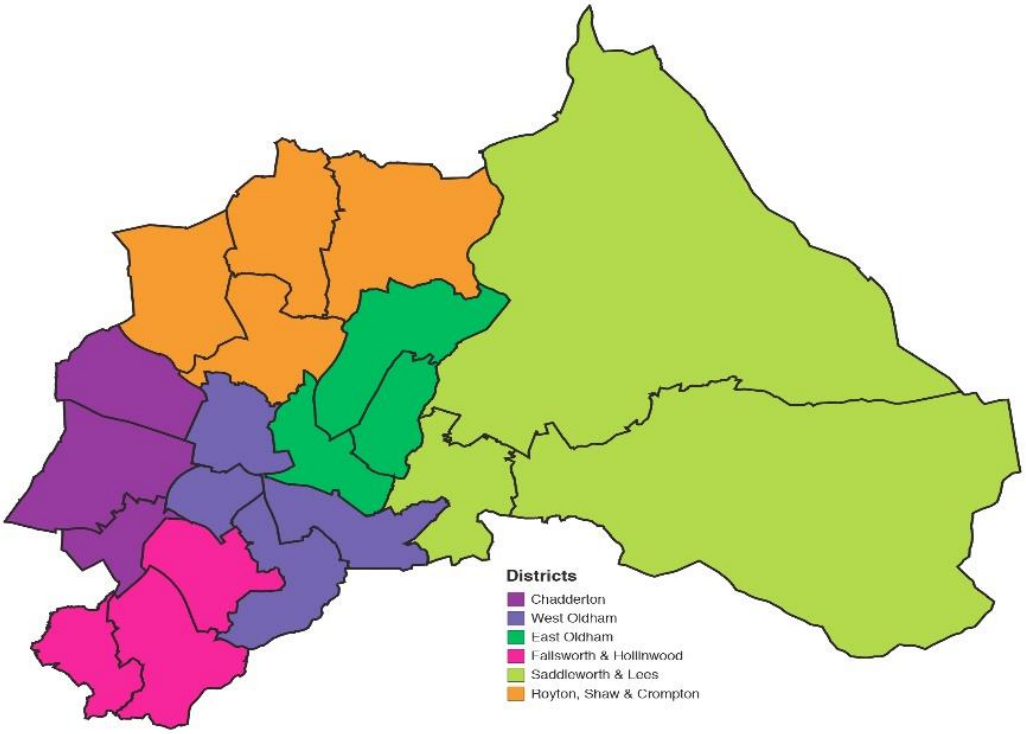
The Oldham Safeguarding Children Strategic Plan for 2021-24 has been developed against a backdrop of considerable change in the Borough over the recent past. The safeguarding partners of the borough have had their governance structure reconfigured as required by recent legislation. That reconfiguration was then implemented in the face of the Covid-19 pandemic, which meant that traditional methods of working were seriously challenged. This new Strategic Plan, therefore, will commence implementation as lockdown from the pandemic begins to ease and the safeguarding partners seek to establish a "new normal" in practice relationships.

Current safeguarding priorities in the borough include injuries to children under two years of age, high-risk domestic abuse incidents, concerns over children's mental health and ensuring effective access and delivery of education services. The safeguarding partners are committed to adopting approaches and practices that ensure that we develop a culture of continuing learning and improvement and give the public confidence that children in the borough are effectively protected. The safeguarding partnership will regularly report on its performance in delivering the objectives of this Strategic Plan.

Dr Henri Giller

Independent Chair, Oldham Safeguarding Children Partnership.

Oldham's Context



Oldham has a population of 233,759 people making it the 7th largest borough in Greater Manchester.

There is a high proportion of Oldham residents under the age of 16 years (22.5%) compared with 15.7% over the age of 65 years.

Although levels of deprivation have improved in the borough, we are still ranked 47th highest out of 327 local authority areas. Four areas within Oldham are ranked amongst the top 1.1% of the nation's most deprived areas.

Oldham has a diverse population with 22.5% of residents from Black and Minority Ethnic (BAME) backgrounds.

The rate of children living in poverty has risen by 8.1% in four years. From 31.8% to 39.9%

In 2020/21 there were:

- 4,278 referrals to children's services
- 612 child protection conferences initiated
- 194 children who became looked after

Our Vision

"For everyone to work together to ensure that all children and young people are safe and feel safe within their homes, schools and communities."

This vision is underpinned by the strategic aims and priorities identified throughout the strategic plan for 2021-2024. It supports the principle that safeguarding is everyone's business and reinforces the need for us all to work together in order to support children and young people in Oldham to achieve their full potential.

Our Purpose

OSCP brings together the Statutory Safeguarding Partners (the Police, Clinical Commission Group and Local Authority) to work in close collaboration with Relevant Agencies to safeguard and promote the welfare of all children and young people in Oldham. This is achieved through the co-ordination of collaborative partnership activity at a local level to identify and respond to local safeguarding need, ensure local arrangements for the safeguarding of children are fit for purpose and provide scrutiny of, and challenge to, those arrangements where appropriate.

Our Strategic Aims

1. Excellent practice is the norm across all practitioners in Oldham
2. Partner agencies hold one another to account effectively
3. There is early identification of new safeguarding issues
4. Learning is promoted and embedded
5. Information is shared effectively
6. The public feel confident that children are protected

Our Principles

Impact of Covid -19 pandemic

Oldham has been hit hard by the COVID-19 pandemic. Since the start of the pandemic we have had 23,243 confirmed cases of COVID in Oldham residents. Since August 2020, Oldham along with other areas in GM, has generally been in the highest-level restrictions in order to control the spread of the virus. Structural inequalities driving enduring transmission mean that the risks for Oldham are greater than most other areas which do not share the same demographic or socio-economic characteristics. We have worked really hard alongside our community leaders to address COVID. The work by our voluntary sector, faith leaders, schools, businesses, and the people of Oldham, to stop the spread of the virus has been incredible. So far, over 150,000 vaccine doses have been administered for our population with 56% of the population now having received their first dose. As our rates of COVID have dropped in 2021, we are seeing reduced pressure on our hospital services, and less people needing to isolate either as cases, or as contacts.

A strong, partnership response was implemented immediately for safeguarding children which saw the introduction of the children's partnership bronze meetings and regular covid assurance meetings with the statutory safeguarding partners. The focus of these daily, weekly and fortnightly meetings focuses on the ensuring support for the most vulnerable children, developing a shared and consistent response across the Partnership and identifying and responding to emerging risks and concerns.

Three key areas of safeguarding risk were identified as priority areas of focus:

1. **Injuries to under 2-year olds**

   During both periods of national lockdown Children's Services saw an increase in the number of children under the age of two years who were experiencing accidental and non-accidental injuries. Whilst the majority of these incidents were as a result of lack of supervision or sibling mishandling the circumstances highlighted the additional stresses and pressures that were being faced by parents of new and young children in the context of isolation and reduced support as a result of the pandemic.

2. **Significant increases in the number of high-risk domestic abuse incidents**

   Oldham saw a significant increase in high risk domestic abuse cases in Oldham during the Covid-19 pandemic, with a 92% rise in serious domestic abuse incidents affecting women and children. In the first week of February 2021 alone the Local Authority recorded 58 serious incidents of domestic abuse, compared to 43 in the whole month of February last year. Many of the families have not previously been known the Children's Services but the severity of the incidents being reported was of significant concern.

3. **Increased concerns for children's mental health**

   Oldham Healthy Young Minds saw a large reduction in referrals in Q1 and Q2 of 2020-21 as the Country entered the first COVID-19 lockdown. Despite the reduction in routine referrals there was a notable increase in crisis referrals. Similar increases have been noted in the incidences of self-harm amongst young people which has risen each quarter since the start of the pandemic.
   These areas are supported by a Partnership action and communications plans to ensure a co-ordinated response and awareness raising of the need and the available support for professionals and local communities.

As the Partnership moves towards recovery planning, the impact that Covid-19 has had and will continue to have on Oldham's families remains in a key area of focus and consideration.

Our Priorities

Domestic Abuse

The impact of the significant increases seen during the pandemic on the support for high risk victims of domestic abuse has prompted questions about the offer in its entirety, including the support offer for medium and standard risk victims and children and young people, work with perpetrators and the preventative offer. The impending Domestic Abuse Bill, which is currently in the later stages of the Parliamentary process, gives further impetus to this being a priority area for the Partnership. The Bill is intended to help transform the response to domestic abuse, helping to prevent offending, protect victims and ensure they have the support they need.

Complex and Contextual Safeguarding

Huge strides have been made in our Partnership approach to Complex Safeguarding over the past 12-18 months, with introduction of dedicated multi-agency complex safeguarding hub whose aim is to ensure that all children, young people and adults who are highly vulnerable to exploitation, either criminal or sexual, are provided with a clear targeted response which enables and promotes a targeted multi-agency response to need and risk. Whilst the Hub is a real strength for the Partnership the focus now needs to be on the mapping and development of the community level support offer, development of a robust multi-agency response to criminal exploitation and gangs and the embedding of our contextual approach to complex safeguarding.

Transitions

Work has progressed significantly within the Local Authority on this priority area over the past six months, resulting in the first draft of a Transitions strategy for 'Children's to Adults'. The document includes key deliverables, strategy and model, practice pathway and standards, tools and processes and implementation including training. The focus for the Safeguarding Partnership will be on widening the strategy to include key partner agencies who have a role within transitions and to those areas of safeguarding that have been identified as priorities such as complex safeguarding and mental health.

Children's mental health and understanding the impact of trauma

There is rising demand in relation to the mental health needs of children and young people and whilst it is acknowledged that there has been a strong crisis response during the pandemic, it is also recognised that there is a real need for greater connectivity across the wider children's system in order to ensure that we are able to deliver the best outcomes. Accountability and governance for this workstream is a key priority for Partners and once established will support the work needed to develop a robust partnership response to supporting the mental health and emotional wellbeing of our children and young people up to the age of 25 years.

Oldham Safeguarding Children Partnership: Business Plan April 2021 to March 2022

Domestic Abuse

Strategic Objectives

A clear and robust offer of support will be available in the local area for all victims and children who are experiencing or at risk of domestic abuse

A confident and competent workforce who are able to recognise and respond to domestic abuse.

Actions

- Work in partnership with the Domestic Abuse Partnership and the Safeguarding Adults Board to review and implement the recommendations of the Safe Lives review.
- Evaluate workforce development against the domestic abuse training framework

Complex and Contextual Safeguarding

Strategic Objectives

Children and young people at risk of or experiencing all forms of exploitation will receive the right support at the right time in order to keep them safe.

A confident and competent workforce who are able to recognise and respond to exploitation at the earliest opportunity.

Actions

- Define and shape our local response to gangs, knife crime and criminal exploitation.
- Map and clearly define the pathways for early possible support and intervention.
- Develop specific multi-agency training in relation to criminal exploitation, gang and knife crime.

Transitions

Strategic Objective

Young people will have clear and robust and timely transition plans across all areas of safeguarding need to ensure appropriate support as they move into adulthood.

Specific pathways for transitions in relation to complex safeguarding and mental health.

Actions

- Implement a multi-agency Transitions strategy across the Partnership.
- Develop specific transitions pathways for complex safeguarding and children's mental health.

Children's Mental Health and the impact of trauma

Strategic Objectives

Children and young people living with mental ill health and/or the impact of trauma are able to access the right level of support at the right time.

A confident and competent workforce who are able to work with children and families in a trauma informed way.

Actions

- Hold a multi-agency summit to identify good practice and areas for improvement in relation to the partnership response to children's mental health.
- Develop clear lines of governance and accountability for children's mental health
- Map the trauma training offer across the Partnership.

Our Model


Designated Safeguarding Leads network meeting
Policy and Performance
Safeguarding Accountability meeting
Rapid Review Panel
Statutory Partners meeting –
Safeguarding Review and Learning Group (Hub)
Strategic Safeguarding Partnership
Young people's Safeguarding Forum
Communications
Task and Finish groups

Rapid Review Panel

- This is an agreed subset of the Safeguarding and Learning Review Group which will pulled together as and when required to respond to rapid review referrals.
- Recommendations from the Panel will be made to the Safeguarding Review and Learning Group to progress.

Policy and Performance Co-ordination:

- Deliver a performance framework and scorecard that is focussed on improving outcomes for children
- Develop and implement appropriate thresholds, policies and procedures that are focussed on improving outcomes for children and families
- Work alongside the Safeguarding and Review Group to provide quality assurance and analysis

Safeguarding Accountability meeting:

Quarterly meeting to provide safeguarding assurance to the Chief Executive of LA, Accountable Officer for CCG and Chief Superintendent for GMP

Statutory Partner meeting

- To agree the agenda for the Partnership
- To receive exception reports from subgroup chairs
- To prepare for Safeguarding Accountability meeting
- To identify cross cutting themes with the Adult Safeguarding Board

Safeguarding Review and Learning Group:

- To define "what good looks like"
- To facilitate the effective management of Child Safeguarding Reviews
- To act as a conduit at a local level for the delivery of any national reviews
- To audit and evaluate the impact of learning on partnership practice
- To develop and drive the partnership training plan, influenced by strategic priorities and learning from reviews
- To develop a culture of continuous learning and improvement across the Partnership to safeguard and promote the welfare of children and promote good practice.

Strategic Safeguarding Partnership:

- Setting the strategic aims and priorities of the Oldham safeguarding children partnership,
- Agreeing and monitoring the partnership budget to deliver on those aims and priorities,
- Monitoring the performance scorecard of the partnership,
- Holding partners to account in relation to their safeguarding responsibilities
- Providing scrutiny and challenge to partners

Young people's safeguarding forum:

- Themed focus groups led by Oldham Youth Voice Family and promoted to children and young people across Oldham.
- To consult on Safeguarding themes and feedback to the Strategic Safeguarding Partnership
- To support priority setting for the Partnership

Communications:

- Develop communications strategy for Partnership
- Lead on cascading of information to wider professionals and communities
- Engage children and young people in the work of the Partnership
- Support Partnership in relation to media interest relating to Partnership activity

Task and Finish groups

- To lead on time limited, task specific pieces of work as directed by subgroups and/or Strategic Partnership

Designated Safeguarding Leads Network:

- Held termly with DSL's to ensure communication and discussion with schools/colleges

Report to HEALTH AND WELLBEING BOARD

Developing a Health Inequalities Plan for Oldham

Portfolio Holders:
Councillor Chauhan, Cabinet Member for Public Health

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Simon Watts, Registrar in Public Health

Date: 16/11/2021

Purpose of the Report

This report outlines a proposal for how a Health Inequalities Plan will be produced for Oldham, key timelines and the role of the health and wellbeing board in overseeing this work.

Requirement from the Health and Wellbeing Board

Board members are asked to discuss and agree the process and timeline outlined in this report and input into this work as the plan is being developed.

Developing a Health Inequalities Plan for Oldham

1. Background

On 14/09/2021 a health and wellbeing board development session was held, themed around health inequalities. A discussion took place about health inequalities in Oldham following a presentation by the Director of Public Health about two recent reports which make a series of recommendations for reducing health inequalities across Greater Manchester. The first report is from the GM Independent Health Inequalities Commission, titled The Next Level: Good Lives for All in Greater Manchester. The second report is from Michael Marmot's team at The Institute for Health Equity, titled Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives.

The presentation and discussion highlighted several important points:

- Health inequalities have existed and have been known about for a number of years, however Covid has exacerbated them, resulting in worse health and social outcomes for those who were already most disadvantaged.
- Oldham residents in particular are badly impacted by these inequalities given the low levels of income in the borough and the higher proportion of residents from minority ethnic groups.
- Recent reports from the GM Independent Health Inequalities Commission and the Institute for Health Equity are an opportunity for action in the borough. A document was circulated which summarised system wide initiatives which was aligned with the recommendations made by Michael Marmot's team. This highlighted a number of areas where the Oldham system is very much fulfilling the recommendations, as well as gaps where more work is needed.
- It was agreed that following the development session a plan would start to be developed for tackling health inequalities in Oldham, which would draw on the findings from these two reports.

GM Report Findings

Key recommendations from the GM Independent Inequalities Commission report were as follows:

- The need for the region to tackle structural racism and all forms of discrimination by empowering marginalised groups; not just to hold decisionmakers to account, but to have a seat at the table.
- Universal basic services (e.g. housing, adult social care, health) should be available to all.
- A GM wide living wage and living hours should be implemented by 2030.
- Put wellbeing and equity goals at the heart of GM strategy and align budgets and programmes to these aims.
- Work with anchor organisations to drive social value, support disadvantaged groups and create good jobs.

Key recommendations from the Build Back Fairer (Marmot) report were as follows:

- Prioritise children and young people in all policy.
- Provide further support and resources for early years settings in more deprived areas.
- Identify the minimum income for healthy living in Greater Manchester and advocate for national resources to meet this in public sector pay.
- Guaranteed offer of universal access to quality services for all, as well as universal access to training, support and employment for young people.

- Develop GM minimum standards for quality of employment, environment, housing, transport and clean air. Advocate for enforcement powers and resources to support this. Encourage and enable residents to challenge organisations that don't meet these standards.
- Track progress through a series of Beacon Indicators that monitor whether improvements to inequality are being made.

2. Current Position

At the last health and wellbeing board development session, it was proposed that the board develop a plan for Oldham to reduce health inequalities.

Working to reduce health inequalities in Oldham is the right thing in terms of fairness and equity, but also makes longer term financial sense for Oldham's public services, the economy and Oldham residents. The sections below outline how this work can be taken forward. This work will be facilitated by public health, but will depend on engagement from partners from across the system as well as resident input.

3. Key Issues for Health and Wellbeing Board to Discuss

Role of the Health and Wellbeing Board

In-line with the functions of Oldham's health and wellbeing board to lead and coordinate action to assess the needs of the population and ensure the council acts to improve public health, the board is well placed to take ownership of this work on health inequalities. The membership of the board will need to be reviewed to ensure it can deliver on this work, given health inequalities are impacted by most parts of the system.

Process for Developing the Health Inequalities Plan

It is proposed that a health inequalities plan for Oldham is developed by:

1. Establishing a time limited task and finish group to steer the development of the plan.
2. Producing an overview of evidence linked to health inequalities in Oldham, highlighting key areas of concerns. This will be drawn from the Joint Strategic Needs Assessment.
3. Engaging with key system partners and residents to understand key issues. Summarise priorities raised linked to health inequalities from discussions.
4. Meet with relevant system partners to understand existing programmes of work and governance and how they interact with the health inequalities agenda; summarise which priorities identified are already being progressed (e.g. by the Equality Plan, Anti-Poverty Plan).
5. Develop a detailed action plan for the priorities which aren't already being progressed by other workstreams. Named individuals assigned to each action with timelines.
6. Outline proposed governance to support implementation of the action plan above, emphasising the role of the Health and Wellbeing Board in driving delivery.

Timeline for Development

Objective		Deadline
1	Establish a task and finish group to steer the development of the health inequalities plan. For discussion at November's HWB.	**Nov-21**
2	Analyse available data and draw on themes from JSNA to understand the	**Dec-21**

	current state of health inequalities in Oldham and recent trends.	
3	Carry out engagement with key partners in the system and residents to discuss what our priorities should be with regards to health inequalities in Oldham, taking account of recent GM Inequalities report recommendations.	**Jan-22**
4	Form a list of priorities based on reviewing the data relating to health inequalities above and from the discussions with partners and residents. Review this list at the January HWB.	**25/01/2022 HWB**
5	Understanding existing programmes of work. Health inequalities link to almost everything the council, NHS and wider system do. An important next step to avoid duplication and promote partnership working is to understand the range of ongoing work in Oldham and Greater Manchester which complements our aim to decrease health inequalities. This includes but is not limited to: a. Oldham poverty action plan b. Oldham's Equality Strategy c. Oldham economic development plan d. Health system work to reduce inequalities	**Feb-22**
6	Identify key gaps based on the priorities identified and taking account of ongoing programmes of work. Develop an action plan with partners to try to meet these gaps, including, where appropriate, areas where Oldham should be advocating at a regional and national level for change.	**Mar-22**
7	Health and Wellbeing Board review and approve Health Inequalities Plan for Oldham.	**22/03/2022 HWB**

4. Recommendation

Board members are asked to discuss and agree the process and timeline outlined in this report and engage with this work as appropriate as the plan is being developed.

Report to HEALTH AND WELLBEING BOARD

Supporting patients with Long COVID, Chronic Pain and Fatigue

Portfolio Holders:
Councillor Chauhan, Cabinet Member for Public Health

Report Author: Dr Murugesan Raja, GP, Oldham, Clinical Lead for Primary Care, Respiratory Medicine, Long COVID, Greater Manchester
Dr Rebecca Towns, Clinical Director- Respiratory, Oldham CCG, Clinical Lead for Long COVID, Oldham Care Organisation

Date: 16/11/2021

Purpose of the Report

In September 2021, Cllr H Sykes wrote to the Chair of the Health and Wellbeing Board, Cabinet Member for Health and Social Care, and Director of Public Health requesting that the Health and Wellbeing Board consider the provision of care for patients living with chronic pain and fatigue conditions within the Borough (Appendix 2).

In response to this letter, Dr Murugesan Raja and Dr Rebecca Towns are briefing the Board on the services available for patients with Long COVID, and how these relate to provision for patients with chronic pain and fatigue. There will also be an opportunity for Board members to discuss current commissioning arrangements and services for chronic pain and fatigue.

Requirement from the Health and Wellbeing Board

Board members are asked to note the report and discuss the questions raised in Cllr Sykes letter of 2/9/21.

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Authors:

Dr Murugesan Raja, GP, Oldham, Clinical Lead for Primary Care, Respiratory Medicine, Long COVID, Greater Manchester

Rebecca Towns, Clinical Director- Respiratory, Oldham CCG, Clinical Lead for Long COVID, Oldham Care Organisation

1.0 Purpose

1.1 To provide an update on the development of local pathways for Long COVID clinics and treatment for patients experiencing long-term health effects following COVID-19 infection.

2.0 Background

2.1 Post-COVID syndrome is defined as:

Signs and symptoms that develop during or following an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis. The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body. Many people with post-COVID syndrome can also experience generalised pain, fatigue, persistent high temperature and psychiatric problems.

Ongoing symptomatic COVID-19: is defined as signs and symptoms of COVID-19 from 4 to 12 weeks.

Long COVID is the term used to describe any symptoms lasting after 4 weeks from the acute episode of COVID.

2.2 On 7 October '20, NHS England and NHS Improvement announced[1] a commitment to establish post-COVID assessment clinics across England, giving patients access to multi-professional advice, so that they are put onto the right clinical pathway to treat their symptoms.

2.3 On 6 November '20, NHS England published commissioning guidance[2] proposing that clinics will offer physical, cognitive and psychological assessments with the aim of providing consistent post-COVID syndrome services for all who need them, whether they were hospitalised or not and regardless of whether clinically diagnosed or by a SARS-CoV-2 test.

2.4 On 15 November '20 NHS England announced[3] the investment of £10million to fund 40 long-COVID clinics across England, 3 of which to be in the North West. It was anticipated this would mean a single clinic for Greater Manchester.

2.5 Colleagues from across community, commissioning and acute care in Oldham formed a Steering Group in November '20 to design and implement local pathways for Long Covid assessment clinics. The Steering Group have continued to work on the objective to develop local pathways.

2.6 On 18 December 20, the National Institute for Clinical Excellence (NICE) issued official guidance on best practice for recognising, investigating and rehabilitating patients living with the long-term effects of COVID-19.

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[1] **https://www.england.nhs.uk/2020/10/nhs-to-offer-long-covid-help/**

[2] **https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/C0840-national-guidance-for-post-covid-syndrome-assesment-clinics-111220.pdf**

[3] **https://www.england.nhs.uk/2020/11/nhs-pioneers-40-long-covid-clinics-to-tackle-persistent-symptoms/**

2.7 The number of patients, who need post-COVID syndrome management, focusing on recovery and rehabilitation, is likely to grow as COVID-19 infection rates continue to rise.

2.8 Services across the Northern Care Alliance have been meeting on a regular basis including operational, clinical and project management support, to ensure clinical excellence in relation to Long Covid pathways for assessment and treatment.

3.0 Evidence base

3.1 According to research undertaken by the Office of National Statistics[4], around 1 in 10 people testing positive for COVID-19 exhibit symptoms for a period of 12 weeks or longer.

3.2 67% of GPs surveyed nationally reported that they are looking after patients with COVID-19 symptoms lasting longer than 12 weeks[5].

3.3 On 8 January, the Lancet published a study[6] looking at the long-term health consequences of COVID-19 patients discharged from hospital. At 6 months after acute infection, COVID-19 survivors were mainly troubled with fatigue or muscle weakness, sleep difficulties, and anxiety or depression. Patients who were more severely ill during their hospital stay had more severely impaired pulmonary diffusion capacities and abnormal chest imaging manifestation and are the main target population for intervention of long-term recovery. The Lancet report adds to the growing body of evidence that long COVID syndrome should be considered serious and is a long-term condition.

3.4 There is increasing evidence that COVID-19 has a disproportionate impact on those in deprived populations and people in black and ethnic minority groups, exacerbating existing health inequalities[7].

3.5 Of those people with persistent symptoms at 20 weeks, the current evidence suggests that the most common symptoms are fatigue (98%), breathlessness (87%), persistent cough (74%), headache (83%), fever (75%), chest pain (73%), muscle ache (88%) and joint pain (78%). However, a wide range of other symptoms are reported, affecting almost all body systems. Of note, people with persistent symptoms often report multiple different symptoms, which can relapse and remit over time.

4.0 Progress

4.1 The post-acute COVID service model is a tiered model recommended by NHS England and by Greater Manchester Health and Social Care Partnership (GMHSCP) and is outlined in appendix A. The principles of management are -

- Confirm the diagnosis (medical assessment, not dependent upon a positive COVID-19 test result;
- Exclude other serious conditions;
- Support & monitor the patient (whilst avoiding over-investigation/over-referral);
- Direct patients to assessment clinics, if appropriate.

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[4] https://www.ons.gov.uk/news/statementsandletters/theprevalenceoflongcovidsymptomsandcovid19complications

[5] Royal College of General Practitioners. (2020) *Ongoing or persistent symptoms of Covid-19.* Parliamentary Inquiry. Available at: *https://committees.parliament.uk/writtenevidence/12976/html/*

[6] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32656-8/fulltext

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

4.2 Long COVID Virtual assessment clinics covering Tier 3 assessment and then the MDT were set up at the end of January 2021 for Oldham. The Tier 4 service is in the process of being fully stood up across GM but Oldham Tier 3 services have been able to access this since the end of September 2021.

4.3 Services for Children and Young People (CYP) are now in place across GM provided solely from the Royal Manchester Children's Hospital (RMCH).
There are 2 pathways one for primary care into the Paediatric long COVID clinic, and one for secondary care direct into the Tertiary long COVID clinic.

5.0 Pathway development

- Tier 1: Self-management- Patients are directed to the Your COVID recovery website and the GM Peer Support group.
- Tier 2: All GP practices have signed up to deliver the NHS Direct Enhanced services for Long COVID which includes guidance on identification, assessment and appropriate investigations prior to referral.
- Development of post-acute COVID assessment clinic (tier 3)

5.3.1 The Group has undertaken the following key activities -

- Agreed a tier 3 model to deliver post-acute COVID-19 assessment services across Oldham.
- The model development has been led by Rebecca Towns Clinical lead and Dr Georges Ng Man Kwong- Respiratory consultant at Oldham with Input from Anna Dalton Pennine care mental health lead.
- The model has been shared with primary care across Oldham on two occasions, the first being September 2020 at an all practice education session- this included recognition of long COVID, expectations of tier 2 and primary care to manage community and self- management services, clinical assessment and investigations that need to occur prior to referrals into the tier 3 services.
- A further education session took place on the 22nd July 21 to all primary care covering the same points but also providing data, outcomes and findings from the 1st 6 months of the Tier 3 assessment and treatment service.

5.3.2

- Tier 3 referrals are received via primary care through the ERS system, and the referrals are triaged by a consultant, Registrar, or advanced practitioner. They are then booked into a virtual clinic where patients will receive a telephone call from a member of the multi-disciplinary team within 12 weeks of referral, this assessment then determines the treatment plan for patients. If clinically complex and further assessment is required, they will then be discussed within the virtual MDT which takes place on a fortnightly or monthly basis dependant on demand.
- The assessment uses a holistic biopsychosocial model of assessment, cognitive assessment, and person-centred approach. This includes questionnaires to take a comprehensive clinical history that involves assessing physical, cognitive, psychological, and psychiatric symptoms, as well as functional abilities.
- If patients are then appointed to be discussed at the tier 3 MDT this will comprise of a Nurse/ Physiotherapist triage, Respiratory Consultant, MH psychiatrist or psychologist and the MDT co-ordinator.

- The MDT will decide if the patient requires a discharge back to the GP practice with a care plan, further tests, and referral into tier 3 post-acute COVID rehabilitation services, MH services or referral into more specialist services.
- The benefits of this virtual assessment clinic and MDT include:
    - Better management of people's expectations of their recovery;
    - More appropriate rehabilitation interventions leading to better patient outcomes;
    - Increased self-management skills and confidence in managing adversity/sickness and taking responsibility for own health and wellness;
    - More efficient and effective use of NHS resources
- Referrals from within the trust for post-acute COVID assessment has also been streamlined into the service to ensure all patients receive an equitable offer.
- Activity has been captured for learning purposes and used to inform the ongoing service models for assessment as well as treatment.
- The data and activity are reported back to NHSEI on a fortnightly basis and is a key requirement for the Trusts providing Long COVID services.
- The Tier 3 assessment service and MDT has evolved to now include community teams and a cardiologist and is a joint MDT across Oldham Bury and HMR.
- We have a regular specialised Tier 3 Long COVID rehabilitation offer in Oldham which involves twice weekly face to face group exercise and education sessions specifically for patients with Long COVID syndrome.

- We are currently in the process of Commissioning a treatment offer for the Oldham Locality for patients suffering with symptoms of fatigue due to Long COVID, this will take the form of the following assessments and treatments:

Activity / Appointment	**Notes**
First Assessment	45-60 mins
Follow-up	30-45mins
Long Covid Management Programme	6 Week programme per patient
Psychology First Assessment	45-60mins
Psychology	30-45mins

- The services following feedback from patients has evolved meaning that the aspirational target is to ensure a telephone assessment and triage within 6 weeks of referral, this ensures rapid assessment and treatment plans being put in place and for those patients who don't require tier 3 MDT or Long COVID Rehabilitation and can be rapidly discharged back into tier 1 and tier 2 existing community service offers these include:

    - Exercise programmes provided by Oldham Community Leisure
    - Healthy minds input
    - social prescribing input
    - Directing to self-management services such as your COVID recovery
    - Oldham MSK for pain management

5.4 Tier 4

- We now have regular open access to the GM Tier 4 MDT which takes place every 2 weeks for the most complex patients who are still suffering with symptoms post tier 3 treatment offers.

5.5 Mental Health

- Oldham CCG commissions a robust Mental Health Offer from Pennine Care Mental Health Trust. This model has been used to inform the wider GM Tier 3 and Tier 4 model. Patient with Long COVID in Oldham have access to mental health support when needed in a timely manner.

6.0 Conclusion

6.1 There is a service delivery provision for all of our patients with long COVID across the different tiers.

6.2 There is a waiting list for provision of these services due to the number of patients who have suffered with COVID and the demand for Long COVID services

6.3 Long COVID is still a new condition and the natural history of the course of the illness and the treatment is still being researched. Some Patients with Long COVID are on a recovery trajectory and some fully recover.

6.4 It will be difficult to extrapolate the services offered specifically to Long COVID to patients with chronic pain and fatigue as the offer required for that group of patients will be more nuanced than the current understanding of Long COVID.

6.5 There is recognition across GM and nationally that service provision needs to improve for our patients with Chronic Pain and chronic fatigue and discussions around Long COVID have only pointed the need for these services.

7.0 Recommendations

The Board is asked to note the report.

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NHS Standard Contract - Service Specification

Service Specification	**V4.0.** *18th Jan 2021*
Service	**Post-Acute COVID-19 services and clinics to support and manage 'post COVID-19 syndrome' in adults** *Includes detail on:* *Tiers 1-4 services*
Commissioner Lead	**Nadia Baig**
Document Authors	Professor Nawar Bakerly, Dr Jennifer Hoyle, Dr Murugesan Raja, and Gareth Lord on behalf of the ***GMEC Strategic Clinical Network***
Provider Lead	Manchester NHS Foundation Trust (MFT) to act as lead provider with Northern Care Alliance (NCA) as key provider for the GM System. SROs – Professor Jane Eddleston and Dr Chris Brooks on behalf of the GM Partnership Medical Executive
Period	**December 2020 onward**
Date of Review	**April 2021**

1. The acute and post-acute phase of COVID-19

The presentation and management of COVID-19 can be broken down in to 3 main phases;

- Acute COVID-19: signs and symptoms of COVID-19 for up to 4 weeks.
- Ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4 to 12 weeks.
- Post-COVID-19 syndrome: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis (NICE 2020).

It is expected, management across these phases should be seamless

In addition to the above, the term "Long COVID" has been commonly used to describe signs and symptoms that continue or develop after acute COVID-19. It includes both ongoing symptomatic COVID-19 (from 4 to 12 weeks) and post-COVID-19 syndrome (12 weeks or more).

The post- acute phase (>4 weeks) is characterised by patient reviews that may feature further investigation and a clinical assessment to determine further management options. Such options may include referral to a post-acute COVID-19 secondary care service (tier 3), if post COVID-19 syndrome is suspected.

This service specification outlines the approach to supporting those with confirmed or suspected COVID-19, in the post-acute phase >4 weeks; with particular attention to those between 4 and 12 weeks and greater than 12 weeks.

2. Rationale and Population Needs

2.1 National context

At present, it is recognised that:

- Many people experiencing ongoing health effects following COVID-19 infection managed their condition independently at home while acutely infected. It is also recognised that not all patients seriously impacted in the longer term were hospitalised or had a positive Severe Acute Respiratory Syndrome by Corona Virus 2 (SARS-CoV-2) test.
- The number of patients who need post-COVID syndrome management focusing on recovery and rehabilitation is likely to grow as COVID-19 infection rates continue to rise.
- People with post-COVID syndrome have reported that whilst GPs have been sympathetic, some have been unsure how to refer into treatment services.
- 67% of GPs surveyed reported that they are looking after patients with COVID-19 symptoms lasting longer than 12 weeks.
- There is increasing evidence that COVID-19 has a disproportionate impact on those in deprived populations and people in black and ethnic minority groups, and thus exacerbates existing health inequalities.
- In patients discharged from hospital with COVID-19, 34% had cough and 69% had fatigue. 14.6% had depression following follow up for a median average of 54 days (Mandal. Thorax 2020). Based on figures from this study, and others; it is reasonable to assume that around 10% of those admitted will need long term input for ongoing symptoms (https://www.bmj.com/content/371/bmj.m3981)
- Academic publications have estimated that 10-20% of people are still unwell after 3 weeks and 1-3% are still significantly unwell after 12 weeks (Tenforde elt al. MMWR 2020).
- This is supported by a prospective study using the COVID Symptom Study app (yet to be published), that found around 4.5% had symptoms lasting more than 8 weeks and 2.3% longer than 12 weeks (Carole H. Sudre 2020).
- NHS England / Improvement are looking to ensure the rapid establishment of clinics to manage post COVID-19 syndrome, by publishing commissioning guidance, and allocating funds to local health systems.
- NHS England / Improvement have allocated funds to General Practices to support seven objectives. The third objective is: *First steps in identifying and supporting patients with Long COVID.*

2.2 Local context

- GM has additional challenges that impact on population health. These include areas of deprivation and vulnerable population demographics such as multiple occupancy homes, high prevalence of chronic lung, cardiac and diabetic conditions known to lead to more serious consequences of infection.
- Taking into account the GM population and the results from the above studies, estimates suggest anywhere between 600 and 2400 patients diagnosed in October 2020 will experience symptoms that may require multidisciplinary specialist support January/February 2021 (refer to appendix one). However, it should be noted, these are crude estimates and accurate predictions remain difficult due to a number of variables.

3. Pathways, guidance and approach

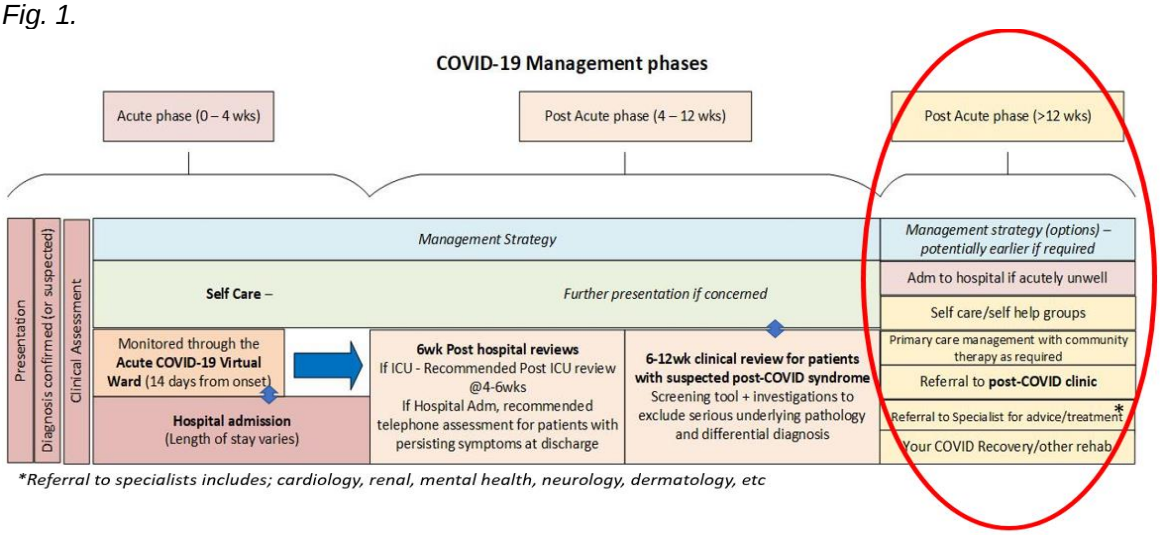
3.1 Pathway and guidance

There are four main routes to supporting people with confirmed or suspected COVID-19 during the post acute phase:

- Self management support (with information and available tools)
- Support using primary care services
- Support using secondary care services, and
- Hospital admission where appropriate

As highlighted in section 1 and in the following figure, the process is fluid, with escalation and de-escalation where necessary.

Fig. 1.



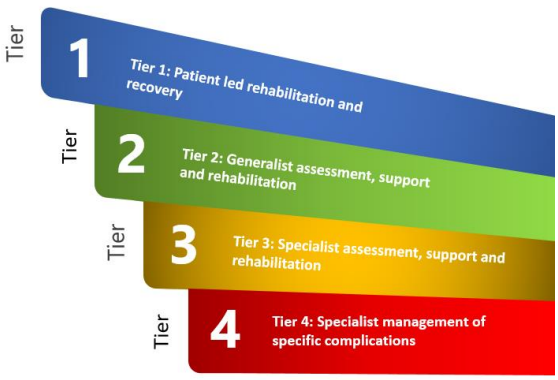
In the delivery of this service, the provider will adhere to the latest *guideline to supporting the recovery and rehabilitation of adults with confirmed or suspected COVID-19 in Greater Manchester (2021)*.

3.2 Tiered approach to the management of Post-Acute COVID-19

Whilst the pathway in fig.1 outlines a linear approach to managing COVID-19, the following figure outlines a management model weighted by the level of intervention necessary (see fig.2).

Typically, the higher the tier, the more resource intensive. Comparatively, it is likely the higher the tier, the fewer patients requiring it.

Fig. 2



The tiers can be summarised as follows:

Tier one: Self-management support (with information and available tools)
Tier two: Support using primary care services
Tier three: Support using secondary care services, and
Tier four: Highly specialist input and rehabilitation for complex patients

The interventions carried out in each tier are as follows:

Tier 1 (Self-management as advised by primary care)

- ✓ Information and Education/material provided about the disease and recovery and options for self-management, this should include advice to carers and family's where available.
- ✓ Referral to Your COVID recovery
- ✓ Self-monitoring and reporting back to GP with worsening and low mood. symptoms such as breathlessness, fatigue, chest pain
- ✓ Voluntary sector and social support

Tier 2 (primary care)

- ✓ Therapeutic relationship with a generalist clinician (e.g. GP, Advanced Nurse Practitioner, Physiotherapist, Occupational Therapist) who takes responsibility for the patient's overall care and helps them navigate the system
- ✓ Full history, clinical examination including functional and psychiatric assessments
- ✓ Confirm that Post COVID-19 syndrome is likely (even in the absence of a positive test); or, if not, other possible diagnosis and document in the medical record
- ✓ Basic tests (e.g. bloods, X-rays, exercise tolerance tests, blood pressure, pulse oximetry etc) if appropriate to exclude alternative diagnoses (e.g. sepsis) and rule out serious complications. Note: not all patients will need such tests
- ✓ Rehabilitation support (remote or face to face - examples include; referral to community based pulmonary rehabilitation, cardiac rehabilitation, smoking support, weight management programmes)
- ✓ Ongoing monitoring and support (e.g. by telephone, video, or in-person check-ups) as needed
- ✓ Management of other long-term conditions (e.g. diabetes, asthma)
- ✓ Offer advice and guidance to tier 3 of what services are locally available
- ✓ Referral to Tier 3 as appropriate
- ✓ Referral to Improving Access to Psychological Therapies or psychiatric services as appropriate (see mental health service guide)
- ✓ Use of validated screening tools for cognitive/mental health identification and triage
- ✓ Use of social prescribing

Tier 3 (Secondary care/ MDT)

- ✓ Dedicated COVID-19 service/clinic (usually respiratory but sometimes neuro- and/ or cardiac)
- ✓ Personalised rehabilitation plan with (e.g.) breathing exercises, supervised pacing and psychological support
- ✓ Referral to other specialties as appropriate e.g. cardiology, neurology, haematology, psychiatry or Multidisciplinary (MDT) approach within clinic itself
- ✓ Testing according to specialist guidelines (e.g. Computerised Tomography (CT), Magnetic Resonance Imaging (MRI))
- ✓ Dialogue and agreed division of responsibility between specialities, Intensive Care Unit (ICU) and primary care.
- ✓ Offers advice and guidance to tier 2 services

Tier 4 (Tertiary care/ MDT)

- ✓ Management of specific conditions (Interstitial Lung Disease (ILD)/ Chronic thromboembolic pulmonary hypertension (CTEPH)/ Transplant)
- ✓ Tertiary neuro-rehabilitation and neuropsychology
- ✓ Chronic Fatigue syndrome services
- ✓ Access to other Mental Health (MH) services

4. Clinical Coding

SNOWMED-CT Coding

- Acute COVID-19 infection (1325171000000109)
- Ongoing symptomatic COVID-19 (1325181000000106)
- Post-COVID-19 syndrome (1325161000000102)

5. Tier 1 services

Tier 1 will include services and tools to enable and support self-management. Information may also include contact details should symptoms change or worsen.

These are signposted by tier 2 services (and where necessary tier 3) for patients who do not require ongoing support from primary and secondary care.

Tier 1 services will include:

1. The provision of general information and advice about COVID-19 that encompasses:
   a) Information about new or continuing symptoms of COVID-19 that the person can share with their family, carers and friends.
   b) ways to self-manage their symptoms, such as setting realistic goals,
   c) details of existing local services that accept self-referral,
   d) sources of advice and support, including support groups, social prescribing, online forums and apps, social care, housing, employment/return to work, and advice about financial support
2. The provision of educational material, like leaflets, on self-help tools that are available locally, and
3. The offer of referral to Your COVID Recovery (if appropriate).

Rehabilitation in tier 1 pertains to personalised self-help goals that are accessible through self-referral where available or via GP's. Examples include; online Cognitive Behavioural Therapy (CBT) programmes, smoking support services, active lifestyle management courses, weight loss programmes, or social / peer support groups.

Appropriate coding needs to be entered within the Electronic Patient Record (EPR) or equivalent digital systems.

6. Tier 2 services

Tier 2 services are provided throughout the COVID-19 recovery pathway:

- During the acute phase / post-acute phase when a patient remains in the community under the care of their GP or other primary care service
- During the post-acute phase when a patient either undergoes a clinical review or self presents, and
- During the post-acute phase to support the management of ongoing symptomatic COVID-19 (>4 weeks), or post COVID-19 syndrome (>12weeks) where secondary care intervention is not deemed necessary.

The primary aim of tier 2 services is to identify and support patients with post-acute COVID-19; and where possible those with post COVID-19 syndrome (in accordance with the 7 priorities outlined by NHS England / Improvement).

Tier 2 services are mainly primary care-led services that:

1- Offer an initial consultation for those concerned about Post COVID-19 syndrome (>4 weeks). This can be either face to face, via telephone, or via video.
2- Review cases where post COVID syndrome is likely and assess as per locality agreement
3- Provide initial assessments, diagnostics, and advice and treatment.
4- Link to expertise from within primary and social care
5- Link to expertise within secondary care capitalising on existing routes like advice and guidance or Consultant Connect
6- Triage patients into the most appropriate care pathway; including initiating urgent referrals to appropriate specialist services (i.e. chest pain clinics, oxygen service, multi-system inflammatory syndrome services in children)

6.1 Assessments and Follow ups

Assessments and/or follow ups by an appropriately skilled clinician (Doctor/Nurse/Allied Health Professional (AHP)) within primary care for:

- A planned review of a non-hospitalised patient following referral from home oximetry/virtual ward models of care (>4 weeks post diagnosis/first symptoms) as appropriate
- A planned review of a hospitalised patient where locally agreed >4 weeks post discharge
- An unplanned review of a patient experiencing post-acute COVID-19 symptoms either through self-presentation or referral from another service, at any point (usually >4 weeks)

Assessments will include:

- Full history, clinical examination and functional assessment
- Basic tests:

a) Offering blood tests, which may include a full blood count, kidney and liver function tests, C-reactive protein test, ferritin, B-type natriuretic peptide (BNP) and thyroid function tests.
b) If appropriate, offering an exercise tolerance test suited to the person's ability (for example the 1-minute sit-to-stand test). During the exercise test, recording the level of breathlessness, heart rate and oxygen saturation.
c) For people with postural symptoms, for example palpitations or dizziness on standing, carrying out a lying and standing blood pressure and heart rate recordings (3-minute active stand test, or 10 minutes if suspected postural tachycardia syndrome, or other forms of autonomic dysfunction).
d) Offering a chest X-ray by 12 weeks after acute COVID-19 if the person has not already had one and they have continuing respiratory symptoms. *Chest X-ray appearances alone should not determine the need for referral for further care.*
e) Offering other tests where appropriate and available such as an Electrocardiogram (ECG), spirometry, an Echocardiogram, pulse oximetry, and standing blood pressure to exclude alternative diagnoses (e.g. sepsis) and explore COVID-19 complications. *Note: not all patients will need all these tests*

- The use of a standardised screening tool to determine if post COVID-19 syndrome diagnosis is likely (an example being the Newcastle post-COVID syndrome Follow-Up Screening Questionnaire; others are available – see appendix 3). This assessment is typically done >10 weeks post diagnosis or initial symptoms but can be done earlier or later.
- Use of psychiatric assessment tools like the Psychiatric Health Questionnaire version 9 or the Generalised Anxiety Disorder Assessment version 7 at regular intervals

Assessment of cognitive function using validated tools like the "6 Items Cognitive Impairment Test", which can be applied over the phone (https://patient.info/doctor/six-item-cognitive-impairment-test-6cit), or the "Addenbrooks Cognitive Examination" (https://www.sydney.edu.au/brain-mind/resources-for-clinicians/dementia-test.html)

Below are examples of outcomes from this assessment:

- Offer referral to rehabilitation services or exercise on prescription
- Offer ongoing monitoring and support (e.g. by telephone, video, or in-person check-ups) as needed
- Support the management of other long-term conditions (e.g. diabetes, asthma)
- Request further diagnostics as appropriate and as available within primary care localities
- Referral to other primary care services such as IAPT, psychiatric services (as per MH pathway currently under discussion), physiotherapy, smoking support services, as appropriate
- Referral to secondary care specialist services, where appropriate (i.e. direct referral to heart failure services for example). Some of these referrals maybe of an urgent nature based on clinical need.
- Referral to the post COVID-19 secondary care services (tier 3) as appropriate (either for clinical review or for advice and guidance). Some of these referrals maybe of an urgent nature based on clinical need.
- In some cases, facilitate urgent referral for a psychiatric assessment if there is an identified risk to the individual (like self-harm)

It is worth noting the following when post COVID-19 syndrome is suspected (NICE 2020):

- Clinical judgement will be used to determine the appropriate support for patients with post COVID-19 syndrome.
- Symptoms vary, and patient decisions need to be taken into account alongside clinical need.
- Not all patients with post COVID-19 syndrome will require tier 3 input. Referral to other primary care services will be considered where appropriate and available.
- Clinical advice will be sought by the locally identified post COVID-19 tier 3 service, where required.
- Referral to post COVID-19 services for post COVID-19 syndrome will be made (tier 3)

6.2 Workforce

Tier 2 services will offer (where available and applicable) access to community based:

- Allied Health Professionals (Physiotherapy, Dieticians, Occupational therapists)
- Mental health support services
- Peer support groups
- Rehabilitation programmes

- Nursing
- Smoking support
- Weight loss programmes
- Physical activity programmes/initiatives
- Social prescribing
- Pharmaceutical support
- Optometrists
- Dentistry

There must be local agreements with tier 3 services as to which services (other than the GP practice) that will assess and refer in to tier 3.

Tier 2 services will offer advice and guidance to tier 3 services when requested, as to what local support can be offered for a patient to aid their recovery.

6.3 Equipment

The provider will provide the tools and equipment to enable the necessary assessments. This also includes the necessary equipment to review results and liaise with the patients and/or their carer.

6.4 Accessibility and inclusion

All healthcare systems should consider health inequalities in the planning and delivery of post-acute COVID-19 care. This includes, but is not limited to:

- Being supportive to those with learning disability and/or autism or pre-existing mental health problems and being aware of diagnostic overshadowing (see here for further resources)
- Socio-economic inequalities
- Black, Asian and minority ethnic (BAME) group inequalities
- Lesbian, gay, bisexual and transgender plus (LGBT+) people
- Sex and gender
- Language and cultural barriers
- People with and existing disability such as visual or hearing impairment
- People in secure units
- Marriage and civil partnership
- Pregnancy and maternity
- Religion and belief

Equity of access must be a key to reviews and assessments. Consideration should be given to disadvantaged groups with regards to how they access and utilise healthcare services and to ensure that no one is discouraged or unable to benefit. This may require a proactive, potentially case finding approach in some populations to identifying those who may typically be less likely to access healthcare. Virtual means and face to face should be considered. Patients should not be disadvantaged from accessing services due to financial costs or language barriers and cultural beliefs. Consideration should also be paid to access for children and young people; clinics should have safeguarding policies in place and work closely with local authorities if social care needs are to be considered.

7. Tier 3 services

Tier 3 services are secondary care services that provide specialist assessments, diagnostics, advice and treatment.

Tier 3 services are provided throughout the COVID-19 recovery pathway: and through all phases:

- During the acute phase / post-acute phase when a patient remains in the community under the care of their GP or other primary care service
- During the post-acute phase when a patient either undergoes a clinical review or self presents, and
- During the post-acute phase to support the management of ongoing symptomatic COVID-19 (>4 weeks), or post COVID-19 syndrome (>12weeks) where secondary care intervention is not deemed necessary.

Non-admitted patients may only require tier 3 services to support the management of post COVID-19 syndrome where it is deemed appropriate.

For hospital follow ups (typically between 4 and 12 weeks) tier 3 services are often respiratory led post COVID-19 clinics, or post COVID-19 ICU clinics where a patient has had a stay in ICU. Following these follow ups, a decision is made as to whether the patient is stepped down to tier 2 services, is referred for post COVID-19 assessments (still at tier 3) or is escalated to tier 4 services; in the case of complex patients requiring highly specialised intervention/rehabilitation.

Where post COVID-19 syndrome is suspected in patients that had a stay in ICU, a decision will be made as to which tier 3 service (post-acute COVID-19 clinics that are respiratory led, or post COVID-19 ICU clinics) will assess them and plan treatment.

7.1 Tier 3 services for the management of post COVID syndrome (>12 wks)

Typically, respiratory led post-acute COVID-19 services, or Post COVID-19 ICU services. However, these should be multidisciplinary or multi-specialist if available.

7.2 Aims

The main aim of this service is to:

- Provide a holistic assessment that includes physical, cognitive, physiological components, taking into account non respiratory COVID-19 symptoms, and,
- Use the expertise available, to adopt a personalised care approach that seeks to plan and provide care based on what matters to the individual.

7.3 Acceptance criteria and referral routes

There are 3 main cohorts of patients to be reviewed within respiratory led post-acute COVID-19 services:

- Suspected or Positive result who have never been admitted to hospital with their acute illness but managed independently or in the community
- People hospitalised with COVID-19
- People cared for in an Intensive Care Unit (ICU) or High Dependency Unit (HDU) with COVID-19

Post COVID-19 ICU clinics will only receive patients that had a stay in ICU.

For those referred to a respiratory led post-acute COVID-19 service from primary care or from tier 2 services, these will have:

- A GP assessment of new, changing or persistent symptoms (>4 weeks as appropriate)
- Alternative diagnoses ruled out using investigations and locally agreed screening tool such as the Newcastle post-COVID syndrome Follow-Up Screening Questionnaire.

Post-acute COVID-19 clinics will collaborate with Post-ICU clinics and be supported by locally developed MDTs (virtual or otherwise) to determine who takes responsibility for the rehabilitation of post-COVID-19 patients (including those admitted to ICU) that are discharged from hospital.

Tier 3 services should provide advice and guidance to referring services to support local management and reduce referrals where possible.

Consideration should be given to having a single point of referral triage.

7.4 Assessment

- Full history, clinical examination and functional assessment
- Availability and access to appropriate specialist tests (e.g. full lung function testing, Echocardiogram, Computerised tomography (CT), Magnetic resonance (MR), including cardiac MR, Cardiopulmonary exercise testing etc.) as appropriate. Note: not all patients will need all these tests
- Psychiatric assessment
- Assessment of cognitive function using validated tools which can also be applied over the phone or via video consultation (please see NICE guidance at: https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#diagnosis)
- Impact of event scale (IES-R) or Trauma screening questionnaire (PTSD) where applicable

It is the responsibility of the clinic to refer patients on to existing services as needed.

Clinic setting is for local determination and may be based in primary, secondary or community services, if there is prompt access to the appropriate diagnostics. A virtual element to the clinics will be considered.

7.5 Minimum service provision criteria

As a minimum the post-acute COVID-19 services for post COVID-19 syndrome should:

- Be available, following clinician referral, to all affected patients, whether hospitalised or not
- Have access to a multidisciplinary team of professionals to account for the multi-system nature of post-COVID syndrome including those from rehabilitation, psychology, and occupational therapy services
- Support collaboration across localities where patients needs require this
- Have age appropriate arrangements in place for managing children and young people with post-COVID syndrome including support for psychological needs
- Have access to diagnostic tests
- Ensure coverage of the population in that geography
- Have a plan for ensuring equity of access (bearing in mind many population groups have been disproportionately affected by COVID-19)
- Have a local communications plan for raising awareness within the clinical community
- Have an external communication plan for informing and raising awareness with patients
- Have plans in place for regular data collection to support audit and quality improvement processes
- Services will have the ability to direct patients to Your COVID recovery phase 2 for ongoing support
- Support vulnerable groups including the homeless, learning difficulties, mental health etc

7.6 Geography and population coverage

Assessments will be carried out virtually, where possible and face to face where necessary.
Face to face assessments will be carried out as close to home as possible and provided using locally agreed COVID-19 safety protocols.

Multi-disciplinary teams will review the results from the assessments and offer a personalised care approach that seeks to plan and provide care based on what matters to the individual.

Multi-disciplinary teams will be provided virtually where possible and may not be limited to the specialisms of a single provider.

The post-acute service must cover the populations locally agreed either at GM level, sector level or at Trust level.

7.7 Workforce

Post-acute COVID-19 clinics will need to appoint a lead respiratory physician. The following professionals need to be considered as part of the wider respiratory led multi-disciplinary team:

- Physiotherapists
- Occupational Therapists
- Specialist Nurses (district nursing, community nursing, psychiatric nursing, Speech and Language Therapy, clinical nurse specialists and general practice nurses)
- Psychologists
- Dieticians
- GP/GPSI

7.8 Equipment

The provider will provide the tools and equipment to enable a holistic assessment to be carried out in accordance with national guidance. This also includes the necessary equipment to review results and liaise with the patients and/or their carer.

7.9 Clinic accessibility and inclusion

All healthcare systems should consider health inequalities in the planning and delivery of post-acute COVID assessment clinics. This includes, but is not limited to:

- Being supportive to those with learning disability and/or autism or pre-existing mental health problems and being aware of diagnostic overshadowing (see here for further resources)
- Socio-economic inequalities
- Black, Asian and minority ethnic (BAME) group inequalities
- Lesbian, gay, bisexual and transgender plus (LGBT+) people
- Sex and gender
- Language and cultural barriers
- People with and existing disability such as visual or hearing impairment
- People in secure units
- Marriage and civil partnership
- Pregnancy and maternity
- Religion and belief

Healthcare systems should monitor the demographic data of those who have been referred and consider adapting referral pathways if needed.

Equity of access must be a key objective of the clinic. Consideration should be given to disadvantaged groups with regards to how they access and utilise healthcare services and to ensure that no one is discouraged or unable to benefit. This may require a proactive, potentially case finding approach in some populations to identifying those who may typically be less likely to access healthcare. Virtual or out-of-hospital clinics should be considered. Patients should not be disadvantaged from accessing services due to financial costs or language barriers and cultural beliefs. Consideration should also be paid to access for children and young people; clinics should have safeguarding policies in place and work closely with local authorities if social care needs are to be considered.

An Equalities and Health Inequalities Impact Assessment has been completed for this post COVID assessment clinic guidance.

7.10 Outcomes

The referrer should be informed of any outcomes from the assessment.

Outcomes from the assessment are to include:

- An MDT evaluation of physical, cognitive and psychosocial need and management of impairments, including a holistic assessment
- A recommendation of service(s) most likely to meet the assessed needs including signposting/ referring to community mental health services (urgent referrals should be initiated in the case of risk to individuals)
- Referral to specialist rehabilitation services as needed (i.e. pulmonary rehabilitation or cardiac rehabilitation)
- Specialist intervention through referrals as appropriate (i.e. referral to heart failure services, referral to renal services etc)
- An indication of the benefits and possible outcomes as a result of the use of the service
- An indication of the likely duration of rehabilitation needs (and further support needs on discharge from the service).
- A plan with patient goals derived from a shared decision-making process with the patient
- Wherever appropriate, stepping the care back to tier 2 through appropriate transition of care

7.11 Onward referrals and interdependencies

Providers will have clear pathways to ensure referral into appropriate services which may include rehabilitation, psychological support, specialist investigation or treatment, or to social care support services or the voluntary, community and social enterprise sector.

The GP will receive communication from the clinic on the patients care, and consideration should be given to the provision of Med3/ fit to work certificates to avoid further appointments, unless the patient is discharged back to the care of primary care for ongoing management.

Clinicians will work together to ensure that physical and mental healthcare are integrated as closely as possible. Where available, patients with mental health and psychological issues with persisting physical problems may benefit from referral to integrated IAPT-LTC (Improving Access to Psychological Therapies-Long Term Condition) services or in the case of an under 18 year old, the relevant children and young people's mental health service.

Transition between children's and adult services will be supported and services should work flexibly to provide support based on the needs of the young person. Where possible an episode of treatment should be completed before consideration of transition to ensure continuity of care.
Services that might be of particular benefit include:

- Specialist lung disease services, sleep clinics, and pulmonary rehabilitation
- Cardiac services
- Pain management
- Gastroenterology
- Renal
- Rehabilitation services
- Dietetics and nutrition services
- Primary care led care including care coordinators and social prescribers
- Improving Access to Psychological therapies (IAPT) and other mental health services
- Co-morbidity management e.g. for diabetes or obesity
- Neurology
- Rheumatology
- Dermatology
- Ear, Nose and Throat
- Infectious disease services
- Occupational health

8. Tier 4 services

Tier 4 services are highly specialised services designed to support highly complex patients or patients requiring highly specialised intervention. This specialist intervention is typically concerned with:

- Post viral fatigue/ chronic fatigue syndrome
- Post ICU syndrome
- Multi organ damage syndrome
- Neurological / neuropsychiatric syndrome

8.1 Aims

The main aim of this service is to:

- Provide a specialist and holistic assessment, and,
- Use the expertise available, to adopt a personalised care approach that seeks to plan and provide care based on what matters to the individual through shared decision making.

Tier 4 clinics will be supported by network-based sector type MDTs with input from tertiary and specialist rehabilitation services to deal with patients who have complex medical or rehabilitation needs as a result of suffering from COVID-19.

Clinicians referring a patient to a complex Post-COVID-19 MDT clinic will assume clinical responsibility of the patient including the coordination of care and until the patient's care has been formally transferred to another clinician through the MDT.

Some localities will choose to have these MDT clinics to be virtual without patients physically present; instead, cases will be discussed in a virtual MDT; and decisions about referring these patients to relevant

services can be made through these MDTs. These can be used as means to coordinate care and make decisions on the best way to proceed with the care of a particular patient.

Tier 4 services should provide advice and guidance to referring services to support local management and reduce referrals where possible (both tier 2 and 3).

8.2 Acceptance criteria and referral routes

- Patients will normally be referred through tier 3 services. Specific reason for referral has to be clearly stated.
- Referral proforma to be agreed by MDTs
- Patients who have been clearly identified through tier 3 to require onwards referral to other specialist tertiary services do not always need to go through the MDT clinic, and can be referred directly to these services (i.e. Interstitial Lung Disease clinics, heart failure and cardiology services)

8.3 Workforce

As a minimum the core tier 4 service should have an MDT consisting of:

- A respiratory specialist
- A neurology specialist
- A Cardiology specialist
- A mental health specialist such as a clinical psychologist
- A chronic fatigue specialist

With links to dermatology, Ear, Nose and Throat, renal etc as required.

The MDT should be supported by an MDT co-ordinator, a system navigator, and the necessary business and technical support.

9. Applicable service standards

NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 (Dec 2020)

Management of the long term effects of COVID-19 v1 (October 2020)

NICE - COVID-19 guideline scope: management of the long-term effects of COVID-19

A guideline to supporting the recovery and rehabilitation of adults with confirmed or suspected COVID-19 in Greater Manchester (2020) v2.4 upward

NICE: Dementia: assessment, management and support for people living with dementia and their carers (Jun 2020)

10. Provider Premises (all tiers)

The provider must be able to improve on this current coverage, providing care close to home and continuity of care for patients.

All premises and equipment to be used must be subject to proper maintenance, the responsibility for the provision of suitable premises and equipment will be with the provider and must be relevant to the service, including as a minimum:

- Premises must be Disability Discrimination Act (DDA) compliant either ground floor or with lift access if not;
- Premises to enable safe and convenient patient access in relation to transport links;
- Adequate seating to enable all patients to sit while waiting, including chairs for patients who have difficulty sitting low down.
- WC facilities should be provided;
- Have access to interpretation and translation services;
- Ensure that all premises and equipment to be used is subject to proper maintenance;

- Decontamination and clinical waste disposal as appropriate;
- Toilet access (DDA compliant);
- Hand-washing facilities for provider/patients;
- Non-slip flooring;
- Patient changing facilities/curtain area;
- Storage facilities for consumables

11. Data collection

- Number of referrals received
- Number of patients accepted, and numbers rejected
- Number of patients reviewed
- Method of review (face to face, Tel, Video)
- Route of referral (Post COVID tier 3 service, community team, physios etc)
- Number of episodes (appointments or contacts) of COVID related care for each patient
- Date of referral for each patient
- Date of initial review for each patient
- Date of initial COVID-19 episode for each patient
- Onward referrals to other services for each patient
- Date onward referral generated for each patient
- Date of discharge for each patient (if applicable)
- Number of patients referred:
  a) With a learning disability/autism/hearing loss/visual impairment/prior diagnosis of dementia
  b) From the criminal justice system
  c) Who are homeless or rough sleepers
  d) Who are refugees and asylum seekers
  e) Who are from gypsy, traveller, and Roma communities
  In full time education
- Number of patients attending the clinic that were able to return to work.
- Outcome of the assessment (discharged, referred onwards to other services including Tier 3) and date
- Service user satisfaction assessed using standardised satisfaction surveys.

12. Research and evidence generation

Services should look at the following research questions and work collaboratively to try and provide some answers to the following:

1- Risk factors for POST COVID-19 syndrome
2- Relationship between severity of acute COVID event, and the incidence of Post COVID-19 Syndrome
3- Possible effective therapies/ interventions for Post COVID-19 syndrome
4- Prevalence of Post COVID-19 syndrome
5- Explore the relationship between on-going systemic inflammation and the occurrence of Post COVID Syndrome

13. Children and Young Adults (addendum)

See attached document.

14. Mental Health

Recommendations to follow when agreed.

NHS in Greater Manchester

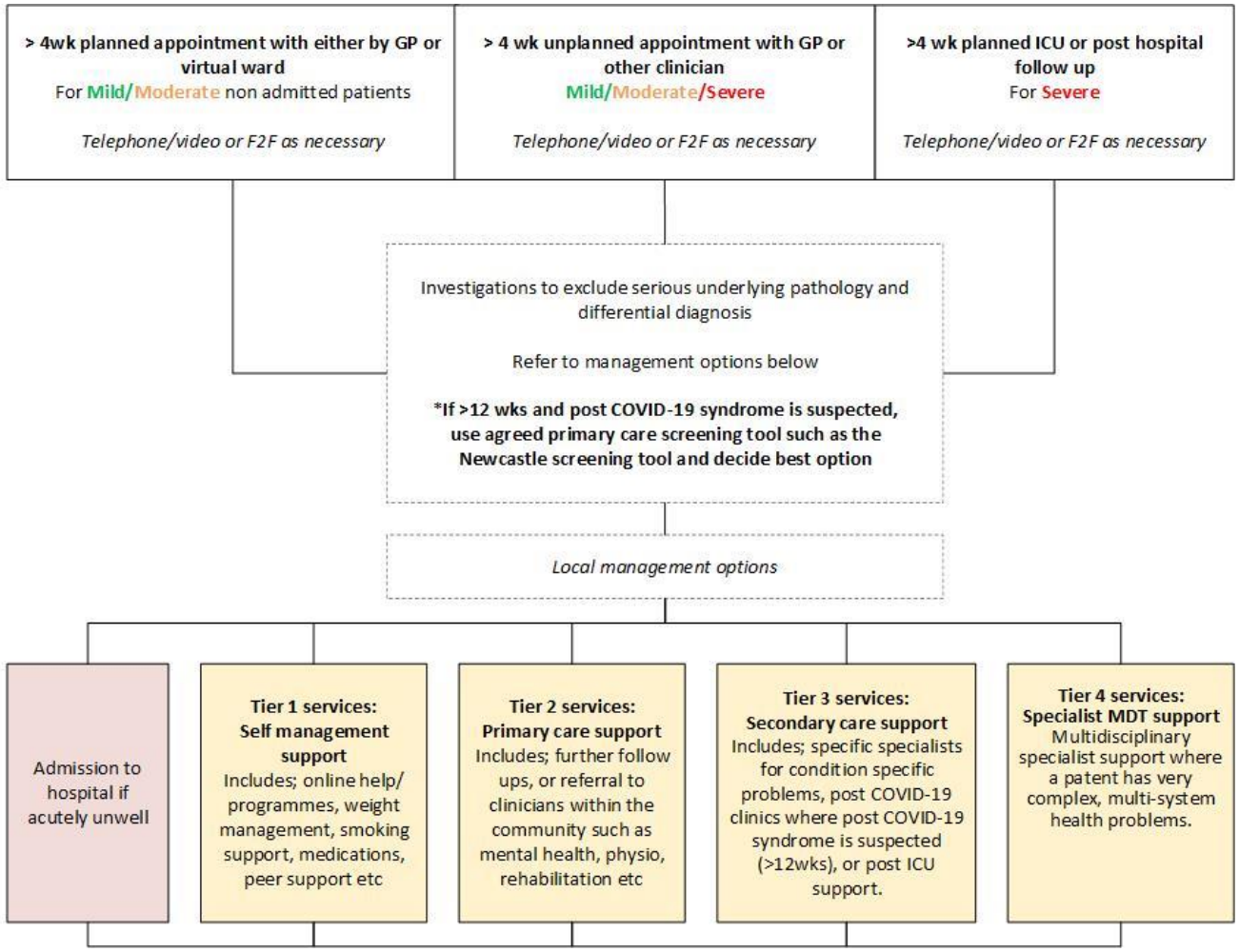
Appendix One – Crude estimates of post COVID-19 syndrome numbers

	March COVID positive Patients (resident)	April COVID positive Patients (resident)	May COVID positive Patients (resident)	June COVID positive Patients (resident)	July COVID positive Patients (resident)	August COVID positive Patients (resident)	September COVID positive Patients (resident)	October COVID positive Patients (resident)	Lower estimate of those diagnosed in Oct having symptoms >90days (1%) (Post COVID syndrome)	Middle estimate of those diagnosed in Oct having symptoms >90days (2.3%) (Post COVID syndrome)	Upper estimate of those diagnosed in Oct having symptoms >90days (4%) (Post COVID syndrome)
Bolton	102	921	511	258	218	465	2,693	5,652	57	130	226
Bury	101	611	392	157	96	254	1,321	3,802	38	87	152
Manchester	228	1,247	897	468	514	1,033	6,770	12,984	130	299	519
Oldham	150	729	541	397	359	804	1,581	5,664	57	130	227
Rochdale	126	564	426	418	363	404	1,438	4,991	50	115	200
Salford	191	697	278	132	187	369	1,772	6,063	61	139	243
Stockport	160	896	431	128	166	222	1,047	4,384	44	101	175
Tameside	116	492	605	281	148	328	1,378	4,191	42	96	168
Trafford	146	584	390	121	207	275	872	3,697	37	85	148
Wigan	124	1,167	717	109	74	152	1,544	7,598	76	175	304
GM Total	***1,444***	***7,908***	***5,188***	***2,469***	***2,332***	***4,306***	***20,416***	***59,026***	***590***	***1358***	***2361***

NHS
in Greater Manchester

Appendix 2 - A structured approach to following up patients with confirmed or suspected COVID-19 in GM >4 wks

GM COVID-19 Acute Pathway >4 wks



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Appendix 3 - Newcastle post-COVID syndrome Follow-Up Screening Questionnaire

With thanks to Dr Graham Burns Consultant Physician in Respiratory and General Medicine, Newcastle upon Tyne Hospitals NHS Foundation Trust

(To be carried out >10 weeks after the acute illness)

The purpose of the questionnaire is to identify patients who may benefit from a comprehensive face to face multi-disciplinary assessment. It is designed to be used remotely and is equally applicable for patients who were either hospital inpatients or managed in the community during the acute phase of their illness.

Most patients who experienced severe symptoms during the acute phase will have residual problems such as fatigue, breathlessness, and poor sleep quality for several weeks. For the majority, these symptoms will resolve, albeit slowly. Unless there are very unusual features, the most appropriate course of action early in the post-acute phase may be advice on graduated physical rehabilitation and the passage of time.

A small proportion of patients however will go on to have symptoms that persist beyond 12 weeks, a condition commonly known as 'Long COVID'. Such individuals require more detailed investigation and are likely to need more intensive and specialist support.

This questionnaire is designed to screen for the issues that might prompt concern if still present 10-12 weeks after the acute illness. To facilitate application to a potentially large cohort the questions are limited and therefore may not necessarily comprehensive. If other issues are identified (that are not obviously related to a pre-exiting condition which may prompt an alternative route of referral) with a plausible and temporal relationship to the COVID illness, referral may still be considered. The full complexity of the post-COVID state and post-COVID syndrome is yet to be fully understood.

Section 1 (to be completed pre call)

Name……..

NHS number ……..……..…..

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Date of Positive Swab…….

Date of Onset of symptoms…….……..

Date of Discharge (for hospital admissions) ……..…..

Date of call _____

Person phoning _____Role _____

Level of respiratory support during acute Illness:

ITU, Intubated ITU, not intubated Enhanced Respiratory support (e.g. CPAP)

Supplemental oxygen Managed in the community

Section 2

1. Have you made a full recovery or are you still troubled by symptoms?

Symptoms Full Recovery

2. Are you more breathlessness than you were before you COVID illness?

a. Is this more than you would have expected by now?or

b. Do you think you're on your way back to full fitness?

3. Do you feel fatigued (worn out/lacking energy or zest) compared with how you were before you COVID illness?

a. Is this more than you would have expected by now?Or

b. Do you think you're well on your way back to full fitness?

4. Do you have a cough (different from any cough you may have had before COVID-19)? Yes No

5. Do you get any palpitaions (sense that you can feel your heart pounding or racing) Yes No

6. How's your physical strength? Do you feel so weak that it still limiting what you can do (more than you were pre your COVID illness)? Yes No

7. Do you have any myalgia ('aching in your muscles')? Yes No

8. Do you have Anosmia ('no sense of smell')? Yes No

9. Have you lost your sense of taste? Yes No

10. Is your sleep disturbed (more than it was pre-COVID)? Yes No

11. Have you had any nightmares or flashbacks? Yes No

12. On your mood

c. Is your mood low/do you feel down in the dumps/lacking in motivation/no pleasure in anything? Yes No

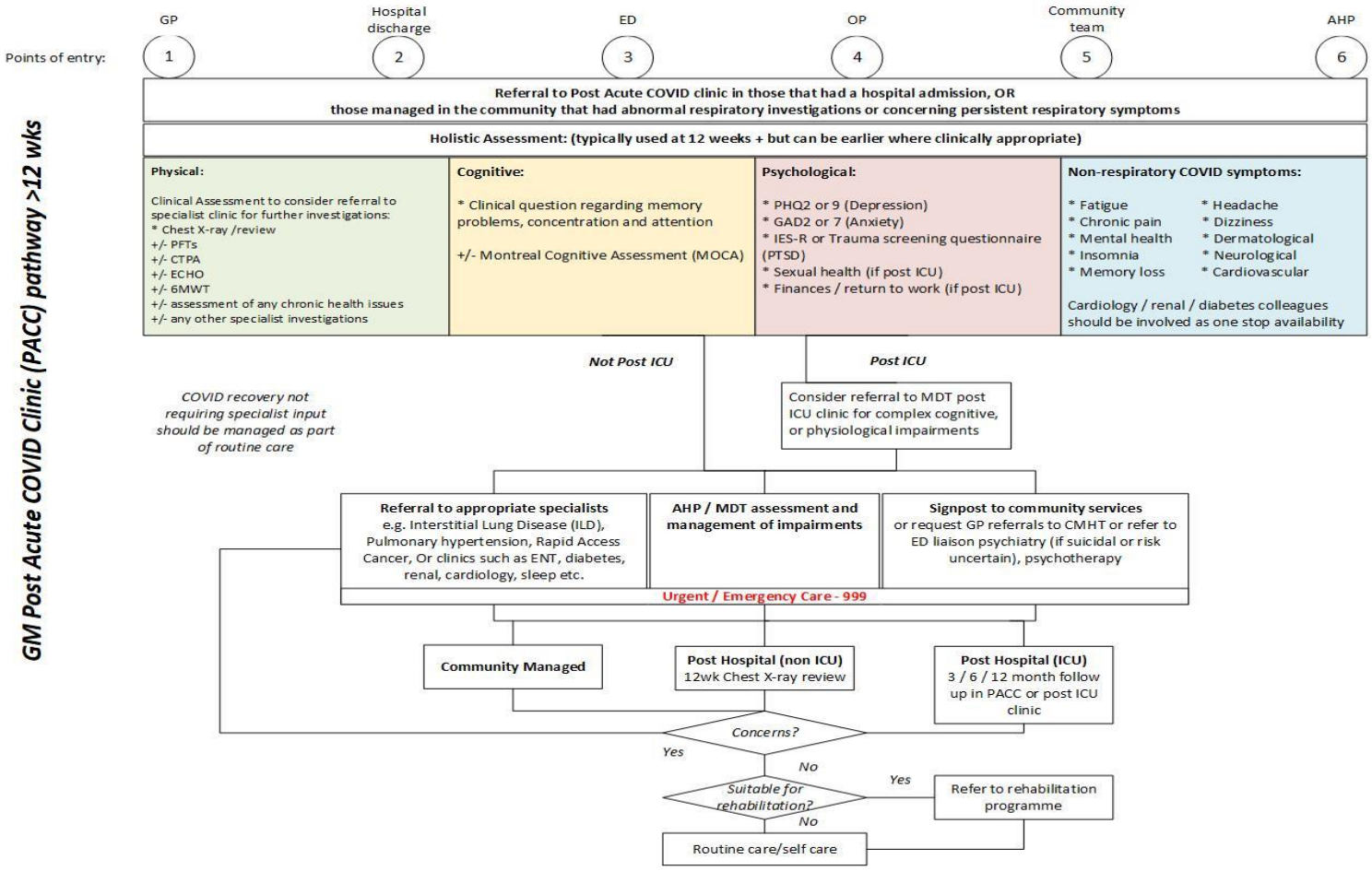
d. Do you find yourself feeling anxious/worrying more than you used to? Yes No

13. Have you lost weight (> ½ stone, 3 Kg) since your COVID illness? Yes No

14. Any other symptoms (list)

NHS in Greater Manchester

Appendix 3



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Addendum to Adult Service Specification for Long-COVID and COVID Complications

GM Paediatrics Services

In line with the proposed model for services to support and manage those with confirmed or suspected COVID-19, in the post-acute phase in adults, there is increasing evidence that children and young people (CYP) post COVID-19 will require follow up depending on their symptoms and severity in primary care or in paediatric services.

The clinical picture of COVID-19 in CYP is very different to that of adults except for a small cohort. The vast majority of CYP experience only mild to moderate symptoms which in the main are managed within the family unit. However, some children do become very ill between 4 and 6 weeks post infection with COVID-19 with Paediatric Inflammatory Multisystem syndrome associated with COVID-19 (PIMS-TS). Initially PIMS-TS is categorised by type of disease – Kawasaki disease like or non-specific disease with initial clinical investigations determining the severity of the disease. The phenotype of the disease should be determined by clinical assessment. PIMS-TS has similar symptoms to Kawasaki, Toxic Shock and hyperinflammatory syndromes such as Hemophagocytic Lymphocytic Histiocytosis (HLH) and Systemic Lupus Erythematosus (SLE). PIMS-TS will require MDT clinical input including, Paediatric Infectious disease & immunology, Rheumatology, Respiratory, Cardiology, Critical Care, Radiology and laboratory services.

There is no current definitive data of CYP impacted by COVID-19 with subsequent secondary complications of PIMS-TS or those CYP who have developed other significant disease. There is a pressing need to establish robust data collection.

With respect to other complications children are presenting with post COVID-19 infection pathologies, such as:

- Type 1 Diabetes Mellitus with DKA presentations (currently figures compared to 2019 in 2020 this has doubled). Current information indicates that at least 25% of these presentations require PICU level 3 and 4. A report by Imperial College London (August 2020)[1] indicates the plausibility of the link between COVID 19 infection and new-onset diabetes in children. Great Ormond Street Hospital (GOSH) reported an increase in referrals of children with DKA during the pandemic, compared to previous years (BMJ, 2020)[2].
- Some children are presenting with ME type symptoms and will require multi-disciplinary team assessment and management.
- CAMHS services are seeing a significant increase in referrals. Further data is required to determine the nature of referrals and the impact that closure of educational establishments has had on CYP mental health, including broader issues

[1] https://www.imperial.ac.uk/news/201473/covid-19-linked-increase-type-diabetes-children/
[2] https://adc.bmj.com/content/early/2020/09/16/archdischild-2020-320471.info

around safeguarding. During the autumn of 2020 as children and young people returned to school, high rates of infection in the North of England compared to the South in the second wave meant that children were frequently sent home to isolate or because of staff shortages leading to further disruption to their education.

The acute and post-acute phase of COVID-19

As described above the clinical presentation for CYP in the main is different from that of adults but that does not alter the presentation and management of COVID-19 which should be broken down in to the acute phase (0-4 weeks) and the post-acute phase (>4 weeks), defined by NICE Guideline NG188 as 'ongoing symptomatic COVID-19', and 'post COVID-19 syndrome' which is typically symptoms lasting 12 weeks or more. Management within these phases should be seamless.

The post- acute phase, or ongoing symptomatic COVID-19, between 4 and 12 weeks is characterised by patient reviews that may feature further investigation and a clinical assessment to determine further management options. Such options may include referral to a post-acute COVID-19 secondary care service (tier 3) or Specialist management of specific complications and ongoing concerns (tier4) if post COVID syndrome is suspected.

This addendum to the adult service specification is specifically for Children and Young people and outlines the approach to supporting those with confirmed or suspected COVID-19, in the post-acute phase >4wks; with particular attention to those between 4 and 12 weeks.

Rationale and Population Needs for CYP

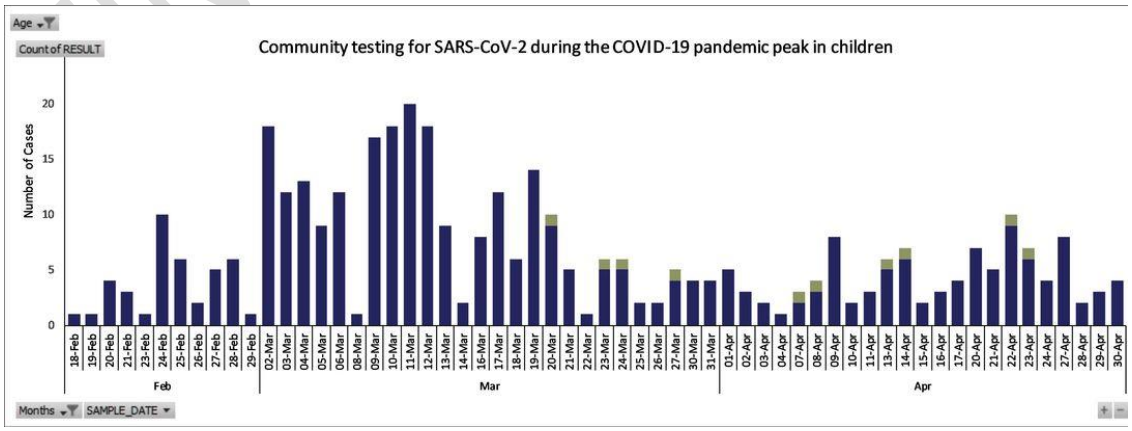
National Context

At present it is recognised that:

- CYP appear to be lower risk of COVID-19, with around 5% being hospitalised in USA of which less than 1% needed critical care. (BPSU RCPCH 2020[3]) This figure is constantly under review as more data becomes available.
- In the UK the detail of the data of incidence in CYP is currently being collated.
- Unlike adults, CYP usually have a very mild illness and it is rarely fatal.
- A number of CYP across the UK have been reported to have severe illness, often requiring paediatric intensive care unit because they are so unwell.
- It is recognised that some CYP develop symptoms around the 4 to 6 weeks post infection either confirmed positive C19 or negative C19, develop a multi-system hyper-inflammation disease currently known as PIMS-TS.
- At the current time research is underway studying the relationship between SARS-CoV-2 and multisystem hyperinflammatory disease.
- Data is currently being collated across the UK and more locally in GM of CYP who have been diagnosed and clinically managed with PIMS-TS.
- CYP can develop post Covid19 symptoms if they have had a positive test or negative test results regardless of symptoms of acute symptoms or asymptomatic.

[3] https://www.rcpch.ac.uk/work-we-do/bpsu

- Likelihood of developing ongoing symptomatic COVID-19 or post-COVID-19 syndrome is not thought to be linked to the severity of their acute COVID-19 (including whether they were in hospital)
- New or ongoing symptoms occur; they can change unpredictably, affecting them in different ways at different times. Be aware that some CYP may not have the most commonly reported new or ongoing symptoms after acute COVID-19
- Post Covid19 recovery time is different for everyone but for most people symptoms will resolve by 12 weeks as yet this is unknown with CYP
- Suspect previous COVID-19 illness as a possible underlying cause of new or ongoing symptoms in CYP after acute COVID-19 as follows:
    - ongoing symptomatic COVID-19 if people present with symptoms 4 to 12 weeks after the start of acute COVID-19 or
    - post-COVID-19 syndrome if the person's symptoms have not resolved 12 weeks after the start of acute COVID-19
- Many CYP experiencing ongoing health effects following COVID-19 infection managed their condition independently at home while acutely infected
- The number of CYP who need post-COVID syndrome management focusing on recovery and rehabilitation is likely to grow as COVID-19 infection rates continue to rise
- Parents and carers of CYP with post-COVID syndrome have reported that whilst some GPs have been sympathetic, some have been unsure how to refer into treatment services.
- 67% of GPs surveyed reported that they are looking after patients with COVID-19 symptoms lasting longer than 12 weeks.
- There is increasing evidence that COVID-19 has a disproportionate impact on those in deprived populations and people in black and ethnic minority groups and exacerbates existing health inequalities
- Support should be made available for access to assessment and care for CYP with new or ongoing symptoms after acute COVID-19, particularly for those in underserved or vulnerable groups who may have difficulty accessing services. This might include providing extra time or additional support (such as an interpreter or advocate) during consultations.
- To date there have been concerns around increased malnutrition, jaundice, anaemias, injuries from NAI, child suicide, magnet and battery ingestion (SK 2021). Further investigation into causality and links with COVID-19 infection and the impact of system response to the pandemic, as well as social factors, is required.



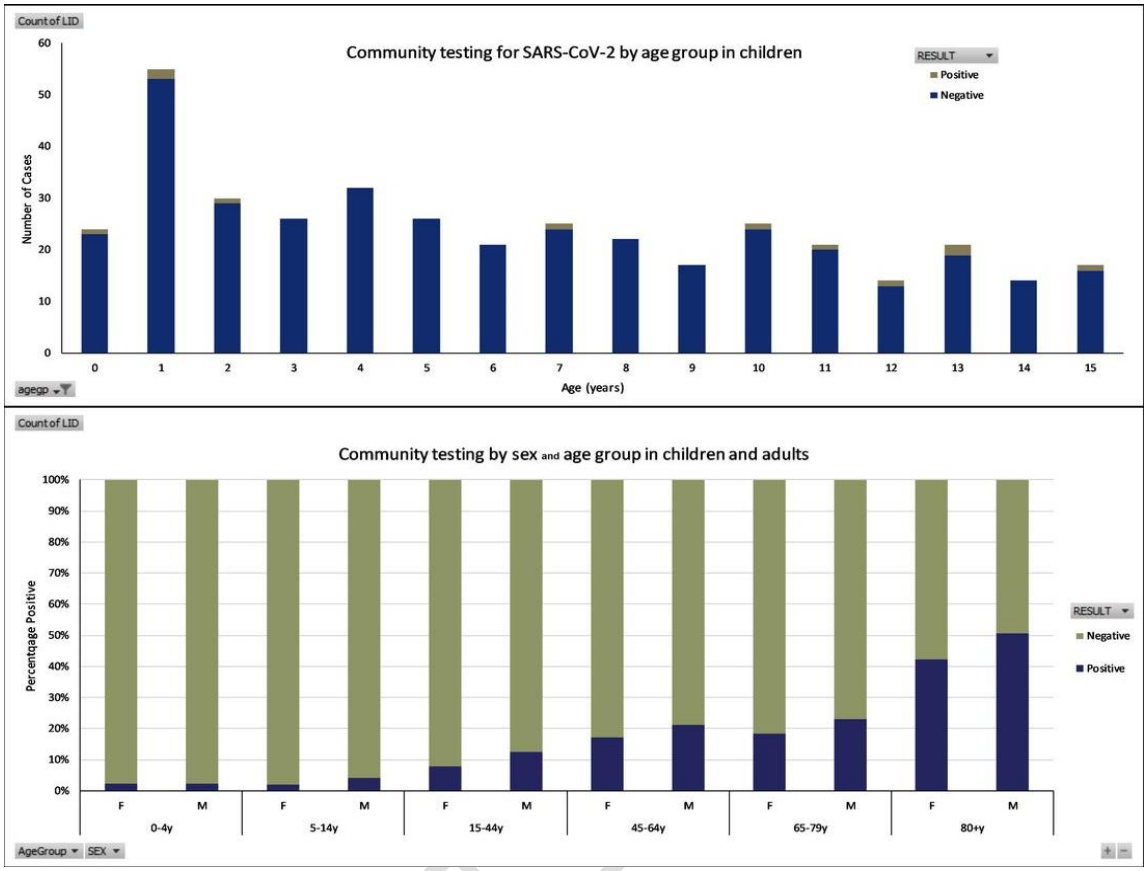
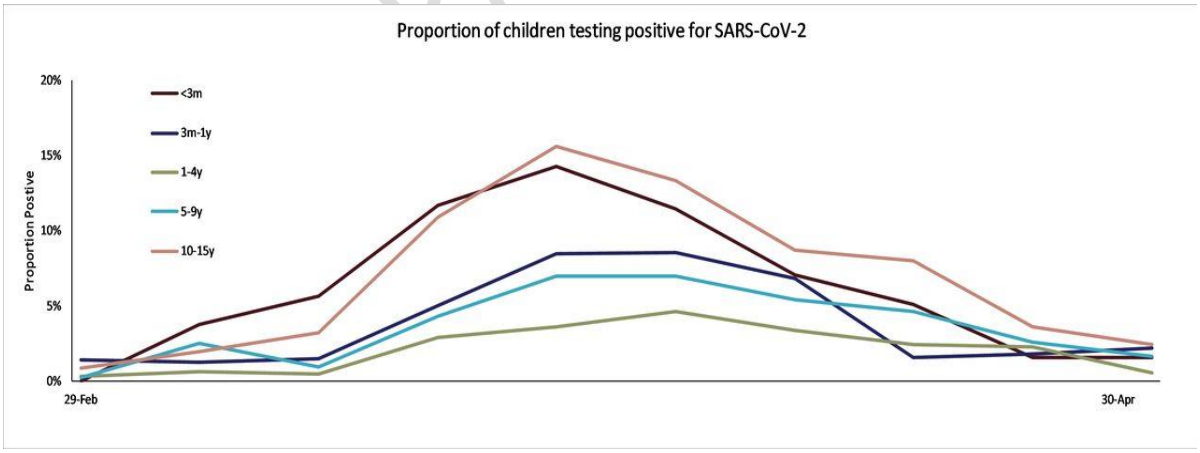


CHART 1: Number of children with acute respiratory infection who were tested for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in general practices across England over the course of the pandemic (A) and by age (B).

Shamez N Ladhani et al. Arch Dis Child 2020;105:1180-1185[4]



[4] Available at: https://adc.bmj.com/content/105/12/1180

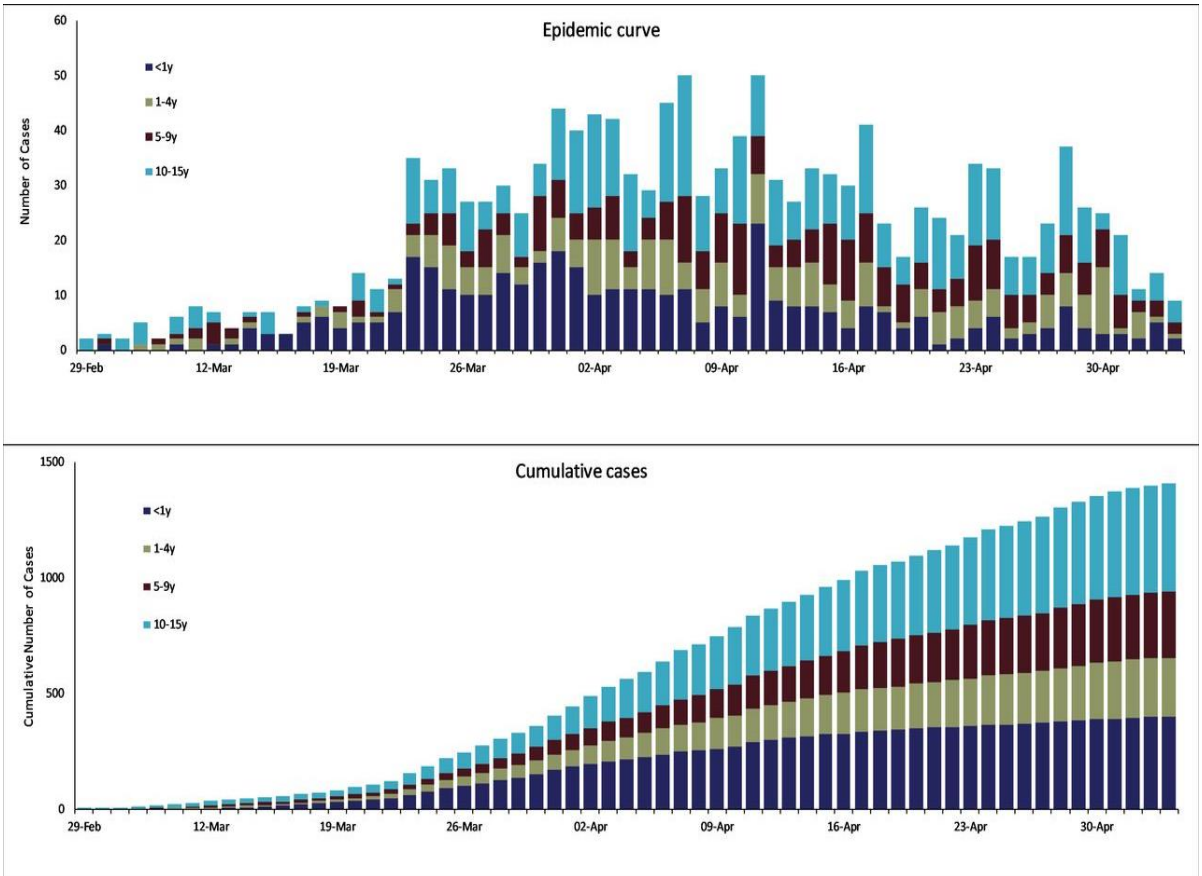


Chart 2: Epidemic curve (A), cumulative number of confirmed cases (B) and proportion of test positives (C) by age group for COVID-19 in children during the first pandemic peak (February to May 2020) in England.

Shamez N Ladhani et al. Arch Dis Child 2020;105:1180-1185[5]

Interpretation of the national data before summer 2020, when mass testing became more widely available and was mostly pillar 1 (hospitals) up to June is of limited value (Above graphs).

Local context

- GM has additional challenges that impact on population health. These include areas of deprivation and vulnerable population demographics such as multiple occupancy homes, high prevalence complex health care needs as well as diabetic conditions known to lead to more serious consequences of infection.
- GM paediatrics has been impacted more significantly than other areas of the UK. This is consistent with the over-representation of this disease in children from BAME backgrounds and the high BAME population within the region. *(The Lancet Child & Adolescent Health, 2020)*.[6]
- The emergence of long covid in CYP is less familiar and has lesser consideration than in the adult population, however there is a qualitative feedback from parents and children of fatigue, gastrointestinal issues, sore throats, headaches, muscle pain and weakness (BMJ opinion 16/10/2020). Other symptoms include fevers, nausea, mood changes, rashes, dizziness, breathing difficulties and cognitive blunting.

[5] Available at: https://adc.bmj.com/content/105/12/1180
[6] Available at: https://doi.org/10.1016/S2352-4642(20)30167-X

- Active case finding in the local community by patient engagement and research in primary and secondary care will aid identification of affected CYP with a needs analysis and assessment of equality and impact (particularly relevant for CYP from vulnerable families and BAME communities).
- There is a need for continuing and developing research into pathophysiology of these symptoms as is being currently investigated by adult cohorts.

PIMS-TS impact

- PIMS-TS, National consensus for management of this disorder is that an MDT approach is Key (Harwood, R. et al, 2020)[7].
- CYP who will develop multisystem hyperinflammatory disease requiring Paediatric intensive care are transferred from DGH's to either Royal Manchester Children's Hospital (RMCH) or Alder Hey Intensive care units where level 3 or 4 can be delivered.
- These critical transfers to tertiary services are co-ordinated and managed by the NWTS team
- Data below identifies the numbers of CYP who have been admitted to RMCH with PIMS-TS. There are other CYP who have been managed locally at the District General Hospital (DGH) with remote clinical care from Manchester University Hospitals NHS Foundation Trust (MFT) which are not included in these figures (not requiring critical care or Biologic Medications)

April 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
3	13	8	6	2	2	5	19	14++

MFT data incidence of CYP admitted with PIMS-TS

- CYP not requiring PICU and can be managed at local DGH's can do with remote support from the Specialist centre (RMCH within MFT). More detail around the data needs collating to identify the numbers of children not transferred to RMCH but that have PIM-TS but managed within the DGHs and remote specialist advice.
- Some CYP need to be transferred to the RMCH for further invasive diagnostics from the Specialist teams.
- Virtual be default is currently the easier way to care for these CYP who require specialist advice from Tertiary consultants when it is initially thought that the CYP can be clinically cared for locally and those not requiring PCC2 or PCC3.
- Support from MFT to the DGH is significantly impacting on service delivery and increasing waiting times for Cardiology, Rheumatology and Infectious Disease.
- It is noted that MDT approach, including General Paediatrics, infectious disease, cardiology, rheumatology and critical care consultants is recommended in the management of PIMS-TS as referenced above (Harwood, R. et al, 2020).

Type 1 Diabetes

- Throughout GM there is variability around the data and numbers of newly diagnosed Type 1 Diabetic CYP however the numbers of CYP with severe DKA has increased.
- The Diabetic Network has undertaken an audit of CYP newly diagnosed and existing patients presenting with or without Diabetic Ketoacidosis (DKA) following COVID19 showing an increase in newly diagnosed Type1 Diabetes

[7]Available at: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30304-7/fulltext

Chart 3: New and Existing patient admissions for Type 1 Diabetes Mellitus (T1DM)

Results so far

Table showing total no. of admissions and whether they presented as a new diagnosis of T1DM or known to have T1DM

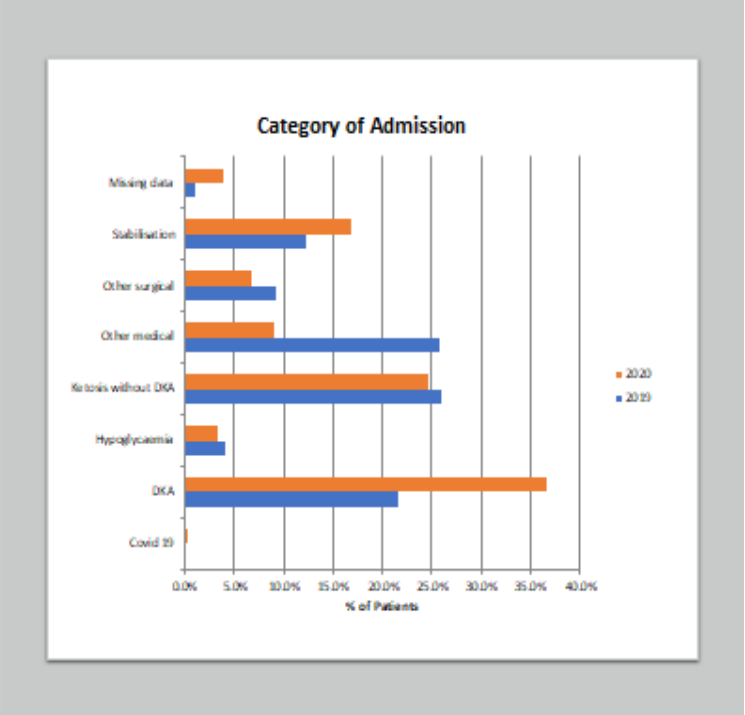
	2019	2020
Existing	241 (62%)	125 (40%)
New	151 (39%)	186 (60%)
Missing Data	0	1 (0.3%)
Total	392	312

In 2020:

- 84 new patients presented in DKA
- 29 existing patients presented in DKA

In 2019

- 49 new patients presented in DKA
- 36 existing patients presented in DKA



- In 2020, 45% new patients presented in DKA compared to 32% in 2019

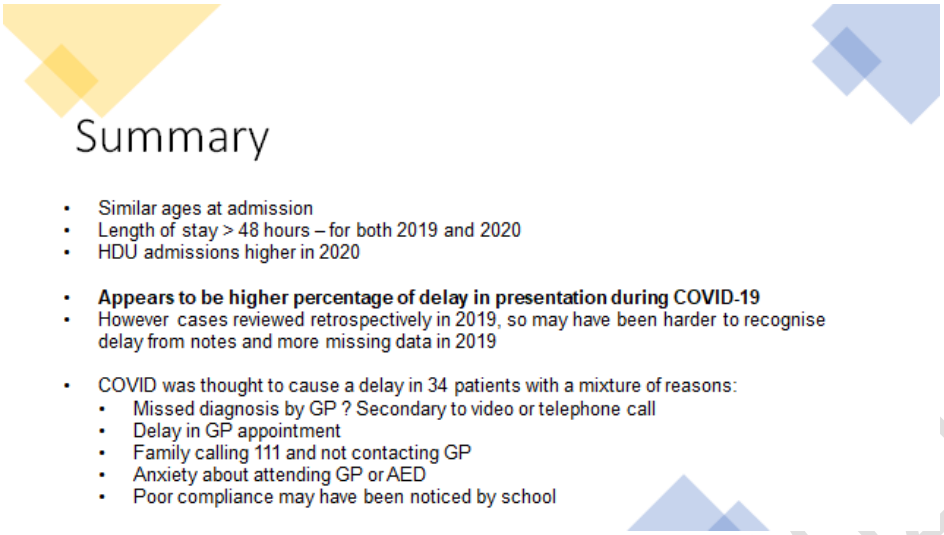
Table 1: DKA at Diagnosis

Summary: DKA at Diagnosis

- In 2020, 45% of new patients presented in DKA
- In 2019, 32% of new patients presented with DKA
- These results are interesting, as the percentages are very high. NPDA data 2018/2019 showed that 20.9% of patients in England and Wales presented in DKA at diagnosis, and 9.3% in North West.

- Learning Points to convey to GPs:

1. Be aware that **increased respiratory rate may be due to acidosis**, rather than LRTI. Ask about symptoms of diabetes, and consider urgent face to face review.
2. Be aware that **polyuria is a symptom of newonset diabetes**. Ensure urine dipstick or glucose level checked same day – beware of mistakenly attributing to UTI.
3. Patient assessment on **phone or video calls carries increased risk of missing clinical signs** – consider more thorough systems review to pick up symptoms of alternative diagnoses such as diabetes.
4. If symptoms consistent with diabetes ensure a **urine dipstick or finger prick glucose is checked same day** – child may develop DKA while awaiting outpatient blood tests.
5. If **urine dipstick or finger prick glucose suggest diabetes child must be referred urgently to hospital** – child can quickly develop DKA even if left for a single day.



- At the present time local GM data of newly diagnosed DTY1 is not complete but early evidence notes an increase in presentations in some districts.

Table 2: responses from Greater Manchester Clinical Community

Wrightington, Wigan and Leigh	Haven't seen increase in Numbers
Salford	12 newly diagnosed since Covid outbreak in March. In the same period last year (Mach-Dec 2019) they had 6 newly diagnosed
Royal Oldham Hospital	Had an increase in type 1. They are approximately up by 40% in 2020 compared to the previous year. (haven't provided exact numbers)

- NHS England and Improvement (NHSEI) CYP Transformation plan expectations/objectives include:
  - having a short and longer term plan to manage the Type 1 diabetes and Type2 diabetes CYP populations and achieve improved outcomes, including transition to adult services using the expertise of the diabetic clinical network
  - increasing our understanding of the potential link between COVID-19 and T1DM in CYP and working with population health.

Primary and Community Care impact

- Data from Primary & Community Care although not a complete set identify that as CYP returned to school/college the increase in positive cases increased with a decrease as schools/colleges restrict and isolated cases.

Table 3: confirmed community infection COVID-19 in Manchester

	0-4y	5-9y	10-14y	15-19y
Sep-20	156	132	199	2659
Oct-20	281	268	525	1746
Nov-20	161	211	416	464
Dec-20	111	138	269	329
	709	**749**	**1409**	**5198**

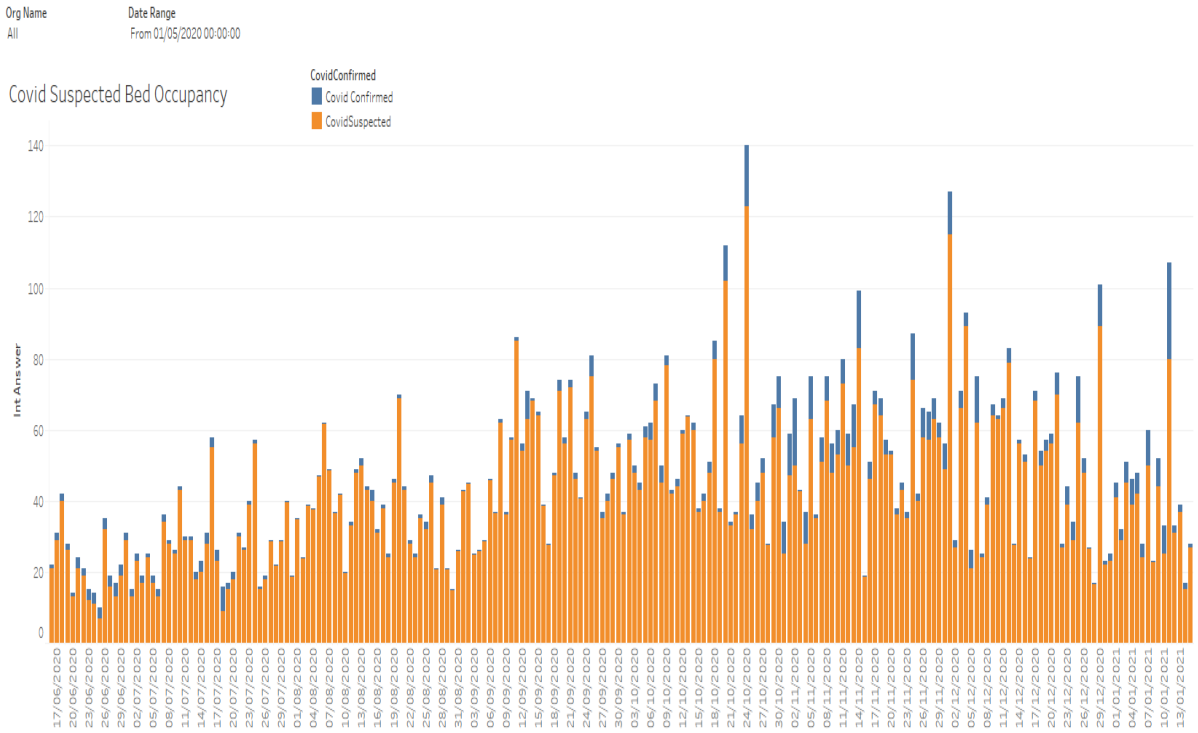
Positive Covid-19 by specimen date, age demographics for Manchester

Secondary Care impact

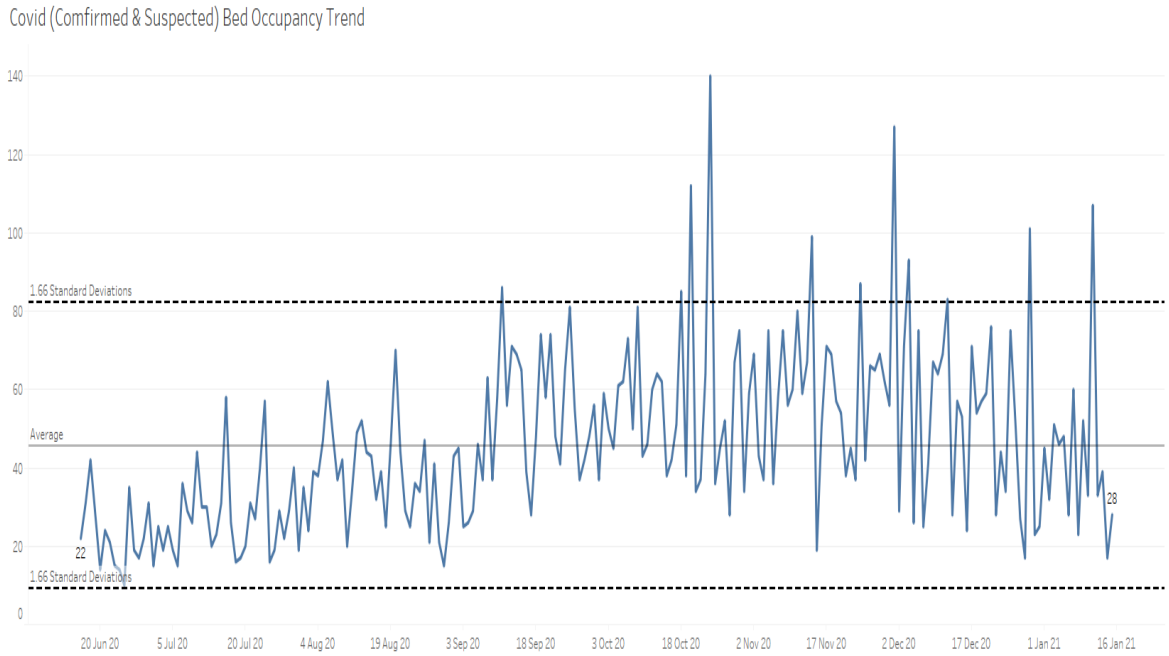
CYP are admitted to all Children's services across GM. The data is collated on both confirmed and suspected cases, albeit the numbers are relatively small in respect of adult admissions.

In the main, children in hospital have the common symptoms of COVID-19, fever and respiratory symptoms. The charts below are based on data captured from the Greater Manchester Tableau Bed Bureau.[8]

Chart 4: COVID-19 suspected and confirmed bed occupancy



[8] Available from: https://www.gmtableau.nhs.uk/t/GMHSCPPublic/views/GMPaediatricBedStatus/CovidConfirmedSuspectedTrend?:showAppBanner=false&:origin=viz_share_link&:display_count=n&:showVizHome=n



Safeguarding impact

- There are concerns about CYP suffering Non-accidental injury (NAI) and clear safeguarding issues going unreported during the lockdown first wave.
- Known incidence of non-accidental injury decreased in GM with the first lockdown period. The relationship between COVID-19 and non-accidental injury/violence toward CYP is currently being reviewed.
- GM police have identified and increasing trend in reports of Violence toward CYP (Chart 5 below)

Chart 5: Violence with and without injury children 5 years and under

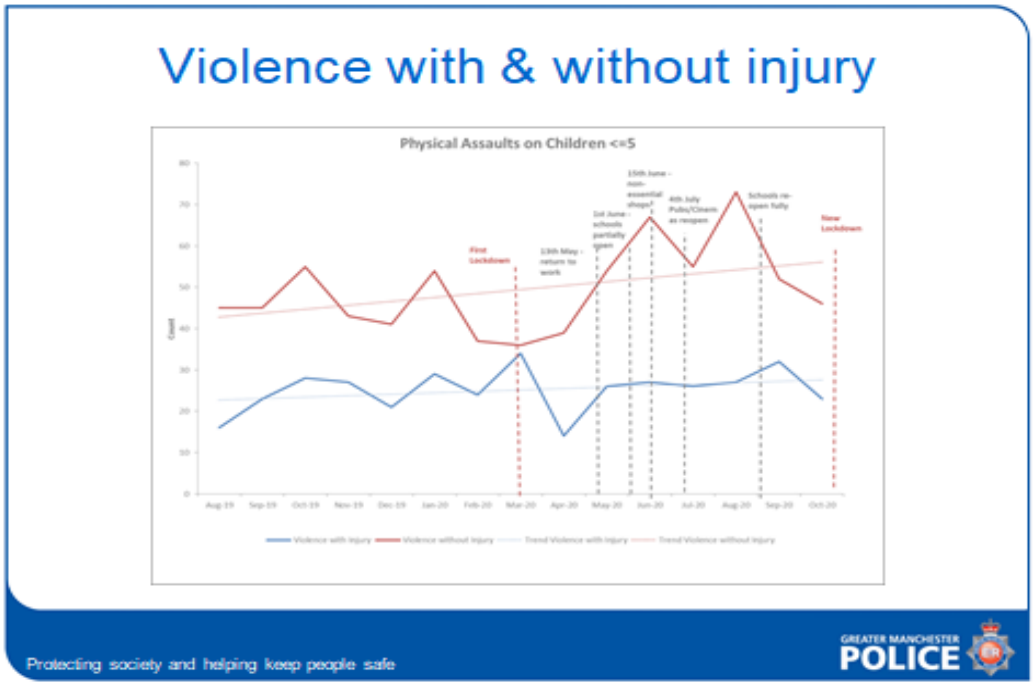


Chart 6: Violence with injury aged 1-17 years

- The incidence of Domestic Violence has increased. The relationship between COVID-19 and the increase in Domestic Violence is currently being reviewed.

Chart 7: Domestic abuse flagged crimes

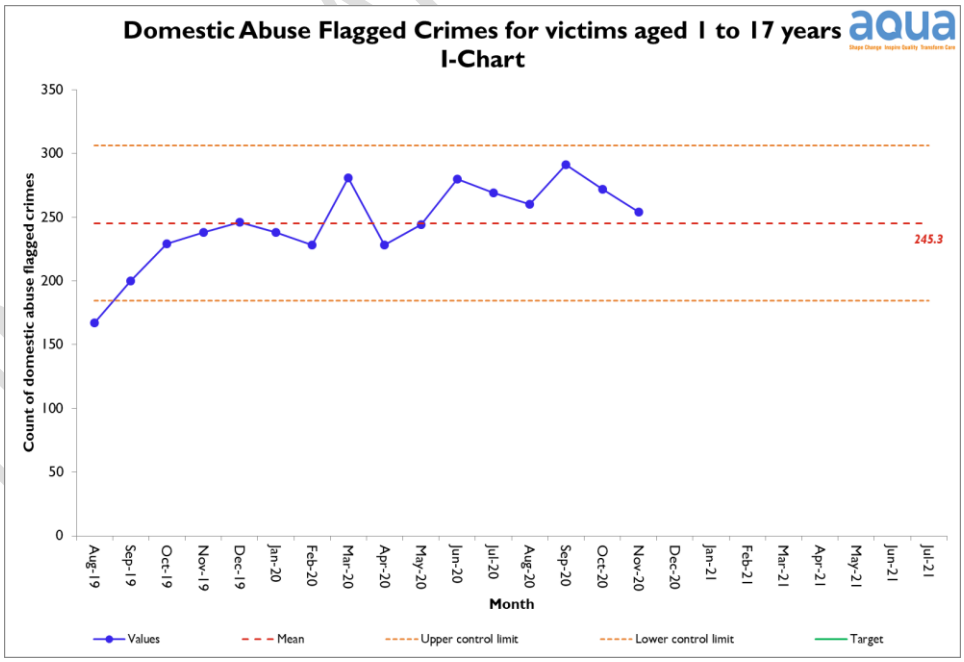


Chart 8: child death statistics

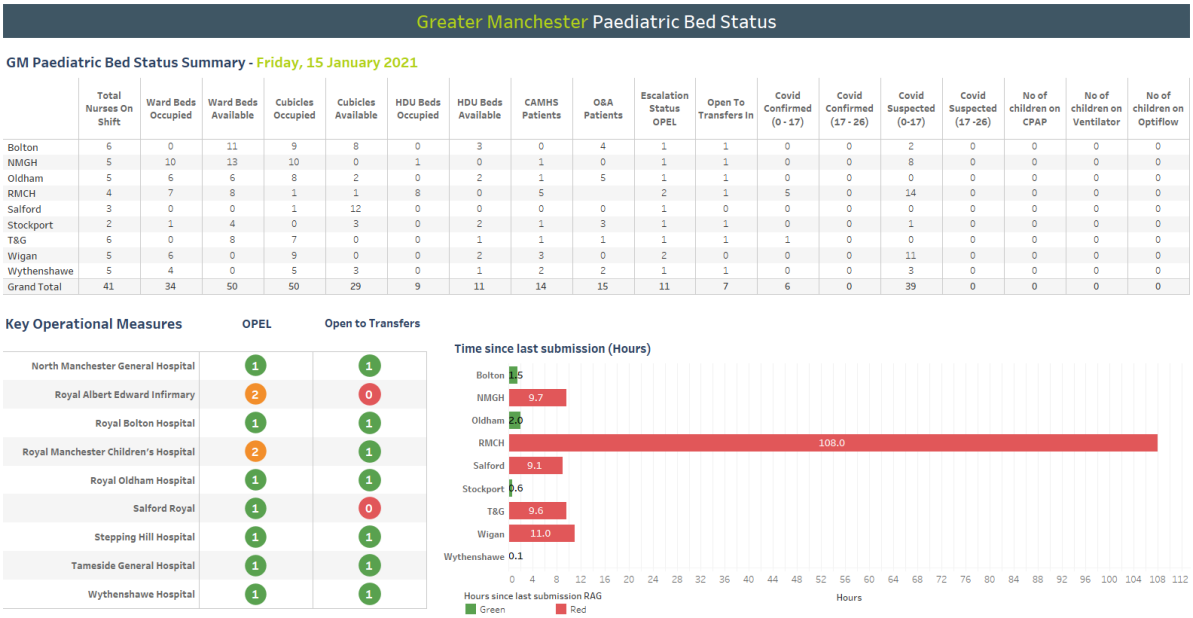
Event which caused the child's death[7]		All child death reviews completed in the year ending 31 March 2020[4]	Modifiable factors identified[5]	No modifiable factors identified[5]	Total
	Neonatal death[8]		290	589	879
	Known life limiting condition[6]		18	52	70
	Sudden unexpected death in infancy		151	48	199
	Vehicle collision		35	20	55
	Drowning		7	6	13
	Fire, burns or electrocution		6	*	6
	Poisoning		*	*	0
	Other non-intentional injury/ accident/ trauma		21	8	29
	Apparent violent related death[2]		42	23	65
	Apparent suicide[3] or self harm		61	47	108
	Acute epilepsy		5	28	33
	Acute asthma or anaphylaxis		11	5	16
	Acute metabolic diabetic ketoacidosis		*	*	
	Cardiac congenital or acquired		33	243	276
	Other chromosomal, genetic, or congenital anomaly		90	439	529
	Infection		54	91	145
	Oncology condition		11	211	222
	Other		10	31	41
	Unknown		11	10	21

Data in relation to cause of CYP deaths is only available until March 2020 but as identified in the table it is a cause for concern. Once data is available it will need to be determined if there is a relationship between COVID-19 and Suicide and Violent related death in CYP.

CAMHS

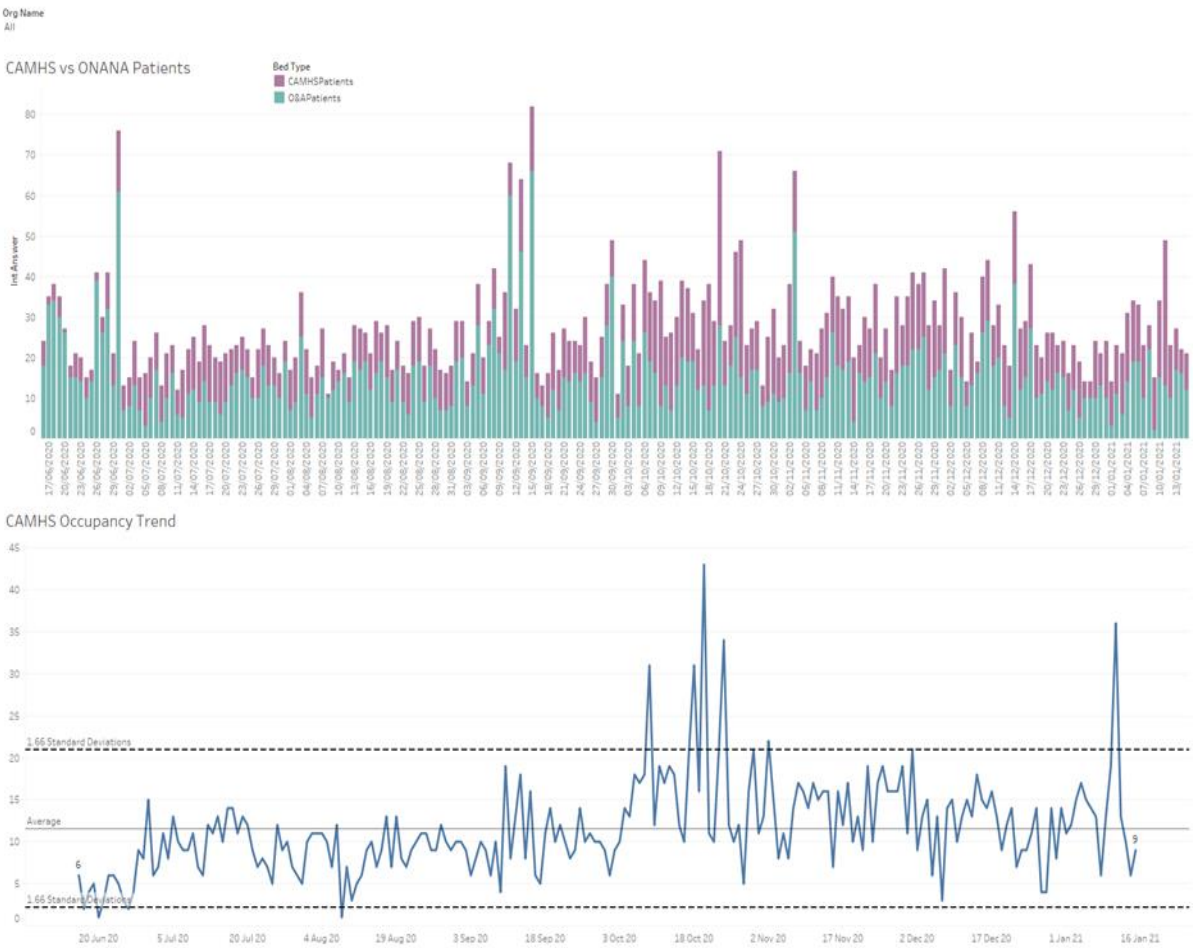
- There has been an increase in CYP attending acute services with Eating Disorders, Self Harm, Suicidal Ideation, Anxiety & Hopelessness and depression, with a subsequent increase in admission to acute paediatric inpatients services.
- CYP often experience irrational thought and fears related to the cognitive stage of development.
- The relationship between COVID-19 and the increase in clinical presentation of CAMHS needs further analysis.

Chart 9: Patients in paediatric acute beds trend



	Total Nurses On Shift	Ward Beds Occupied	Ward Beds Available	Cubicles Occupied	Cubicles Available	HDU Beds Occupied	HDU Beds Available	CAMHS Patients	O&A Patients	Escalation Status OPEL	Open To Transfers In	Covid Confirmed (0 - 17)	Covid Confirmed (17 - 26)	Covid Suspected (0-17)	Covid Suspected (17 -26)	No of children on CPAP	No of children on Ventilator	No of children on Optiflow
Bolton	6	0	11	9	8	0	3	0	4	1	1	0	0	2	0	0	0	0
NMGH	5	10	13	10	0	1	0	1	0	1	1	0	0	8	0	0	0	0
Oldham	5	6	6	8	2	0	2	1	5	1	1	0	0	0	0	0	0	0
RMCH	4	7	8	1	1	8	0	5		2	1	5	0	14	0	0	0	0
Salford	3	0	0	1	12	0	0	0	0	1	0	0	0	0	0	0	0	0
Stockport	2	1	4	0	3	0	2	1	3	1	1	0	0	1	0	0	0	0
T&G	6	0	8	7	0	0	1	1	1	1	1	1	0	0	0	0	0	0
Wigan	5	6	0	9	0	0	2	3	0	2	0	0	0	11	0	0	0	0
Wythenshawe	5	4	0	5	3	0	1	2	2	1	1	0	0	3	0	0	0	0
Grand Total	41	34	50	50	29	9	11	14	15	11	7	6	0	39	0	0	0	0

Chart 10: CAMHS patients admitted 21.06.2020- 10.01.2021 and trend data



Numbers of children admitted with CAMHS issues on a daily basis can be as high as 25% of children in beds across GM.

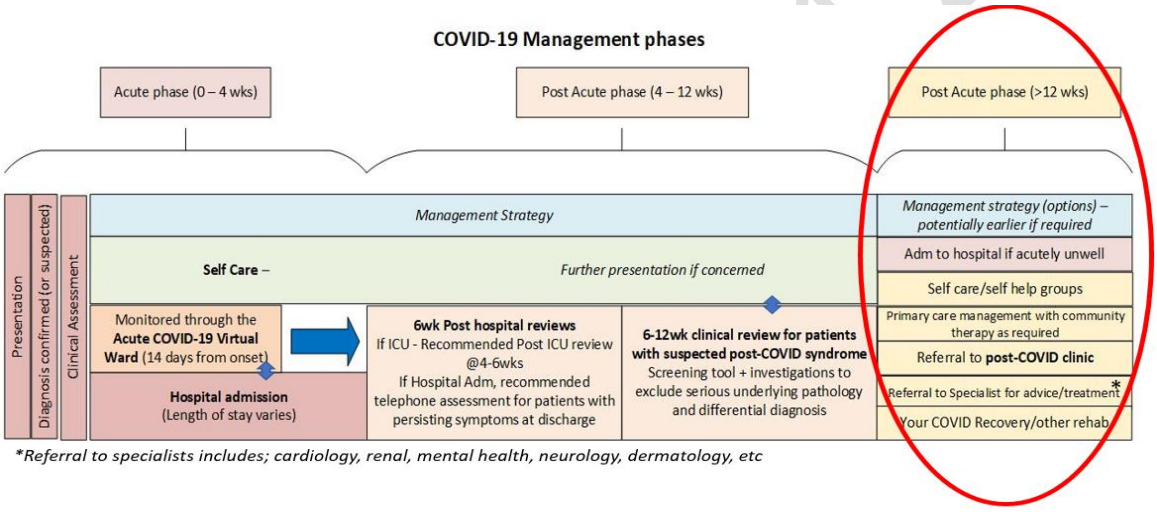
Pathways, guidance and approach

It is known that some CYP do present and require hospitalisation with COVID-19 signs and symptoms early-on in the disease process, and that most of these children will only require DGH secondary care services. By the same rule some CYP will show no symptoms at the point of infection and require only very limited health service. At the present time it is unknown how many of these children will go on to develop PIMS-TS or Long Covid or covid complications. Data is currently being sourced to determine the likelihood of this happening in view of determining a MDT approach to the continuing health care needs.

A small number of CYP will need PICU services at the point of initial infection or later if presenting after 4 weeks being diagnosed with PIMS-TS.

In line with the adult service specification the CYP will follow the same model with the phases clearly identified as Figure 1 below.

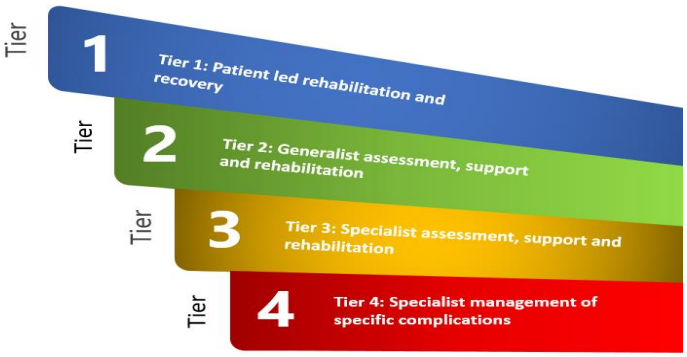
Figure 1: Guideline to supporting the recovery and rehabilitation of adults with confirmed or suspected COVID-19 in Greater Manchester (2020).



Tiered approach to the management of Post-Acute COVID-19

Whilst the pathway in fig. 1 outlines a linear approach to managing COVID-19, the following figure outlines a management model weighted by the level of intervention necessary (see fig.2). Typically, the higher the tier, the more resource intensive. Comparatively, it is likely the higher the tier, the fewer CYP requiring it.

Figure 2: Tiers of intervention post-COVID-19



Tier 1 (Primary care)

- ✓ Parent/ carer support to aid 'patient-led'
- ✓ Education/material provided about the disease and recovery e.g. https://www.longcovidkids.org/resources
- ✓ Referral to Your COVID recovery
- ✓ Parent, care and/or young person Self-monitoring and reporting back to GP with worsening symptoms

Tier 2 (primary care)

- ✓ Therapeutic relationship with a generalist clinician (e.g. GP, ANP, Children's Community Nursing team (CCNt), physio, OT) who have responsibility for the CYP overall care and helps them navigate the system
- ✓ Full history, clinical examination including functional and psychosocial assessment
- ✓ Confirm that Post COVID Syndrome is the likely or possible diagnosis (even in the absence of a positive test), and document on medical record
- ✓ Investigations to determine on underlying illness unrelated to post COVID-19 e.g. bloods, FBC ferritin, CRP, U&Es, LFTs, Bone TFTs, coeliac screen, glucose. These children need to be reviewed in paediatric OPD within the DGHs.
- ✓ Ongoing monitoring and support (e.g. by telephone, video, or in-person check-ups) as needed
- ✓ Management of other long-term conditions (e.g. diabetes, asthma)
- ✓ Offer advice and guidance to tier 3 of what services are locally available
- ✓ Referral to Tier 3 as appropriate
- ✓ Referral to CAMHS

Tier 3 (Secondary care/ MDT)

- ✓ Within RMCH Dedicated Paediatric COVID-19 rehabilitation clinic, currently these have developed within existing services and need to be realigned with an increase in available sessions without displacing the day to day service business
- ✓ CYP require assessments at 2 and 6-week intervals post-discharge and continue beyond three months.
- ✓ Personalised rehabilitation plan with (e.g.) breathing exercises, supervised pacing and psychological support
- ✓ Referral to other specialties as appropriate e.g. cardiology, rheumatology
- ✓ Testing according to specialist guidelines (e.g. CT, MRI)
- ✓ Dialogue and agreed division of responsibility between specialities, ICU and primary care.
- ✓ Offers advice and guidance to tier 2 services

Tier 4 (Tertiary care/ MDT)

- ✓ GM dedicated MDT PIMS-TS service for all children that required critical care
- ✓ Management of specific conditions, cardiac, rheumatology, general paediatricians, intensivists
- ✓ Psychosocial and CAMHS input
- ✓ Chronic Fatigue Syndrome services

Proposals to support Long-COVID-19 and COVID-19 complications for GM CYP.

Tier 3 & 4

In line with the support for tier 3 & 4 it is clear that current provision of Specialist care is under extreme pressure. Non-urgent and new referrals are currently not able to be accommodated with in the current services. Waiting list for routine activity in some of the specialist departments is now at peak level of 50 weeks plus. Clinics for PIMS-TS have developed rapidly within existing services at MFT RMCH.

To enable follow up the services would need to expand in both Rheumatology and Cardiology. Broadening both of these teams at consultant level will capture the majority of post-covid and covid complications in children.

It would be wise to consider additional support especially in relation to Rheumatology with an expansion of the team to include an Advanced Care Practitioner post.

To provide a dedicated GM MDT PIMS-TS service will require additional funding and personnel over and above what is currently in the Medical job plans.

For those CYP who straddle tier 2 and 3 and especially those that have been clinically managed locally with specialist input from RMCH given remotely, MDT clinics need to be developed. These clinics should run at the DGH localities. There should be availability for CYP who have been inpatients for follow up as described in the guidance of routine OPD as well as access if needed to the more specialist MDT outreach clinics.

Ideally the clinics should be held locally within reach form the tertiary specialist to form an MDT. This would create significant impact on the existing pressures at RMCH. If each of the respective DGH's had at least 1 MDT clinic with input from RMCH it would require 7 clinic sessions across GM. This would again increase the workload not only of RMCH but also the DGHs to clinically manage OPD for CYP with Long-Covid or Covid complications. That said it would make inroads for Primary and Community services to access clinics for CYP who present in the localities.

Tier 1 & 2

In line with support for tier 1 & 2, those CYP who require follow up should be able to access General Paediatric OPD clinically managed local with an option to access the more specialist MDT in-reach OPD clinics. Some CYP will require input from the specialist teams and both secondary and primary care teams, plus children's community health services (Local Care Organisation- LCO) such as CCNt, physiotherapy or school health.

Currently DGH services are liaising with RMCH for specialist advice. A recent diary exercise (RMCH) highlights the increase in numbers of remote consultations and time of support via telephone is a much as 2 hours a day. Any investment in development of the specialist services to maintain this substantial increase in demand on their services would need to include the 'Hot Line' specialist advice for DGHs.

Expansion of existing MDT capacity needs consideration for Virtual clinics and virtual MS Teams meetings.

Less is known about CAMHS services at the present time. And, while not a priority at the present time it is essential that acknowledgement of the considerable increase in demand for CAMHS services. It is likely to become a much bigger predicament in the very near future. There is clearly an immense issue with CYP and the anxiety/depression they are experiencing. More needs to be developed to aid the CYP cognitive ability to understand COVID19 and the impact it is having on society.

What is perfectly reasonable and understandable to adults in conversations with Children they tell us they have limited understanding of Covid19 beyond it is a virus that makes people become very ill and die. The children especially younger children with low cognitive levels have real fear and anxiety that Covid is all around…….even under their bed waiting to get them !!

It is of major importance that we can help children and alleviate their anxieties by simplifying the message and media we can develop and share.

Less is known on the demand from Primary care and the demand for follow up for CYP. It is clear that some CYP will require follow up in DGH OPD paediatric clinics while others will require more specialist input. There is limited data available to determine the demand at the present time.

GLOSSARY

ANP/ACP	Advanced Nurse/Care Practitioner
BPSU RCPCH	British Paediatric Surveillance Unit Royal College of Paediatrics and Child Health
CAMHS	Child and Adolescent Mental Health Service
CCNt	Children's Community Nursing team
COVID-19	Coronavirus Disease 2019
CT (scan)	Computerised Tomography (scan)
CYP	Children and Young People
DGH	District General Hospital
DKA	Diabetic Ketoacidosis
DKA	Diabetic Ketoacidocis
GP(s)	General Practitioner(s)
HLH	Hemophagocytic Lymphocytic Histiocytosis
KAWASAKI DISEASE	A rare condition that mainly affects children under the age of five. It is also known a Mucocutaneaous Lymph Node Syndrome.
MDT	Multidisciplinary Team(s)
ME (CFS)	Myalgic Encephalomyelitis (also known as Chronic Fatigue Syndrome)
MFT	Manchester University Hospitals NHS Foundation Trust
MRI (scan)	Magnetic Resonance Imaging
NAI	Non-Accidental Injury
NHS	National Health Service
NHSEI	NHS England and Improvement
NWTS	North West and North Wales Transport Service
OPD	Outpatient Department
OT	Occupational Therapy/ist
PICU	Paediatric Intensive Care Unit
PIMS-TS	Paediatric Multisystem Inflammatory Syndrome
RMCH	Royal Manchester Children's Hospital (tertiary care)
ROH	Royal Oldham Hospital
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SLE	Systemic Lupus Erythematosus
T1DM	Type 1 Diabetes Mellitus

Councillor Howard Sykes MBE

Our ref: HDS/KR/4632

Date: 2 September 2021

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Dear all,

Re: Supporting patients with chronic pain and fatigue conditions

I am writing to request the Health and Well-being Board revisits the provision of care for patients living with chronic pain and fatigue conditions within the Borough.

Long-COVID Clinic

I welcomed the establishment of a specialist clinic under the auspices of the Northern Care Alliance at the Royal Oldham Hospital, as part of a government-funded national network, for the treatment of long-COVID patients in the borough.

Clinical evidence suggests one in five people who have contracted COVID-19 exhibit long-term post-viral symptoms, including brain fog, anxiety, depression, breathlessness, pain and chronic fatigue.

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These symptoms are similarly experienced by sufferers of Myalgic Encephalopathy, Fibromyalgia, Chronic Fatigue Syndrome, Post Viral Fatigue Syndrome, Rheumatoid Arthritis, Osteoarthritis, and other chronic pain and fatigue conditions.

Given their similarities, I would be grateful if the Board can examine whether the capacity and expertise of the long-COVID clinic could also support patients with these conditions?

As I understand it presently Oldham patients can access the Greater Manchester Mental NHS Foundation Trust 'Living with Pain and Fatigue Service' and Northern Care Alliance NHS Group 'Acute and Chronic Pain Service'.

Could the Board therefore also examine how these services could work with the long-COVID clinic to provide a more holistic and accessible service for patients and their carers?

Drug-free treatments

In addition, I should like the Board to look at the availability of approved non-drug treatments locally to ensure that patients wishing to access drug-free treatments can be best served?

I am sure you are aware that NICE (the National Institute for Health and Care Excellence) in August 2020 published its 'Guideline - Chronic pain in over 16s: assessment and management' paper for consultation.

I have yet to see the response to the consultation, but the paper included the following recommendations of non-drug therapies to health authorities:

Exercise for chronic primary pain

Offer a supervised group exercise programme (for example, cardiovascular, mind–body, strength, or a combination of approaches) to people aged 16 years and over to manage chronic primary pain.

Encourage people with chronic primary pain to carry on with their exercise for longer-term general health benefits.

Psychological therapy for chronic primary pain

Consider acceptance and commitment therapy (ACT) or cognitive– behavioural therapy (CBT) for pain for people aged 16 years and over with chronic primary pain.

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Acupuncture for chronic primary pain

Consider a course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system, for people aged 16 years and over to manage chronic primary pain

I would like us to determine if this provision is available locally and if patients electing for non-drug treatments are able to have their needs met?

This also fits well with our agenda to promote social prescribing. Access to free yoga and mindfulness classes, an allotment or community gardening project, or a walking group is I am sure greatly beneficial in many instances to patients living with chronic pain and fatigue conditions, who often sadly also suffer social isolation and depression.

Listening to patients and carers

I am sure we are all committed to co-production ensuring patients and carers, and their representative organisations, are properly consulted prior to improvements in health care.

I would venture that will probably partnership working with Healthwatch Oldham, Carers Centre, Action Together and national bodies such as the M.E Association https://meassociation.org.uk/ and Fibromyalgia Action UK http://www.fmauk.org/

Can I therefore please recommend we reach out to these patients, carers, and to local and national groups, to take account of their lived experience?

Our efforts will be more inclusive and robust as a result and will help ensure our Oldham offer is the best for these most deserving patients and those who care and support them.

Thanks for your consideration of these requests. I look forward to your response and to seeing how we can take them forward through the Health and Well-being Board and with our partners.

Yours sincerely,

Howard Sykes

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