

FOI REF: 22/757

23rd January 2023

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FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Your post COVID assessment service and related data collection

Please disclose:

1. **When did your post COVID (long COVID) assessment service become operational?**

[January 2021.](#)

2. **A copy of the operational policy for your post COVID (long COVID) assessment service**

[Please find attached the Service Specification for Post-Covid Assessment and Support Service \(PCASS\).](#)

3. **The titles of the rows and columns of your central database/ spreadsheet on the referrals received, patients seen and outcomes of assessments**

[Information is collected as per NHS England Reporting requirements.](#)

4. **What information do you hold on the occupations of people referred with post COVID (long COVID) syndrome?**

[Recorded in Clinical Records as appropriate, but not specifically reported on.](#)

5. **Do you record how many of the people referred are current or former NHS workers?**

[NHS staff members recorded at point of initial assessment as per NHS England reporting requirements.](#)

Cont.../

6. **What data do you submit to NHS England and or other central bodies about the work of your service and the characteristics of the patients who you treat?**

Data submitted as per NHS England templates and reporting requirements.

7. **To where are patients referred if assessment concludes that they need rehabilitation for post COVID (long COVID) syndrome?**

Rehabilitation pathways are in place as part of the Post Covid Service, or an onward referral is made if the PCASS does not meet the rehabilitation need of that individual. If patients need rehabilitation for Post Covid, then they might be referred to Speech and Language Therapy, Dietetics, Joint Community Rehabilitation, Neuro Outpatients, Adult Social Care and social prescribing services (these are the main services).

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
esh-tr.foi@nhs.net

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

| | |
|----------------------------------|--|
| Service Specification No. | |
| Service | Post-COVID Assessment and Support Service (PCASS) and Post-COVID treatment and rehabilitation pathways |
| Commissioner Lead | |
| Provider Lead | |
| Period | 1 st April 2022 to 31 st March 2023 |
| Date of Review | |

| |
|--|
| <p>1. Population Needs</p> <p>1.1 National context and evidence base</p> <p>It is recognised that people of all ages and backgrounds, irrespective of the severity of initial infection, can experience ongoing symptoms following COVID-19 well after their initial infection. The NICE/SIGN/RCGP rapid guideline on managing the long-term effects of COVID-19 sets out the following clinical definitions:</p> <ul style="list-style-type: none"> ▪ <i>Acute COVID-19</i>: signs and symptoms of COVID-19 for up to four weeks. ▪ <i>Ongoing symptomatic COVID-19</i>: signs and symptoms of COVID-19 from 4 to 12 weeks. ▪ <i>Post-COVID-19 syndrome</i>: 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. It usually presents with clusters of symptoms, often overlapping, which can fluctuate and change over time and can affect any system in the body.¹ <p>'Long COVID' is defined as signs and symptoms persisting after the first 4 weeks following acute infection, so encompasses both ongoing symptomatic and post-COVID-19 syndrome. It is a multi-system condition with a wide range of debilitating symptoms spanning fatigue, breathlessness, cough, chest pain, heart palpitations, fever, headache, muscle pain, gastrointestinal problems and loss of taste and smell. Many people with Long COVID may experience a range of psychological and cognitive symptoms such as depression, anxiety, post-traumatic stress disorder (PTSD) and 'brain fog' or other cognitive impairments, in addition to physical symptoms. This can also have a social impact and can impact significantly on a person's ability to carry out day-to-day activities and work. Some of those experiencing long term symptoms following COVID-19 will not need to seek NHS help, and others can be supported by their primary care team or in a community care setting. Others, however, will need specialist assessment and treatment.²</p> <p>As an initial response to the challenge of Long COVID, in October 2020 NHS England and NHS Improvement set out a 5-point plan supported by a £10 million investment to support local</p> |
|--|

¹ NICE guideline [NG188] COVID-19 rapid guideline: managing the long-term effects of COVID-19 (NICE/SIGN/RCGP, Dec 2020)

² Long Covid: The NHS plan for 2021/22 (NHS E/I, June 2021)

systems to establish multi-disciplinary assessment teams for those experiencing post-COVID syndrome. The provision would include physical, cognitive and psychological assessments as well as immediate advice, signposting and referral to appropriate rehabilitation and support services.

As these assessment services mobilised, understanding increased both locally and nationally of the ongoing rehabilitation and support needs of people living with Long COVID symptoms, and in June 2021 the NHS Long COVID Plan was published to enhance the offer. The Plan outlined 10 key steps including expansion of care pathways to provide treatment and rehabilitation, as well commissioning of a Primary Care Enhanced Service and specialist assessment for children and young people. The plan built on the recently updated commissioning guidance and was underpinned by additional national funding.³

It is difficult to estimate the prevalence of Long-COVID in the population due to the spectrum of symptoms and the uncertainty of the emerging clinical evidence. The ONS Short Report on Long COVID (July 2021) noted that estimates of symptom prevalence at 12 weeks post-infection range from 2.3% to 37% depending on study design, and from 1.2% to 4.8% when considering only debilitating symptoms, with fatigue being the most frequently reported persistent symptom.⁴ The modelling for the NHS Long COVID Plan was based on the provisional assumption that around 2.9% of people who have COVID-19 will go on to need NHS support, around 342,000 people nationally.⁵

Consistent risk factors across studies include increasing age, female sex, overweight/obesity, pre-existing asthma, pre-pandemic poor physical and mental health, and working in a health and social care setting. Symptoms appear more severe for those who were hospitalised with the initial infection, although it is acknowledged that not all patients seriously impacted in the longer term were hospitalised or even had a positive test.⁶ The REACT-2 Study notes the higher prevalence of symptoms for people on low incomes (51% compared with 28.7% for those on high incomes) and for those living in the most deprived areas (42.6% compared with 34.7% for those in the most affluent areas).⁷

Data indicates that non-white ethnic minority groups are less likely to report long COVID,⁸ and as we know that initial COVID-19 infection disproportionately affects ethnic minority groups in terms of rate and severity of infection,⁹ this would seem to indicate inequality of access to Long-COVID assessment and support. The condition has the potential to further exacerbate existing inequality through chronic illness and the implications of this for people's lives and livelihoods as well as health outcomes. The national service model for Long COVID therefore places a significant emphasis on equity of access and a proactive approach to supporting disadvantaged groups to access and utilise healthcare, through:

- Understanding the need: Consistent recording of ethnicity, deprivation, disability, existing multimorbidity.
- Better access: Educational materials for healthcare workers and the public, printed resources as well as online, translation into other languages and easy-read.
- Co-production with people with lived experience: Engagement to include diverse voices and perspectives at national, system and local level.
- Participatory research: Participant group in clinical research is diverse and reflective of population served.
- Culturally competent communications: Aware of healthcare disparities and the impact of socio-cultural factors on health.
- Multiagency support: The voluntary sector and local authorities involved in taking a holistic approach to physical, mental and cognitive health alongside employment, care needs and housing.¹⁰

³ Long Covid: The NHS plan for 2021/22 (NHS E/I, June 2021)

⁴ Short Report on Long COVID (ONS, July 2021)

⁵ Long Covid: The NHS plan for 2021/22 (NHS E/I, June 2021)

⁶ Short Report on Long COVID (ONS, July 2021)

⁷ Whitaker M, Elliott J, Chadeau-Hyam M, et al. Persistent symptoms following SARS-CoV-2 infection in a random community sample of 508 707 people (Imperial College London, June 2021)

⁸ Short Report on Long COVID (ONS, July 2021)

⁹ Disparities in the risks and outcomes of COVID-19 (Public Health England, August 2020)

¹⁰ National guidance for Post-COVID syndrome assessment clinics (NHS, April 2021)

1.2 Local context and evidence base

In response to the original national guidance, the Sussex Health and Care Partnership (SHCP) developed a Sussex-wide clinical assessment model for patients with post COVID symptoms which launched in January 2021 as the Post Covid Assessment Service (PCAS). The initial remit of the service was to assess patients still experiencing symptoms 12 weeks after initial COVID infection to identify their ongoing care and support needs. The existing community providers were identified as the lead providers; Sussex Community NHS Foundation Trust in West Sussex, Brighton & Hove, and High Weald, Lewes, Havens; and East Sussex Healthcare Trust in the rest of East Sussex, working collaboratively with wider system partners and stakeholders, and with shared strategic oversight and clinical leadership at SHCP. This pan-Sussex approach has enabled rapid mobilisation, parity of delivery across the system, cost and time efficiencies in operations, rapid and safe introduction of new clinical pathways and appropriate alignment with secondary care and long-term condition management across the geography.

Following publication of the NHS Long COVID Plan and the announcement of additional funding in June 2021 the system developed a Long COVID service plan to enhance the service offer, covering the whole pathway from primary and community to specialist care. This included enhancing the remit of PCAS to provide support as well as assessment, with the introduction of Care Coordinator roles and additional clinical expertise, so that it became the Post-COVID Assessment and Support Service (PCASS), as well as developing community rehabilitation and treatment pathways. These pathways are informed by intelligence gathered to date on the needs of patients, so are focused on fatigue management, breathlessness management, cognition, and vocational rehabilitation. Some of the treatment and rehabilitation pathways are delivered within PCASS, and some are built into existing community service infrastructure to help with sustainability.

As noted above, it is difficult to estimate the prevalence of Long COVID within the Sussex population due to the uncertainty of the emerging clinical research, but applying the national modelling assumption to the cumulative COVID-19 cases in Sussex at July 2021 we would expect 3,582 people in Sussex to need NHS support for Long COVID:

Figure 2. Estimated prevalence for Sussex using national modelling assumptions Aug 2021

| | West Sussex | Brighton & Hove | East Sussex | Sussex Total |
|---|-------------|-----------------|-------------|--------------|
| Cumulative COVID-19 cases at July 2021 ¹¹ | 60,250 | 39,298 | 23,986 | 123,534 |
| Estimated prevalence according to REACT-2 Study definition - 37.7% with at least one persistent symptom at 12 weeks ¹² | 22,714 | 14,815 | 9,043 | 46,572 |
| Estimated prevalence according to NHSE/I modelling - 2.9% will go on to need NHS support ¹³ | 1,747 | 1,140 | 696 | 3,582 |

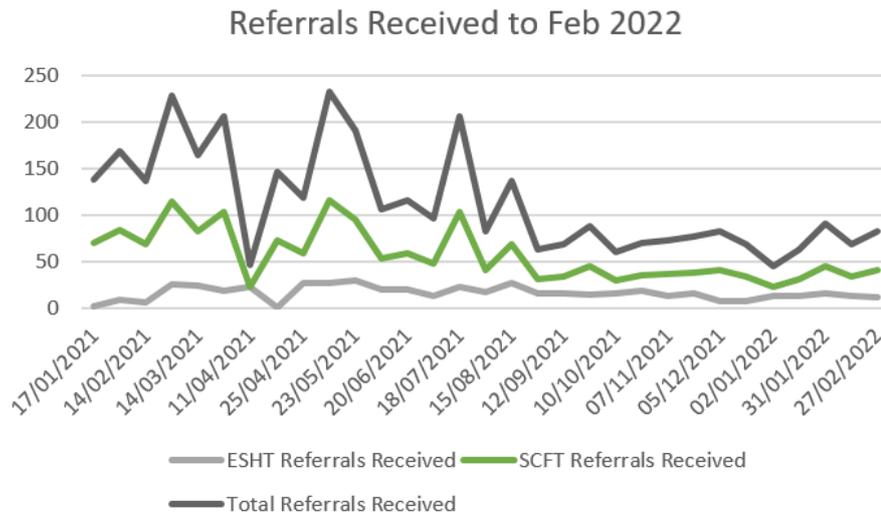
When compared against the actual referral data up to the 27th February 2022, uptake to date has been significantly lower than this modelled demand, with a total of 1,753 referrals received across Sussex. This could potentially suggest unmet need, however it is notable that following initial fluctuation, demand has stabilised at an average of 35 referrals per month since August 2021, which would indicate that the service is now embedded in the local system.

¹¹ <https://coronavirus.data.gov.uk/>

¹² Persistent symptoms following SARS-CoV-2 infection in a random community sample of 508,707 people (Imperial College London; REACT Long Covid Paper, June 2021)

¹³ Long Covid: The NHS plan for 2021/22 (NHS E/I, June 2021)

Figure 2. Actual PCASS referral data up to 27th Feb 2022



As noted above, an essential element of Post COVID services is ensuring equity of access. An Equalities and Health Inequalities Assessment (EHIA) has been completed to ensure that the service meets the needs of vulnerable groups, including those who may be disproportionately affected by Long COVID because of their socio-economic situation or ethnicity, those who are most likely to be impacted by health inequalities, and those who may not usually access healthcare services.

Referral data for PCASS up to 22nd February 2022 indicates the following demographics for those accessing the service:

- 68.4% white ethnicity (compared to 83.5% in August 2021), although it should be noted that a large number of patients in the SCFT service have 'Unknown' ethnicity recorded
- 66% female
- Highest in the 45-54 age group
- 10% from deprived areas

While this is consistent with the national picture described above, it is acknowledged that this is not necessarily reflective of the demographic profile that we would expect given that rates of COVID-19 and severity of infection are higher in males, older age groups and those from ethnic minority backgrounds. Patterns of access for some groups are likely to be an artefact of wider health inequalities and patterns of health seeking behaviour.

The service model has been developed and will continue to evolve in a way which seeks to address these issues, including for example:

- Robust data collection and analysis to understand access patterns and inform service plans
- A flexible delivery model with options for online and face-to-face assessment and support where appropriate
- An accessible referral pathway which considers referrals from wider health and social care professionals as well as GPs (although as noted below medical investigations may be requested at the point of triage)
- Engagement with a system-wide communications plan which is inclusive and promotes access to all people living with Long COVID
- Plans to engage peer leaders and people with lived experience to provide peer support and co-design service developments.

The EHIA concludes that if such measures are robustly implemented the service will have a positive impact by ensuring that existing health inequalities do not worsen as a result of Long COVID.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

| | | |
|----------|--|---|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | x |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | x |
| Domain 4 | Ensuring people have a positive experience of care | x |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

3.1.1 Multidisciplinary assessment and support

The service aims to provide equitable access to assessment and support for people experiencing Post COVID-19 Syndrome. This includes:

- Multidisciplinary assessment with consideration of physical, cognitive and psychological needs;
- An enhanced assessment and support offer including supported self-management and care coordination to help patients navigate their recovery journey; and
- Innovative treatment and rehabilitation pathways for patients whose needs fall outside of existing community pathways.

The service continues to evolve in accordance with national guidance and developing understanding of how best to meet the needs of patients with Long COVID. In response to the NHS Long COVID Plan (June 2021) an enhanced multidisciplinary service offer has been developed which includes:

- Care Coordinator roles to provide support and guidance through regular contact with patients following assessment to help navigate their rehabilitation journey
- Inclusion of GP and secondary care Consultant input to the MDT to provide direct medical input and oversight
- Psychologist support for the assessment service and rehabilitation pathways
- Rehabilitation packages specifically tailored to the needs of Long COVID patients; breathlessness, fatigue, cognitive rehabilitation and vocational rehabilitation
- Physiotherapists, Occupational Therapists and Therapy Assistants
- Nursing
- Administration and implementation support

Some of the treatment and rehabilitation pathways are delivered by PCASS, while others have been embedded within existing community teams. Enhancing the infrastructure of existing community services will support sustainability and help to mitigate the workforce challenge associated with time-limited funding.

3.1.2 Personalised care

The service aims to provide personalised care and support throughout the pathway, adopting a “what matters to me” methodology. The assessment should take full account of the patient’s journey, the difficulties they have faced and their goals for the future, and treatment should be holistic and personalised according to their individual rehabilitation needs. Care Coordinators are central to delivering this approach and should draw on community assets to maximise the resources available to support the population living with Long COVID. The ambition is to support and empower patients through active self-management, and to create a network of patient champions to inform the ongoing development of the service and develop peer group opportunities across the geography.

3.1.3 Equity of access

The service aims to provide equity of access to all patients across Sussex, including to groups who may be disproportionately affected by Long COVID because of their socio-economic situation or ethnicity, those who are most likely to be impacted by health inequalities, and those who may not usually access healthcare services. To support this, providers are required to collect and report demographic data including age, gender, ethnicity and location for patients accessing the service, and to analyse this in the context of health inequalities. Providers will work in partnership with commissioners, people with lived experience, and other stakeholders to deliver targeted communications to promote access where needed, and to co-design service developments which remove barriers to access. The service should offer face-to-face and online options for assessment and treatment where possible and should be flexible in accepting referrals.

3.2 Service description/care pathway

3.2.1 Screening and referral

Prior to referral to PCASS, screening should be completed using the *Sussex PCASS Screening Tool* to rule out other potential causes for the presenting symptoms with access to the necessary diagnostic tests.

Referrals should be made using the PCASS Referral Form via the Single Point of Access for each provider Trust:

West Sussex, Brighton & Hove, High Weald Lewes Havens:

sc-tr.scftpostcovidassessment@nhs.net

East Sussex:

esht.postcovidassessment@nhs.net

It is expected that the majority of referrals will come from Primary Care to ensure that sufficient medical screening is completed in advance of referral. If not sufficient, a referral may be placed on hold by PCASS (but not ‘rejected’) whilst further information is awaited from Primary Care. However, it may be appropriate in some cases to accept referrals from other health and social care practitioners in order to maximise accessibility for disadvantaged groups who are not registered with, or do not routinely access support from, Primary Care. In this instance medical investigations may be requested at the point of triage, potentially with support from the embedded medical practitioner.

Referrals may also come from Secondary Care, and there is a dedicated referral pathway for Occupational Health, to enable rapid access to assessment and support for health and social care staff who may be disproportionately affected by Long COVID.

3.2.2 Assessment

Once the medical screening has been completed and the referral has been accepted, a welcome pack will be issued to the patient with resources to support them while they wait for their initial assessment, which should take place within 6 weeks. The initial clinical assessment will be a holistic assessment using the *Sussex PCASS Assessment Form*. In accordance with national guidance, this includes assessment of breathlessness and dysfunctional breathing; cognitive function; post-exertion malaise, fatigue and neurological symptoms; mobility; and psychosocial assessment.

3.2.3 Support

Following assessment, the team will work with the patient to develop a personalised care and support plan which may include the following elements:

- Signposting to useful resources for supported self-management.
- Access to dedicated Care Coordinators to help guide them through their rehabilitation journey and to navigate the system in receiving medical, social care and voluntary sector support for their needs.

3.2.4 Rehabilitation pathways

Some patients will be referred into specialist rehabilitation pathways which will continue to evolve in response to emerging clinical evidence:

- 1) Managing your fatigue
- 2) Managing your breathlessness
- 3) Improving your cognition
- 4) Helping you return to work
- 5) Peer support group

A bespoke rehabilitation offer may be required for patients who do not fall within these core pathways.

3.2.5 Follow-up

Patients will be contacted at 3-months and 6-months following intervention from the service to assess progress and identify any further support needs.

3.3.6 Onward referral

The service will have access to direct referrals to specialist services in the community, secondary care, and mental health services for patients who require onward referral, without the need to revert to Primary Care. Some of these pathways are still in development.

3.3 Population covered

The services will provide support to patients across Sussex. The service provided by Sussex Community NHS Foundation Trust will support patients within the West Sussex CCG area, Brighton and Hove CCG area, and the High Weald, Lewes, Havens area of East Sussex. The

service provided by East Sussex Healthcare Trust will support patients in the remainder of the East Sussex CCG footprint.

3.4 Any acceptance and exclusion criteria and thresholds

The services should accept referrals of patients presenting with Post-COVID syndrome, that is, 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, irrespective of whether they originally tested positive for COVID-19 or were hospitalised.

As noted above, screening will need to be completed prior to acceptance of a referral in order to exclude alternative diagnoses. Ideally this will be completed within Primary Care prior to referral however the services should seek to maximise access to disadvantaged groups, and so should consider all referrals of patients within Sussex, including those who are not registered with a GP.

Some patients may not require referral to PCASS following screening and should be signposted directly to self-supported management through the Your Covid Recovery platform and other resources available at:

East Sussex: www.esht.nhs.net/rehabilitation

West Sussex, B&H HWLH: www.sussexcommunity.nhs.uk/services/covid-19-rehabilitation.htm

Patients referred to PCASS must be medically stable with no acute symptoms. Some patients may alternatively require direct referral to Secondary Care.

The services are primarily aimed at adults over the age of 18. Children and young people presenting with post-COVID symptoms should be referred to local acute paediatric teams for assessment in the first instance, with support from regional specialist CYP hubs which are currently being mobilised. In some cases, it may be appropriate for the paediatric team to refer a 16-or 17-year old on to PCASS for treatment with a shared care approach.

Specific inclusion criteria:

- Patients with ongoing post-COVID symptoms following COVID-19 infection
- Reporting ongoing difficulties following confirmed, or probable, COVID-19 infection
- MUST be medically stable with no acute symptoms
- MUST be able and willing to engage in the service

Specific exclusion criteria:

- Patients who have underlying serious pathology, acute or life threatening mental or physical health illness, or symptoms that can be accounted for by an existing condition

3.5 Interdependence with other services/providers

Interdependences include but are not limited to:

- Primary Care: to recognise the presentation of Long COVID, provide appropriate medical screening, provide advice and support including from care coordinators and social prescribers where indicated, and refer on to specialist provision from PCASS if required. This is supported by implementation of a National Enhanced Service for Primary Care.
- Secondary Care: to recognise the presentation of Long COVID and refer on to PCASS if required, and to provide specialist management for patients with Long COVID whose

needs cannot be met by PCASS and the associated treatment and rehabilitation pathways.

- Occupational Health services: to recognise the presentation of Long COVID, undertake appropriate screening and refer in to PCASS if required.
- IAPT and other mental health services: to enable patients to access ongoing psychological support and cognitive management if required.
- Social Care, Voluntary and Community Services: to enable patients to access wider support services if required.
- Acute paediatric services and regional CYP specialist hubs: to provide assessment and support to under 18s, and refer to PCASS to provide shared care for 16- and 17-year olds if clinically appropriate.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

COVID-19 rapid guideline: managing the long-term effects of COVID-19
NICE guideline [NG188], NICE/SIGN/RCGP Published 18 December 2020

National guidance for Post-COVID syndrome assessment clinics
NHS Published 26 April 2021

Long Covid: The NHS plan for 2021/22
NHS Published June 2021

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

As Long COVID is a new condition and the clinical model is still emerging, evaluation at a local and national level is critical in order to understand the prevalence, nature and course of the disease, and which treatments and pathways improve outcomes for patients, as well as understanding demand for services, equity of access, and potential areas of unmet need. Evaluation will also inform service plans and future funding requirements.

National data requirements consist of a fortnightly SITREP at provider level to monitor access, and regular submission of patient-level referral data to the Data Landing Portal (DLP) to map longitudinal patient journeys across services. Local requirements consist of minimal additions to this to inform the Sussex Long COVID dataset and highlight report.

The national planning guidance for 2022/23 notes that there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

Access

The national SITREP dataset (Figure 4 below) provides a comprehensive overview at provider level of referral, activity, waiting time, demographic and pathway data. The same dataset should be reported to the CCG on a monthly basis with reporting at place level, and with the additional fields of number and percentage of patients seen for initial assessment within 6 weeks of referral, and number and percentage of patients waiting longer than 15 weeks from referral.

Figure 4. National SITREP information requirements

| |
|---|
| 1. Number of referrals to the post-COVID assessment service in the reporting period by origin of referral (include rejected referrals) |
| 2. Number of patients still waiting for an initial clinical assessment at the end of the reporting period |
| 3. Number of patients who have had an initial clinical assessment in the reporting period (include number of NHS staff) |
| 4. Of those who had an initial clinical assessment in the reporting period (Q3.1), what was the time from referral to initial clinical assessment? |
| 5. Of those who had an initial clinical assessment in the reporting period (Q3.1), what is the breakdown by ethnic group? |
| 6. Of those who had an initial clinical assessment in the reporting period (Q3.1), how many were from a deprived background? |
| 7. Of those who had an initial clinical assessment in the reporting period (Q3.1), what was the breakdown by sex as recorded in your clinical system? |
| 8. Of those who had an initial clinical assessment in the reporting period (Q3.1), what was the age breakdown? |
| 9. Number of follow up appointments undertaken in the reporting period |
| 10. Number of completed assessments in the post covid assessment service in the reporting period |
| 11. Number of diagnostic tests requested in the post-COVID assessment service for those with completed assessments in the reporting period |
| 12. In the reporting period, once a patient completed their assessment in the post-COVID assessment service (Q10), what pathway(s) did the patient then follow? |

Outcomes

Patient reported outcome measures will be taken at assessment, 3 month follow-up and 6 month follow-up using the EQ5DL. Outcome data should be included in the monthly report to the CCG.

Patient Experience

A Sussex-wide Patient Experience questionnaire has been developed, including the Friends and Family Test. A monthly report should be provided to the CCG. The report should include a comment on uptake and providers should take action to increase uptake to ensure that data is as representative of the patient cohort as possible.

The information requirements described above for PCASS are summarised as follows:

| Information Requirement | Local/ National |
|--|--------------------|
| Fortnightly submission of SITREP dataset to regional/national team | National |
| Submission of patient level data to Data Landing Portal | National |
| Monthly report to the CCG reported at place level to include: | Local |

| | |
|--|-------|
| <ul style="list-style-type: none"> • SITREP dataset; • Additional fields of number and percentage of patients seen for initial assessment within 6 weeks of referral, and number and percentage of patients waiting longer than 15 weeks from referral. • Outcome data from EQ5DL tool. | |
| Monthly report to the CCG of patient experience data | Local |

Each provider should have a named data lead. The core SITREP dataset is critical for the reasons outlined above, so data completeness must be maintained using manual input where required to supplement gaps in automated reports. Providers should collaborate and engage with the Data Working Group to ensure consistency of coding against the national codes.

Personalised care

Providers will also work with Personalised Care Leads to provide data as required regarding the implementation of personalised care approaches.

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

7. Individual Service User Placement

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate