Expert Report for the UK Covid-19 Public Inquiry

Module 3: Impact of the Covid-19 pandemic on healthcare systems in the 4 nations of the UK

Non-covid conditions:

Child and Adolescent Mental Health Services

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Author statement

"We confirm that this is our own work and that the facts stated in the report are within our own knowledge. We understand our duty to provide independent evidence and have complied with that duty. We confirm that we have made clear which facts and matters referred to in this report are within our own knowledge and which are not. Those that are within our own knowledge we confirm to be true. The opinions we have expressed represent our true and complete professional opinions on the matters to which they refer."

Dr Guy Northover, Dr Sacha Evans

20th August 2024

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Preamble

1. Dr Guy Northover is an experienced Consultant Child and Adolescent Psychiatrist, taking up his first consultant post in 2010. He presently works in Berkshire Healthcare NHS Trust in the Children and Young People Psychosis and Mania Pathway. Dr Northover has extensive experience working within and designing CAMHS crisis services. Dr Northover has been the trust's Lead Clinical Director since 2016 and as such is operationally responsible for the seven clinical directors across all community health and mental health services. He has also been the trust's Chief Clinical Informatics Officer since 2016 and takes responsibility for the quality and safety of the trust's clinical digital systems.

2. Dr Guy Northover was appointed as the Getting It Right First Time National Clinical Lead for CAMHS crisis and inpatient services in 2018. Initially independent of NHS England, GIRFT was later integrated into NHS England's governance and operational structures. He stopped being the GIRFT national lead in April 2024.

3. During the period of this report, he actively participated in the Clinical Reference Group (CRG) for children and young people's mental health, learning disability and autism services, where he chaired the data subgroup. This CRG covers secure and non-secure children and young people mental health, learning disability, autism and eating disorders services, providing expert clinical leadership to support the effective delegation of children and young people mental health services through NHS Provider Collaboratives. It aims to deliver seamless community-based care, reducing treatment in hospital settings except for the most complex cases.

4. Dr Guy Northover has extensive experience relating to young people with autism and learning disabilities admitted to general admission CAMHS inpatient units, but has less experience with the specific challenges and clinical processes of specialist Learning Disability and Autism Inpatient units, and as such, the impact of Covid-19 on these units lies slightly outside his area of expertise.

5. He has been a member of a number of NHS England projects, including a group on the use of psychotropics within inpatient units and the CAMHS currency working group. He attended in the capacity of a GIRFT lead. He continues to undertake these roles despite stepping back from the GIRFT role.

6. Dr Northover was appointed as Finance Officer for the Faculty of Child and Adolescent Psychiatry in the summer of 2022, providing access to the opinions of the Faculty and its members.

7. Dr Sacha Evans is a Consultant Child and Adolescent Psychiatrist at the Mildred Creak Unit, Great Ormond Street Hospital, which treats children aged eight to 13 years with eating disorders, functional presentations and emotional and behavioural disturbances. She is also the secretary of the paediatric liaison network.

Background

8. The proposed date range for Module 3 (“the relevant period”) is from 1 March 2020 (the month in which the UK went into lockdown) to 28 June 2022 (the setting-up date for this Inquiry as specified in the Terms of Reference).

9. In response to the Covid-19 pandemic in the United Kingdom, the UK Government introduced various public health and economic measures to mitigate its impact. Devolution meant that the four nations' administrative responses to the pandemic differed; the Scottish Government, the Welsh Government, and the Northern Ireland Executive produced different policies to those that applied in England. Numerous laws were enacted or introduced throughout the crisis.

10. The UK Government had developed a pandemic response plan in previous years. This was initially developed in 2011 as the UK influenza Pandemic Preparedness Strategy in collaboration with the devolved governments. There were no specific plans in place for mental health inpatient services in the UK's pandemic preparedness despite the likely serious toll on everyone's mental health due to social isolation, anxiety, financial stress and grief. No consideration was given to the impact on children and teenagers, who would face disrupted schooling and social isolation. In response to the first confirmed Covid-19 cases in January 2020, the UK Government introduced advice for travellers coming from affected countries in late January and February 2020, and began contact tracing, although this was later abandoned. The government incrementally introduced further restrictions on the public, in society and also within healthcare settings as the virus spread across the country in the following weeks. The Prime Minister Boris Johnson announced the first national lockdown on 23 March 2020 and Parliament introduced the Coronavirus Act 2020, which granted the devolved governments’ emergency powers and empowered the police to enforce public health measures.

11. As the governments across the four nations began lifting the stay-at-home orders, policies and approaches diverged between the four nations. Across the country, localised lockdowns, social distancing measures, self-isolation laws for those exposed to the virus and rules on face-coverings were introduced, as well as efforts to expand Covid-19 testing and tracing. In autumn and winter 2020, further lockdowns were introduced in response to a surge in Covid-19 cases and the Alpha variant. A Covid-19 vaccination programme began in December 2020. In mid-2021, most restrictions were lifted during the third wave driven by the Delta variant, until the "2021 Autumn/Winter plan" (the UK Government’s comprehensive approach designed to steer the country through autumn and winter 2021/22) reintroduced some rules in response to the Omicron variant in December that year. Remaining restrictions were lifted in England from 24 February 2022. A timeline of the measures that directly impacted on mental health inpatient units is covered in Annex 2.

12. During the Covid-19 pandemic, mental health inpatient units in the UK implemented various social distancing and testing policies to prevent the spread of the virus. These policies evolved over time as the understanding of the virus and its transmission improved. The policies varied slightly between England, Scotland, Wales and Northern Ireland. However, the iterative and varied nature of these policies, alongside other

confounding and service-specific factors, resulted in slightly different strategic approaches being taken across CYPMH inpatient units throughout the relevant period. It is not practicable to set out or define the slight differences between strategies across units and nations. Therefore, the impact of the various social distancing and testing policies are considered in this report as UK-based.

Terminology

13. *CAMHS/CYPMH:* Child and adolescent mental health services/children and young people mental health. Both terminologies are used, often in the same report and both describe the same thing: namely the mental health services for children and young people. The terminology has changed as young people surveyed have reported a preference for CYPMH.

14. *ARFID:* Avoidant Restrictive Food Intake Disorder. ARFID is characterised by a pattern of avoiding certain foods or food groups and/or consuming small quantities. This behaviour is not due to food scarcity or cultural practices (e.g. fasting or dietary restrictions for religious reasons. The condition is unrelated to body image concerns and is not aimed at weight loss.

15. *Mental Health Act:* The Mental Health Act, 1983 is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder in England and Wales.

16. *Mental Health (Care and Treatment) (Scotland) Act, 2003 as amended by the Mental Health Act (Scotland) Act, 2015;* the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder in Scotland.

17. *Mental Health (Northern Ireland) Order, 1986*: This is the main piece of legislation which provides the legal framework for the assessment, treatment and rights of individuals with mental health conditions in Northern Ireland.

18. *A&E:* Accident and Emergency. May also be called the Emergency Department.

19. *QNIC:* Quality Network for Inpatient Child and Adolescent Mental Health Services: Works with a network of inpatient unit members to develop an accreditation process to promote a high-quality of care and share best practice.

20. *PICU:* Psychiatric Intensive Care Unit.

21. The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. It monitors, inspects and regulates hospitals, care homes, dental and general practices and other care services to ensure they meet fundamental standards of quality and safety. The CQC has the power to register and de-register care providers and it can take enforcement action if services are not meeting the required standards.

22. In Scotland, the equivalent regulatory body for inpatient units is Health Improvement Scotland (HIS). It inspects impatient services, including mental health inpatient care to ensure they meet the required standards of quality and safety

23. In Wales, the regulatory body is Healthcare Inspectorate Wales (HIW). It inspects impatient services, including mental health inpatient care to ensure they meet the required standards of quality and safety.

24. In Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) is responsible for monitoring and inspecting the availability and quality of health and social care services. The RQIA works to ensure that services meet the required standards of quality and safety, and it encourages continuous improvement in the quality of these services.

25. *GIRFT:* Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. The GIRFT Children and Young People Mental Health report was England only.

Methodology

26. This report is based on personal experience, knowledge gathered through the period of the report and after (including through undertaking visits to most provider collaborative areas as part of the GIRFT report).

27. A literature review and interviews with members of staff from multiple units across the four nations were conducted in April/May 2024. These interviews occurred at a unit level with a multidisciplinary team with representation from multiple units. In addition, a presentation prepared by Dr David Kingsley identifying the specific issues within the secure setting was referred to.

28. Additional expert opinion was sought from Dr Josephine Holland, University of Nottingham and Professor Kapil Sayal, University of Nottingham and Chief Investigator of the Far Away From Home Programme.

29. The data in this report has been identified through the GIRFT report, NHS Benchmarking reports and the data returns for the UK Covid-19 Inquiry from all four nations. The amount of data available from England was significantly greater than from the other nations. This is likely due to the NHS England Specialist Commissioning function for CAMHS inpatient units which requires good data collection to discharge its duties. The GIRFT report was also England only. Where possible, appropriate data from all four nations has been added to the report. There has been no obvious difference in the messages being seen within the data from the four nations.

Overview of inpatient mental health services for those aged under 18

30. CAMHS inpatient units are often described as being a Tier 4 service, and whilst this terminology is falling out of favour it still requires explanation.

31. The tiered model of mental healthcare was developed in 1995 and rapidly became the most commonly adopted mental health system in the UK. It separates mental health services into four tiers based on the type of service provision.

32. *Tier 1:* Includes universal, non-specialist primary-care services, such as school nurses and GPs. These offer general advice and treatment for less-severe mental health problems such as mild anxiety or stress related to situations such as exams or minor life events, low mood that has not persisted for an extended time, mild behavioural concerns and mild sleep disorders.

33. *Tier 2:* Involves workers who are more specialised, but still provide a primary care service, such as counselling services.

34. *Tier 3:* Comprises specialist multidisciplinary outpatient teams, who deal with more complicated mental health problems such as severe depression or anxiety disorders that have not responded to initial interventions, eating disorders, psychotic disorders, complex post-traumatic stress disorders and high risk self-harm or suicidal behaviours. This is often described as specialist CAMHS.

35. *Tier 4:* Consists of specialised services which are provided as part of national commissioning. Typically, this includes day and inpatient units, to provide care for patients with the most severe problems; however, in some areas this will also include intensive home treatment teams and in some areas, day hospitals are considered Tier 3. Examples of presentations would be psychosis with significant risk to self or others or severe and persistent self-harm or suicidal ideation. Northern Ireland uses the similar terminology of:

    Step 1: Universal prevention

    Step 2: Early intervention

    Step 3: Specialist intervention

    Step 4: Intensive intervention

    Step 5: Intensive interventions (inpatient and regional specialist)

36. For the purpose of this report, the child and adolescent inpatient units are all considered Tier 4 units or inpatient units that meet the requirement of Step 5: Intensive interventions.

Provision within England

Inpatient Units

37. NHS child and adolescent mental health inpatient units are commissioned by individual NHS Trusts or independent providers. Decisions on closing or setting up new units are decided between the trust and NHSE, with NHSE holding the final decision on funding. According to the GIRFT report, during the period identified within this report, there were 34 units provided by NHS providers and 25 units provided by independent providers, totalling approximately 1,300 beds. The provider organisations are responsible for the estates, human resources, governance and effectiveness of the inpatient units. There is no structural difference between NHS-provided and independent-provided units. Finance

for the units is via the National Specialist Commissioning Team. As indicated by the Prescribed Specialist Services Manual there is an explicit difference between commissioning and contracting within the operating model (NHS England, 2023). All commissioning (for example, setting priorities and strategic direction) is done nationally, while all contracting and the prime focus for local relationship management with providers is the role of the regional area teams. Each of the regional area teams hold a single NHS England contract with providers in their area for all agreed service provision for specialised services. Finances are distributed through provider collaboratives

Provider collaboratives

38. There are 18 provider collaboratives across England. The principle behind provider collaboratives is to enhance collaboration between NHS trusts and independent and voluntary sector providers to deliver more efficient and sustainable services, to work in partnership with people with lived experience to improve the quality of care provided and to tackle health inequalities for the local population. The provider collaborative enables a more collaborative and joined-up approach to commissioning and associated service delivery through admissions and discharge planning, increasing the likelihood of patients getting access to appropriate services that best suit their needs at the earliest possible opportunity, including accessing appropriate community treatment rather than going into hospital if it is not needed.

39. Each provider collaborative is required to have a lead organisation that will provide the quality and governance assurance and be responsible for the financial oversight of the provider collaborative. Good practice assurance remains with the lead provider and provider collaboratives are responsible for managing an agreed budget, and reinvestment governed through a partnership approach.

40. At present the provider collaborative areas do not match with the ICS areas, which can add complexity to the system. There is an additional provider collaborative across England supporting the low-secure and medium-secure units (these units are explained in more detail below at paragraphs 54-55).

Specialised Commissioning

41. NHS England's Specialised Commissioning team is responsible for direct commissioning of a number of services, including CYPMHS inpatient services. It exercises these commissioning functions centrally and in each of NHS England's seven regions. Its work involves the assurance of the clinical governance, safety and effectiveness of the providers' services – whether services are delivered by NHS trusts or the independent sector. However, it also includes monitoring the care of individual patients. This might involve attending reviews and achieving assurance that a person is getting good care and the right treatment, progressing towards appropriate discharge from inpatient care. This occurs rarely and only where specific issues have been escalated to NHS England. Case managers are responsible for oversight of the pathway of an individual and carry out service reviews to ensure that they are delivered against the contracted and published service specification. As indicated by the Manual, much of that oversight is now undertaken by the NHS Lead in Provider Collaboratives, with NHS England obtaining assurance that collaboratives are fulfilling this role (NHS England, 2018).

Provision within Scotland

Inpatient Units

42. As in England, NHS Boards are responsible for the estates, human resources, governance and effectiveness of the inpatient units. There are three General Admission Units with a total of 54 beds and one Children's Unit with six beds, totalling 60 beds.

43. As indicated in a parliamentary response, these units are split in regions across the North of Scotland, South and East and West (Scottish Parliament, 2024). These units admit children and young people from health boards in that region, with the flexibility to admit from other regions if the unit closest to a child or young person is full.

44. Additionally, the National Child Psychiatry Inpatient Unit in the Glasgow Royal Hospital for Children has six beds for children under 12, admitting patients from across Scotland based on clinical need. This includes one to two beds for children with profound learning disabilities and mental health disorders.

45. During the period covered by this report, Scotland had no low or medium secure beds. When such beds are required, these will be directly commissioned within England-based units resulting in significant travel for families. A National Secure Adolescent Inpatient Service is currently being built.

Provision within Wales

46. As described in the Welsh Specialised Services Specification (Welsh Health Specialised Services Committee, 2023). There are two NHS-provided inpatient units in Wales providing 30 beds in total. During the period of the report there was one independent unit, however this unit was removed from the Commissioning Framework in 2018 and as such should not have been used for NHS-led admissions.

47. The units are run by individual NHS providers in the same manner as in England. The Welsh Health Specialised Services Committee undertakes the same role as the NHSE specialised commissioning team. Given that there are only two units, there is no need for a provider collaborative structure in Wales.

48. Forensic admissions are commissioned from English units on a spot purchase basis. A 2019 review identified 11 young people in English units with five in low-secure settings, four in medium (Mills, 2019).

Provision in Northern Ireland

49. Northern Ireland has a single CAMHS inpatient unit with 33 beds serving all five mental health trusts.

50. There are no dedicated forensic units, necessary beds are spot-purchased from England, requiring the child to travel there.

Description of unit types

51. Child and adolescent inpatient units are typically grouped together, but in practice, there are distinct unit types. These types are consistent across all four nations and are described in the Tier 4 CAMHS general adolescent service specification (NHS England, 2018).

52. As mentioned, Tier 4 inpatient CAMHS services in the four nations offer care at four levels to support the effective management of differing nature of risk presented by children and young people under 18.

53. Secure services provide care and treatment for individuals with mental and/or neurodevelopmental disorders detained under the Mental Health Act (MHA) 1983, Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Health (Northern Ireland) Order 1986 and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings.

54. Medium-secure services accommodate young people with mental and neurodevelopmental disorders, including learning disability and autism, who present the highest levels of risk of harm to others, including those who have committed grave crimes.

55. Low-secure services are facilities that provide care for young people who have mental health or neurodevelopmental disorders. These facilities have lower levels of security compared to medium-secure services, but still have significant measures in place to ensure the safety of the young people and others around them. These measures include physical security (e.g. locked doors), relational security (e.g. staff-patient trust) and procedural security (e.g. having strict rules and routines). The young people in these facilities usually fall into one of two groups:

    a. The "forensic" group: These are young people who have a history of causing significant harm to others or are at risk of doing so due to their mental health condition.

    b. The "complex non-forensic" group: These young people may not be a significant risk to others, but they display challenging behaviour, engage in self-harm or are highly vulnerable due to their mental health condition.

56. Psychiatric Intensive Care Units (PICU) manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. These units require similar levels of physical security (e.g. locked doors), relational security (e.g. staff-patient trust) and procedural security (e.g. having strict rules and routines) as low-security settings.

57. General adolescent services provide inpatient care without the need for enhanced physical or procedural security measures. Some general adolescent services admit

young people with a severe eating disorder whereas others may rely on specialist eating disorder services.

58. Specialist eating disorder services admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding if these cannot be done in an outpatient setting.

Overview of mental health problems for children and young people under 18 and criteria and processes for admission to inpatient care

59. Adolescent inpatient units admit young people based on their complex presentation, rather than on a basis of diagnosis alone. Typically, admissions occur when the individual's presentation involves either a high level of risk or a need for frequent intervention that cannot be managed in the community.

60. Units will support young people with learning difficulties or autism as part of their presentation, but would not admit them if these were the sole diagnoses. There are eight wards in England who support young people who have a mental disorder and a learning difficulty or autism, which require care in an environment that needs to be tailored to their needs. These units are not covered within this report.

61. Specialist eating disorder units will only admit young people who have a primary presentation of anorexia nervosa or bulimia nervosa. It is possible that they may admit young people with an avoidant restrictive food intake disorder; however, those presentations are usually better managed on a general admission unit. As the presentations within specialist eating disorder units are also managed within general admission units, these unit types are combined within this report.

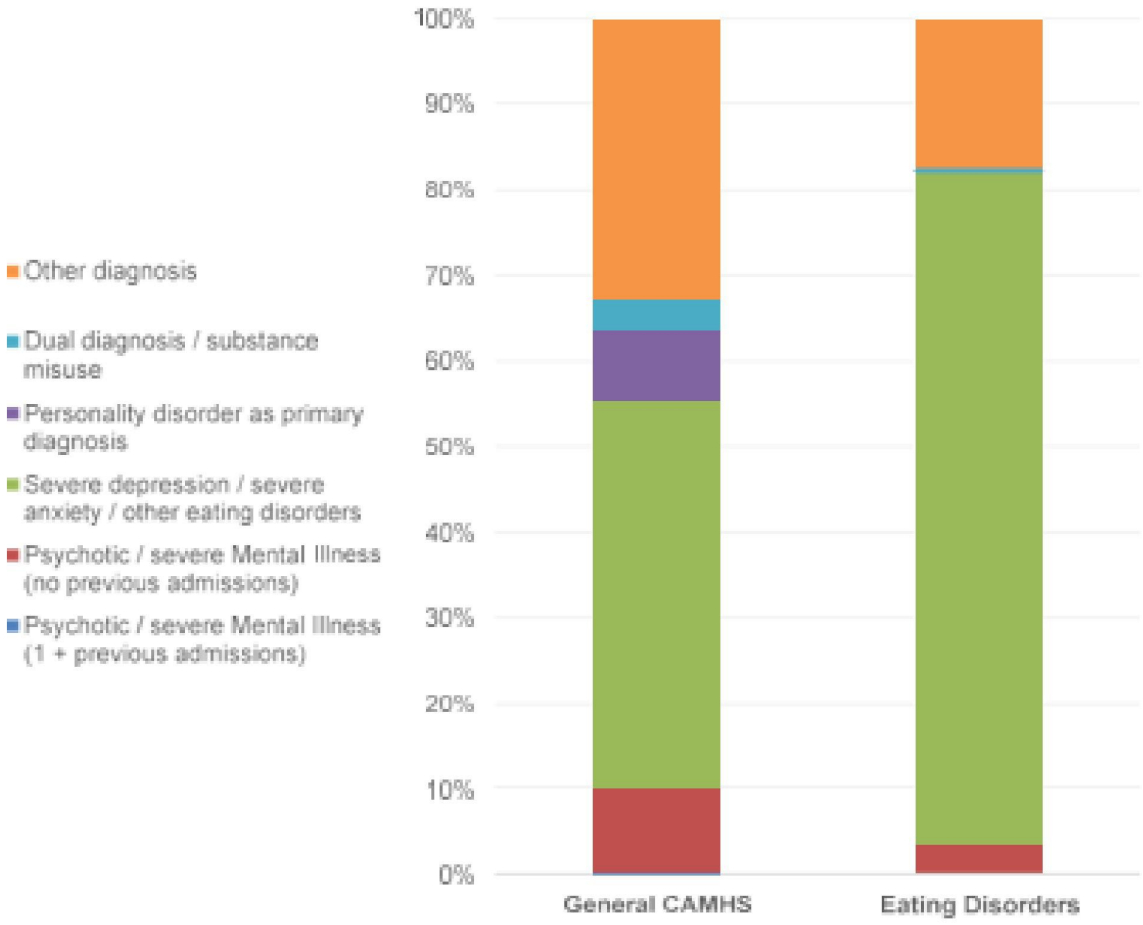
62. In low-secure and medium-secure units, individuals typically have complex chronic mental disorders, which are linked to offending or seriously harmful behaviour. Some individuals will be involved with the criminal justice system (CJS), courts and prison and may be in the unit due to a court order. Medium-secure services accommodate young people who present the highest levels of risk of harm to others, including those who have committed grave crimes. These presentations are 'forensic': i.e. the young people are undergoing, or have undergone, legal or court proceedings. Low-secure services accommodate some 'forensic' presentations (including children posing a risk to others), but also complex non-forensic presentations (including children who are vulnerable or at risk of self-harm, or whose behaviour is otherwise challenging).

63. Children's inpatient units admit children aged up to 13 years old. There are six units in England offering up to 66 beds. Similar to adolescent inpatient units, admissions are based on the complexity of presentation rather than diagnosis alone, when they are unable to be supported in the community.

64. As indicated in the graphs below, from the GIRFT National Speciality report the most common presentation for an admission is depression, anxiety or eating disorder, followed by personality disorders and psychosis (GIRFT, 2022). The GIRFT report covers England only, and admissions by diagnostic group was not available for the devolved nations;

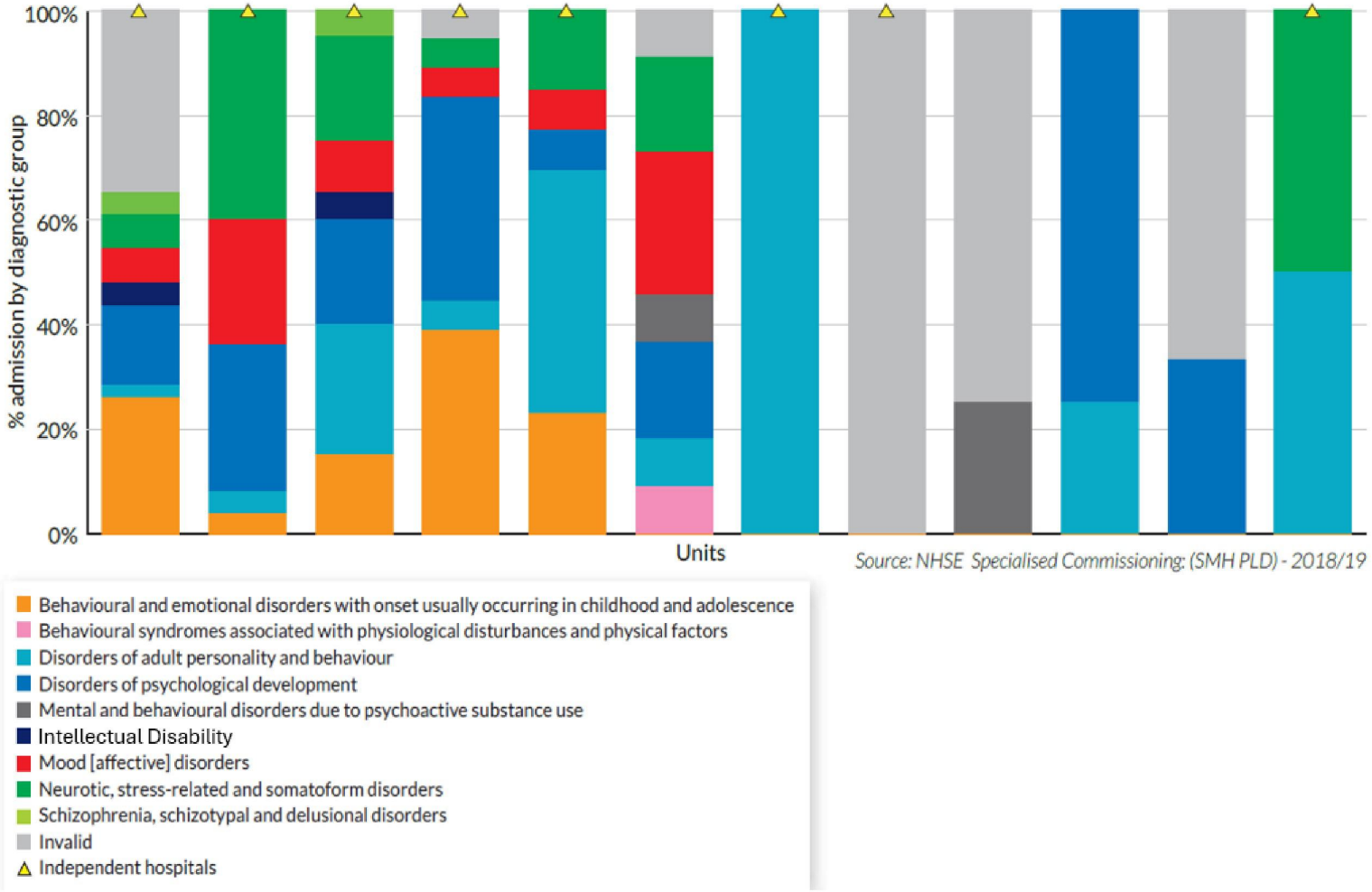
however, there is no clinical reason to suspect a different pattern of admissions within the devolved nations.

Figure 1: Proportion of admissions by diagnostic group, England



Source: NHSBN, 2018/19

Figure 2: Low secure unit - proportion of admissions by ICD10 diagnostic chapter



Source: NHSE Specialised Commissioning Data, 2018/19

The number of child and adolescent psychiatric inpatient units in each of England, Northern Ireland, Scotland and Wales

Table 1: Number of CAMHS inpatient units and beds in each Nation.

Nation	Unit Type	Number of Units	Number of beds
England	GAU/SEDU	59 (-6 children)	1300 (approx.)
	Low Secure	11	
	Medium Secure	7	
	Children	6	
Scotland	GAU	3	54
	Children	1	6
Wales	General Admission	2	30
Northern Ireland	General admission	1 (2 wards)	25 (and an additional 4 PICU beds)

65. There are currently 54 Child and Adolescent Mental Health Service (CAMHS) inpatient beds across Scotland for children and adolescents.

66. Forty-eight of these beds are commissioned on a regional basis. Additionally, the National Child Psychiatry Inpatient Unit in the Glasgow Royal Hospital for Children has six beds for children under 12 years and admits children from across Scotland. This includes one to two national beds for children with profound learning disabilities and mental health disorders.

67. There are two NHS-provided inpatient units in Wales providing 30 beds in total.

68. In Northern Ireland, there is one child and adolescent mental health inpatient unit with two wards and 29 beds. The unit will accept referrals from across Northern Ireland; for secure units, referrals are made to England.

Details of staffing of inpatient paediatric psychiatric units

69. CAMHS inpatient units are staffed by a multidisciplinary team made up of medical, psychological, nursing and social care staff. While specific staffing levels are determined by individual providers, QNIC standards (Quality Network for Inpatient CAMHS, 2022) set clear expectations for a 12-bedded unit, including:

    a. Two qualified nursing staff at all times during the day and one at night, with enough nursing staff to safely meet the needs of young people at all times

regardless of the acuity level of the ward (the acuity level describes how challenging the ward is based on the mix of patients, their individual needs, and the overall environment. Some patients may require more attention and support than others, and the ward's acuity can change over time. No matter how complex the situation is, there should always be enough staff to provide safe, high-quality care to every young person on the ward.);

b. 1.5 WTE responsible clinician input, at least 0.5 WTE of which should be provided by a consultant psychiatrist, supported by one FTE non-consultant psychiatrist;

c. 1 WTE clinical psychologist who contributes to the assessment and formulation of the young people's psychological needs and the safe and effective provision of evidence based psychological interventions;

d. 0.5 WTE family therapist;

e. 0.5 WTE social worker;

f. 1 WTE occupational therapist;

g. easy access to a dietician; and

h. formal arrangements to ensure easy access to a speech and language therapist.

70. Staffing levels within inpatient units vary greatly depending on the staffing models. Data from the NHS Benchmarking network identifies on average (NHS Benchmarking Network, 2024):

a. general admission: 35.2 staff per 12 beds; or

b. eating disorder: 33.7 staff per 12 beds.

71. With a workforce split as indicated below.

Figure 3: Inpatient CAMHS workforce profile

	All Participants
Total Nursing	29%
Support worker / Unqualified Nursing Staff	43%
Nursing Associates - Band 4	1%
CAMHS consultant psychiatrist	2%
Other medical	2%
Clinical Psychology	3%
Psychotherapy	1%
Therapists	2%
Allied health professionals	3%
Social worker	1%
Education (staff employed by CAMHS)	1%
Inpatient Operational Management	2%
Other	3%
Admin	6%

Source: NHSBN, 2018/19

72. Support workers do not require a specific qualification. Their role is to assist with daily activities such as personal care, meals and recreational activities, monitoring young people's well-being, reporting concerns and maintaining a supportive and therapeutic environment.

73. Staff training and experience of managing physical health care: All health staff are expected to have training in understanding physical health problems. All units will have a physical health examination room; QNIC standards indicate that a physical health review should begin within four hours of a young person's admission. All units are able to request physical health investigations and have good links with their local acute hospital. There are specific physical health monitoring requirements for young people on specific medications which are audited at a national level. This is consistent across all four nations.

Access and admission to inpatient treatment.

74. This report focuses on specialist commissioned CAMHS inpatient beds and excludes private admissions arranged outside of these processes (such as an individual or family paying for an admission).

75. Whilst there are some operational process differences across the four nations, which are described below, the principles behind access and admission to inpatient units is consistent.

76. Inpatient CAMHS can usually only be accessed via:

    a. a referral from a community Tier 3 CAMHS team such as specialist CAMHS team, a specialist eating disorder team, early intervention in psychosis team or a crisis team.

    b. an unplanned admission via a crisis presentation at an emergency department or health place of safety.

    c. referrals from schools, GPs, social care, self-referrals or family usually go to a community team which may then assess and determine if an inpatient admission is necessary.

77. A health-based place of safety is defined across all four nations as a 'place of safety for the purpose of an assessment.' It is a place where a person can be taken for a mental health assessment if they are believed to be suffering from a mental disorder and are in need of care for their own protection or the protection of others. It requires the young person to be transported by police to the place of safety.

    a. In England and Wales, young people are detained and transported under Section 135/136 (S135/136) of the Mental Health Act 1983 (amended 2007).

    b. In Scotland, the equivalent of Section 136 of the Mental Health Act 1983 (England and Wales) is Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

    c. In Northern Ireland, the equivalent of Section 136 of the Mental Health Act 1983 in England and Wales is Article 129 of the Mental Health (Northern Ireland) Order 1986.

78. Planned admissions are less common and may be described as arranging an admission due to the young person requiring medically necessary treatment that cannot be provided in another setting or a lower level of care, but is not related to an immediate risk to the young person. This can happen for several reasons. For example, they may need to start taking a new medication that requires close monitoring of their physical health, which cannot be done safely while they are at home. In other cases, a young person may need more intensive therapy than what can be provided through community-based services. Additionally, if a young person has been receiving support through crisis care but their mental health continues to worsen, a planned admission to an inpatient unit may be necessary to provide a higher level of care.

79. An unplanned/urgent admission may be described as an urgent or involuntary admission to a psychiatric inpatient unit needed to maintain the patient's safety or avoid an immediate and significant deterioration of their mental health. An example may be a young person presenting to A&E with significant risks of suicide or a patient presenting with a psychosis leading to harm. Whilst it may take a number of days to identify a bed for the young person to be admitted to an appropriate mental health unit, the time taken to find the bed does not make the admission planned.

80. The initial aim of an assessment is to determine if the young person required an admission to an inpatient unit or if a less restrictive alternative is suitable. The second part of the assessment would be to determine if the young person is able to consent to the admission or if they require an admission under the Mental Health Act.

81. Detentions under the Mental Health Act (MHA) 1983, Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Health (Northern Ireland) Order 1986 do not determine if an admission is planned or unplanned but are related to the young person's ability to consent to the admission and the treatment to be offered.

82. Young people awaiting a planned admission typically remain in the community, for example in the family home.

83. Most admissions are voluntary, where the young person is in agreement with the plan; however, a percentage of admissions are under the Mental Health Act (MHA) 1983, Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Health (Northern Ireland) Order 1986.

84. The referral in England is completed on a standardised form across all provider collaboratives and units (NHS England, 2018). These referrals are reviewed by the provider collaborative, which decides on the admission. On most occasions, the young person will not be seen in person by the inpatient team prior to admission. On occasions, there can be a difference of opinion between the community team and the provider collaborative on the appropriateness of an admission; however, it is widely accepted that the provider collaborative holds the knowledge and experience to make the final decision on admission or a recommended community package of care.

85. In Scotland, there is a consistent referral form to all these units across all Health Authorities Regions. The admitting team will usually aim to review the patient prior to admission.

86. In Wales, almost all referrals to the inpatient units will be reviewed in person by the inpatient unit prior to an admission being agreed. This can lead to a young person staying in a paediatric environment for a period of time or briefly being admitted to an adult ward prior to transfer to the inpatient unit, depending on the availability of the assessing team. This process ensures robust admissions decisions. In Northern Ireland, all referrals are discussed in detail, but are usually not reviewed in person.

87. There are no specific targets for time taken from referral to admission to inpatient services in England, Scotland, Wales or Northern Ireland. However, the Care Quality Commission (CQC) released guidance on the care of children and young people in unsuitable hospital settings (which identified a range of criteria including those young people admitted in a mental health emergency and awaiting a suitable care or treatment package such as a CAMHS inpatient bed (CQC, 2023). Once it has been determined by a multi-agency team that a young person requires a CAMHS Tier 4 inpatient bed, and one is unavailable, they are considered to be within an unsuitable hospital setting. There are circumstances when an acute hospital ward is the right place for a young person presenting with a mental health disorder, for example if they are physically compromised or require a physical health intervention. Healthcare Improvement Scotland recognises the need for paediatric staff to have appropriate skills and training, but only the CQC has released such specific guidance.

Changes to the admission process during covid:

88. Verbal reports from inpatient staff and data from NHSE data showed a decline in the number of planned admissions throughout the Covid-19 period (Tsiachristas et al., 2024), (NHS England Digital, 2024). The hypotheses behind this, to which the authors agree, were:

    a. The admission process during the Covid-19 period involved a sustained period of isolation on admission to a unit, complicating visits from relatives and making community-based options more appealing to families and professionals.

    b. Most therapeutic support shifted to virtual therapy; diminishing the benefits of admission for young people less likely to engage with online therapy.

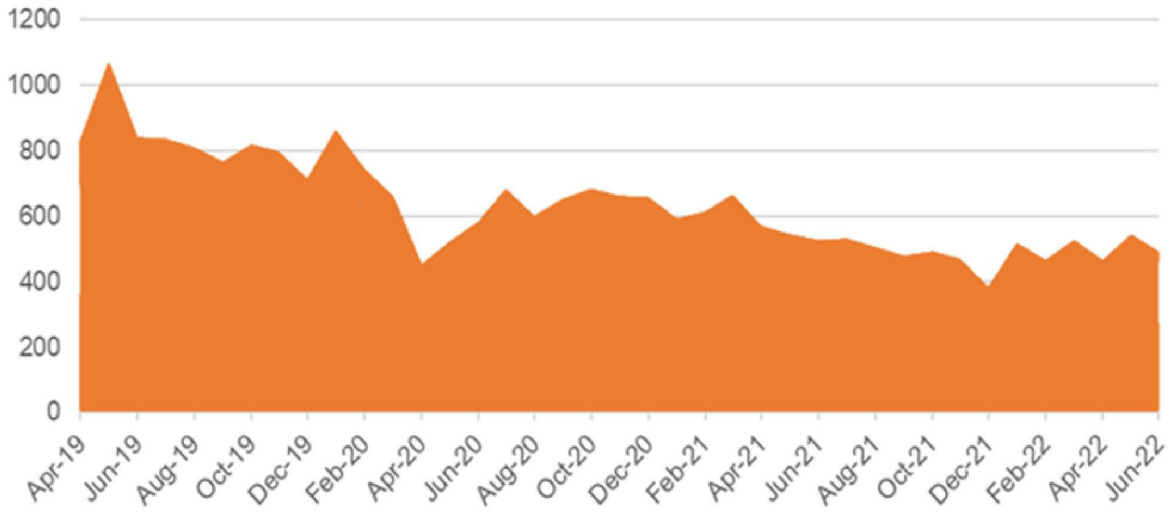
    c. There was an associated increase in the provision of alternatives to inpatient admission, such as home treatment and the provision of virtual and face-to-face therapy at home.

89. The time taken from the decision to admit to being admitted onto a psychiatric inpatient ward increased substantially during the period of Covid-19. This was due to reduced bed availability, confirming the patient's physical health, such as Covid-19 status checks, and increased staffing challenges for patient reviews. This was balanced by increased psychiatric support onto paediatric wards; however, it is difficult to ascertain if this resulted in longer admissions or other harm given all the confounding factors at this time. It is however clear that the patient experience would have been impacted given that the young person would have been defined as being in an inappropriate environment whilst awaiting admission.

90. In Wales, there was a reported significant decline in the number of face-to-face assessments conducted by staff from inpatient units before a young person was admitted to the mental health inpatient unit. The unit that was contacted for this report suggested that some admissions might have been less suitable than indicated on referral documents. The restrictive environment of an inpatient unit can sometimes increase distress and worsen mental health symptoms for individuals with complex presentations, which can also lead to longer admissions. Robust pre-admission assessments can sometimes identify appropriate community support which may lead to a quicker recovery from their crisis. These admissions and extended stays may have strained bed availability. This was a specific issue for Wales as pre-admission assessments by inpatient unit staff do not frequently occur in England, Scotland or Northern Ireland.

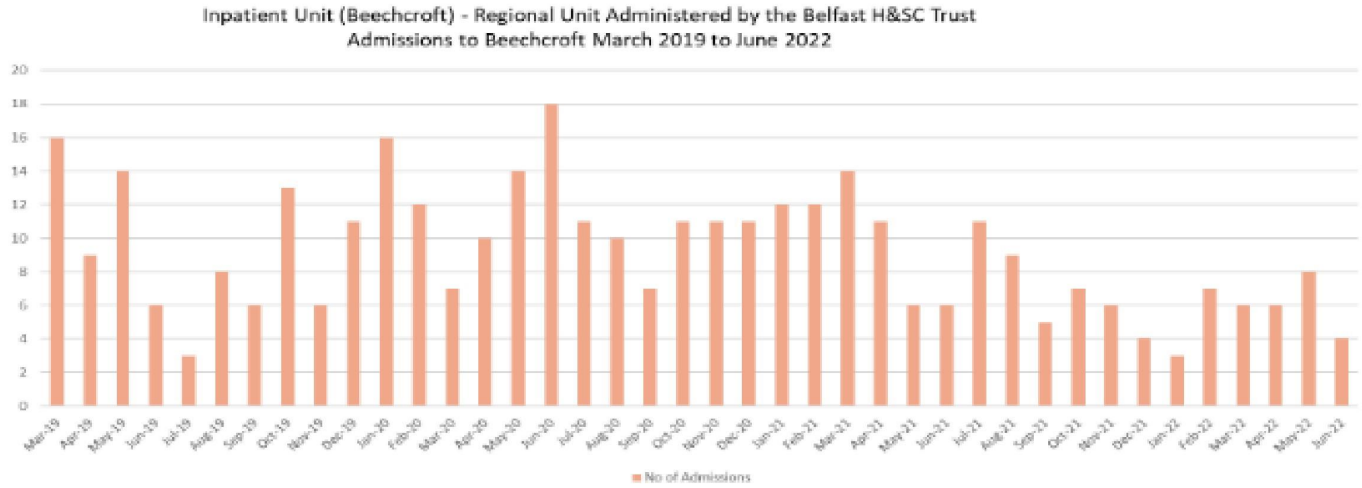
91. We were not able to review this data at the level of population health or through the lens of health inequalities.

Figure 4: CAMHS inpatient admissions, ages (0-17), England, monthly, April 2019 to June 2022

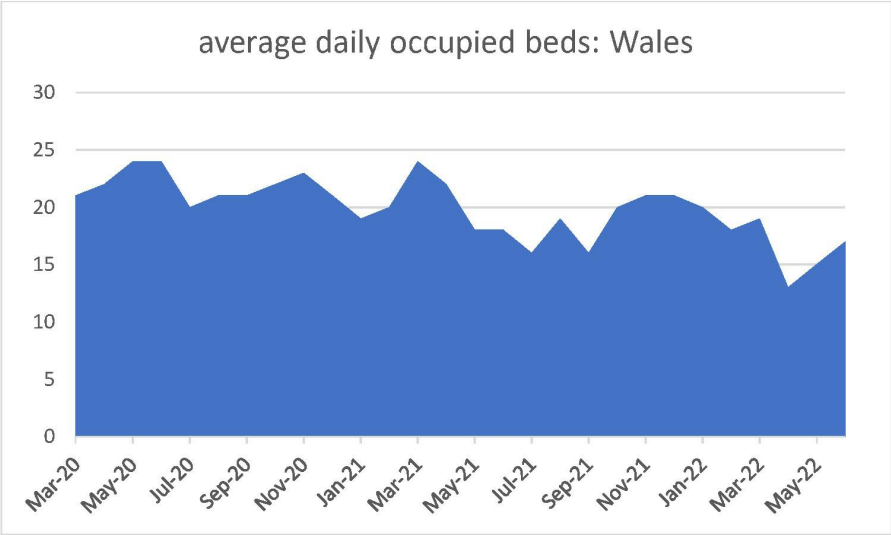


Source: MHSDS data, 2019-2022

Figure 5: Northern Ireland admission data, March 2019 to June 2022



92. We were not able to access admission data from Wales, but we did have access to average daily occupied bed days.



93. We could not locate the Scotland admissions data for this report, but the Scottish Government's Mental Health and Learning Disability Inpatient Bed Census shows CAMHS inpatient unit occupancy rates of 87% in 2019 and 98% in 2018. The census recorded 46 CAMHS inpatients in 2022, compared to 52 in 2019 and 57 in 2018 (Scottish Government, 2022).

The impact of Covid-19 testing on admissions

94. No unit that we spoke to identified that there was a challenge in the availability of testing for Covid-19 for patients. However, the regulations requiring isolation on coming into the unit until a negative test could be confirmed added significant challenges (Holland et al., in press).

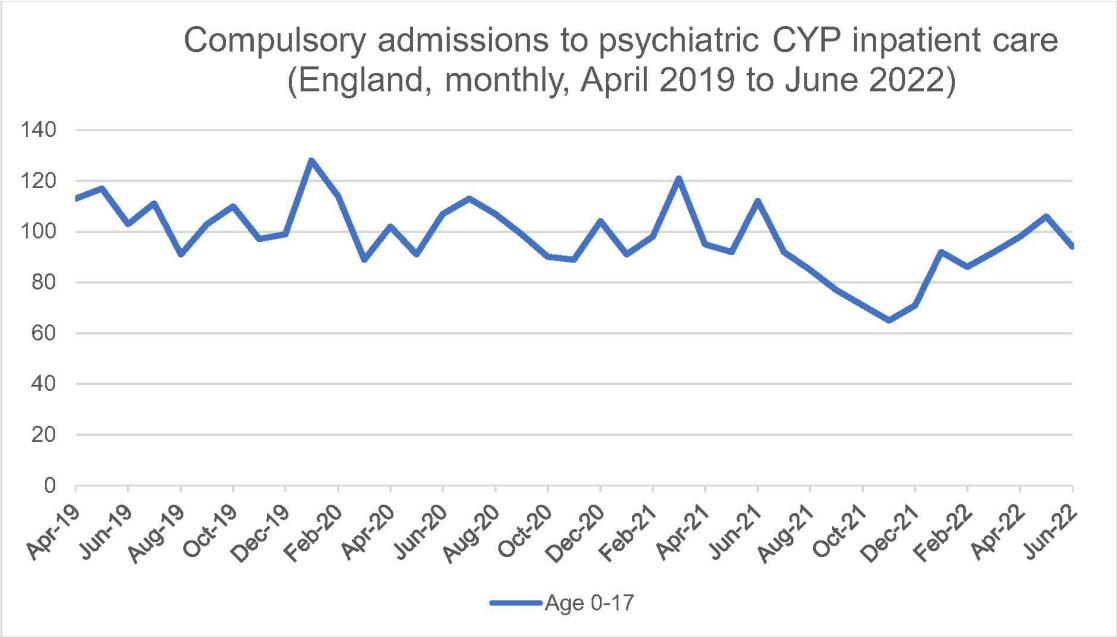
95. Each unit we spoke to identified that the length of time (which varied based on the isolation rules at any particular time during the Covid-19 pandemic) that the young person spent in isolation was detrimental to the provision of therapy and socialisation of the patient. These views were also shared by young people and parents interviewed following inpatient admissions (Holland et al., in press). Isolation periods also hindered family visits, as even brief departures necessitated further isolation. After the initial increase in discharges, before the social distancing rules were implemented and when the unit and family were able to consider different options to inpatient care, there was a reported difficulty in discharging patients. Discharge became more challenging as increasing periods of leave took longer with periods of isolation on returning to the ward.

96. All mental health inpatient units for young people in the UK experienced changes in their usual discharge processes. Typically, before a young person is fully discharged from the unit, they are given a period of leave to test how well they cope outside the hospital environment. However, due to the restrictions imposed by the pandemic, the units were unable to provide this trial period of leave. As a result, the units felt compelled to keep the young person in the hospital for longer periods, until they were more confident that the patient had recovered sufficiently to manage without the need for a gradual transition

through a leave period. This led to longer admissions overall, as the units aimed to ensure a higher likelihood of successful discharge without the usual opportunity to test the patient's stability outside the hospital setting. Young people can struggle with the impact of having their movements and access to the community restricted and it is a known risk factor for challenging behaviour on an inpatient unit to have leave or visits cancelled, it can therefore be hypothesised that increasing these restrictions could have led to increased risk of aggressive behaviour on some units.

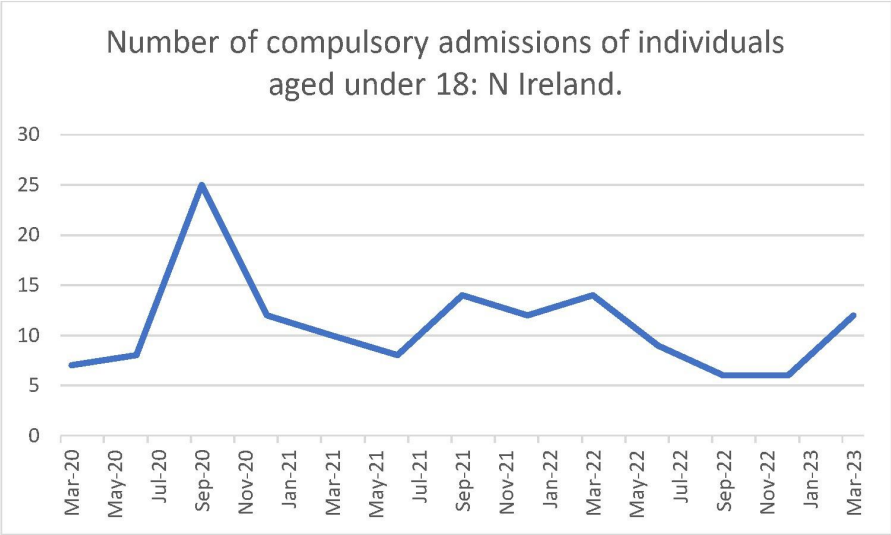
Compulsory admissions under Mental Health legislation

Figure 6: Compulsory admissions to psychiatric CYP inpatient care



Source: MHSDS data, 2019-2022

97. There is no clear reason for the apparent drop in detentions under the Mental Health Act in October 2021, which is not replicated in the Northern Ireland data. The low number of monthly detentions can cause seemingly significant data fluctuations. Certainly, by January, the detentions appear to follow the long-term trend once again.



98. The data on the number of patients admitted under the Mental Health Act in England shows there was no significant change during the pandemic. Although there is a slight decrease in the number of detentions, the low numbers make it hard to determine the trend's significance.

99. This data has some notable limitations: it excludes patients initially admitted voluntarily who were later detained under the Mental Health Act as inpatients, and it does not account for the total number of Mental Health Act assessments, as those not leading to detention are unrecorded.

100. The Northern Ireland data shares the same limitations and is more difficult to interpret given the very low numbers of detentions under the Mental Health Act within this population. Given this, it is difficult to draw any conclusions about the spike in detentions seen in September 2020.

101. The decline in Mental Health Act admissions during the Covid-19 period is less pronounced than the overall decline in total admissions, suggesting a higher proportion of patients were admitted under the Mental Health Act, despite the numbers remaining constant.

102. Despite these limitations, when we talked to individual units in England, Scotland, Wales and Northern Ireland, they all said they did not see a big change in the number of young people detained under the Mental Health Act during the pandemic.

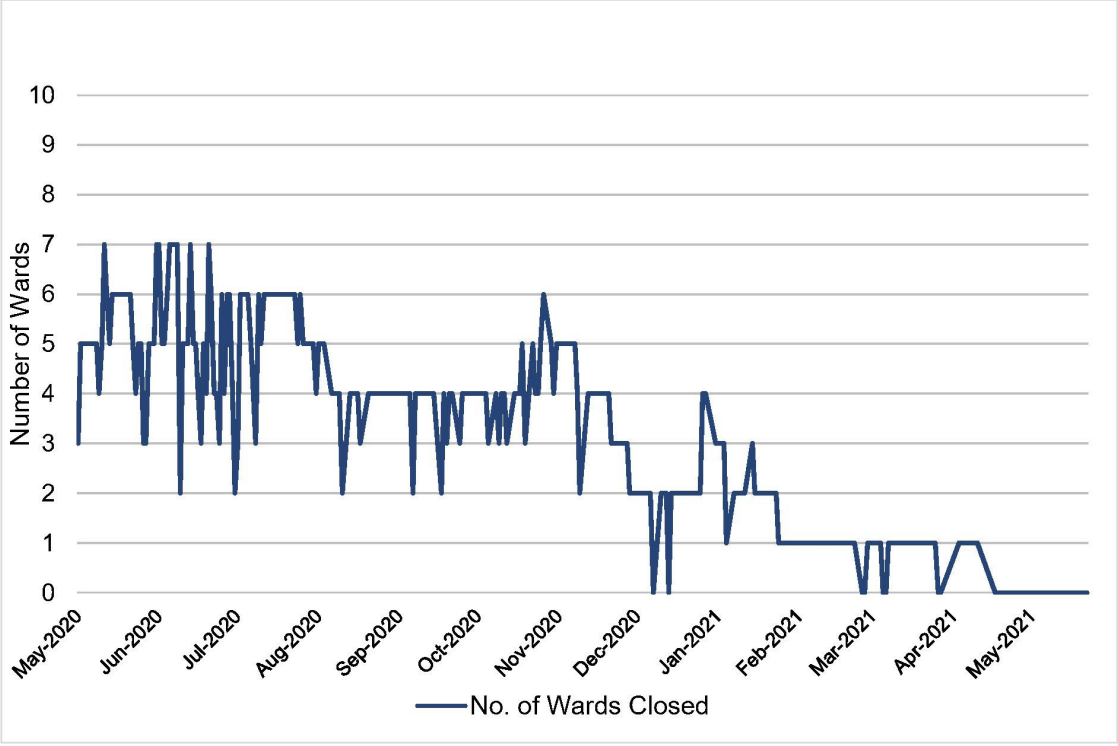
Changes in demand for inpatient services

103. Children and adolescents are at higher risk of anxiety and depression due to social isolation and lockdown, as evidenced in a rapid systematic review (Loades et al., 2020).

104. All staff within inpatient units contacted for the purpose of this report identified a feeling of decreased capacity on inpatient units at the time of Covid-19. It appears that capacity on units did decrease during the pandemic period, with multiple providers needing to close one ward to ensure that their second ward was able to remain open and some units moved from inpatient to day service only. Other units reported that the social distancing and

visiting rules that were in place made it difficult to keep all beds occupied, for example multi-occupancy rooms had to be converted into rooms for a single young person. Staff sickness may also have been a factor in keeping all beds open and the potential need for increased staffing levels to support young people who were having to self-isolate. This is maintained in the English data, which suggests that at the beginning of the Covid-19 pandemic between five and seven wards were closed at any one time within England. It is reported that the Welsh, Northern Irish and Scottish wards all remained open. However, there is no clear reason why England closed units but Wales, Northern Ireland and Scotland did not. The reason for this discrepancy is unclear, though it is suggested that English units, typically having multiple wards, had the flexibility to close one while keeping others open—an option not available to single-ward units. This presents a trade-off between maintaining multiple wards with suboptimal staffing and reduced capacity versus closing one ward to optimise staffing and capacity in another.

Figure 7: CAMHS inpatient wards closed completely for reasons related to Covid-19. (England, daily, 5 May 2020 to 26 May 2021)



Source: NHS England Mental Health, Learning Disability and Autism Demand and Capacity SitRep, 2020-2021

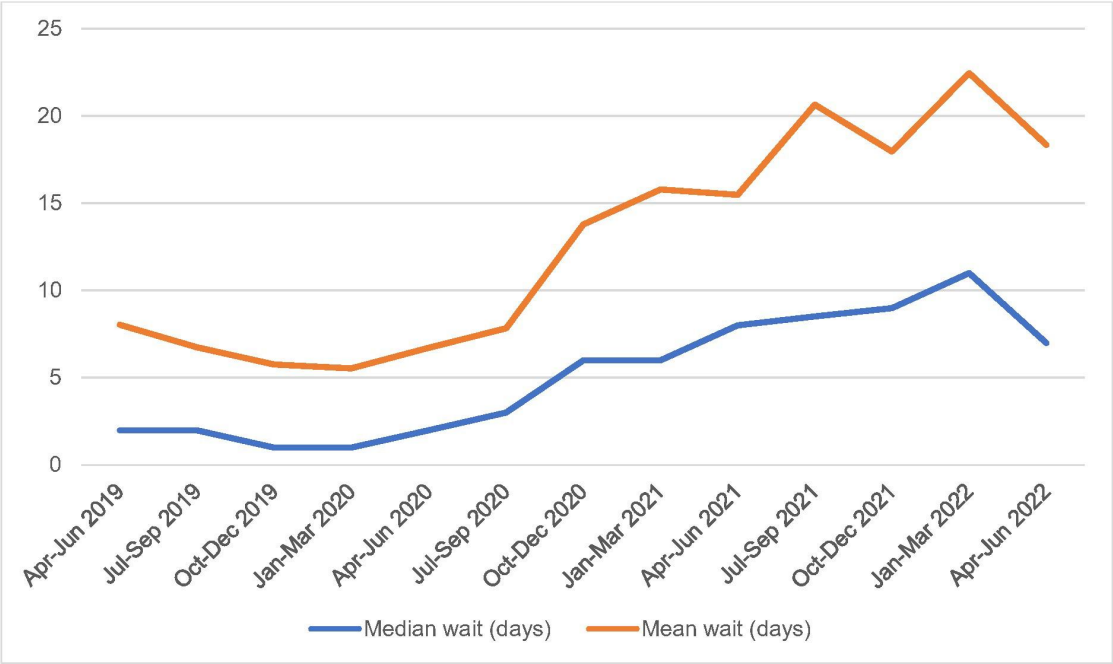
105. There was an increase in admissions to adult wards over the period of this report. A young person admitted to an adult ward must be reported to the CQC and, as such, there is robust data for England. The CQC received 45 notifications of admissions lasting 48 hours or more in the first three months of 2019, 56 in the same period of 2020, and 66 for the same period in 2021 (CQC, 2022). Covid-19 restrictions would have been in place when the young person was admitted to the adult ward and again if they were to transfer to a CAMHS inpatient unit, exacerbating the challenges of accessing appropriate therapeutic

support in a timely manner. If a young person is admitted to an adult ward, then the ward is required to provide 1:1 observations at all times to that young person, which potentially fed into the decision making on where the young person would remain awaiting a CAMHS bed. It is possible that young people were maintained for longer in a health-based place of safety, although this data is not specifically collected.

106. A CQC review of mental health care of children and young people during the Covid-19 pandemic identified that in England there was an increase in the number of young people in an acute hospital setting awaiting a specialist CAMHS bed, along with longer wait times for bed availability (CQC, 2021). Although data on admissions of young people awaiting admission from a community setting is not available, the same challenges in admission may be present. In Wales, one unit reported increased admission times, but specific data was not readily accessible.

107. NHS Mental Health Services Data Set (MHSDS) indicates that there was a significant increase in the average wait time between referral and admission, increasing from an average median of one to two days wait to a peak of 111 days wait in the last quarter of 2021/22 (NHS England Digital, 2024). This data must be taken with some caution because very long waits for a bed are usually as a result of a need for a highly specialised bed, differences in opinions between community teams and inpatient teams on appropriateness of admission, or due to coexisting complex health presentations. However, both providers and clinicians acknowledge the average increase in admission time. This may have been related to further assurances of the physical health of the young person, more time being spent trying to identify a less restrictive treatment option and wards may have struggled with admitting more than one person in a day. For the purpose of this report, we did not identify Mental Health Act assessments being overruled by unit-level access assessments as a reason for this increase in wait time (on occasions a young person may be assessed in the community under the mental health act and recommendations to detain made however on review by the inpatient unit it becomes apparent that the unit does not feel that the mental health condition will improve if admitted and as such cannot admit the young person). Whilst this increase was seen across all areas of England and all four nations, the data for this report was not broken down in enough detail to understand if there were any trends or themes across the four nations.

Figure 8: Average wait times between referral and admission to inpatient CAMHS services (England, quarterly, 2019/20 Q1 to 2022/23 Q1)



Source: National Case Management System (NCMS), 2019-2022

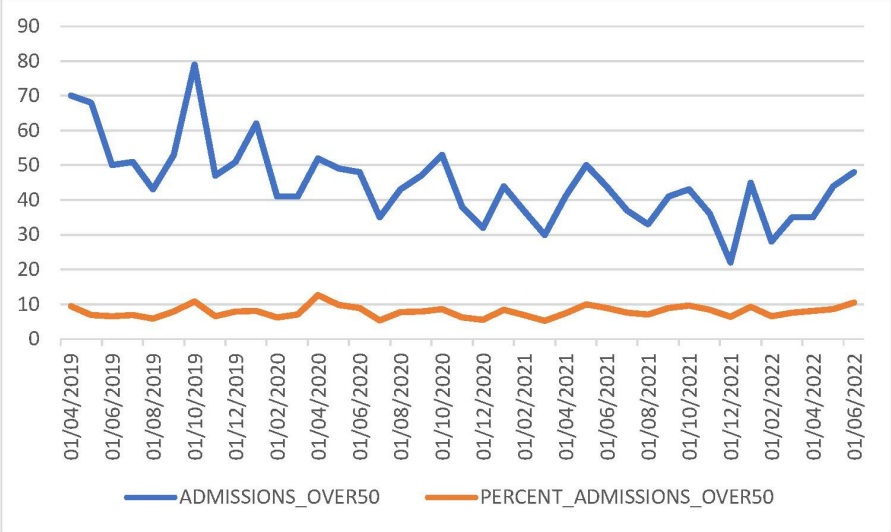
108. The CQC review identified that the largest increase in young people in an inappropriate setting were young people presenting with an eating disorder. There is substantial evidence to suggest that severe eating disorder presentations significantly increased during and beyond Covid-19. Some good practice arose as a result of these pressures, with acute physical health hospitals working with mental health providers to minimise/mitigate the impact of any delays through provision of training on the units and increased eating disorder outreach services. In some areas, a recognition that the research literature suggests that best practice in the treatment of anorexia nervosa can include multiple readmissions onto a paediatric ward with intensive community support rather than a CAMHS inpatient admission (Herpertz-Dahlmann et al., 2014), (Gowers et al., 2007).

109. During the pandemic, the rise in eating disorder admissions was due to an increase in presentations of eating disorders of varying severities across the four nations, not merely an increase in admissions of known cases. This significant increase continued post-pandemic and has further impacted the ability of community eating disorder services to manage capacity. An analysis by the Royal College of Psychiatrists using NHS data on Child and Adolescent Mental Health Services (CAMHS) eating disorders services between October and December 2023 found that just 63.8% of children and young people needing urgent treatment from eating disorder services were seen within one week and only 79.4% of those with a routine referral were seen within four weeks (Royal College of Psychiatrists, 2024).

110. During the relevant period, the percentage of young people admitted to inpatient units more than 50 miles from their homes remained relatively stable, fluctuating between 5-10% which is consistent with the trend pre- and post-pandemic. This trend is illustrated in the

graph below, which demonstrates that despite the challenges posed by the Covid -19 pandemic, there was no significant increase in the proportion of young people who were admitted to facilities far from their place of residence.

Figure 9: Percentage admissions over 50 miles from home



Source: MHSDS, 2019-2022

111. Being treated in an inappropriate setting can lead to a person receiving a lower quality of care, prompting the CQC report on young children in an inappropriate setting. (CQC 2023). Being treated within an inappropriate setting inevitably has an impact on the time taken for young people to recover as, despite all best efforts to mitigate, effective and appropriate treatment would have taken longer to implement. Young people with mental health needs on a paediatric ward can also impact the delivery of non-psychiatric care on the paediatric ward, for example through presentations of challenging behaviour, the requirement to ensure that young people do not abscond and on occasions young people requiring restraint on the paediatric ward. The Healthcare Safety Investigation Branch (HSIB) published its report on August 4, 2022, investigating the provision of inpatient mental health care for children and young people on paediatric wards (Healthcare Safety Investigation Branch, 2022). The report was initiated due to the rising number of mental health crises among young patients admitted to these wards, which are not designed for such cases. Key findings included increased admissions, a lack of specialized training and inadequate facilities.

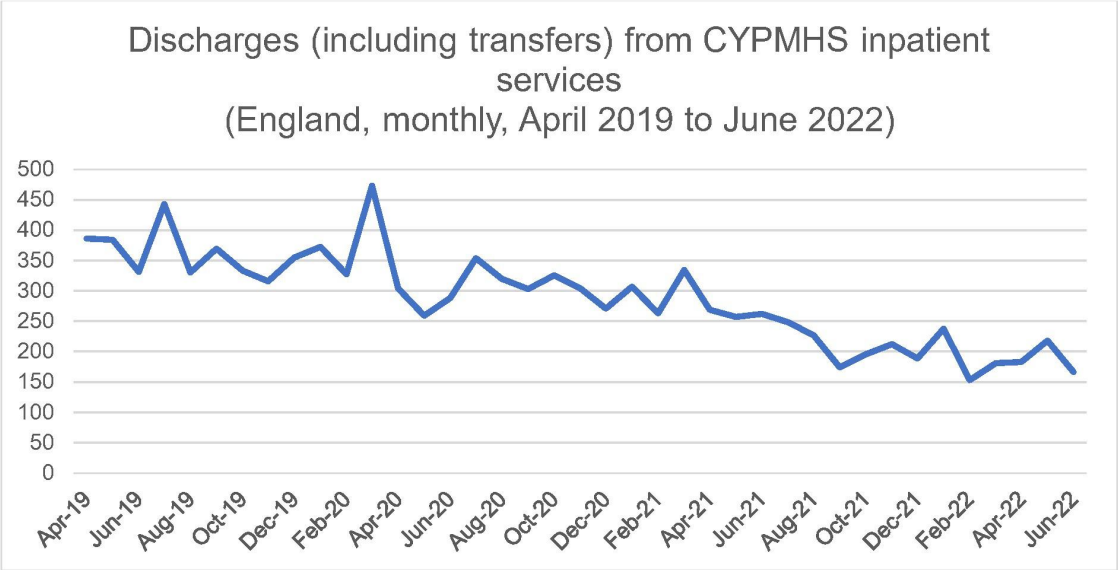
112. There was no notable change in the number of readmissions to CAMHS inpatient units during the period of this report. Historically, readmission rates for children and young people's mental health units have been low, ranging from two to 12 re-admissions per month across England's CAMHS inpatient facilities (NHS England Digital, 2024).

113. Research has indicated that at the start of the first lockdown, there was a significant rise in the number of admissions from the most deprived areas of the country (Tsiachristas et al., 2024). Further studies have suggested that the pandemic most significantly affected people

from deprived areas and worsened health inequalities within child and adolescent mental health care (Serrano-Alarcón et al., 2022).

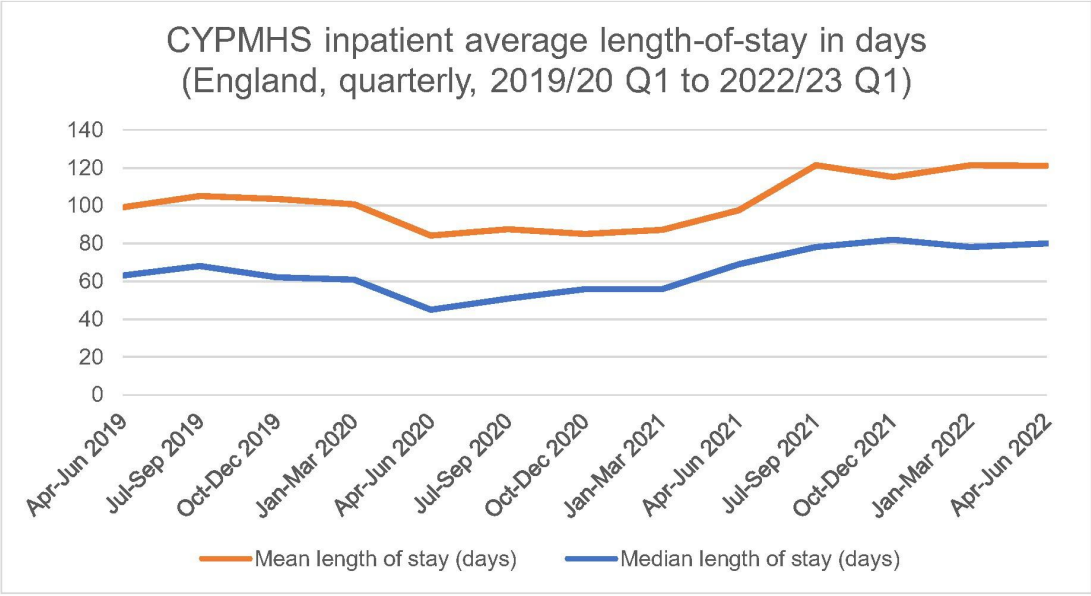
Inpatient treatment

Figure 10: Discharges from CYPMHS inpatient services



Source: Specialised Mental Health Patient Level Data Set (SMH PLD) 2019-March 2021: MHSDS, April 2021-2022

Figure 11: CYPMHS inpatient average length of stay



Source: MHSDS, 2019-2023

114. The first graph depicts a rapid rise in monthly discharges at the onset of the pandemic due to NHS England's directive to free up bed capacity and reduce Covid-19 transmission risk. This trend was consistent across the UK. Subsequently, discharge numbers declined until the end of the relevant period, dropping below 2019 levels. The second graph indicates that

the median length of stay (LoS) in England decreased initially, but then gradually increased beyond 2019 levels by the end of the relevant period. The impact of Covid-19 on LoS continued beyond the data collection period, showing a continuing upward trend, peaking at 132 days in May 2022. Young people were discharged to the care of crisis services or enhanced community support. If a young person absolutely required to remain in an inpatient unit, then an earlier discharge would not have been considered.

115. This discharge pattern and subsequent increase in LoS is not surprising and is a combination of most, if not all of the factors identified within this report: namely, staffing issues, increased time to admit, subsequent self-isolation rules, changes in the delivery of therapy, difficulties with discharge planning and changes to the therapeutic environment due to infection, prevention control measures.

116. Whilst there are delays in discharge of young people who are ready to return to the community, they are less frequent than in acute medical wards. Delays to discharge are most often related to there being appropriate social care arrangements in place, for example where a looked-after child requires a placement or additional social support is required for the parents. Data collected by Tsiachristas et al. indicated that after the second lockdown, there was an immediate rise in the proportion of looked-after children admitted to hospital, followed by a quick decline, resulting in post-pandemic admission rates lower than pre-pandemic levels (Tsiachristas et al., 2024).

Inpatient processes for young people when they turn 18

117. When a young person reaches their 18th birthday, they are usually transferred to their local trust adult inpatient unit, unless a community discharge is considered likely in a short period of time. Given the potential distress of transferring a young person to a new unit, CYPMH inpatient units work towards an aim of discharge if possible. There were no reports from any of the units contacted regarding any changes or difficulties in processes in transferring young people to adult units if required.

Impact of staff shortages on the quality of care or patient outcomes

118. Data on staffing levels and vacancies is difficult to come by. Units reported a decrease in staff turnover during the period covered by the Inquiry. However, there was no apparent improvement in recruitment. Young people and parents reported that they experienced an increased use of bank and agency staff during the period, and this brought difficulties with continuity of care, a view backed up by research (Holland et al., in press).

119. NHS Benchmarking data, which provides a yearly snapshot of vacancies, turnover and staff sickness in England does not suggest that the Covid-19 pandemic had a significant impact. However, given the data is annualised, this may not represent what was felt on the ground during the height of the pandemic.

Table 2: Annual staff vacancy rates

	018/19	019/20	020/21	021/22	022/23	
Staff vacancy rates						
Mean	18%	21%	15%	22%	25%	28%
Median	18%	19%	15%	22%	17%	21%
LQ	12%	11%	9%	13%	10%	18%
UQ	25%	25%	22%	29%	45%	38%
Staff sickness and absence						
Mean	5%	5%	5%	7%	6%	7%
Median	5%	5%	5%	6%	6%	7%
LQ	4%	4%	3%	5%	5%	5%
UQ	6%	6%	6%	9%	8%	8%
Staff Turnover						
Mean	16%	20%	15%	24%	22%	26%
Median	14%	18%	12%	23%	19%	23%
LQ	7%	10%	8%	11%	13%	17%
UQ	22%	27%	20%	32%	33%	32%

Totality of CYPMHS bed types
Totality of general admission CYPMHS beds
General admission children's beds (0-12)
General admission adolescent beds (13-17)

Source: NHS Benchmarking data, 2018-19 to 2022-23: please note that from 2019 onwards this data includes comprehensive participation from Wales and from 2021/22 the data includes comprehensive participation from Scottish Health Boards. NHSBN has done analysis on how this has affected the data and the addition of the devolved nations has had no material impact on the figures reported.

120. All units were required to develop a contingency plan to ensure safe staffing levels in the face of expected significant sickness absence. The self-isolation requirements posed the most significant staffing challenges, as reported by the units. Despite implementing staff distancing protocols, a single staff member contracting Covid-19 frequently led to multiple staff members falling ill or needing to self-isolate. In at least one unit, this situation compelled the unit to discharge young people who would have otherwise benefited from remaining under their care, in order to ensure the safety of those who absolutely required continued inpatient treatment. Consequently, several of these prematurely discharged young people deteriorated in the community and needed readmission, as they were released before they were fully prepared for discharge.

121. Early in the pandemic, a number of wards in England temporarily closed due to staffing issues: As previously indicated, between three and seven wards were closed at any one time. Speaking to staff on units, the reason for this was usually due to staff shortages resulting in only one of two units being able to be maintained. There was less pressure due

to staff sickness during the second lockdown as a result of the use of vaccinations and less stringent self-isolation and lockdown requirements.

122. Some independent providers reported greater challenges in developing staffing contingency plans as they were more isolated and not able to call on community CYPMH staff to provide emergency cover: For example, one unit reported developing a contingency plan where the reception/administrative staff were given basic training to be able to cover on the ward if required (this did not need to be implemented).

123. There is a clear message that staff demonstrated dedication and goodwill throughout the pandemic, going above and beyond their usual duties by working extra shifts, extending their hours, and covering wherever needed. Feedback from units has suggested that this resulted in psychological impact for the staff, experiences of burnout, a perceived lack of recognition for the additional work and changed personal priorities as a result of pandemic experiences. Managers who were consulted now doubt that staff would be willing or able to maintain such extraordinary efforts in the event of another pandemic occurring in the near future.

124. Members of the therapeutic team were advised to work from home, when possible, which may have had an impact on the delivery of therapeutic care as this was either decreased in frequency or undertaken virtually. Some units speculated that this had an impact on the quality of the therapeutic care leading to slower recovery for the patients.

125. Staff sickness did lead to an increased use of agency staff as regular staff were taking more time off due to the need to isolate/stay off work. This reportedly led to less consistency of support and less engagement from patients with the therapeutic programme due to the time needed to build therapeutic relationships.

126. Staff absenteeism also resulted from household Covid-19 infections, requiring self-isolation. Occupational health rules also identified some staff who were required to work at home or self-isolate. Additionally, a number of units reported absenteeism due to inadequate childcare as initial school closures and subsequent teacher or children's' sickness forced staff to stay home to care for their children.

Treatment for physical health problems

127. No concerns were raised over CYPMH inpatients requiring physical health support or challenges with transfers to an acute hospital which may occur in the context of self-injurious behaviours or an eating disorder. It is unusual for clinically vulnerable children, clinically extremely vulnerable children or severely immunosuppressed children to be admitted into CYPMH inpatient units and CYPMH inpatients do not frequently require physical health support beyond that which can be provided by the inpatient staff.

Changes to inpatient care

128. There were clear changes in frequency of interactions between staff and patients, through the requirement to use PPE, social distancing, remote therapies, sickness and staff

shortages. All these reasons and impacts are explained within the relevant sections of this report.

129. Interactions between inpatients were reduced, most notably on admission and the requirements for isolation. Many wards were able to establish more than one 'bubble' within the unit so that if a patient tested positive then this would not affect the whole ward.

130. Staff working on wards during this period reported a stronger feeling of community on the inpatient units at this time, with staff and patients connecting more and taking more responsibility for one another.

131. All units aim to restrict the use of physical restraint with most having projects in place to reduce restrictive interventions prior to Covid-19. No units reported a noticeable increase or decrease in the use of restraint during the relevant period.

Challenges in implementing infection prevention and control guidance in inpatient settings

132. There was a consistent theme that staff across all four nations felt unprotected and at risk of catching Covid-19 from the work setting and a feeling of having to fight to be given PPE. Staff felt that they had not been given guidance on what to explain to young people, and young people often expressed a belief that PPE was up to the staff to decide on, not national guidance. Independent hospitals and NHS-provided hospitals reported that they did not find accessing PPE to be a challenge. In our opinion this discrepancy between the feelings of front-line staff and operational managers arises from the complexity of the messages regarding PPE from NHS England and the continually changing messages, the difficulties in communicating complex messages across a large organisation and the additional stress of working on the front line with potentially Covid-positive patients resulting in worries that the guidance was not going to be effective.

133. There is no question of the importance of PPE during a pandemic with staff requiring the right level of protection, which includes face coverings and recognising that there are strategies to minimise the impact of, for example, communicating with a face covering on. PPE can also be reassuring to the patients and enable them to feel safe in a therapeutic environment. However, specific PPE issues arose in psychiatric inpatient units, such as the risk of PPE being used for self-injurious behaviours. For example, one unit reported removing the metal band from the nose of facemasks as this was a potential object for harm. This was not in any policy across the four nations, but would have been undertaken by the unit as part of their risk assessment of the young person.

134. Communicating with patients was sometimes inadequate as wearing masks in therapy sessions, for some young people but certainly not all, could hinder the patient-therapist relationship and lead to increased risk of miscommunication, a fact borne out in research (Bakhit et al., 2021). This impact is likely to be more pronounced for young people with social communication or hearing difficulties, as facial expressions are crucial for understanding spoken language. This can impact both the young person's and therapist's comprehension. Particular concern was raised for young people who are hard of hearing and rely on lip reading to fully understand a conversation. Many units asked about the

availability of clear face masks to enhance communication however these were not available during the Covid-19 pandemic.

135. The implementation of Infection Prevention and Control (IPC) measures made the process of restraint more complex and challenging. Staff were required to be in close contact with each other and with patients during restraint procedures, increasing the risk of Covid-19 transmission. Some patients would 'weaponise' the threat of Covid-19 by spitting or coughing at staff during restraint, further complicating the situation.

136. Staff on psychiatric inpatient units may not have understood the IPC guidance or have had previous experience of using the measures imposed. This may have led to inconsistencies in the application of IPC protocols at the start of the pandemic.

137. The design and layout of many CAMHS psychiatric inpatient units posed challenges in implementing effective IPC measures during the COVID-19 pandemic. For instance, therapy rooms and family rooms were often small, making it difficult to maintain social distancing. Some units had shared bedrooms meaning not all the beds in the unit could be used. Furthermore, many units had poor ventilation options.

138. The small size of the rooms in some units meant that group therapy sessions could not be conducted safely, as social distancing requirements could not be met. As a result, these group sessions could not be held. In other units, certain therapy rooms had to be closed entirely due to their inability to accommodate social distancing measures. This reduced the available space for individual therapy sessions and other essential activities.

Impact of infection prevention and control measures on quality of care and patient outcomes

139. This section is best considered in two areas, firstly the impact of self-isolation for patients and secondly the impact of social distancing.

Impact of self-isolation

140. NHS policy indicated that where an individual was suspected or confirmed to have Covid-19, self-isolation procedures should have been followed, and they should have been tested immediately, and regular observations taken. This resulted in new patients who were admitted requiring varying lengths of self-isolation prior to being able to engage in ward-based activities. The impact of this was:

    a. a delay in receiving the appropriate therapeutic intervention.

    b. young people often remained under a higher level of observation than would otherwise have been the case as the usual rewards for improving behaviour (for example access to lounge areas, dining areas, use of shared play equipment) could not be used.

    c. Decreased use of short-term leave due to the impact of returning after leave.

141. All of these issues were likely to have increased the length of stays and delayed the recovery of the young person. The units reported that each time the self-isolation rules

were relaxed, there was a noticeable improvement in the well-being of the young patients, highlighting the significant impact these restrictions had had on their mental health and overall progress.

Impact of social distancing

142. In many circumstances, therapies became online/virtual as social distancing rules required staff who were able to work from home. Unfortunately, some units did not have the infrastructure; such as laptops for staff to use at home, the ability for staff to access patient records remotely or the right computer equipment in the inpatient unit for patients to use to join their therapist remotely. This meant that at the beginning of the Covid-19 pandemic, some individual therapies could not be provided. There are a wide variety of therapies offered in inpatient units, some of which are more difficult to provide virtually than others, for example art therapy. Psychodynamic approaches also require the therapist to be aware of body language and other forms of non-verbal communication.

143. There was decreased use of family visits as family members were not part of the inpatient 'bubble.' Families reported feeling disconnected from the treatment their child was receiving; feeling unable to comment on how their child was; feeling disempowered to be part of decision-making. Visits which did take place were notably shorter.

144. As the pandemic progressed, the impact of not being able to see family members who were shielding became evident. Changes to policies on the use of mobile phones were implemented across most units to aid communication with family members. Whilst this alleviated some of the communication challenges, it certainly does not replace the option of a face-to-face visit with a family member.

145. Group therapeutic interventions required significantly more space to implement due to the need for patients and staff to maintain social distancing. Some units reported that they did not have rooms large enough to accommodate both the young people and staff while maintaining the necessary distance between individuals. As a result, some units had to stop offering group therapies altogether, while others adapted their therapy programs to allow for smaller groups of young people to receive therapy at any given time.

146. One unit informed us that they were fortunate in having multiple, large visiting rooms. This allowed visitors to maintain social distancing rules and for the post-visit cleaning to be undertaken in a way that meant the unit could accommodate multiple visits a day. Conversely, other units had visiting rooms so small that visits had to be limited to a single relative to ensure social distancing.

Summary

147. It is clear that the impact of social distancing had the biggest impact on the delivery of care from all of the Covid-19 interventions, from changing the way therapies were delivered, and in some circumstances stopped, to changing the way young people could receive visits from friends and families. However, feedback from staff on the units contacted was that the social distancing and isolation rules were appropriate where there were many physically unwell people, but were inappropriate in CYMPHS inpatient units where the population was not significantly at risk from Covid-19 infection. Staff felt the impact on mentally ill children and young people was not considered.

148. However, it is important to remember that these rules were in place for both patients' and staff's physical health. Healthcare workers, including mental health nurses, were on the frontlines and faced a higher risk of exposure and therefore illness compared to the general population. The impact of Covid-19 outbreaks on CAMHS inpatient units led to increased use of agency staff to cover sickness and in some circumstances, in England, complete closure of a ward.

149. Within this section, there is positive learning developing from the use of technology. However, remotely-delivered therapies were not always the best option, for example remote therapies limit the ability of mental health professionals to observe and assess patients' body language, make it more difficult to interpret facial expression or recognise when a patient is hearing voices. Additionally, some young people find it more difficult to stay focused and engaged during remote therapy sessions. Nevertheless, all units reported that, once the infrastructure was in place, the use of virtual consultations for multi-agency meetings led to greater attendance and often more helpful outcomes. For example, having a well-engaged community team throughout a young person's inpatient admission leads to better continuity of care as the young person's experiences are better understood and the community challenges that the young person may face can be addressed earlier in the admission. Moreover, staff had to adapt to managing these virtual meetings effectively to ensure all participants could contribute.

150. The use of patient mobile phones has always been a contentious point on CYPMH inpatient units with an assumed position that they are harmful. Units are concerned that young people will access inappropriate websites, which having a mobile phone allows, may experience ongoing bullying or exploitation which may be part of the trigger for the mental health relapse and young people may record other patients or staff on the unit without permission. Most units managed these risks, pre-Covid, by putting significant restraints in place on the use of mobile phones. However, throughout the pandemic, mobile phones were crucial for young people to maintain contact with their friends and families. Post Covid-19, most units have now altered how they perceive mobile phones, from something to be controlled and often banned to something that is part of the unit life and part of the therapeutic programme should be supporting young people in appropriate use of mobile phones. This may be through discussions in group therapy, ensuring parents have an understanding of what their children are accessing on their phones with support in managing difficult conversations rather than a simple ban on phone usage.

Legislation and national guidance to mitigate the impact of Covid-19 on inpatients

151. Multiple guidance was released on supporting patients who were unwell with Covid-19 in mental health settings. For example, on 30 April 2020, NHS England published the first version of guidance for "*supporting patients of all ages who are unwell with coronavirus (Covid-19) in mental health, learning disability, autism, dementia and specialist inpatient facilities.*" This was updated on 18 May 2020 and a second version was released on 24 January 2022. Wales published similar guidance on delivering mental health services on 23 April 2020.

152. The Coronavirus Act 2020, which was granted Royal Assent in March 2020, contained provisions that allowed for modifications to mental health legislation throughout the UK,

including the Mental Health Act 1983 (England and Wales). The new legislation permitted a reduction in the number of approved doctors required to conduct a Mental Health Act assessment from two to one (a Mental Health Act Assessment is a formal assessment to determine if a patient needs to be treated for their mental illness without their consent. It is undertaken by two doctors who are approved under section 12 of the Mental Health Act, one of the doctors must be independent of the patient's treatment, and an approved social worker). However, this measure was only to be implemented in cases of severe staff shortages and has not been activated.

153. In Scotland, similar adjustments were made. The Mental Health Tribunal (all patients who are detained against their will in any of the four nations have access to an appeal process, this appeal process is heard by Mental Health Tribunals which are proceedings, chaired by a judge to determine if the appropriate criteria for detention is met) for Scotland (MHTS) continued to conduct hearings but adapted to the pandemic conditions by holding remote hearings using teleconference and video conference technologies. Additionally, certain legislative changes were introduced under the Coronavirus (Scotland) Act 2020 to provide flexibility and ensure that the tribunal could continue to operate effectively despite the pandemic. The Act allowed for extensions of timescales for hearings and decisions and the possibility of hearings being conducted without the physical presence of the patient, where necessary.

154. To limit the spread of Covid-19, face-to-face medico-legal hearings were suspended for a six-month period starting from March 23, 2020. This was to enable tribunals to manage their workloads effectively. On March 26, 2020, Sir Ernest Ryder, the senior President of Mental Health Tribunals (MHTs), issued a Pilot Practice Direction stating that a Judge alone would hear all future tribunal applications (instead of a panel comprising a Tribunal Judge, a medical member, and a lay member). The Judge would seek expert advice from the medical member and specialist lay member, but the hearing would be conducted solely by the Judge. These hearings would be conducted by phone or video instead of in-person MHT hearings. Prehearing examinations were also suspended.

155. In England and Wales, Section 12 (2) and Approved Clinician (AC) approval is valid for five years. Psychiatrists who wish to renew their Section 12 and AC status typically have to attend a face-to-face refresher's course in the last year before their renewal is due. However, due to Covid-19, Section 12 and AC re-approval have been extended by an additional 12 months, and online training courses have been approved.

156. Of note within mental health, there was some variation in the interpretation of face-to-face vs virtual Mental Health Act assessment. Towards the end of the period of this report it was clarified that a Mental Health Act assessment must be undertaken face- to-face, there were a number of trusts who undertook virtual assessments. There was no available data to identify the impact of this on children and young people as this occurred in a relatively small number of trusts, and as a proportion of the total number of assessments for children is low, it was not felt that this had a significant impact on children and young people.

157. In addition, there were recommendations to ensure that there is a 24/7 single point of access for urgent mental health support that was available to the public and efforts should

be made to divert patients away from accident and emergency and into mental health provision, such as crisis hubs.

158. There were national recommendations on setting up ethics committees in case providers needed to make difficult decisions in the context of reduced capacity and increasing demand.

Local initiatives to mitigate the impact of Covid-19 on inpatients

159. During the Covid-19 pandemic there was a concerted effort to establish more robust community crisis services and alternatives to inpatient admissions. Prior to the pandemic, there was significant variation within crisis models in terms of hours of service, interventions offered and staffing levels. The national GIRFT report noted that the highest performing providers were all able to demonstrate a joined-up crisis pathway with robust processes to ensure multi-agency assessments prior to admission with determination of the aims of the admission, what would be offered and what outcomes would be necessary for discharge back to the community. The Covid-19 pandemic hastened the roll out of such services across the four nations.

160. Covid-19 saw the implementation of a number of crisis hubs which were implemented with the aim of ensuring that people with a primary mental health presentation had an alternative to the acute hospital when in a crisis. There were anecdotal reports of high satisfaction with such hubs. However, despite initial enthusiasm, these hubs have not developed across the four nations as expected. The authors are not clear as to why this is the case.

161. As previously mentioned, a number of areas were able to shift the care of patients presenting with anorexia nervosa to a community-based model with an acceptance of readmissions to a paediatric ward for refeeding if required.

Healthcare systems

162. There is no evidence to suggest that the UK healthcare systems had specific plans for mental health inpatient services in the event of a pandemic, beyond those for all healthcare inpatient services. Prior to the Covid-19 pandemic, it does not appear that the UK's preparedness and response capabilities considered mental health illness, either adult, community, child or inpatient.

163. Pandemics can have a significant impact on mental health, as evidenced by the Covid-19 pandemic. Social isolation, loneliness, anxiety about the disease, financial stress and grief over lost loved ones can all contribute to increased rates of depression, anxiety and other mental health issues.

164. Pandemics can have a significant negative impact on child and adolescent mental health. The Covid-19 pandemic exposed young people to known risk factors for mental illness, such as disrupted schooling, social isolation, health anxiety and economic instability. Longitudinal studies have shown an increase in symptoms of depression, PTSD, and other mental health issues among children and adolescents during the pandemic. Following an initial decrease, eating disorder presentations rose significantly during the Covid-19 pandemic: 41% of young people who were receiving care for an eating disorder experienced a worsening in eating disorder symptoms post-lockdown. Consequently, those starting to recover but still needing clinical support relapsed, requiring longer treatment periods, though referrals were unaffected. (Graell et al., 2020). Machado et al demonstrated that the initial Covid-19 lockdown significantly correlated with symptoms of disordered eating and difficulties maintaining feeding routines (Machado et al., 2020). Given that eating disorders have the highest mortality rates of any mental illness and the increase in presentations to inpatient units during Covid-19, this is a specific area that should be considered in pandemic planning.

165. Young people with eating disorders are often isolated, which may have been made worse through the pandemic and this may have exacerbated the loss of contact with trusted adults, such as at school. Increased internet use and virtual education may have exposed young people to more fat-phobic messaging and the increased anxiety and stress amongst caregivers will all have had an impact. The public health messaging to avoid unnecessary health care use and anecdotal worries about contracting Covid-19 by attending clinics exacerbated the issue. Stopping face-to-face visits with a cohort who require accurate weights and clear observations of weight loss/gain would have played a part. Finally, prior to the pandemic, eating disorder services had already been struggling to meet demand.

166. Experience from Covid-19 suggests that pandemics exacerbate health inequalities. For example, the 2021 MHCYP survey reported that since 2017, mental health deteriorated for 39% of six to16-year-olds while improving for 22% (NHS England Digital, 2021). Children from advantaged backgrounds likely found home life easier and more productive compared to those in challenging home environments. It is also important to consider the impact on young people with social communication difficulties who may have had a reduction in school-based anxiety during lockdown but experienced a significant exacerbation in anxiety on return to school.

167. Future planning for pandemic preparedness must consider this burden and impact with the development of strategies to mitigate the risk through addressing the known risk-factors (disrupted schooling, social isolation, health anxiety and economic instability).

International child and adolescent mental health care systems

168. Review of the literature describes similarities across comparative healthcare systems in terms of the challenges in responding to the pandemic. The World Health Organisation published a report looking at *The Impact of Covid-19 on mental, neurological and substance use services* where it surveyed 194 member states between 15 June and 15 August 2020. This found that only 17% of the 130 responding countries had ensured full funding for mental health and psychosocial support plans in response to the pandemic, although a sizable majority, 116 out of 130 (89%) reported that mental health and psychosocial support plans formed part of their Covid-19 response plans. It is not clear to what extent these plans had been considered prior to the onset of the pandemic. In terms of response to the pandemic, only 7% of countries surveyed said that all services remained fully open. However, inpatient services were impacted less than community services, with 70% of mental hospital inpatient services remaining fully open (WHO, 2020).

169. A survey looking at the perceived initial impact of the Covid-19 pandemic from the perspective of the heads of academic departments across Europe found that the impact on child and adolescent psychiatry services was 'major' or 'extreme' (Revet et al., 2022). This survey from 20 European countries estimated a reduction in bed occupancy of around one-third, but the ability of teams to respond to the crisis was good.

170. Across the literature, there are key themes similar to those identified in this report; Leffler *et al* identified practice changes and lessons learned, based on data from 20 sites across the USA (Leffler et al., 2021). The need for Covid-19 testing and infection and prevention control measures, moves to single room occupancy and reduction of bed capacity, reduction in visitor numbers, implementation of virtual meetings and telehealth and management of staff sickness were all important responses to the pandemic.

171. There is no evidence from the literature that other healthcare systems proved more resilient to the Covid-19 pandemic. However, it could be argued that given the high levels of diagnosable childhood mental health difficulties in the UK[1], the impact of the pandemic had a comparatively greater impact on CAMHS/CYPMHS services due to the system already being under strain (Ahmed et al., 2023), (Creswell, 2023).

Alternate and international models of inpatient CAMHS services

172. Much of the responses to the pandemic were a response to UK- issued or healthcare trust guidance. For example, undertaking family therapy remotely or patients engaging in group consultation via tablets were responses to the social distancing requirements, testing requirements or the implementation of 'bubbles' (Leffler et al., 2021). Whilst these have not provided new models of care, they have provided an additional flexibility which has

[1] Data from the 2017 Mental Health of Children and Young People (MHCYP) survey in England showed that rates of probable mental health disorders rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020; rates subsequently remained stable to 2022 (Newlove-Delgado et al., 2022).

continued beyond the pandemic and allows patients, families/carers and staff to access therapeutic spaces and meetings that may not have previously been available.

173. As in other areas of healthcare, at the start of the pandemic, there was a switch to telephone- or video-facilitated remote appointments (Carretier et al., 2023). This was most clearly documented in the switch from in-person to online day patient eating disorder programmes. These programmes are described as bridging the gap between inpatient and outpatient treatment. Whilst day patient programmes in the treatment of eating disorders are not entirely novel, these online, more intensive programmes provided much- needed support for the rising numbers of children and young people who were experiencing such difficulties during the pandemic (Nicholls, 2023). Whilst there are disadvantages, and evaluations of these programmes appear to favour in-person approaches, intensive online programmes offer an alternative, accessible step prior to admission ((Catenacci and Couturier, 2023), (Brothwood et al., 2021).

174. In March 2020, there was a major reorganisation of North Central London child and adolescent health services. Paediatric patients who required admission were transferred to two paediatric wards specifically set up at Great Ormond Street hospital, which typically does not admit patients acutely. Two crisis hubs were also created to assess mental health presentations directly redirecting patients away from emergency departments. Whilst this reorganisation was primarily focused on acute paediatric mental health admissions, rather than inpatient CAMHS, it demonstrated that new models of care could be rapidly and successfully implemented. It made the case for integrated multi-disciplinary approaches. Given the increasing number of mental health presentations to acute paediatric wards and the rising prevalence of eating disorder cases, improved paediatric liaison psychiatry provision and better training, resources and support for paediatric professionals could help mitigate some of the challenges created by the pandemic (Hudson et al., 2022).

Lessons to be learnt and recommendations.

175. The recommendations and lessons learnt outlined below are relevant to all four nations notwithstanding small differences in policy and practice of inpatient units across and between the four nations, which are recognised in this report. No recommendation is specific to one nation.

176. Whilst these recommendations focus on the delivery of care from an inpatient/tier 4 perspective it is imperative that consideration is also given to reducing the need for inpatient beds through:

    a. Ongoing local and national investment in community mental health services to ensure that there are effective, early interventions for conditions that may result in inpatient admissions.

    b. Recognition, through pandemic preparedness planning by National Governments and National Healthcare Organisations of the need to keep schools, other educational settings and other specialist facilities that support children and young people active and accessible throughout a pandemic. These facilities provide important avenues of care and identification of mental health or safeguarding concerns.

177. UK pandemic preparedness must include a focus on mental health and strategies to minimise the impact of those risk factors that are known to increase during a pandemic and are directly related to increased mental health presentations:

    a. disrupted schooling: schools were not treated as essential within the pandemic, however in future planning consideration should be given to keeping schools open if at all possible.

    b. social isolation: social distancing focused on physical safety. However, future plans should consider the impact on emotional wellbeing within psychiatric inpatient units where the condition being treated is unlikely to be of a physical nature, requiring a balance between the restrictions on visits to friends and families and physical safety.

    c. health anxiety: there are now opportunities for online support and computerised CBT that should be adapted to support specific health anxieties and other anxieties that arise within a pandemic and for such support to be universally available.

    d. Economic insecurity: the most vulnerable to economic insecurity in the event of a pandemic are also at greatest risk of mental health presentations. The link between the two is well established and future consideration to ensuring the economic security of this vulnerable group is important.

178. Pandemic preparedness must include the ability of systems to provide virtual care and virtual therapeutic interventions during a future public health emergency. There must be clarity over when virtual therapeutic interventions are appropriate over face-to-face interventions, considering the environment, modality, patient presentation, patient demographics and risks of face-to-face therapy.

179. Further research is needed to enable better planning for the delivery of care and greater understanding of the mental health impact of social distancing and lockdowns on the delivery of therapeutic care. This research should focus on

    a. Identification of which CAMHS patient groups (for example age, diagnosis, deprivation decile) respond best to virtual therapeutic interventions

    b. Greater understanding of the impact of virtual therapeutic interventions in the context of inpatient care

    c. Ensuring that a digital approach, including virtual interventions, advice and early support is embedded across the entire CAMHS care pathway.

180. As part of pandemic preparedness planning, National Healthcare organisations must consider the size and layout of psychiatric inpatient units to enable social distancing and visiting during a future pandemic without interfering with the delivery of care

    a. At a minimum each unit must have multiple rooms that may be used for therapies, receiving visitors, team meetings or assessing patients so that no activities would stop in the event of social distancing.

b. CAMHS inpatient provider organisations should review their estate and develop detailed plans on how services would continue in the context of social distancing in the future.

c. Local and national organisations should commit the necessary funding to remedy any identified shortcomings.

181. Pandemic preparedness guidance must include clarity on how CAMHS units should respond to rules on social distancing and self- isolation. This guidance should:

a. Include clear guidance on when visits from family members or carers is appropriate and how this may be enabled, and support of young people when required to isolate on a unit and on return from leave.

b. Should be in age-appropriate language and be clear on what should be done when a young person is not willing to or cannot understand why to social distance.

c. Should be developed at a national level with input from National Teams, Royal Colleges, policy teams, service managers, clinicians and service users at a minimum.

182. Pandemic preparedness should include consideration to a likely increase in eating disorder presentations and the impact this may have on paediatric wards and inpatient CAMHS units. This should include:

a. There must be a continued focus on the access and waiting times for young people with eating disorders, taking into consideration possible surges in demand in the future, so that in a future pandemic, services are able to manage demand

i. National Health Organisations and local providers must ensure that their community eating disorder services are meeting the national access and waiting time standards.

ii. National Health Organisations and local providers must include, in their pandemic preparedness planning, the management of a significant increase in eating disorder presentations.

b. There must be appropriate and effective support for young people concerned about their eating, through charitable organisations, the education system and NHS trusts. This may be through public health initiatives, accessible online information, mental health support in school to name a few.

c. Each Integrated Care System must understand what advice and support services are presently available for young people concerned about having an eating disorder within their area. They must assess the appropriateness of the offer and if felt to be inadequate ensure that appropriate services are commissioned.

183. Systems ('Providers of child and adolescent mental health tier 4 (inpatient) services across the UK') must continue to develop strong links through CAMHS provider collaboratives to ensure that staffing levels can be maintained in all CAMHS inpatient

184. UK Governments must fund further research on the use of facemasks in mental health inpatient units. Identified negative impacts should be mitigated, for example, through the development of transparent masks. Providers of mental health care must receive an adequate supply of PPE which is intended to mitigate these impacts.

185. The National Governments must provide clear, national on the use of the Mental Health Act during a pandemic and periods of social distancing both in regard to remote Mental Health Act Assessments and potential reduction in the number of doctors required when capacity does not allow two to be in attendance. This must be developed with all appropriate stakeholders and service users.

186. The National Governments must act to reduce health inequalities before there is a further pandemic.

    a. Integrated care systems should ensure that there are effective ways to understand health inequalities within the child and adolescent populations they serve

    b. Integrated care systems should improve the quality, provision and access to preventative and universal child and adolescent mental health services.

187. Pandemic preparedness must include ability for all healthcare workers to access wellbeing support and childcare. This will minimise sickness resulting from the emotional impact of working through a pandemic and enable healthcare workers to be at work in the event of their usual childcare not being available.

Annex 1: Timeline of social distancing and self-isolation rules.

March 2020 - June 2020:

- All new admissions were required to self-isolate for 14 days, regardless of symptoms or test results (NHS England, 2020).
- Patients were tested for Covid-19 upon admission and during their stay if they developed symptoms (NHS England, 2020).
- Social distancing measures were implemented, including limiting group activities, and encouraging patients to maintain a distance of at least two metres from others.

July 2020 - December 2020:

- New admissions were required to self-isolate for 14 days, but this could be reduced to 7 days with a negative test result on day 5 (UKHSA, 2022).
- Routine testing was introduced for all patients on days 1, 3, and 5 of their admission (UKHSA, 2022).
- Social distancing measures remained in place, with a gradual reintroduction of group activities where possible.

January 2021 - June 2021:

- Self-isolation period for new admissions was reduced to 10 days, with the option to end isolation earlier with a negative test result on day 7 (NHS England, 2020).
- Routine testing continued for all patients on days 1, 3, and 7 of their admission (NHS England, 2020).
- Social distancing measures were maintained, with a focus on outdoor activities and virtual group sessions.

July 2021 - June 2022:

- Self-isolation period for new admissions was further reduced to 7 days, with the option to end isolation earlier with a negative test result on day 5 (NHS England, 2021).
- Routine testing was reduced to days 1 and 5 of admission, with additional testing for symptomatic patients.
- Social distancing measures were gradually relaxed, with a return to more normal group activities and visitor policies, subject to local risk assessments.

In the UK, mental health inpatient units implemented various social distancing and testing policies for Covid-19 from March 2020 to June 2022. The policies varied slightly between England, Scotland, Wales, and Northern Ireland. Here is an overview of the policies and the duration of patient self-isolation:

England:

- March 2020: Mental health inpatient units implemented social distancing measures and restricted visitor access. Patients were required to self-isolate for 14 days upon admission.
- April 2020: Regular testing for staff and patients was introduced.

- December 2021: Self-isolation period for patients reduced to 10 days.
- April 2022: Self-isolation period further reduced to 7 days.

Scotland:

- March 2020: Similar to England, mental health inpatient units implemented social distancing measures and restricted visitor access. Patients were required to self-isolate for 14 days upon admission.
- May 2020: Regular testing for staff and patients was introduced.
- December 2021: Self-isolation period for patients reduced to 10 days.
- April 2022: Self-isolation period further reduced to 7 days.

Wales:

- March 2020: Mental health inpatient units implemented social distancing measures and restricted visitor access. Patients were required to self-isolate for 14 days upon admission.
- June 2020: Regular testing for staff and patients was introduced.
- January 2022: Self-isolation period for patients reduced to 10 days.
- April 2022: Self-isolation period further reduced to 7 days.

Northern Ireland:

- March 2020: Mental health inpatient units implemented social distancing measures and restricted visitor access. Patients were required to self-isolate for 14 days upon admission.
- July 2020: Regular testing for staff and patients was introduced.
- January 2022: Self-isolation period for patients reduced to 10 days.
- May 2022: Self-isolation period further reduced to 7 days.

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