Witness Name: Dr Lade Smith CBE
Statement No.:
Exhibits: LS/1 (INQ000400039) to LS/34 (INQ000410875)
Dated: 26 February 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR LADE SMITH CBE

I, Dr Lade Smith, will say as follows:

1. I am the President of the Royal College of Psychiatrists ("the RCPsych"/"the College") and have held this post since 11 July 2023.

2. I am also the Clinical Director of the Forensic Service at South London and Maudsley NHS Foundation Trust and have held this post since February 2020.

3. I am a clinician with 32 years' experience who worked on the frontline during the Covid-19 pandemic.

4. I offer this statement in response to the Rule 9 request the RCPsych received from the Covid-19 Inquiry team on 11 July 2023 and on behalf of the entire College.

5. I welcome the opportunity to make this statement and submit relevant documentation pertaining to Module 3 of the UK Covid-19 Inquiry.

Introduction

6. This section outlines the role, function and aims of the RCPsych, its interests in the pandemic, the scope of our submission, key areas covered, and the RCPsych's work during the relevant period of the pandemic.

Role, function and aims of the RCPsych

7. The RCPsych is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of our members and the profession. Representing over 21,000 members and with approximately 1,600 mental health services signed up to our quality networks (a range of professional networks that connect our members and support their work in areas such as Child and Adolescent Mental Health Inpatient Services, eating disorders, and psychiatric liaison services to work toward quality improvement in these fields), we work in all four nations of the UK, as well as supporting members internationally. The RCPsych is a charity, with approximately 280 employees and more than 150 patient and carer representatives, registered in England and Wales (228636) and in Scotland (SC038369).

8. Our core objectives are to support our members; deliver education, training and research in psychiatry; promote recruitment and retention in psychiatry; improve standards and quality across psychiatry and wider mental health services, supporting the prevention of mental ill health; be the voice for psychiatry; support psychiatrists to achieve their professional potential by providing an excellent member experience; and ensure effective management of our resources and deliver an excellent employee experience.

9. A wide range of members and staff, including the Past President, Professor Wendy Burn CBE, Immediate Past President, Dr Adrian James, and other College Officers who were in post during the pandemic, have been consulted to ensure their experiences are reflected in this statement.

10. This statement has been drafted following engagement with patient and carers. We held a workshop with RCPsych patient and carer representatives with the aim of better understanding the impact of legislation and decision-making, and where lessons could

be identified for the future. Patient and carer experiences have been anonymised where they are included throughout this statement.

Interest of the RCPsych in the Inquiry

11. The RCPsych works with Health Education England ("HEE"), NHS Education for Scotland ("NES"), Health Education and Improvement Wales ("HEIW") and Northern Ireland Medical and Dental Training Agency ("NIMDTA"), as well as a range of other organisations, to support improvements to the planning of education and workforce programmes. In working to ensure that we have a workforce of well-supported psychiatrists delivering high-quality, safe care and leading sustainable services for patients, the RCPsych plays a major role in ensuring people with mental illness get the psychiatric support that they need. Our continued work will be influenced by the conclusions the Inquiry draws, and significantly impacted by any subsequent associated workforce decisions taken by the UK Government and devolved administrations.

12. The RCPsych is also a member of the Academy of Medical Royal Colleges ("the Academy"). The Academy is the membership body for the UK and Ireland's 24 medical royal colleges and faculties. We have also contributed to the Academy's response to their Rule 9 request.

Scope

13. Throughout the pandemic, we witnessed the exemplary efforts of NHS staff who worked tirelessly to provide treatment, care and support to patients in the most difficult of circumstances. There have been many positive outcomes and learnings from the pandemic that we have taken and continue to use to improve mental health services across the UK.

14. Although this statement includes evidence and details of work undertaken in England, Wales, Scotland and Northern Ireland, its conclusions and recommendations are restricted to the UK Government and departments, agencies and public bodies in England for the following reasons:
    - in collating our evidence, the majority of information we received from members related to experiences in England;

- it is our understanding that these matters have been, may have been or will be considered in respective jurisdictions and we would expect the RCPsych in Wales, the RCPsych in Scotland, and the RCPsych in Northern Ireland to each be engaged in those settings, at the appropriate stage, on matters that have yet to be examined;
- and so as not to preclude the RCPsych in Wales, the RCPsych in Scotland, or the RCPsych in Northern Ireland from making separate recommendations and drawing attention to experiences, learnings and failings, where appropriate and should this be required in future.

15. We also know that there are issues with the safety of many NHS services due to consistent under-prioritisation. In fact, the mental health estate has experienced years of underinvestment and is home to some of the oldest estates in the NHS. Data for 2021/22 shows that 15.5% of mental health and intellectual disability sites in England were built before the NHS was established, compared with 9.2% of general acute sites. In eight NHS trusts, it was found that more than a quarter of their mental health and intellectual disability estates were erected prior to 1948. If governments persistently underinvest in the NHS, its staff, public health and wider local authority services, there will inevitably be a rate-limiting factor on the extent to which their work can be stepped up during a national crisis and, thus, on the ability to provide safe and therapeutic care. This would have a devastating impact on morbidity, mortality, patient experience, and staff morale.

16. Generally, in England, we found communication between the RCPsych and national bodies to be good, with open and regular channels. The Academy played a significant role in supporting meetings and facilitating access to senior decision-makers across Public Health England ("PHE"), the Department of Health and Social Care ("DHSC") and NHS England and Improvement ("NHSEI"). We also found the working relationship between NHSEI's Mental Health, Learning Disability and Autism ("MHLDA") Covid-19 Response Cell, the Royal College of Nursing ("RCN") and Unite the Union to be positive and instrumental for sharing information, developing guidance and providing support to the MHIDA sector.

17. However, in light of evidence from extensive consultation with our members and reflection on our role throughout the pandemic, our considered opinion is that the UK Government and national bodies in England fell short in relation to their preparation for, and management of, the response of healthcare systems to the pandemic across MHIDA settings.

18. As such, it is the RCPsych's overall position that the UK Government, along with the departments, agencies and public bodies in England that this statement specifies, did not offer the same degree of protection and support to those with a mental illness, intellectual disability and/or autistic people, of all ages, in the prevention, treatment and management of Covid-19, compared with other members of the population. In doing so, it failed in its duty to ensure parity of esteem between mental and physical health, as enshrined in law through the Health and Social Care Act 2012 in England.

19. We have identified six key areas where we believe the UK Government and relevant departments, agencies and public bodies in England fell short of what was required: see paragraphs 20–32 below. We hope that by identifying these shortcomings, lessons can be learned for future pandemics.

Key areas

Planning

20. First, we consider that the leadership teams and core decision-making of the UK Government and relevant departments, agencies and public bodies in England did **not**:

- adequately consider the potential impact of a pandemic of this nature on the delivery of mental health care
- sufficiently include psychiatric expertise in their core decision-making and leadership teams, at all levels and on all relevant matters pertaining to the healthcare systems' response to the Covid-19 pandemic
- collect, utilise and share service-level data, situational reports and Covid-19 mortality data in relation to mental health, intellectual disability and autism services and patients, which were of sufficient quality.

21. Planning is discussed further in paras. 99–136.

- Paras. 100–19 show a timeline of RCPsych and government responses to initial Covid-19 outbreaks, along with explanations of how these responses were viewed and experienced by stakeholders and healthcare workers.
- Paras. 120-22 discuss data collection and reporting.
- Paras. 123-31 discuss the RCPsych's influencing.
- Paras. 132–34 discuss the impacts on the delivery of mental health care.
- Para. 135 outlines our position on government planning and response.
- Para. 136 gives our recommendations.

Capacity and collaboration

22. Second, we consider that the UK Government and relevant departments, agencies and public bodies in England did **not** adequately consider the following as part of their ongoing response to the pandemic:

- the management of capacity and demand across the mental health system before, during or following the acute phases of the pandemic

- the extent to which the mental healthcare system and the wider health system were working together.

23. Capacity and collaboration are discussed further in paras. 137–230.

- Paras. 137–42 discuss managing capacity and demand.
- Para. 143 discusses Northern Ireland.
- Paras. 144–47 discuss RCPsych influencing.
- Paras. 148-64 outline our modelling of the available data and summarise patient–carer discussions we held to glean first-hand expertise on the impacts of legislation and healthcare responses.
- Paras. 165-78 discuss anecdotal experiences the RCPsych has gathered.

- Paras. 179–85 discuss use of emergency powers and our efforts to influence what these should be and when they should be utilised in England.
- Paras. 186-88 discuss patient experiences of emergency measures.
- Paras. 189-91 discuss consultation on emergency powers.
- Paras. 192-197 discuss emergency powers in Scotland.
- Para. 198 discusses emergency powers in Wales.
- Paras. 199-200 discuss emergency powers in Northern Ireland.
- Paras. 201-03 discuss access to medication during the relevant period.
- Paras. 204-08 discuss clozapine.
- Para. 209 discusses sodium valproate.
- Para. 210 discusses access to medication in Northern Ireland.
- Paras. 211-20 discuss undelivered care as one of the indirect harms of Covid-19.
- Paras. 221-28 discuss the impacts of undelivered care.
- Para. 229 outlines the RCPsych's position on capacity and collaboration during the period.
- Para. 230 gives our recommendations.

Infection prevention and control and nosocomial transmission

24. Third, we consider that the UK Government and relevant departments, agencies and public bodies in England did **not** adequately prepare, prevent and manage nosocomial transmission of Covid-19 within mental health, intellectual disability and autism settings, which contributed to avoidable and substantial harm from both Covid-19 and non-Covid-19-related causes for patients, staff and families, friends and carers.

25. Infection prevention and control is discussed further in paras. 231–308.
    - Paras. 231–52 discuss guidance on, supply of, and communication regarding personal protective equipment ("PPE").
    - Paras. 253-63 discuss Aerosol Generating Procedures ("AGPs").
    - Paras. 264-71 discuss testing of staff and patients.
    - Paras. 272-83 discuss visiting guidance around patients in inpatient care and hospitals.
    - Paras. 284-95 discuss the MHIDA estate.
    - Paras. 296-301 discuss the impact of nosocomial transmission.

- Paras. 302-06 discuss clinically extremely vulnerable ("CEV") individuals and 'shielding'.
- Para. 307 outlines our position on infection prevention and control during this period.
- Para. 308 offers our recommendations.

Supporting patients who are unwell with Covid-19

26. Fourth, we consider that the UK Government and relevant departments, agencies and public bodies in England did **not** adequately consider, in their strategic and operational planning:

    - whether providers of mental health services and healthcare professionals were sufficiently prepared to manage acutely unwell patients with Covid-19 in MHIDA inpatient settings
    - how well the mental healthcare system and the wider health system were working together as part of their ongoing response to the pandemic.

27. Supporting patients with Covid-19 is discussed further in paras. 309–40.
    - Paras. 309–14 discuss supporting patients of all ages who are unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities.
    - Paras. 315-20 discuss upskilling NHS staff during Covid-19.
    - Paras. 321–31 discuss Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") orders.
    - Paras. 332-38 discuss Covid-19 deaths of hospital patients with pre-existing mental health conditions and patients in mental health, intellectual disability and autism inpatient facilities.
    - Para. 339 outlines our position on supporting patients with Covid-19.
    - Para. 340 offers our recommendations.

Protection of doctors, nurses and other healthcare professionals

28. Fifth, we consider that the UK Government and relevant departments, agencies and public bodies in England did not adequately protect doctors, nurses and other healthcare professionals, including those in training, and specific groups of healthcare

workers, such as minoritised ethnic staff, from avoidable harm both during the pandemic and the post-pandemic period.

29. Protection of doctors, nurses, and other healthcare professionals is discussed further in paras. 341–78.
    - Paras. 342–43 discuss the guidance we published on protecting health professionals.
    - Paras. 344-45 discuss working outside of usual scope of practice.
    - Paras. 346-52 discuss redeployment.
    - Paras. 353–59 discuss support for NHS staff in England.
    - Paras. 360-62 discuss support for NHS staff in Scotland.
    - Paras. 363-68 discuss RCPsych influencing.
    - Paras. 369-70 discuss staff in independent practice.
    - Paras. 371–75 discuss minoritised ethnic groups.
    - Para. 376 discusses IT systems.
    - Para. 377 outlines our position on the protection of doctors, nurses, and healthcare professionals.
    - Para. 378 offers our recommendations.

Recovery and restoration of mental health services

30. Sixth, we consider that the UK Government and relevant departments, agencies and public bodies in England have not addressed the recovery and restoration of mental health, intellectual disability and autism services in a way that is commensurate with the priority placed on other areas of healthcare, despite the historical underfunding of these services compared to other areas of health.

31. Recovery and restoration of mental health services is discussed in paras. 379–438.
    - Paras. 380-93 discuss recovery planning in England.
    - Paras. 394-95 discuss recovery planning in Wales.
    - Paras. 396-97 discuss recovery planning in Scotland.
    - Paras. 398-416 discuss referrals, admissions and hospitalisations.
    - Paras. 417-24 discuss population level impacts on children and young people.
    - Paras. 425–26 discuss workforce growth.

- Paras. 427-32 discuss Long Covid (Post-Covid Syndrome).
- Paras. 433–36 discuss research agendas and funding.
- Para. 437 outlines our position on recovery and restoration of mental health services.
- Para. 438 offers our recommendations.

32. We believe that these factors contributed to substantial avoidable patient, staff and public harm from both Covid-19 and non-Covid-19-related causes.

33. I will now set out, in detail, the relevant work the RCPsych undertook during the period with which the Inquiry is concerned, before addressing each of the preceding conclusions in turn. I will also include relevant recommendations at the end of each section.

Work of the RCPsych during the relevant period of pandemic

34. This section details a range of work carried out by the RCPsych over the relevant period, including groups we were a part of; representations, submissions and advice provided; guidance published, including for clinicians and information resources for patients, carers and the general public; research and analysis; and a range of media statements made.

Groups

35. The RCPsych played a key leadership role from the outset and throughout the pandemic in advocating for its members, the teams they work with and the patients and carers they treat and support. We engaged extensively with senior representatives across the DHSC in England, NHSEI, the Department of Health in Northern Ireland ("DoH"), the Welsh Government and the Scottish Government, as well as other government departments, arms-length bodies, other medical royal colleges and other relevant stakeholders.

England

36. In England, the RCPsych worked with NHSEI (now known as NHS England ("NHSE"); DHSC; PHE (which was reorganised on 18 August 2020 and subsequently known as the National Institute for Health Protection ("NIHP") but has since been disbanded with health improvement functions transferred to the Office for Health Improvement and Disparities ("OHID") and its health protection functions transferred to the UK Health Service Agency ("UKHSA"); the Care Quality Commission ("CQC"); HEE (now merged with NHSE); NHS Digital ("NHSD") (now merged with NHSE); the Cabinet Office, the Academy, RCN, Unite the Union, and the General Medical Council ("GMC"). We were a member of the Covid-19 Group with medical royal colleges and the National Medical Director, NHSE; medical royal colleges and Chief Medical Officer Group, DHSC; Mental Health Independent Advisory and Oversight Group, NHSE; and the Adult Mental Health Steering Group, NHSE. The RCPsych was also a member of the Long Term Plan Steering Group on Indirect Harms, NHSE; and the National Post-Covid Syndrome (Long Covid) Taskforce, NHSE, amongst other task and finish groups.

Wales

37. In Wales, we are a member of the Academy of Medical Royal Colleges Wales, the Welsh NHS Confederation Health & Wellbeing Alliance, the Welsh Government Ministerial Oversight & Delivery Board, the Welsh Government Clinical Advisory Group, and the Health Education and Improvement Wales ("HEIW") Mental Health Workforce Plan Implementation Board. We were also previously a member of the Wales Alliance for Mental Health. The RCPsych was also a member of several Senedd Cross-Party Groups ("CPGs") that undertook relevant work during the pandemic, including CPGs for mental health, suicide and self-harm, Post-Covid Syndrome and dementia. We also host the Royal College Mental Health Expert Advisory Group ("RCMHEAG"), providing a Chair and secretariat to the group. This is an independent group of royal colleges, societies and organisations working across primary, community and secondary care mental health services in Wales that was formed in response to the challenges presented by the Covid-19 outbreak.

38. The RCPsych in Wales is also a member of several Welsh Government task and finish groups, most notably one on mental health legislation and one on ethnic minority mental health. Prior to the beginning of the Covid-19 outbreak, we were

commissioned by the Welsh Government to develop standards for prison mental health in Wales as part of a Prison Partnership Agreement between Welsh Government, HMPPS and Public Health Wales.

39. We were regularly invited to, and attended, the Welsh Government Mental Health Incident Group, giving us the opportunity to raise areas that we felt needed priority. This included informing the group how mental health services were to be deemed essential, and not to be stood down; as well as evidencing and providing the group with opportunities in tackling a rising waiting list for memory assessment services.

40. We contributed to the Mental Health and Learning Disability Coordination Centre, which was run by NHS Wales' National Collaborative Commissioning Unit. This included disseminating guidance developed by the College across services in Wales.

Scotland

41. In Scotland, the RCPsych gave evidence to the Equalities Committee and was a member of the legislative stakeholders group that also included the Mental Welfare Commission, Mental Health Tribunal Service in Scotland, the Scottish Government, and other stakeholders. The RCPsych in Scotland worked on emergency mental health measures for Covid-19 legislation, on which we collaborated with the Minister for Mental Health and other Scottish Parliament members. Staff from the RCPsych in Scotland also engaged with the Holyrood Education and Skills Committee on its Vulnerable Children Inquiry. We also worked directly with the Scottish Government's Mental Health Directorate to escalate and address active issues. We were members of Scottish Government's Mental Health Quality and Safety Board, Mental Health Stakeholders Group and other forums which informed key workstreams, including the Mental Health Transition and Recovery Plan. Through our membership of the Scottish Academy of Medical Royal Colleges, we actively engaged with the NHS-wide Covid-19 response and, as Co-Chairs of Scotland's Mental Health Partnership ("SMHP"), we maintained active engagement and information-sharing with relevant professional bodies and third-sector parties.

Northern Ireland

42. As part of our commitment to collaborative partnership working in Northern Ireland, the RCPsych utilised the Policy Group (NI), a semi-formal collaboration of four organisations (the RCPsych in Northern Ireland, Action Mental Health, Inspire and the British Psychological Society) to share reflections on the mental health impact of Covid-19, engage in joint influencing opportunities and offer peer support to staff and members alike.

43. Through the RCPsych's Diaspora Groups Committee, and in reaction to the devasting third Covid-19 wave in India, RCPsych also considered the importance of support for carers.

Clinical guidance

44. The RCPsych convened a UK-wide Covid-19 College Advisory Group and developed/contributed to over 75 pieces of guidance for clinicians. This guidance was adapted as required and used in the College's response across the devolved nations of the UK. The list of guidance (in no particular order) is as follows:

- College responds to Coronavirus Bill
- Patient engagement: Covid-19 guidance for clinicians (LS/1 – INQ000400039)
- Covid-19 Arrangements: decision aid for the Annual Review of Competency Progression
- Covid-19: Community mental health settings
- Covid-19: Secondary and specialist mental health settings (LS/2 – INQ000400040) (LS/3 - INQ000400043)
- Covid-19: Organisational wellbeing
- Covid-19 Mental Health Improvement Network Webinars
- Helping our staff work safely during Covid-19
- Legal matters: Covid-19 guidance for clinicians
- Safely resuming ECT services and Covid-19
- Help for people experiencing anxiety during the pandemic
- Covid-19: Providing medication
- Covid-19: Guidance for clinicians

- Further advice on Covid-19
- Covid-19: A-Z for clinicians
- Covid-19: Mental health before, during and after pregnancy
- Responding to Covid-19
- Our service to you during Covid-19
- Covid-19: Supporting recruitment
- Covid-19: Infection prevention and control (IPC) (LS/4 – INQ000400041)
- Information about the Covid-19 vaccine
- Covid-19: Eating Disorders
- Covid-19: Eating disorder services
- Covid-19: eLearning: Prevention and treatment
- Covid-19: eLearning resources from other Royal Medical Colleges
- Covid-19: eLearning resources for psychiatrists (A-Z)
- Covid-19: Inpatient services
- Covid-19: Liaison psychiatry services
- Covid-19: Support for patients and carers
- Covid-19: Accessing medication for mental health
- Covid-19: Alcohol
- Covid-19: Managing individuals with alcohol problems
- Covid-19: Going to hospital for a physical illness or injury
- Covid-19: Guidance for community and inpatient services (LS/5 – INQ000400042)
- Covid-19: Secure hospital and criminal justice settings
- Covid-19: Working with vulnerable patients (LS/6 – INQ000400044)
- Covid-19: Change packages
- Digital - Covid-19 guidance for clinician
- Further resources – Covid-19 guidance for clinicians"
- Covid-19: guidance for UK psychiatric trainees
- Covid-19 learning resources for clinicians
- Covid-19 Mental Health Improvement Network
- Resources from the Covid-19 Mental Health Improvement Network
- Covid-19: Podcasts for members
- Covid-19: Information for those who use drugs
- Covid-19: Self-harm and suicide

- Covid-19: Self-harm in young people
- Covid-19: Guidance on risk mitigation for minoritised ethnic staff in mental healthcare settings
- About our Covid-19 guidance for clinicians
- Covid-19: Looking after your mental health – for young people and their parents and carers (LS/7 - INQ000400045)
- Covid-19: Staying well and monitoring health at home
- Post-Covid-19 syndrome and 'long Covid': guidance for clinicians (LS/8 – INQ000400046)
- Covid-19: Remote consultations
- Covid-19: Guidance for clinicians
- Covid-19: Supporting healthcare professionals
- Covid-19: Supporting someone with autism or an autism spectrum disorder (ASD)
- Covid-19: Taking care of yourself
- Operational guidance for adults (16-64 years) with a Severe Menal Illness and Intellectual Disability
- Covid-19: Wellbeing and support
- Covid-19: Workforce
- Covid-19: Ethical considerations
- Guidance for staff on Covid-19: attendance at work

Welsh language guidance:

- Covid-19: Anhwylderau bwyta
- Covid-19: Aros yn iach a monitro iechyd yn y cartref
- Covid-19: Alcohol [Welsh]
- Covid-19: Cymorth i gleifion a gofalwyr
- Covid-19: gwybodaeth i seiciatryddion yng Nghymru (**LS/10 - INQ000400049**)
- Covid-19: Gofalu am eich iechyd meddwl - i bobl ifanc a'u rhieni a'u gofalwyr
- Covid-19: Meddyginiaeth ar gyfer iechyd meddwl
- Covid-19: Ymgynghoriadau o bell
- Covid-19: Ysbyty ar gyfer salwch neu anaf corfforol

Wales specific guidance in English:

- Covid-19: information for psychiatrists in Wales (LS/10 – INQ000400049)

Northern Ireland specific guidance:

- Covid-19: information for psychiatrists in Northern Ireland (LS/11 – INQ000400047)

Scotland specific guidance:

- Working in the time of Covid-19
- Covid-19: information for psychiatrists in Scotland (LS/12 – INQ000400048)

Services, networks and resources

45. The RCPsych's College Centre for Quality Improvement ("CCQI") exists within the RCPsych and collects and reports on service-level data. It publishes a range of resources, research, evaluations, and annual reports relating to our Quality Networks and Accreditation. CCQI worked on a National Audit of Dementia, which focused on memory assessment services during the pandemic.

46. The RCPsych's Psychiatrists' Support Service ("PSS") increased capacity during the pandemic. This service provides free, rapid, high-quality and confidential peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties.

47. The RCPsych also established a Covid-19 Mental Health Improvement Network, which provided a platform to share resources with services and healthcare professionals. The network ran for six months and provided a space for mental health teams to share changes they introduced in response to Covid-19, whilst discussing challenges and learning. We also held webinars on communicating with families, patients and staff, and about ideas for reducing restrictive practices. This guidance was used in the RCPsych's responses across Wales, Scotland, and Northern Ireland.

48. On 6 May 2020, the RCPsych ran two webinars on the Covid-19 Mental Health Improvement Network. The first was on suicide prevention with the National Confidential Inquiry into Suicide and Safety in Mental Health, and the second was on

connecting with carers with the British Association of Social Workers and the RCN. We also shared a patient self-care workbook on the Hub at this time, as well as restrictive interventions guidance and a care bundle. We also published threads on the Hub's forum in the first week of May 2020 about helping patients understand PPE; creating a safe, supportive and 'NOvid' room for staff; and psychological responses that staff may experience during Covid-19.

49. The RCPsych developed the Covid-19 eLearning Hub to support psychiatrists and healthcare professionals working in mental healthcare across the UK and abroad. The Hub included podcasts, online modules, webinars, and external resource links, all of which were free to access.

Representations, submissions, advice and information

50. The RCPsych corresponded with the UK Government, devolved administrations, and healthcare bodies regarding workforce, guidance and service delivery. We also worked internationally with the World Psychiatric Association and the European Psychiatric Association to disseminate research about the impact of Covid-19 on people with severe mental illness.

51. The RCPsych produced, and contributed to, a range of reports and position statements on a number of issues relevant to psychiatry and mental healthcare services. For example, during the pandemic we produced a report on the impact of Covid-19 on minoritised ethic staff in mental healthcare settings and a risk assessment tool for staff. In England, we produced a briefing on the need for investment in mental health ahead of the Government's Spending Review in 2021.

52. The RCPsych also developed a broad range of patient information resources in response to the Covid-19 pandemic. On 25 March 2020, a proposal was developed which considered the responsibility to provide information to help patients, carers and the general public across the UK respond effectively to the developing situation and its impact on mental health services. Topics were agreed based on need and considered factors, such as if changes had been identified in care and patient experience, whether other organisations had already addressed this need and if the RCPsych was best placed to fill the information gap.

England

53. The College provided MPs and Peers in Westminster with regular written briefings throughout the pandemic. In chronological order, these included briefings:

- confirming the RCPsych's support for the Government's emergency Covid-19 response legislation, provided safeguards are maintained and measures promptly reviewed after the crisis ended (March 2020)

- detailing the results of an RCPsych members' survey showing that a significant proportion of psychiatrists were unable to access recommended PPE or obtain Covid-19 tests for themselves, family members, or patients (April 2020)

- calling for an additional 4,370 psychiatrists by 2029 to meet the 'tsunami' of mental health needs expected to follow the pandemic (June 2020)

- highlighting the disproportionate impact of Covid-19 on minoritised ethnic frontline workers and recommending risk assessments for all minoritised ethnic workers to provide people with individualised risk mitigation plans (June 2020)

- warning of rising mental illness incidence following lockdowns, particularly among minoritised ethnic communities (June 2020)

- detailing results of an RCPsych members' survey demonstrating that 43% of psychiatrists had seen increases in urgent and emergency cases following lockdowns, and 45% had reported decreases in routine appointments despite rising care needs (June 2020)

- recommending significant investment in mental health services including infrastructure and people following the pandemic (August 2020)

- urging the major expansion of Children and Young People's Mental Health Services ("CYPMHS") and an accelerated rollout of mental health support teams in schools, following an RCPsych members' survey that found 51.4% of CYPMHS

psychiatrists had seen increased demand for specialist mental health care in their field (September 2020) (LS/13 – INQ000400051)

- calling for investment in technology to improve psychiatrists' ability to respond to rising demand for remote specialist mental health care, following an RCPsych members' survey revealing that only 19.7% of psychiatrists considered themselves 'fully equipped' to operate the necessary IT for remote consultations (October 2020)

- outlining the impacts, direct and indirect, of Covid-19 infection and lockdown on mental health across the UK and highlighting that a robust response would be necessary (October 2020)

- detailing the changes in how patients with serious mental illness accessed urgent and emergency care, noting the positive change that many were now being seen in 'mental health emergency departments' (assessment areas for mental health patients as alternatives to accident and emergency ("A&Es") as covered in paragraphs 118 and 119) but warning that this could increase the risk of disjointed care (October 2020)

- highlighting the impact that the pandemic had had on the nation's mental health ahead of the second lockdown and calling for investment in IT infrastructure and the mental health estate (November 2020)

- welcoming the Government's commitment to spend an additional £500m on mental health services by April 2022 and provide £50m to support patients discharged from inpatient wards as part of the 2020 Winter Plan for mental health (November 2020)

- outlining the negative impacts of the pandemic on the quality of inpatient dementia care, as staff were often deployed to other areas and pandemic regulations required more digital literacy than many patients possessed in order to continue to access mental health services (November 2020)

- warning about the negative impacts of the pandemic on eating disorder services, with referrals for under 18s increasing by 46% between April 2019 and April 2020 (February 2021) (LS/14 - INQ000400052)

- highlighting the impact of the pandemic on the mental health of children and young people, following an RCPsych members' survey showing over half of child and adolescent psychiatrists reported increased demand for emergency intervention and 48% were seeing increased demand for urgent care (February 2021) (LS/15 – INQ000400053)

- warning about the pandemic's impact on the mental health of Black people due to a "triple whammy of threats" to their mental health, income, and life expectancy (February 2021)

- detailing the pandemic's effects on the mental health of imprisoned people, including increased self-harm in women's prisons in England and Wales, and calling for improved assistance for vulnerable prisoners (March 2021)

- explaining the impacts on drug and alcohol services, noting that psychiatrists were reporting significant increases in demand for care including urgent interventions following lockdown (March 2021)

- demonstrating that the pandemic was seriously impacting new and expectant mothers with serious mental illness, with many struggling to access care due to digital exclusion, learning difficulties, English language barriers, poverty, insecure housing and domestic abuse (March 2021)

- summarising the longer-term impacts of Covid-19 on mental health: one in three people who were severely ill with Covid-19 was diagnosed with a neurological or psychiatric condition within six months of infection (April 2021)

- raising concerns about a 37% real-terms cut between 2013/14 and 2019/20 in youth addiction services, depriving thousands of people access to specialist support and potentially contributing to life-long addiction issues (April 2021)

- confirming rising rates of mental illness in children, with one in six children between the ages of five and 16 years old being diagnosed with a mental disorder in 2021 compared to one in nine in 2017 (June 2021) (LS/16 – INQ000400054)

- warning of the "biggest mental health crisis since the Second World War", with a 99% increase in referrals to CYPMHS: between May 2019 and May 2021, an estimated 153,000 adults and 16,000 new and expectant mothers were unable to access specialist mental health care (October 2021)

- highlighting the impact of Covid-19 on people who use alcohol and drugs, including greater risk of contracting the virus and developing serious complications such as atypical pneumonia and acute respiratory distress syndrome (October 2021)

- calling for an additional £4.9bn investment in mental health services by 2025 to meet demand for specialist treatment following the pandemic (October 2021); and

- detailing how services were struggling to respond to increased demand for specialist treatment for eating disorders, including rising rates of hospital admissions and unacceptably long waiting times (March 2022).

54. During the pandemic, the RCPsych wrote to Government Ministers requesting clarification and recommending action in select policy areas. This includes writing to the:

- Secretary of State for Health and Social Care Rt Hon Matt Hancock MP, requesting that he use emergency powers under the Coronavirus Act to implement temporary changes to the Mental Health Act of 1983 (8 April 2020) (LS/17 - INQ000410871)

- Secretary of State for Health and Social Care Rt Hon Matt Hancock MP outlining our concerns regarding nosocomial transmission and that many patients receiving assessment and treatment for a mental illness, chronic neurological condition, and/or intellectual disability were being cared for in residential settings or settings akin to care homes (22 July 2020) and (10 August 2020) (LS/18 - INQ000410876)

- Secretary of State Rt Hon Sir Gavin Williamson MP, urging him to suspend his threat of fines for parents whose children miss school and instead increase mental health support and resources for children (27 August 2020)

- Secretary of State for Health and Social Care Rt Hon Matt Hancock MP outlining our concerns regarding nosocomial transmission in MHIDA inpatient settings and our recommendations to improve the mental health urgent and emergency care pathway (23 October 2020) (LS/19 – **[INQ000058534]**)

- Secretary of State for Health and Social Care Rt Hon Matt Hancock MP, calling on him to establish physician-led occupational health services for NHS workers experiencing mental health difficulties (17 May 2021)

- Secretary of State for Justice Rt Hon Sir Robert Buckland MP, calling for a plan to meet the growing demand for mental healthcare in prisons, including among prison workers (5 June 2021)

- Secretary of State for Health and Social Care Rt Hon Sajid Javid MP, seeking clarification on how much of the Government's £36bn investment in health and social care was going to be spent on mental health services and how the Government intended to address the huge backlog and demand for specialist care (28 September 2021).

55. The RCPsych provided written and oral evidence to parliamentary committees and all-party parliamentary groups ("APPGs") on a number of pandemic-related issues. Evidence was given to the Education Committee, the Health and Social Care Committee, the Justice Committee, the Women and Equalities Committee, the Covid-19 Committee on Digital Technology and Mental Health, the APPG on Dementia, the APPG on Domestic Abuse and the APPG on Mental Health. The details of these submissions follow.

56. To the Education Committee in May 2021, the RCPsych's oral evidence outlined the crisis state of CYPMHS and stressed that demand for specialist care could be expected to rise sharply.

57. To the Health and Social Care Committee:

- written submission calling for additional investment in mental health services, urgent action to enable staff to access recommended PPE and testing, greater general support for NHS workers, and public communications urging people experiencing mental health problems to seek professional support (May 2020)

- written submission addressing burnout and resilience within the NHS and social care, and recommending that staff were provided with opportunities to share their experiences and given sufficient break time, access to hot food and drinks, and parking bays (September 2020)

- written submission highlighting a College members' survey in which more than half of psychiatrists were reporting a deterioration in their wellbeing as a result of the pandemic (November 2020)

- oral evidence addressing burnout and resilience in the NHS and social care, highlighting the disproportionate impact on minoritised ethic groups. We considered the impact on international staff – for instance, support for those grieving loss of family and loved ones abroad, enabling people to take leave a visit when borders opened (November 2020)

- written submission calling for the rollout of Mental Health Support Teams ("MHSTs") linked to schools, which had been delayed by the pandemic (February 2021)

- written submission addressing the treatment backlog, which highlighted a lack of resources to respond to demand for specialist mental healthcare and recommended prioritising prevention and early intervention to reduce waiting times (September 2021)

- oral evidence addressing the treatment backlog, which highlighted the increasing demand for specialist mental healthcare in England and Wales (September 2021)

- written submission calling for mental health A&Es in select areas and 24/7 all-age, open-access mental health crisis lines to support people with urgent mental health needs (October 2021).

58. To the Justice Committee:

- written submission calling for improved access to remote consultations and in-cell phones in prisons to reduce the risk of self-harm and mental ill health among prisoners (May 2021)

- oral evidence highlighting the negative impact of the pandemic on prisoners' wellbeing and mental health (June 2021).

59. To the Women and Equalities Committee, the RCPsych provided a written submission on the impact of the Coronavirus Act 2020 on people with protected characteristics, which recommended that staff should use the least restrictive options available to them when supporting patients and that emergency powers granted under the Mental Health Act should be used only when patients are at risk.

60. To the COVID-19 Committee on Digital Technology and Mental Health (House of Lords), the RCPsych provided a written submission warning about the possible mental health risks due to increased use of social media during the pandemic and calling for significant, new funding for technology in the healthcare service, including a £65 million expansion of the Digital Aspirant programme to a further 10 mental health trusts by 2024/25.

61. To the APPG on Dementia in April 2021, the RCPsych provided evidence that pandemic restrictions had negatively impacted patient contacts, the availability of equipment due to infection control concerns and dementia research.

62. To the APPG on Domestic Abuse in July 2021, the RCPsych provided evidence that the pandemic had increased domestic abuse, with victims forced to spend time at home with their abusers leading to increased fear, helplessness, anxiety and isolation.

63. The RCPsych also hosted a series of events on behalf of the APPG on Mental Health, including meetings to discuss:

- the impact of the pandemic on mental health services, including a reduction in routine appointments, increased urgent and emergency activity and high rates of Covid-19 infection on inpatient wards (November 2020)

- the reform of the Mental Health Act, at which point we called for the legislative changes to be prioritised (April 2021)

- how NHS mental health services responded to the pandemic and the impact on the mental health needs of different groups, particularly those from minoritised communities (July 2021).

Scotland

64. The RCPsych in Scotland directly engaged the Scottish Government, requesting clarification or prioritisation of legislative activities and contributing to discussions on multiple relevant topics during the pandemic, including:

- providing clarification from the Restricted Patient Team on sufficient contact conditions for people on conditional discharge

- identifying prioritisation areas for implementing video-conferencing options and the clinical settings which had the greatest need for them, including crisis teams

- contributing to discussions on PPE guidance for mental health services, specifically requesting government clarification around the conflicting advice that existed across Scotland, the availability of FFP3 respiratory masks and policy on Cardiopulmonary Resuscitation ("CPR") provision without FFP3

- meeting weekly with Ministers to discuss pressure on mental health service provision created by redeployment of staff and to share concerns about further pressures on acute services

- warning that too many mental health wards were being given over to acute care and flagging the ensuing negative impacts on mental health provision

- sharing its thinking as to what considerations should be taken into account regarding people with mental health conditions and/or intellectual disabilities during discussions of easing lockdowns, highlighting increased vulnerabilities to isolation and impacts of pauses on practical aspects of care plans

- warning that workstreams being launched on redesigning urgent care for the post-Covid era were lacking psychiatric representation. This resulted in appropriate representatives being added to these workstreams

- sharing concerns in writing to Health Protection Scotland that the need for rapid Covid-19 testing for patients on mental health wards to avoid extended isolation periods could result in distress

- warning that the physical monitoring hubs set up for the pandemic excluded mental health patients, which led to a sense that a mental health patient's needs should be wholly served by the mental health sector rather than collaboratively.

Wales

65. The RCPsych in Wales met regularly with officials in the Welsh Government during the relevant period. There was a scheduled monthly engagement meeting with lead officials in the mental health and vulnerable groups division. Additional meetings were held on an ad-hoc basis as challenges emerged and opportunities were presented.

66. On invitation, the RCPsych in Wales also attended meetings of the Welsh Government Mental Health Incident Group. This group pulled together officials in Welsh Government and lead officers throughout the NHS and Social Care covering a range

of urgent planning scenarios, such as treatment escalation planning and the development of guidance in response – for example, video consultation guidance.

67. The RCPsych in Wales gave evidence to several Senedd inquiries, three of which took place during the early stages of the pandemic, and two at later stages – which were regarding the impacts of the pandemic. Specifically, these inquiries were as follows:
    - The Health and Social Care Committee's Inquiry into mental health inequalities;
    - The Children, Young People & Education Committee's Inquiry into Mental Health support in higher education
    - The Culture, Welsh Language and Communications Committee's Inquiry into the impact of Covid-19 on the arts
    - The Children, Young People & Education Committee's Inquiry into the impact of the Covid-19 outbreak on children and young people in Wales
    - The Health and Social Care Committee's Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales.

68. The RCPsych in Wales provided written evidence to two Senedd Committees in shaping further inquiries for the Sixth Senedd, on areas that had been exacerbated by the impacts of the pandemic. In our written evidence for the Senedd Health and Social Care Committee inquiry into priorities for the Sixth Senedd, we highlighted the need to focus on work into mental health inequalities.

69. In our written evidence for the Senedd Children, Young People and Education Committee inquiry into priorities for the Committee, we highlighted the need to focus on the mental health support required for students in higher education.

70. In our written evidence to the Children, Young People & Education Committee's Inquiry into the impact of the Covid-19 outbreak on children and young people in Wales, we highlighted the impact of the Covid-19 outbreak on the mental health of children, including specifically on children in poverty, those with intellectual disability or autistic children, children with adverse childhood experiences, children with severe mental illness and those with protected characteristics. We also presented information and recommendations regarding the delivery of core Child and Adolescent Mental Health

Services during the pandemic and beyond. Our submission also provided information relevant to, and recommendations about, recovery planning.

Northern Ireland

71. In Northern Ireland, the RCPsych worked closely with the DoH, including the Mental Capacity Unit, the Mental Health Directorate, the Chief Medical Officer's Office and the six Health & Social Care Trusts. We advised the DoH in relation to the Covid-19 emergency legislation measures and, as part of the Covid-19 Reference Group which the RCPsych in Northern Ireland established in 2020 in response to the pandemic, we advised the Chief Medical Officer's office on the advice, guidance and policy they provided impacting psychiatric units. Through this group, we worked closely with psychiatrists who sat on Trust Clinical Committees to ensure a consistent approach in service delivery.

72. Throughout the pandemic, the RCPsych in Northern Ireland attended various meetings with the Northern Ireland Health Minister, Robin Swann MLA, and the Department of Health. We provided advice on the impact of Covid-19 on the mental health of the population during the relevant period.

73. On 29 September 2021, the Chair of the RCPsych in Northern Ireland presented a verbal briefing to Northern Ireland Health Minister Robin Swann on the impact of Covid-19, and its associated risks, win regard to the health of mental health patients and the pressures being felt in mental health services across the nation. Specifically, this briefing expressed the RCPsych in Northern Ireland's keenness to ensure that the mental health impact of Covid-19 was addressed, noting that, after age and weight, having a severe mental illness ("SMI") was the single greatest predictor of mortality in Covid-19 (hence the need for prioritisation of those with SMI for vaccination); and the severe negative impact on the care in community population, including those with severe schizophrenia and psychoses. The briefing also emphasised the importance of acknowledging the potential mental health 'Covid sequelae' (including post-intensive care unit ("ICU") post-traumatic stress disorder ("PTSD"), risk to staff of PTSD and moral injury); complex presentations, such as Covid-19 and catatonia; and the additional risk from Covid-19 for some of the most seriously ill patients taking clozapine. It also highlighted how there was a high incidence of delirium in patients

being treated for Covid-19. More broadly, it stated problems of chronic shortages in staffing, beds and funding; and made clear that the biggest challenge that we face in the next five years is the uncertainties in relation to a stable Assembly.

74. The RCPsych in Northern Ireland also submitted a consultation response to the Northern Ireland Assembly Health Committee Inquiry into the impact of Covid-19 on Care Homes and a response to the DoH Consultation on Cross Departmental Covid-19 Vulnerable Children and Young People's Plan.

Examinations

75. There were derogations for training made by the GMC, including for exams and support for trainees to ensure workforce progression. This meant that exams could be taken online and in any order for the duration of the pandemic. Additionally, the minimum number of Work-place Based Assessments ("WPBAs") was suspended, which enabled flexibility for trainees.

76. In April 2020, the RCPsych decided to digitise its Member of the Royal College of Psychiatrists ("MRCPsych") examination and it took five months to do so. This enabled the delivery of a digital Clinical Assessment of Skills and Competencies ("CASC") in September 2020, taken by 494 candidates. By the end of 2020, the RCPsych had run one of the biggest digitised exams of any medical royal college, with two diets of the CASC, two diets of Paper A and two diets of Paper B, with a combined total of 3,218 candidates sitting at least one of the diets. While Diet 1/spring written papers were cancelled in 2020, written exams were delivered digitally via Pearson VUE from October 2020, with no changes made to the blueprint or standard. Derogation was made to allow people to apply for and sit the CASC without holding a pass in any written exams due to the cancellation of diet 1, with the first online CASC was delivered in September 2020.

77. In May 2021, derogation to allow candidates to sit the CASC without holding a pass in written exams ended. The RCPsych did, however, continue to deliver all of its exams digitally with CASC remaining totally remote and the use of Pearson VUE test centres increasing for written exams. A review of the RCPsych's assessment strategy was also agreed in 2021.

78. In 2022, the College continued to deliver all exams digitally. Written exam candidates were able to take their exams at home or at a Pearson VUE Test Centre. We recommended to candidates that they take their written exams at a Pearson VUE test centre as home connections could, at times, be unreliable.

79. The assessment strategy review was completed, and recommendations were made to our Council and Board of Trustees in early 2023, including to stop the online delivery of the CASC.

Research

80. The RCPsych ran regular UK-wide membership surveys about the Covid-19 response and convened a Covid-19 Research Group. The surveys were initially conducted approximately fortnightly, but then were based on emerging priorities. They were in the field from 15–17 April 2020, 1–6 May 2020, 18–26 May 2020, 10–15 June 2020 and 1–9 September 2020 (LS/20 – INQ000410878) (LS/21 – INQ000410879) (LS/22 – INQ000410880) (LS/23 – INQ000410881) (LS/24 – INQ000410882) (LS/25 – INQ000410883) (LS/26 – INQ000410872). We conducted a rapid review of emerging evidence of the impact of Covid-19 on the incidence and prevalence of mental illness.

81. The RCPsych has five academic journals. Any papers relating to Covid-19 were published in their 'accepted version' so they could be made available as quickly as possible. We also made any papers relating to Covid-19 free to view. The journals are managed by the College and are published by Cambridge University Press on behalf of the College. The complete list of journals is as follows: *The British Journal of Psychiatry* ("*BJPsych*"), *BJPsych Bulletin*, *BJPsych Open*, *BJPsych Advances*, and *BJPsych International*. All five published papers on Covid-19 and mental health.

82. Internationally, we worked with the World Psychiatric Association and the European Psychiatric Association and disseminated research about the impact of Covid-19 on people with severe mental illness. Working with the European Union of Medical Specialists (Section of Psychiatry), RCPsych staff were also involved with compiling EU policies regarding the prioritisation of patients with SMI for Covid-19 vaccines, as well as supporting the compilation of a Covid resource library.

83. As part of our work to support members during the pandemic, RCPsych staff carried out research (literature reviews, for example) to assist members and inform their own research. Research topics included Long Covid and mental health; Covid-19 and mental health in prisons; Covid-19 neuropsychiatric sequelae; impact of Covid-19 on schizophrenia; mental health and the financial impact of Covid-19; post-traumatic growth in healthcare workers following Covid-19. Additionally, in the early stages of the pandemic, in the absence of specific information about the new virus, the RCPsych developed a systematic literature review on the mental health aspects of Pandemic Influenza. This information was published on our website under the Covid-19 section on research.

84. In April 2020, the RCPsych's History of Psychiatry Special Interest Group ("HOPSIG") reviewed information available in the RCPsych's library about pandemic responses with RCPsych staff. Specifically, this was conducted by rapidly performing a literature search on 'flu pandemics and mental health'. The results of this search were posted on the RCPsych's library webpage, meaning they were openly accessible to anyone. The RCPsych also acquired a major textbook on disaster psychiatry. At the time, we found nothing in the records about Spanish Flu or Hong Kong Flu. HOPSIG also discussed the need to collate and archive information with regard to RCPsych activities during the pandemic with RCPsych staff in 2020; a particularly important part of this was the 'Future Archives' essay competition in 2020 and 2021 in which psychiatrists were asked to reflect on their own experiences during the pandemic through various different forms, including prose, poetry, drama, film, paintings, cartoons and music. All entries have been stored in the RCPsych archives. It was felt that it was important to obtain details of personal experiences of the pandemic. The winning entries were posted on the website and comprised personal accounts of individual doctors on the impact of the pandemic and on them personally, including those in training and some specific groups of healthcare workers by ethnic background.

Media

85. Throughout the relevant period, the RCPsych issued a range of press releases calling on the Government and relevant public agencies to implement measures to mitigate the impacts of the pandemic, including those that were preexisting but exacerbated by

the crisis. These press releases capture much of the research and analysis conducted by the RCPsych's staff and members over the course of the pandemic.

86. Regarding investment:

- In May 2020, the RCPsych warned that mental health services were dealing with a rise in emergency and urgent cases while also preparing for a 'tsunami' of mental illnesses still to come. This warning was based on a survey conducted by the College which found that 43% of 1,300 psychiatrists had seen a rise in their urgent and emergency caseload, while 45% had seen a reduction in their routine appointments. More patients were staying away from mental health services while the pandemic was simultaneously making it more difficult for services to provide routine appointments. This led to more people presenting in crisis.

- In July 2020, the RCPsych called for a ring-fenced investment of an additional £3.3 billion to improve mental health facilities at the next spending review. New research at the time by the College found a third of clinicians in England felt the quality of mental health buildings had compromised the care of patients during the pandemic. The College also called for immediate action to reduce the risks posed by a second wave of coronavirus for the coming winter, and to ensure high-quality and safe mental health services into the future, advising £376m (25%) of the Prime Minister's then recently announced £1.5bn of NHS capital funding for 2020/21 to be ring-fenced for mental health NHS trusts and for a £1bn building and redevelopment programme to enable 12 major mental health projects to be completed by 2030.

- In September 2020, we developed our recommendations to Government, advising them to use the spending review to reverse the cuts and enable local authorities to work towards investing £374m into adult services so they can cope with the increased need for treatment. These recommendations were supported by our analysis which found that 8.5 million adults were drinking at 'high-risk' levels, up from 4.8 million in February that same year. The number of people addicted to opiates seeking help had also reached its highest level since April 2015. The College warned years of cuts to addiction services meant they were ill-equipped

to cope with the increased pressure and called for a multi-million-pound funding package in the upcoming spending review for that year.

- In March 2021, the RCPsych reported on new research which found that the average number of referrals to eating disorder inpatient settings and emergency admissions to acute hospitals increased by 20% from March 2020 to November 2020 when compared with data from July 2018 to February 2020. This data showed that waiting times for potentially life-saving treatment more than doubled from 33 days to 67 days. The average distance from home to treatment also increased from 42 miles to 62 miles during the pandemic, with seven patients sent to Glasgow as no beds were available in England. The lead author of the research was the Chair of the College's Eating Disorder Faculty. We called on the Government to urgently address eating disorders by improving access to treatment and increasing funding for both community and inpatient services. We also said that NHSEI must work to deliver waiting-time targets for adults, otherwise the unfair postcode lottery of their treatment will continue despite the commitments made in the NHS Long Term Plan.

- In September 2021, we reported that 1.5 million people were in contact in mental health services in June 2021 – the highest number since records began – and 12.4% more than at the same time the previous year. We advised that the Government should use its spending review to address this problem.

- In October 2021, the RCPsych reported that, in the medium term, millions of people would struggle with their mental health over the next few years due to the pandemic, advising that investment would be needed in the spending review. We estimated that a £3bn capital investment, plus £1bn for the day-to-day running of the mental health estate was required over the next three years, to ensure existing hospitals were safe.

- In February 2022, the RCPsych President at the time, Dr Adrian James, called for the government to fund six new mental health hospitals as part of its promise to build 48 new hospitals by 2030 in an article in *The Guardian.* Nearly twice as much of the mental health estate in use at the time was built before the founding of the

NHS in 1948 as the acute estate, and thousands of people with mental illness in England were being treated in dangerously old hospitals.

- In June 2022, the RCPsych called for an urgent £300m cash injection into NHS mental health services to match inflation at the time, highlighting how the cost-of-living crisis posed a threat of pandemic proportions to the nation's mental health and that, of the £2.3bn pledged to mental health investment after inflation in the Long Term Plan over the five-year period until 2023/2024, only £2.05bn was set to be delivered on the latest inflation rate (LS/27 – INQ000400055).

87. Regarding children and young people:

- In September 2021, we presented new analysis by the College showing that 190,217 people aged 18 or younger had been referred to CYPMHS between April and June 2021, up 134% on the same period the year before. We called on the then education secretary, Nadhim Zahawi MP, to make children and young people's mental health needs a top priority, including schools having plans in place to respond to pupils' mental health needs and investment in staff training to improve the roll-out of Mental Health Support Teams (LS/28 – INQ000400056).

- In April 2021, we warned that 400,000 children and 2.2 million adults had sought help for mental health problems one year after beginning of the pandemic. We said that the additional £500m (including £79m for children) promised for mental health needed to urgently reach frontline work to help tackle the crisis. We emphasised how children and young people were bearing the brunt of the mental health crisis created by the pandemic and were at risk of lifelong mental illness (LS/29 – INQ000400057).

- In February 2022, that years of funding cuts to youth addiction services and the pandemic were causing thousands of children and young people to fall through the cracks, and that spending on youth addiction services had fallen in real terms by £30.5m in the last eight years. The College welcomed the government's announcement of £780m in the new budget for drug treatment over the next three years (LS/30 – INQ000400058).

- In July 2022, we reported on a recent study which showed that emergency hospital visits for self-harm were twice as likely for boys, and three times as likely for looked-after children, compared with pre-pandemic levels, emphasising the importance of considering the impact of measures put in place during the pandemic on self-harm so that mental health services could plan for the future (LS/31 – INQ000400059).

88. Regarding workforce shortfalls:

- In October 2021, RCPsych President at the time, Dr Adrian James, warned that the pandemic and a historical mental health backlog had created a perfect storm of unprecedented mental healthcare needs and insufficient care. The College's 2021 census revealed that there were not enough psychiatrists to treat record numbers of people requiring treatment. The College called for 7,000 more medical school places and a £1.73bn annual investment to tackle the issue.

- In March 2022, we also reported that, following successful campaigning by the RCPsych and others, the House of Lords voted in favour of an amendment requiring the Government to publish regular independently verified assessments of current and future workforce numbers every two years. We advised MPs to retain this clause when they next considered the Bill so that it would become law, and we reported that more than 340 psychiatrists wrote to their local MP asking them to support this amendment. This amendment, however, was rejected, leading the RCPsych to support a compromise – an amendment which required the Government to lay a health and social care workforce report before Parliament 'at least once every three years' from April 2022 onwards. However, this was also rejected. We voiced our disappointment when the Bill passed in April 2022 without any agreement by the Government to publish regular updates on the health and social care workforce.

89. Regarding inappropriate out-of-area placements:

- In April 2022, the RCPsych highlighted that patients with acute mental health needs were being sent miles away from home because a bed was not available locally, despite Government pledges to end adult mental health inappropriate out of area placements by the end of 2020/21. Our analysis found there were 58,735 inappropriate out-of-area placement days between October–December 2021. Nearly 80% of inappropriate placements that ended in December lasted for 15 or more nights while 44% lasted for 31 or more nights. We called for the Government to continue to invest in the expansion of community services with investment in line with post-pandemic demand. We said this was needed to reduce the number of people reaching crisis point and needing hospital admission.

- In June 2022, we made a number of similar points, calling on the NHS to adopt a 'zero tolerance' approach to inappropriate out-of-area placements and to take urgent action to ensure all patients get the care they need from properly staffed, specialist services in their local area.

90. In March 2021, the RCPsych and the Royal College of Occupational Therapists published a report calling for social prescribing services to be expanded to tackle the mental health consequences of pandemic-related isolation. We also called for commissioners to include social prescribing in community and inpatient mental health services, as this would benefit people's physical and mental health.

91. In May 2021, we reported on new College research which found 84% of the public thought climate and ecological emergencies would affect mental health in a decade at least as much as Covid 19. Only 22% of people thought climate and ecological emergencies were a contributing factor to the global outbreak of Covid-19. We called for international cooperation and urgent action, publishing a position statement titled *Our planet's climate and ecological emergency*, which provides recommendations for psychiatrists, the NHS, research institutes and Government to tackle the crisis and promote more sustainable clinical practices.

92. In July 2021, the RCPsych warned that a postcode lottery in England was putting the mental health of expectant and new mothers at risk. Due to the pandemic, thousands of women had not been able to get necessary help with their mental health during pregnancy or after giving birth. The College called for funding for perinatal mental health facilities in the next spending review and for local health bodies to invest in services in their areas.

93. In February 2022, the RCPsych NI launched its manifesto in which it encouraged Ministers in Northern Ireland to close the funding gap for mental health services.

94. The RCPsych also amplified its support for national-level decisions, where appropriate, including: temporary changes to the Mental Health Act which allowed Approved Mental Health Professionals ("AMHPs") to apply to detain someone under the Mental Health Act with the agreement of just one registered medical professional rather than two; extending time limits on nurse, doctor, police and magistrate holding orders and amending second opinion and appeal procedures; the Government's announcement to provide an extra £150m investment over the next three years to fund NHS mental health services to better support people in crisis outside of A&E and enhance patient safety in mental health units in June 2022; and the National Institute for Health and Care Excellence's ("NICE") publication of the first guideline in 12 years to help clinicians identify, treat and manage depression in adults in June 2022.

95. The RCPsych in Wales featured in mainstream media activity during the pandemic. This included coverage of a national rollout of FDG-PET scanning to aid dementia diagnosis. We also issued our own media pieces, including one piece on the national rollout of an injectable buprenorphine (Buvidal) for at-risk ex-heroin users and another related to one of our member's substantial input into the national rollout of a video consultation service.

96. RCPsych in Scotland developed and released a number of media pieces outlining the pandemic's impacts on mental health, offering information on dealing with pandemic-related isolation for adults and children, and warning governments about knock-on effects of pandemic legislation. Throughout the relevant period, members of the RCPsych in Scotland issued statements on a range of issues, including the adverse

impacts Covid-19 would likely have on children with existing mental health issues; the need for mental health support for NHS staff; the variety of emotions easing restrictions would cause, from anger to anxiety; and the pandemic's impact on parents and new families, as well as stigma surrounding mental health issues for new parents.

97. The RCPsych in Northern Ireland also developed and released a number of media pieces to explain the impact of the Covid-19 pandemic on mental health services; how to help frontline workers deal with stress and burnout from the pandemic; the prevalence of eating disorders linked to the pandemic; and the underfunding of mental health services with reference to the country's recovery from the pandemic.

Key Areas

98. This section covers six thematic areas in turn: planning; capacity and collaboration; infection prevention and control and nosocomial transmission; supporting patients unwell with Covid-19; protection of doctors, nurses and other healthcare professionals; and recovery and restoration of mental health services. At the end of each section, we draw conclusions and make recommendations.

Planning

99. To the best of our knowledge, the RCPsych has not been included in any pandemic preparedness exercises specifically relating to flu. We are not aware of the extent to which any exercises, such as, for example, Exercise Cygnus, considered how the NHS estate providing mental health, intellectual disability or autism services would cope under various emergency scenarios. We take that away as important learning for the future.

Timeline of early responses

100. I personally recall attending the RCPsych's Forensic Faculty Conference at Liverpool from 4 March to 6 March 2020. The Conference, which usually saw high attendance, was noticeably lighter on the ground than in previous years. It also had a different feel and, strikingly, was being held following worrying reports from Italy and

Spain. On Thursday 5 March, several scheduled speakers, one of whom was a colleague from Italy, appeared by video link. At this point, in my own professional capacity as Clinical Director for forensic services at South London and Maudsley NHS Foundation Trust, I thought it was wise to draft a phased contingency plan, covering measures ranging from what we might do should we have an outbreak on the ward all the way to the service closing for admissions. I had completed this plan by that Thursday afternoon in Liverpool. Within a week, the Cheltenham horse racing festival and the Champions League game in Liverpool 'superspreader' events had taken place.

101. On 13 March 2020, RCPsych staff had their first call with the Communications team at NHS England and Improvement ("NHSEI") about the Covid-19 pandemic and the healthcare systems' response. On the call, they asked all medical royal colleges to review the current webpages on the NHSE Covid-19 Hub to see if the information was accurate for the clinicians we represent. At this time, the Covid-19 Hub consisted of two sub-sections: primary care and secondary care. Upon review of this information, including standard operating procedures, guidance and resources, we found there was nothing relating to mental health, intellectual disability or autism, or specifically, how the Covid-19 virus should be managed in these settings.

102. During the same meeting, Claire Murdoch CBE, National Mental Health Director at NHSEI, gave an update to say that her team had started work to produce public information relating to the mental health aspects of Covid-19.

103. Concurrently, RCPsych staff were receiving a significant number of messages with concerns and questions from members across the UK about healthcare systems' response to the pandemic. RCPsych Officers and staff expressed concern that there appeared to be a lack of central coordination and direction from government and public bodies relating to mental health, intellectual disability and autism services. It appeared to us that no preparation had been undertaken previously to consider how a contagious virus would be managed across these settings or for people experiencing a mental illness, an intellectual disability, or autistic people. The first time we raised concern about the preparedness of public bodies to lead, advise and support the pandemic response across mental health settings was on 13 March 2020.

104. It is in response to these concerns that we immediately, on the same day – 13 March 2020, formed our own Covid-19 Advisory Group. Comprised of representatives from across the RCPsych. The purpose of this group was twofold: first, to provide advice and guidance to the public and clinicians on the mental health aspects of Covid-19 in its broadest sense, and second, to comment and advise on the related mental health elements of the emergency legislation and its implementation. In response to the paucity of clinical guidance across the UK, we began to draft guidance on a range of topics with input from the advisory group. As agreed with NHSEI, guidance was developed by the RCPsych, shared with colleagues at the RCN and Unite the Union, and then returned to NHSEI's MHLDA Covid-19 Response Cell for sign-off, given the Level 4 Incident response.

105. On 13 March 2020, the RCPsych in Scotland agreed to work in partnership with the Scottish Association for Mental Health to develop guidance that was applicable to Scotland. Throughout March, the RCPsych in Scotland also worked with the Scottish Government to influence the development of national mental health guidelines and principles.

106. On 16 March 2020, RCPsych staff in England had their first call with Emma Wadey, Head of Mental Health Nursing within NHSEI's MHLDA Covid-19 Response Cell, during which they asked us to help prepare dynamic and brief principles, rather than detailed standard operating procedures, with respect to vulnerable patients; care pathways and patient management; and engagement strategies. We also learned of the first cases of Covid-19 on a small number of wards and were informed that appropriate actions were being taken. The MHLDA Covid-19 Response Cell at NHSEI advised the RCPsych that they were setting up six workstreams to support healthcare systems' response to the pandemic. While we were pleased with this progress, we remained concerned that this was significantly delayed compared with other sectors. By this point in the pandemic, primary care, community care and acute services all had relevant detailed operational guidance.

107. The NHSEI Covid Hub website provided information and resources on primary care and secondary care. These included standard operating procedures ("SOPs") for

primary care settings. These documents provided practical guidance to support primary care teams in managing contact with, and presentations of, patients who suspected they may have Covid-19. This included general practice, primary dental care settings, community pharmacy and primary care optical settings. These SOPs were published on NHSEI's website on 27 February 2020 and disseminated to relevant providers.

108. Similarly, under the 'Secondary care' section of NHSEI's Covid-19 Hub, there were several SOPs and resources. One of these included a 'Standard operating procedure for Coronavirus (2019-nCoV): Priority Assessment Service (version 3)'. This SOP was designed to explain the actions to take should an individual who suspects they may have Covid-19 present to your department. This was applicable to A&Es, urgent treatment centres, minor injury units and walk-in-centres. There was no mention of MHIDA services within this SOP. This was published on 6 March 2020.

109. By 11 March 2020, there was a third section added to NHSEI's Covid-19 Hub on its website, 'Community based health and social care and ambulance services'. Within this, there was no mention of MHIDA settings specifically and it was unclear where they would best fit into the existing categories given many MHIDA services span settings that are similar to primary care, secondary care, community and urgent and emergency care. Within this section of the website, it included Covid-19 guidance for ambulance trusts, which had been updated on 13 March 2020. It was not until the 4 April 2020 that NHSEI amended this sub-section to include mental health trusts: 'community health, social care, mental health trusts and ambulance services'. This demonstrates the comparative delay in clinical guidance and SOPs being published for MHIDA settings compared with other areas of the NHS. It is unclear whether MHIDA settings were simply forgotten, considered less of a priority or considered not to need any guidance compared with other settings. All of these scenarios are entirely unsatisfactory and undermine the principle of parity of esteem between mental and physical health services.

110. By 17 March 2020, NHSEI had published a document titled, *Next steps in response to Covid*, which stated that MHIDA providers must plan for Covid-19 patients at all inpatient areas and needed to identify areas where Covid-19 patients requiring urgent

admission could be most effectively isolated and cared for. The document also said that case-by-case reviews would be required where any patient was unable to follow advice on containment and isolation, advising that staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, so that they were clear about triggers for transfer to acute inpatient care if indicated.

111. On 20 March 2020, the RCPsych's Covid-19 Clinical Guidance pages went live across the UK with information relating to 20 different areas. From there, we ensured that published guidance remained up to date and we continued to develop new guidance for different service areas, including liaison psychiatry and secure care. The publication of this guidance was well received and, within three days, its landing page on our website had 7,350 unique page views equating to approximately 6,000–7,000 visitors. Our Covid-19 guidance on community and inpatient services was, by far, the most used subpage, with 6,400 page views, equating to approximately 4,500–5,500 unique visitors; our guidance on patient engagement for clinicians was the second most popular, with 2,300 unique page views (approximately 1,500–1,800 unique visitors).

112. That same day, the RCPsych in Scotland met with representatives from the Scottish Government to discuss the development of guidance for mental health professionals. The RCPsych's published guidance was edited to reflect the Scottish context, before being sent to the Scottish Government.

113. On 24 March 2020, given the lack of information on these areas and following our member webinar, we advised NHSEI that we would be developing guidance on cohorting; ethical considerations for psychiatrists; liaison mental health services; intellectual disability services; secure services; staff support and managing trauma; alcohol use and Covid-19; medication (clozapine, and depot clinics which specialise in providing a preparation of medication that is given by injection and is slowly released into the body over a number of weeks); and electroconvulsive therapy ("ECT") and anaesthetists. While this relationship was collaborative, there was a sense of frustration among some of our members about sign-off processes within NHSEI that were required in order for material to enter the public domain. We wanted to produce guidance for our members and the wider mental health sector in order to fill a void left

by NHSEI but were required to enter protracted discussions about sign-off given the Level 4 incident.

Anecdotal experiences

114. My experience on the ground, at this time, can be characterised by a lack of Government guidance. I was one of the Physical Health Leads for my Trust and was of the view that we needed to have contingency plans for patients. Instead of receiving guidance on this point, my colleagues and I were talking to colleagues in other countries, including China, Germany and Italy, for example. Due to the lack of information, the South London and Maudsley NHS Foundation Trust ("SLaM") held its own internal physical health meeting to enable the creation of our own guidance. We were of the view that our patients were vulnerable to Covid-19 but were instead being told that as Covid-19 was a physical illness, it was not likely to impact patients with a mental illness. We disagreed with this notion, however, and started to make our own targeted plans for our patients who were the most vulnerable. A lot of our patients, for example, had obvious risk factors, such as those who were elderly or infirm, who were at high risk of poor outcomes should they contract Covid-19. Protocols and plans, therefore, had to be in place. It was important that we identified high-risk patients so that we could effectively isolate people who were coming in with Covid-19. Based on what we heard from members, this experience was common across other NHS trusts.

115. The RCPsych has since heard from members that a perceived lack of initial consideration and subsequent lack of urgency in planning and disseminating guidance for MHIDA settings, left people, patients, healthcare systems and professionals to navigate an unknown virus by relying largely on their own common sense and judgement. Our members have expressed to us their feeling that they witnessed two extremes in terms of decision-making: some higher-level government decisions were too prescriptive and left no room for individualised approaches, while the ability to make other decisions conferred upon staff complete autonomy to do what they thought was most appropriate, with little to no guidance. This led to a lack of coordination within regions and across trusts in England. In some units, for example, vulnerable adolescents were sent home from mental health units prematurely while adults were prioritised for treatment; in others in the same region, no contact with their family was allowed whatsoever. In some cases, however, our members expressed that processes

were implemented to assess positive risk, allowing for decisions to be made in a manner that was semi-autonomous and regionally consistent, ensuring similarities across services. We heard from our trainees that discrepancies in practice across settings in response to the same national rules caused frustration and fostered a sense of injustice in advocating for patients. This was particularly applicable to psychiatry given how vulnerable patients with severe and enduring psychiatric disorders are.

116. One of our patient representatives, who was on a mental health inpatient ward which experienced an outbreak, expressed to us her feeling that the guidance and rules provided during this time period were difficult to comply with on an individual, face-to-face level while also not allowing for care to be provided at a level that was both expected and necessary. We were told how she was unable to access a patient kitchen due to the need to reduce footfall, as well as other indignities that occurred regularly as a result of facilities feeling the need to enforce the government's guidance at face value, which had not been designed for such contexts.

117. RCPsych members working in liaison psychiatry in hospitals in England have expressed to us that decisions relating to their work were, for the most part, made in local areas and by individual hospitals, as opposed to through the adoption of national guidance. We heard that this worked in well-defined areas where services were familiar and had a close working relationship with each other, including large cities and in the devolved nations, with an open sharing of ideas and policy co-development. While this grassroots approach to decision-making led to more flexible and creative ways of working, allowing for solutions to be designed at pace and, without long, drawn-out processes to seek and obtain permissions to do so, it did, however, lead to unforeseen issues.

118. For example, psychiatrists working in liaison services were directly involved in the request from acute hospitals to set up assessment areas for mental health patients as alternatives to A&E. The purpose of these areas was to reduce pressure and allow A&Es to focus on those who were acutely unwell with Covid-19.

119. In a survey conducted by the RCPsych's Liaison Faculty, 86% of A&Es and liaison services developed alternative assessment areas. Many members felt these areas

showed some benefits, including providing a more appropriate environment for assessment with more space for social distancing, as well as reductions in activity within the A&E and in waiting times for patients. However, several significant drawbacks were also reported by liaison services, including the feeling that physical health concerns were overlooked at times, problems with staffing, and a delay in the mental health pathway. The most worrying concern about the establishment of these alternative non-A&E assessment areas was that they increased stigmatisation of, and discrimination against, patients with mental health problems. They were also underutilised as many patients still needed to attend A&E because of a physical health comorbidity. It is important to recognise that while liaison teams were flexible, services felt they had no choice but to do their best to support A&Es in the development of mental health assessment areas, given the urgency of the situation. It was also a struggle to close areas down once the acute phase of the pandemic had passed.

Data collection and reporting

120. On 25 March 2020, the RCPsych learned from NHSEI that the current daily Covid-19 Situation Reports ("SitReps") collection was focused on providers of acute physical health services and did not include MHIDA services. NHSEI's MHLDA Covid-19 Response Cell advised us that they were working with NHSEI's analytical team to consider how SitReps could capture these sectoral needs. This fact was, and remains, particularly alarming as SitReps were key to NHSEI understanding how the healthcare system was responding to the Level 4 Incident and, therefore, informed its development of policy and operational guidance. The MHLDA Covid-19 Response Cell at NHSEI advised mental health providers at this point to include any information that they believed to be helpful in the 'Other' and 'Issues' sections of the next SitRep return. It was not until 24 April 2020 that we heard that MHIDA service information was being collected by the NHSEI SitRep team, leaving what we understand to be a 7-week delay of SitRep data collection. We had raised concerns that providers of MHIDA services had not been asked to provide real-time information, and we saw no clear rationale for this omission. At the time, we assumed that this was because these providers were not considered a key part of the response to Covid-19, which we knew to be untrue. If this data had been received earlier, it may have alerted senior leaders in NHSEI to the emerging situation across MHIDA sites.

121. The omission to collect data, outlined above, should be considered alongside a letter from Claire Murdoch CBE, National Director for Mental Health at NHSEI on 30 March 2020 to the mental health system leaders, which stated: "in line with this and with immediate effect, unless otherwise stated in the Appendix to this letter, all Mental Health Transformation Programme assurance and additional or bespoke reporting requirements over and above routine data collections to the Mental Health Services Data Set ("MHSDS") and Improving Access to Psychological Therapy ("IAPT") Datasets, are paused temporarily until further notice. As per steer from Chief Operating Officer's ("COO") office, it is our expectation that routine national data collections will continue, as this data is essential in understanding system pressures during this period."

122. As such, routine monthly reporting continued throughout the first wave but, given the inherent delays in publication of this data, the impact on services was reported at a significant remove. Therefore, the provision of mental health reporting within SitReps would have ensured mental health impacts were considered in a timelier fashion.

RCPsych influencing

123. On 27 March 2020, we learned that Sir Jonathan Montgomery (Co-chair of the Medical Ethics Advisory Group ("MEAG")), Professor Helen Stokes-Lampard (immediate RCGP Past Chair) and Dr Ganesh Suntharalingam (President of the Intensive Care Society) were asked by the four Chief Medical Officers to develop national guidance on clinical prioritisation and risk thresholds to guide organisations and clinicians during the response to the outbreak. It was our understanding that the MEAG had already worked closely with the RCP, BMA and intensive care groups on this and collated evidence from around the world. We learned that this work would include guidance relating to a priority scoring system, including co-morbidities and age; critical care capacity management; and operationalisation and oversight. Following discussions with patient representation and faith leaders regarding the disproportionate impact on certain groups' needs, linking to the Equality Act and protected characteristics, it was agreed the document would be launched and then refined as required, and that the group would also have weekly oversight. The RCPsych raised issues relating to pre-hospital decision-making, advanced planning, Recommended Summary Plan for Emergency Care and Treatment ("ReSPECT")

forms, pastoral support and language. Although the RCPsych was not involved in this work, instead receiving updates via the Academy, when given sight of confidential drafts, we were concerned about the disproportionate impact a priority scoring system would have on people with a mental illness, intellectual disability and/or autism, and the lack of clarity around how to mitigate this. Given our fears that this patient group was being overlooked, we wrote to the MEAG on 20 March 2020 asking for our President at the time, Professor Wendy Burn CBE, to be co-opted (LS/32 – INQ000410873). However, this request was not met.

124. On 8 April 2020, the RCPsych in Scotland sent comprehensive feedback to the Scottish Government on their draft Principles for Mental Health Services, asking for clearer messaging and to rethink the singling out of certain vulnerable groups, while leaving out other vulnerable groups. On 1 May, the Covid-19 Principles for Mental Health were published.

125. On 8 April 2020, the President of the RCPsych at the time, Professor Wendy Burn CBE, was asked via a follower on Twitter to promote the fact that patients with specific health conditions could carry a letter from their doctor stating that they could go out outdoors with a "reasonable excuse" for doing so.

126. On 30 April 2020, the RCPsych signed a letter with the Mental Health Policy Group about food and medicine supplies for people with a mental illness. We had attempted a number of times to raise this directly with officials and ministers but had not been able to get a resolution. We therefore decided it required a heightened response to bring the issue to what we hoped would be a sensible conclusion. The open letter was sent to the Secretary of State.

127. On 12 May, we had an update from DHSC clarifying that anyone who was unable to go out to the shops because of a mental health problem was eligible to seek help from the NHS Volunteer Responder Scheme. While we were advised that this had, in fact, been the case since the scheme started, DHSC amended its website to explicitly include mental health conditions on the list of reasons for which someone may require support from a volunteer for help with shopping.

128. In early June 2020, after initially not being included in a meeting between medical royal college presidents and the then Secretary of State for Health and Social Care, Rt Hon Matt Hancock MP, the RCPsych proactively asked to attend future meetings. Subsequent meetings proved to be extremely valuable and gave us an opportunity to raise the profile of various issues affecting our members and the wider sector. However, it is worth noting that the DHSC and the Health Secretary did not initially identify the RCPsych as a key organisation to work with in its pandemic response, underlining our feeling that psychiatrists and mental health professionals were not regarded as being part of the 'frontline' of the NHS's Covid-19 response.

129. On 10 July 2020, the RCPsych President at the time, Dr Adrian James, along with the Academy, met with the Chief Medical Officer ("CMO") for England, Professor Chris Whitty. Questions posed by Dr Adrian James related to how the Government was receiving mental health advice, as well as how the Scientific Advisory Group for Emergencies ("SAGE") received mental health input given its role in advising COBRA and the Cabinet Office. At this time, we were aware of two psychologists belonging to SAGE who, we understood, represented a health psychology perspective. The RCPsych felt that psychiatric expertise would also be beneficial on SAGE, and we sought to make representations. At this point, the CMO for England advised that he did not feel they had adequate mental health advice and that this needed to be looked at in a subsequent meeting.

130. On 7 August 2020, NHSEI published its letter to support implementation of phase 3 of the NHS response to the Covid-19 pandemic. This letter included a separate section on mental health. By this point, the advice and guidance for MHIDA providers was much more detailed.

131. On 5 September 2020, during a meeting between the RCPsych and the MHLDA Covid-19 Response Cell, we became aware that each 'cell' within NHSEI had been asked to submit their learning from the first wave of the pandemic to Professor Keith Willets, NHS National Director for Emergency Planning and Incident Response. We heard that the MHLDA Covid-19 Response Cell's feedback was critical of the NHS policy and communications response because it was not timely and commensurate with other areas of healthcare, and this caused direct and indirect harm to patients,

and to people with intellectual disabilities, in particular. We also heard there had been a loss of trust and confidence in the national NHS team. We were pleased to hear that some of our concerns had been reflected in this feedback. We heard from the MHLDA Covid-19 Response Cell that their feedback had been the most critical of any team, with Professor Keith Willets, NHS National Director for Emergency Planning and Incident Response, promising to prioritise MHIDA services in future responses to Covid-19. Further to this, on 2 November 2020, Dr Adrian James, RCPsych President at the time met with Professor Willets to discuss the impact the pandemic was having on mental health services and the ways we could learn from the first wave. During this meeting, we discussed our concerns around nosocomial transmission in MHIDA settings; discharge from inpatient settings; infection prevention and control policies; do not attempt cardiopulmonary resuscitation ("DNACPR") guidance; cohorting patients and the mental health estate; mental health services within prisons; volunteer support; mental health emergency departments; and mental health data.

Impact on the delivery of mental health care

132. We have heard from our members about the difficulties they experienced in managing, following and implementing the broad array of guidance that was being disseminated at different levels and from different bodies. There was, for example, central government guidance being issued; public health guidance for both the public and healthcare staff; regional guidance; and local guidance. We heard that it was particularly challenging to follow regional and local guidance simultaneously, due to the rapid pace at which the evidence base was changing; the overlap between jurisdictions and those issuing advice; unclear communication; and the lack of clarity around whether any one specific piece of guidance was being adhered to or overridden due to a particular management or clinical reason. Members from the RCPsych's South West Division in England reported encountering conflicting guidance which changed daily, and the basis on which decisions were made being unclear to staff on the frontline at the time. As such, valuable time was spent interpreting and implementing guidance at a time where real urgency was required, with guidance and rules often not adapted for working with children.

133. Regarding ECT specifically, many ECT services moved into general hospital theatres, where limited emergency theatre time was spread between all surgical specialties.

134. On 23 September 2020, the Royal College of Anaesthetists ("RCoA") published guidance on anaesthesia for ECT during the Covid-19 pandemic. It stated that RCoA and the Association of Anaesthetists acknowledged that ECT is a NICE-approved treatment that is an urgent and important element of the management of some patients. It recommended that only Standard Infection Control Precautions ("SICPs") need be used in low-risk patient pathways. When patients presenting for ECT are in medium-risk or high-risk pathways, it will be necessary to use airborne transmission-based precautions ("TBPs"). The RCPsych had the opportunity to be involved in the drafting of this document and we supported its publication in that it highlighted the essential nature of ECT services and provided guidance as to how these services could be safely resumed.

Conclusions and recommendations

135. **It is clear that the first weeks of the pandemic were critical in preparing and supporting the mental health systems' response. Based on a considered assessment of the information known to us, it is the RCPsych's position that:**

135.1. **DHSC and NHSEI were unprepared to respond to a pandemic of this nature – both in terms of its scale and the fact that it involved a novel coronavirus (whereas previous planning had been based on an influenza pandemic) – and, specifically, to facilitate sufficient delivery of mental health care. There is limited to no evidence that any pre-pandemic thinking or planning ever took place in relation to how sufficient mental health care would continue to be delivered in a pandemic situation. Had such planning happened, it is our view that the mental health estate would have been identified as not being fit for managing the virus.**

135.2. **The UK Government did not sufficiently include those with psychiatric expertise in its core decision-making and leadership teams,**

including SAGE and MEAG, at all levels and on all relevant matters pertaining to the healthcare systems' response to the Covid-19 pandemic.

135.3. **NHSEI did not consider, in its most senior core decision-making and leadership, the potential impact of a pandemic of this nature on the delivery of mental health, intellectual disability and autism services as evidenced by the vacuum of information for these settings in the critical early weeks. Instead, the MHLDA Covid-19 Response Cell at NHSEI initially prioritised information for the public on the mental health effects of a pandemic. Furthermore, NHSEI's Covid-19 Hub webpages did not refer to mental health trusts or MHIDA settings at all until 4 April 2020.**

135.4. **DHSC was proactive in seeking RCPsych's advice about emergency provisions in the Coronavirus Bill and the dialogue between the organisations was good throughout the pandemic.**

135.5. **NHSEI were reliant on the RCPsych developing, publishing and disseminating clinical guidance in relation to mental health service delivery. While we consider this function to be a key part of our leadership role to our members and the profession, should the RCPsych not have had the resources or expertise internally to develop this information quickly, it is our assessment that the void would not have been filled in a reasonable or proportionate timescale. The impact of that would have resulted in even more significant local and regional variation in the mental healthcare systems' response to the pandemic, as we saw from providers developing their own local guidance and protocols, with clinicians feeling unsupported by NHSEI. For instance, one of our members shared with us their trust's guidance on community and inpatient settings and the management of patients with an influenza-like illness or confirmed influenza on 15 March 2020 for our information and to support us in developing guidance for other areas. From other members, we subsequently received, further pieces of guidance which addressed a similar issue but in a different way.**

135.6. **Taken together, this initial lack of, and delay in providing, necessary information meant that NHSEI did not provide national leadership for NHS mental health, intellectual disability and autism services in the early stages of the pandemic.**

135.7. **By the third phase of the NHS's response to the pandemic in England, NHSEI were able to provide comprehensive information to systems on how to ensure the mental health commitments within the NHS Long Term Plan continued to be prioritised and investment continued to flow. This messaging was important and demonstrated the leadership role provided by NHSEI through business-as-usual activity.**

135.8. **NHSEI did not adequately request, collect and utilise SitReps on Covid-19 from MHIDA settings for the first 7 weeks of the Level 4 incident response. Once these data were being collected, they were not published or shared, even with organisations developing guidance relating to Covid-19 like the RCPsych. Given the two-month lag between mental health services data being collected and published online, as well as the drop-off in the participation rate during the pandemic, which meant that some of these data were of limited use, the SitRep reports were essential.**

135.9. **It was appropriate for NHSEI to undertake a learning exercise after the first wave of Covid and, as we understood it at the time, they rightly found that the feedback from the MHLDA Covid-19 Response Cell at NHSEI to be the most critical of any team. We understand conversations internally within NHSEI resulted in a new commitment from senior leaders to prioritise mental health in future responses to the pandemic.**

136. **Based on the positioning outlined above, the RCPsych makes the following recommendations with respect to planning:**

136.1. **DHSC, UKHSA and NHSE should undertake new pandemic preparedness exercises. These should involve the RCPsych and other organisations representing the mental health, intellectual disability and**

autism services and include an assessment of the suitability of the mental health estate in the event of a future pandemic.

136.2. **The Government should extend mental health representation within the SAGE, MEAG and/or related sub-groups to include RCPsych.**

136.3. **The Government should establish a cross-government mental health leadership group at Cabinet level.**

136.4. **NHSE must ensure that the national leadership response to any future pandemic includes senior leaders from NHS mental health, intellectual disability and autism services.**

136.5. **To prepare for future pandemics of any scale or nature, NHSE need to ensure there is sufficient priority and resource within the MHIDA directorate to enable them to respond in a manner that is timely and commensurate with other healthcare sectors.**

136.6. **In the case of a comparable Level 4 Incident, NHSE should request, collect and utilise situational reports from MHIDA settings; publish National SitReps on a weekly basis in order to be transparent and aid decision-making by other organisations involved in the healthcare systems' response; mandate all critical mental health data collections during a similar incident to ensure quality and sufficient coverage in order to aid decision-making; and undertake learning exercises at appropriate moments in order to adapt and improve its national response.**

Capacity and collaboration

Managing capacity and demand

137. On 16 March 2020, the Government announced the requirement for self-isolation for 14 days when someone in a household was symptomatic of Covid-19, leading to confusion as to the implications for the NHS workforce and to significant concerns

about the supply of staff in the short term. In England, the RCPsych contacted Claire Murdoch CBE, NHSEI's National Mental Health Director, to gain clarity on how this announcement applied to the NHS workforce, but she was unable to provide an answer, indicating a lack of coordination between the Government and NHSEI at that time. Subsequently, we were advised that Prerana Issar, Chief People Officer at NHSEI, provided confirmation that the announcement did apply to healthcare workers. This raised major concerns about staff absence rates and the management of capacity and demand across mental health, intellectual disability and autism services.

138. On 19 March 2020, the UK Government and NHSEI published Covid-19 Hospital Discharge Service Requirements but made no specific reference to mental health, intellectual disability and autism services. Alongside a letter sent two days earlier by Simon Stevens, Chief Executive of NHSEI and Amanda Pritchard, Chief Operating Officer at NHSEI at the time, these requirements set out how providers of community services should release capacity to support the Covid-19 preparedness and response. The priorities for providers of community health services, at this time, were to support the immediate home discharge of patients from acute and community beds, as mandated in the new hospital discharge service requirements, and to ensure that patients being cared for at home received urgent care when they needed it; to use technology to provide advice and support to patients wherever possible and by default; prioritise support for high-risk individuals who would be advised to self-isolate for 12 weeks; and to apply the principle of mutual aid with health and social care partners, as decided through their local resilience forum. While the letter was addressed to all NHS trusts, it did not specifically reference community mental health services. This resulted in confusion, with some providers proceeding to follow this advice and others not. This invariably led to a substantial number of patient discharges from community mental health caseloads. It is unclear whether this was NHSEI's intention at the time, but it was our assumption that it was not.

139. On 20 March 2020, the RCPsych published its own guidance for clinicians on allocating resources with a community mental health clinical decision framework. The purpose of this was to support clinicians and the wider team to create clear and concise clinical decision tools to enable the allocation of care and treatment for community mental health patients based on need. The guidance concluded that

patients who were risk-assessed using the Red, Amber, Green ("RAG") scale as having a 'red' rating, i.e., were vulnerable and at high risk, must have frequent face-to-face contact. For those with 'amber' ratings, we recommended regular monitoring and review via telephone with an option to step up to face-to-face contact, if required. For those with 'green' ratings, we recommended telephone contact, with a need for a telephone review to be prioritised over a face-to-face review. We also produced guidance on managing care pathways with limited staff resources. This was approved for publication by the NHSEI MHLDA Covid-19 Response Cell.

140. On 18 March 2020, the Mental Health Tribunal Service updated its guidance to reflect that hearings were to be held via teleconference. This update was shared with our members in Scotland. On 23 March 2020, the RCPsych in Scotland raised concerns about the move to teleconferencing with the Mental Health Tribunal Service President, Lara Dunlop. Specifically, we raised the points that consideration needed to be given to the fact that patients on wards may be self-isolating and appropriate contingencies would need to be made. We also asked whether scanned paperwork, as opposed to originals, would be accepted, which would allow for renewal reviews to undertaken from anywhere.

141. On 3 April 2020, NHSEI's National Mental Health Director, Claire Murdoch CBE, wrote to mental health trust CEOs and mental health system leaders requesting that all areas prioritise the establishment of 24/7 urgent NHS mental health telephone support, advice and triage in the coming week. NHSEI conducted a rapid audit of mental health provider websites in mid-March which showed that just over half of mental health trusts did not at that time have a public-facing 24/7 telephone number for access to urgent mental health support. Of those that did, some were difficult to find, and, even more pressingly, a number of websites were directing people to NHS 111, A&E and 999 as the local default option for urgent mental health support. This letter noted that it was more important than ever for people not to be diverted to these services, as their needs could be met by mental health services, and for NHSEI to provide unequivocal clarity to the public in every part of the country on how to access specialist urgent mental health support.

142. The above letter also requested that children and young people and their parents and carers had access to crisis lines, through an all-ages or dedicated access point.

Northern Ireland

143. On 17 September 2020, the RCPsych in Northern Ireland provided a formal response to a Surge Planning Strategic Framework document. The response made the following five recommendations:

- Many patients with severe and enduring mental illness and intellectual disability have motivational and cognitive impacts of their illness. These would affect their ability to take steps to protect themselves in the Covid-19 crisis, to take appropriate action should they became physically ill, and to seek help (including medication) with their mental disorders should they begin to deteriorate. It was therefore very important that community staff had increased input to these patients at these times (allied to co-ordination with the Community and Voluntary groups who were involved with these patients).
- Staff in mental health and intellectual disability services are the main mode through which support and therapy are provided to these patients, and much of the focus is on the individual relationship and personal knowledge of the patient. It was important that this was not disrupted through re-deployment of mental health and intellectual disability staff. For this reason, staff members in these services should be protected from redeployment to other sections during pandemic waves.
- Given the long-haul nature of this planning exercise, new patients coming into mental health services were going to struggle to get to know staff (both clinical and support), with the means and frequency of interaction quite different and challenging to relationship development. This required special attention in care planning.
- The Care Home sector needed additional urgency in approach, as well as consideration for greater protection of residents and staff – such as the type of bubble method used in the school network and greater restrictions on staff working in multiple settings – given the re-emerging prevalence of the virus in Care Homes and the levels of prevalence and death already

seen to this point in the initial surge. This sector needed a more intense scrutiny on infection control, care needs, clinical care and communication with residents during lockdowns to ensure consistency of the application of the highest standards of care and human rights across the region. The mental health effects of the catastrophe in Care Homes in the first phase were intergenerational as this was an issue which had adversely affected the mental health of residents, families and staff alike and hence required intense focus in the months ahead to minimise further damage.

- A final comment was that, overall, the document may have underplayed the increased demand we believed we were likely to see in mental health and intellectual disability services.

RCPsych influencing

144. On 17 November 2020, NHSEI updated its guidance on managing capacity and demand within inpatient and community mental health, intellectual disability and autism services for all ages, drawing from the learning from the first wave of the pandemic. Major changes to the guidance included those in relation to blended approaches between face-to-face and remote delivery; hospital discharge service requirements and NHS trusts' statutory duty for people who are homeless; Covid-19 testing for people being discharged to a care home; safe and appropriate use of Section 17 leave; Covid-19 testing and appropriate bed allocation and isolation of patients on admission; cohorting; regular review of changes to service configurations; avoiding partial or complete closures; transfer of people in prisons and immigration removal centres to and from mental health inpatient services; transfer and remission across organisations; delay in adhering to service specifications and guidance; and communication across mental health inpatient assessment services (secure and non-secure).

145. From Early 2021 until June 2021, we issued a series of regular briefings to Welsh Government's mental health & vulnerable groups division on the impacts of Covid, and the opportunities to inform Covid recovery. We issued guidance with TEC Cymru 'Home Working Guide: Promoting Mental & Physical Health'.

146. In the early stages of the pandemic, there was a diversion of anaesthetists and operating department practitioners into ICUs prior to anticipated surges in ICU demand. Staff were diverted away from provision of urgent care, including cancer surgery and, crucially for psychiatry, ECT. This resulted in tangible harms to patients who required such interventions. Although this initial reaction was understandable given the uncertainties at the time around the magnitude of the demand that was to come for ICU services, crucially, there was no flexibility in the systems to subsequently roster staff to departments according to demand during a particular week. It wasn't until months into the pandemic that senior management in acute care provider organisations adopted a more flexible approach and conceded that staff would be better deployed in a more balanced manner.

147. ECT is carried out under general anaesthetic, usually for people experiencing severe depression, and it involves non-invasive ventilation. As such, the diversion of anaesthetic staff had a significant impact on patients being treated in ECT services, with most continuation and maintenance patients, who were reliant on regular treatments, having their therapy stopped. The decision to withhold regular, necessary treatment resulted in patients relapsing into severe illness and would have been unthinkable for patients receiving comparable physical treatments. Dialysis services, for example, rightly stayed open.

Modelling

148. On 25 March 2020, RCPsych staff began modelling what a 20%, 40%, 60% and 80% staff absence rate would mean for community mental health, liaison mental health, and CYPMHS in England. Modelling was based on the state of play as of December 2019, which was the most recent data point for both the workforce and mental health services data set from NHSD. We used data from the MHSDS showing the number of people in contact with services as a proxy for patients in these staff absence ratios. Workforce data was broken down by specialties, where patient data was available, and by grade to allow, for example, for the reduction of foundation year one doctors, as we were aware that they were being transferred to the acute sector. Given the challenges around trust footprints, models were based on HEE regions.

149. Overall, we found that, as at the end of December 2019, 1,377,180 people were in contact with mental health services and 9,255.6 full-time equivalent psychiatrists were in posts across English NHS trusts. There were 149.3 patients per full time equivalent ("FTE") psychiatrist, ranging from 81.8 in North West London to 200.7 in West Midlands. We found that there would be 186.6 patients per psychiatrist if 20% of staff were absent, 248.8 at 40%, 373.2 at 60% and 746.4 at 80%. We concluded that if all foundation year one doctors were to be transferred to the acute sector, 365.2 FTE doctors would be lost from the workforce, taking the initial ratio to 155.4 patients per psychiatrists.

150. For child and adolescent psychiatry, modelling was based on the number of people in contact with CYPMHSs (235,706) as opposed to the number of 0- to 18-year-olds in contact with mental health services as a whole (368,398). There were 234.1 people in contact with CYPMHSs for each psychiatrist working in such services. We found that there would be 292.6 patients per psychiatrist if 20% of staff were absent, 390.2 at 40%, 585.2 at 60% and 1,170.5 at 80%.

151. For old age psychiatry, there were 292,507 people aged 65+ in contact with services and 1,030.5 old age psychiatrists at all grades, including 22.7 foundation year one FTE psychiatrists. This meant that the number of people in contact with services per psychiatrist was therefore 283.8, ranging from 135.4 in North, Central, and East London to 412.7 in West Midlands. We found that there would be 354.8 patients per psychiatrist if 20% of staff were absent, 473.1 at 40%, 709.6 at 60% and 1,419.2 at 80%.

152. For intellectual disability psychiatry, there were 126,114 people in contact with intellectual disability services and 427 FTE psychiatrists at all grades, with no foundation year one doctors in this specialty. This meant that the number of people per psychiatrist was therefore 295.4, ranging from 123.3 in north-west London to 565.4 in Thames Valley. We found that there would be 369.2 patients per psychiatrist if 20% of staff were absent, 492.3 at 40%, 738.4 at 60% and 1,476.8 at 80%.

153. Although usually in overall charge of an individual's care, psychiatrists do not personally look after every person in contact with services in the above population

groups by any means. As such, RCPsych staff made calculations to account for consultants; specialist, associate specialist and specialty ("SAS") doctors; mental health nurses; applied psychologists; and psychological therapists combined. This gave us an initial number of 24.6 people in contact with services per staff member, ranging from 14.6 in North West London to 37.0 in Kent, Surrey, Sussex. In terms of staff absences, this would mean that there would be 30.7 patients per staff member if 20% of staff were absent, 41.0 at 40%, 61.4 at 60% and 122.8 at 80%.

154. We shared the above modelling and assessment with NHSEI and DHSC and, on 26 March 2020, NHSEI published its first national guidance on MHIDA settings managing capacity and demand. The guidance was accompanied by a set of principles to inform our response as a mental health, intellectual disability and autism system.

155. On 30 March 2020, the MHLDA Covid-19 Response Cell published its IAPT guide for delivering treatment remotely during the coronavirus pandemic. We were not involved in the development of this guidance. In May 2020, the RCPsych's Medical Psychotherapy Faculty developed guidance for remote working during psychotherapy sessions as it became necessary for therapy services to offer sessions by video or via telephone. This constituted a profound change to the setting. The RCPsych's Medical Psychotherapy Special Advisory Committee worked with the RCPsych's Dean at the time, Dr Kate Lovett, to develop guidelines for trainees undertaking their psychotherapy training experience; this guidance covered the move to remote working for trainees already undertaking psychotherapy with patients, as well as guidance for those who were not already seeing patients.

156. On 8 April 2020, NHSEI issued guidance to mental health providers on a range of operational priorities (e.g., managing caseloads; approaches to staffing); flow of funding; impacts of service changes on specific groups (e.g., people with eating disorders); programme-wide considerations (e.g., physical health for people with severe mental illness, rehabilitation needs, psychological therapies for severe mental illness, and individual placement and support); and considerations for vulnerable groups (e.g., people who were shielding, older people, young adults, and rough sleepers and homeless people).

157. While mental health, intellectual disability and autism services remained open throughout the pandemic – with the exception of memory assessment services and, notably, many electroconvulsive therapy services – many operated under a different model in order to respond to national guidance, availability of PPE and infection prevention and control ("IPC") guidance, staff absence predictions and redeployment concerns. In responding to the situation at the time, based on the information available, the effect of this guidance – both from NHSEI and the RCPsych – undoubtedly resulted in fewer patients with mental illness being seen face to face by a psychiatrist or the wider mental health team. For some patients, this would have led to poorer mental health outcomes.

158. We heard from a patient who had received care from CYPMHS that reduced face-to-face appointments and lockdown conditions meant they had less access to distractions from their illness. This patient also experienced longer waiting times for crisis support, spending 32 hours in A&E on one occasion so that they could receive a mental health assessment. Patients transferring from CYPMHS to Adult Mental Health Services also experienced difficulties, particularly where adults were not permitted to have face-to-face appointments.

159. On 5 May 2020, the charity Mind issued a press release which stated that "hundreds of people unable to access mental health support as experts warn of suicide spike". Similarly, on 4 June 2020, the charity Rethink Mental Illness published a briefing that included the results of a public survey it had run, which indicated that respondents' mental health had worsened because of lack of support from the NHS. However, data from our own members' survey from the corresponding period (17 April 2020 to 6 May 2020) indicated that in England, 48.3% of respondents reported no change in their workload associated with emergency interventions or appointments which are usually conducted within four hours. An increase was reported by 27.1%, whereas a significant increase was reported by 4.3%. A decrease was reported by 16.1%, whereas a significant decrease was reported by 4.2%. For work associated with urgent interventions or appointments, which are usually conducted within 72 hours, 40.5% of respondents reported no change, 35.5% reported an increase, 5.6% reported a significant increase, 14.9% reported a decrease and 3.5% reported a significant decrease. Anecdotally, we heard that many patients suffered due to the lack

of face-to face contact and, despite having community teams involved in their care, some attended A&E so they could see someone face-to-face.

160. In terms of the application of the Mental Health Act ("MHA") (England and Wales) 1983, in England, the overall number of new detentions under the MHA has been rising in recent years; however, this may not reflect the true change in detentions as data quality has improved over time. Between 1 April 2021 and 31 March 2022, there was a total of 53,337 new detentions under the MHA across all age groups, a small increase of 0.3% from 53,239 detentions between April 2020 and March 2021 and an increase of 4.9% from 50,893 detentions just prior to the pandemic from April 2019 to March 2020.

161. For children and young people, in particular, the annual number of detentions has decreased since the start of the pandemic. From April 2019 to March 2020, there were 1,172 new detentions among children aged 17 and under (2.3% of the total number of detentions). This figure decreased by 3.2% in 2020–21 (1,134 detentions, 2.1% of the total) and dropped by 17.8% in 2021–22 (963 detentions, 1.8% of the total).[1,2,3]

162. According to the monthly statistics at the time, the total number of people subject to detention under the Act at the end of March 2020 was 6.7% less (14,555 in total) than that recorded at the end of February 2020 (15,602 in total). The detained population decreased by a further 665 patients at the end of April 2020 (13,890 in total), a reduction of 11.0% since February. There was a substantial reduction of 11.1% in the total number of people subject to detention in adult acute mental health care from February 2020 (5,724) to March 2020 (5,088). The number of detained patients in acute adult wards continued to decrease to 4,688 in April 2020, a reduction of 18.1% since February 2020.[4,5,6]

[1] NHS Digital, Mental Health Act Statistics, Annual Figures 2019-20, 27 October 2020
[2] NHS Digital, Mental Health Act Statistics, Annual Figures 2020-21, 26 October 2021
[3] NHS Digital, Mental Health Act Statistics, Annual Figures 2021-22, 27 October 2022
[4] NHS Digital, Mental Health Services Monthly Statistics, Final February 2020, 14 May 2020
[5] NHS Digital, Mental Health Services Monthly Statistics, Final March 2020, 11 June 2020
[6] NHS Digital, Mental Health Services Monthly Statistics, Final April 2020, 16 July 2020

163. NHSD statistics reported a decrease in the number of people subject to the Act on 31 March each year since the beginning of the pandemic in March 2020. There were 20,494 people who were subject to the MHA on 31 March 2021 and 20,312 people were subject on 31 March 2020, following the national lockdown on 23 March 2020. In comparison, 21,196 patients were subject prior to the Covid-19 pandemic in March 2019, equating to a 4.2% decrease in one year and a 3.3% decrease across two years. On 31 March 2022, the number of people subject to the MHA reached pre-pandemic levels, with 21,282.[7] The CQC highlighted concerns that reduced access to community mental health services during the pandemic may have contributed to the initial decrease and subsequent increase in the number of people being detained under the MHA.

164. Detentions under the mental health acts in the UK are particularly challenging and assessments for detention should ideally not be done remotely; as such, it is expected that the Covid-19 pandemic and subsequent lockdowns will have had an impact on the number of detentions across the UK.

Anecdotal experiences

165. The RCPsych recognises that guidance at the time meant that more people were discharged from care and fewer people were seen face to face, and it is our position that these decisions were taken based on the best available information in order to deliver quality care in a resource-constrained scenario. That said, in hindsight, the impact of undelivered care across some mental health specialties, and particularly CYPMHS, is likely to have contributed negatively to patient outcomes.

166. While people with pre-existing mental ill health were able to access mental health services online, which provided some continuity of care during the pandemic, this may also have acted as a barrier. Additionally, relative digital poverty of people with intellectual disability exacerbated their social isolation during the height of the pandemic.

[7] NHS Digital, Mental Health Act Statistics, Annual Figures 2021-22, 27 October 2022

167. One of our patient representatives, who was an inpatient under the MHA on a mental health ward which experienced an outbreak during the pandemic, characterised her experience as traumatic, finding that the clinical inpatient environment declined as books, magazines and newspapers were banned to reduce contamination. This patient representative also shared with us how people were confined to their rooms during the outbreak of the virus on the ward, with nothing to do except watch the time.

168. Our members have reported that there was significant pressure to discharge patients from older adult wards at this time. Care homes, however, were reluctant to accept discharged patients. Additionally, psychiatrists working in liaison services have noted that patients were discharged from the acute hospital too early during the initial period of the pandemic. The early use of care homes had a significant impact on patients, carers and families, with some feeling rushed into decisions.

169. We heard from one of our patient and carer representatives about their difficulties working as a senior care assistant in a care home throughout 2020 and 2021: staff were forced to bring Covid-19-positive residents back to the care home from the hospital but had so few test kits that they tested five people at random each day. This patient and carer representative witnessed many deaths at the care home, which was detrimental to their own mental health, and they were never certain whether, or when, they might contract Covid-19 themselves. The care home did not have PPE and shifts were 12 hours long. After several months working under these conditions, their mental health problems were gravely exacerbated. They began misusing medications and, in late 2020, attempted suicide.

170. We have heard from members that acute trust colleagues were under such pressure that discharges were often conducted without the appropriate level of care or consideration. This also applied to patients who were nearing the end of their lives, with relatives being deprived visiting rights. The emotional impact witnessed by liaison services was vast, and not just regarding relatives but also young staff in the acute hospital. In CYPMHS, we have heard from our members that some young patients felt less included in their own care planning and discharge planning meetings.

171. On 10 July 2020, during an online meeting with other medical royal colleges, the President of RCPsych at the time, Dr Adrian James, asked Professor Chris Whitty, CMO for England, about any work that was happening to deal with digital exclusion. Professor Whitty said that this was an extremely important issue and something DHSC had come to realise was something it needed to address. He expanded this into a discussion about those for whom regular communication channels did not meet their needs and he expressed that he felt that the Leicester outbreak was, in part, related to this. The College also raised concerns that the health outcomes of people who could not come to hospital and whose access to digital technologies was limited would potentially be the poorest.

172. We heard from one of our carer representatives, who is a mental health carer who looks after her brother. She explained that if not been caring for her brother during the pandemic, he would not have been able to access services, such as a psychiatrist, as he is not digitally literate. We also heard from this carer that she felt that lockdowns placed extra burdens on her as a carer – she felt forced to lobby for access to doctors and to use digital communication, which was difficult for the person she cares for.

173. We heard from another carer representative that he was shocked at the reliance on digital literacy to secure appointments; while he and his mother, who he cares for, did have digital access at the time, his mother was not digitally literate, and many other people and families did not have access to appointments. As such, we heard that digital poverty rendered resources totally unavailable to many.

174. Although there is a good body of evidence which points to improved outcomes from face-to-face therapeutic relationships for patients with mental health problems, more research is required to understand the efficacy of digital and telephone therapy; specifically; there is a need to understand the impact of the digital format on the patient experience of therapy (both on a one-to-one and group basis), as well as the impact on concordance with medication and ongoing reviews.

175. Anecdotally, we have heard from members that, while digital therapies did, and continue to, provide some patients with the potential for better access and engagement, due them otherwise being constrained by their geographical location,

this shift can also have a negative impact on patients with complex trauma and/or anxiety, if they also lack digital literacy. For example, we have heard from members who work in medical psychotherapy that patients with a history of complex trauma and abuse found it difficult to engage in online sessions. Some patients found it difficult to attend and engage in sessions while their children or other family members were at home, while others found themselves left to deal with difficult emotions, once the appointment ended and the screen went blank, at home alone. On one hand, the closer, physical proximity of face-to-face meetings creates an environment in which anxiety may be more prominent – making the patient more likely to be open to exploration with the psychotherapist. On the other hand, however, it could be argued that the distance created by meeting over screens paradoxically allows for a kind of 'intimacy at a distance' that promotes openness and disclosure from patients. Ultimately, though, gauging, assessing and managing psychological risk was compromised by the absence of face-to-face contact.

176. We heard from one of our carer representatives, based in rural Northern Ireland, who is a mental health carer for her daughter who is diagnosed with a SMI. She said that the support her daughter had access to, which kept her well, such as support groups and weekly contacts with her mental health team, became unavailable overnight. As a result, her daughter became increasingly unwell, which increased stress in the household. This representative reported that telephone contact with her daughter's mental health team was brief, and that the team appeared, particularly in the early months of the pandemic, wholly unable to provide the same level of care remotely. We heard how her daughter's mental health worsened as she was unable to find support outside the home and was admitted to hospital in June 2020.

177. We also heard from our trainees that, due to reduced face-to-face interactions with patients and clinical opportunities to identify relapse, they felt limited in their use of core skills as psychiatrists to move their patients' care 'forward' through psychoeducation, managing social issues, and building trust to work towards larger steps the patient needs support in taking. However, trainees also reported that this was balanced by much more efficient ways of interacting with patients who needed to be medically monitored, including those undergoing routine assessment who were

stable, or who were on a pathway of treatment (e.g., incremental medication changes, talking therapy, occupational therapy).

178. More broadly, trainees have also reported a range of other positives to come out of the pandemic, including more opportunities to demonstrate and develop relevant skills; accessibility of a variety of technological platforms; increased learning with greater access to resources and online learning; enhanced team working and communication; and an opportunity to reflect on the bigger picture and the important things in life. However, trainees have also reported a range of negative impacts, including reduced opportunities to engage in teaching, psychotherapy, special interest time, research and workplace-based assessments, with some saying they felt penalised; stress, anxiety and burn out, and an overall detrimental effect on their mental health; poor communication from various organisations, including employing trusts, deaneries and the College, with trainees reporting feeling poorly supported; and loss of usual supports through isolation of remote working.

Emergency powers

179. On 8 March 2020, DHSC shared the first draft of emergency powers legislation with the RCPsych, which was to make changes to the MHA (England and Wales) 1983. We were largely supportive of the summary of measures that were outlined to us as they were proportionate steps to be introduced for a temporary period, if required, to respond to a high level of staff sickness due to Covid-19. If enacted, these provisions would have amended certain aspects of the MHA regarding second-opinion safeguards and detention periods by: enabling existing mental health legislation powers to detain and treat patients using just one doctor's opinion, and temporarily allowing the extension or removal of time limits in mental health legislation to allow for greater flexibility where services were less able to respond.

180. Such measures would work to ensure that patients could safely and effectively receive the care and treatment they needed.

181. However, the RCPsych wrote to DHSC on 13 March 2020 to follow up on a number of issues, including sharing our concern that consideration to extend the emergency provisions to the Second Opinion Appointed Doctor ("SOAD") service was not

currently included within the planned emergency legislation (LS/33 – INQ000410874). While we strongly believed that a patient's right to a SOAD opinion should not be suspended unless absolutely necessary, we were of the view that the decision to exclude consideration for emergency provisions in the SOAD service should be revisited in light of the significant delays patients were currently experiencing in receiving a SOAD visit and given that waiting times were likely to markedly increase due to SOAD sickness. Many SOADs were currently working for an NHS Trust or were responsible clinicians in the private sector providing NHS services. As such, we believed that thought should have been given as to which role should take priority. Specifically, given the principle that patients' safety must not be compromised, which includes not depriving them of receiving necessary care and treatment because of administrative problems, we advised that an extension to time limits, as well as amendments to the wording in relation to the grounds for use of Section 62, could be considered as options on how to manage the inevitable serious delays to SOAD availability.

182. On 25 March 2020, the emergency Coronavirus Act 2020 was passed, which contained a number of emergency provisions which, if enacted, would amend certain aspects of the MHA with respect to second-opinion safeguards and detention periods. At this point, the MHA emergency provisions were not enabled. However, on 27 March 2020, the RCPsych received messages from members informing us that some clinicians were acting as if the MHA provision of the Coronavirus Bill had already been enabled, when this was not the case.

183. On 30 March 2020, the MHLDA Covid-19 Response Cell published legal guidance for mental health, intellectual disability and autism, and specialised commissioning services supporting people of all ages during the pandemic alongside relevant documents on the NHSEI website. We understood that this guidance had been developed two weeks prior to its publication. RCPsych was not closely involved in the development of this guidance and following its publication, we were critical in our feedback. We found the guidance to be unhelpful because it did not address many of the dilemmas that clinicians were facing on the frontline. We said that it would have been more helpful for this guidance to have been published at the same time the Coronavirus Bill was introduced to avoid confusion across the system. Members

expressed their frustrations to us over the length of time sign-off processes within NHSEI seemed to take, as well as what they saw as helpful aspects of guidance being removed during these stages by lawyers. We believe that these factors undermined the confidence of clinicians in leadership at NHSEI at a critical moment and suggested a lack of coordination between DHSC and NHSEI.

184. Following the publication of the above legal guidance, the RCPsych received a substantial number of questions from members, particularly about the issues of seclusion and isolation, and non-cooperation. It was our view at the time that DHSC, NHSEI, and the CQC were apprehensive and unwilling to publish more information on this issue due to the emerging situation. We felt that NHSEI could, and should have, clearly explained that people could be secluded for failing to isolate when the reason for doing so was related to their mental illness. We saw this as a failure of Government leadership at the time.

185. One of our members presented to us a case study which challenged the usefulness of the legal guidance and made the case for working flexibly, based on the needs of the patient and the settings in which they were being provided care:

A patient with multiple mental health diagnoses severely deteriorated in the community and refused admission. They were detained under Section 3 of the Mental Health Act just as social isolation policies were implemented.

The ward that the patient was on was an annexe of an old house, spread over two floors, with shared toilets and bathrooms, multiple fire doors between main areas, including dining rooms and therapy rooms. This accommodation was generally cramped, with poor ventilation in the winter. In short, it was not designed for a highly contagious pandemic, and not at all geared towards infection control.

To ensure that the patient did not spread the virus to the rest of the ward, their psychiatrist suggested that they be treated and cared for in the only room which had ensuite facilities for a week or until it was clear that the patient no longer had Covid-19. Senior hospital managers were very concerned about this being 'illegal' and that it might constitute 'long-term segregation', but eventually accepted the psychiatrist's

rationale, and asked the patient to consent to the arrangement which they reluctantly did.

Within 24 hours, the patient had developed a temperature, abdominal symptoms, and high C-reactive protein and low lymphocytes, which were common among people with Covid-19. These symptoms lasted intermittently for approximately ten days. Around that same time, the ward had three staff test positive for Covid-19, one of whom became very unwell.

It was unlikely that the patient and the staff illnesses were related, but by caring for them in isolation and using PPE – before it was nationally approved – the risk of spreading the infection was reduced and, two weeks after the patient had been detained and admitted, no more patients on the ward had contracted Covid-19.

Patient experiences of emergency measures

186. Similarly, we heard anecdotal reports of increased prevalence of restrictive practices, such as seclusion and long-term segregation in inpatient and forensic wards. During lockdowns and outbreaks throughout the relevant period, onsite patients were required to isolate themselves in their rooms. At later stages of the pandemic, they were only required to do so if they tested positive for Covid-19. Understandably, many patients found it incredibly challenging to spend such a significant amount of time in their rooms, particularly in the early stages of the pandemic when isolation periods lasted up to 14 days. Additionally, all permitted leave or time away from the ward from inpatient units was cancelled and no visits from family or friends were allowed, leading to further isolation of patients.

187. Patients in long-stay wards were significantly restricted. They were not able to take their leave and, thus, could not take a walk, for up to one hour a day, that the general public were permitted to do under lockdown measures. Any leave that patients took had to be within hospital grounds. Also, they were unable to see family as most hospitals suspended general, or all, visiting. Being put in this position is especially hard for anyone who has been detained for months or years. Also, patients were required to spend lots of time in their rooms with minimal access to therapies. There was inevitably, therefore, an increase in restrictive practices.

188. One of our patient representatives told us of her experience of being held in a mental health inpatient unit for weeks, where she was not permitted to walk to the kitchen to make a cup of tea and was left without access to reading materials or other ways to spend the time. She noted that the total lack of flexibility from the ward in their goal to keep infection levels as low as possible significantly worsened her mental health at the time. She described the experience as nothing short of mental torture.

Consultation on emergency powers

189. On 7 April 2020, we were advised by the National Medical Mental health Forum that they were drafting a letter for DHSC to call for mental health emergency powers to be enacted owing to staff absence and availability of section 12 doctors. The following day, DHSC confirmed that emergency provisions had not yet been enabled but that SOADs could do their work virtually. Over the weekend that followed, DHSC got in touch to ask for more detail to support our call for enactment of the emergency Coronavirus Act; at this time, we heard that the Rt Hon Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health at the time, felt that the Government was handling the crisis well and that there was no need for the mental health emergency powers to be enacted. The RCPsych was aware, however, that there were no figures available from NHSEI with respect to how many psychiatrists were away from work at this point. On 15 April 2020, through the RCPsych's work with the Mental Health Medical Directors Forum of the NHS Confederation, it appeared that the significant shortage of Section 12 doctors or approved mental health professionals ("AMPs") was causing serious issues.

190. On 25 January 2021, NHSEI updated their legal guidance for services supporting people of all ages during the coronavirus pandemic.

191. On 4 February 2021, Claire Murdoch CBE, National Mental Health Director at NHSEI, sent a letter to mental health system leaders outlining a court's ruling on remote MHA assessments – a practice that had been introduced during the pandemic. The letter outlined that Devon Partnership NHS Trust sought a declaration from the Court as to whether remote assessments could be used to lawfully detain someone under the MHA. The letter stated that the Court's ruling was restricted to its

interpretation of the phrases "personally seen" in section 11(5) and "personally examined" in section 12(1), and concluded that the physical attendance of the person in question (the AMHP and doctor) was required when assessing a person for detention under the MHA. Based on this ruling, it was advised that a Court would find a detention following a remote assessment carried out under section 11(5) and section 12(1) to be unlawful. NHSEI therefore advised that there were to be no further remote assessments for detention or constraint under section 11(5) and section 12(1). With regards to section 2, section 3, section 4 or section 7, anyone who was, at the time, currently detained in hospital under section 2, 3, 4 (or who was subject to section 7) as a result of such a remote assessment, should be reassessed without using remote technology as soon as possible; and NHSEI guidance on conducting remote assessments during the pandemic period was redacted. The RCPsych updated its website with this new information.

Emergency powers: Scotland

192. The RCPsych in Scotland also liaised regularly with the Government of Scotland on its emergency legislation. We were a member of the Scottish Government Mental Health Legislation Oversight Group, through which we provided ongoing input. We also provided guidance to our members in Scotland regarding the emergency provisions, including through a web hub and webinars, and communicated the point that they were not to be enacted unless triggered by members.

193. We raised significant concerns with the initial legislation on 31 March 2020, outlining suggested changes. Specifically, the RCPsych in Scotland was of the view that a suspension of Section 268 of the Mental Health (Care and Treatment) (Scotland) Act 2003: excessive security appeals, should be included in the bill. We were glad to see provisions allowing local authorities to use section 13ZA when guardianships, intervention orders or powers of attorney with relevant powers had been granted, or when applications were in process for such guardianship orders, intervention orders or powers of attorney with relevant powers. It was our view that the requirement for guardianship to be able to move patients from hospital should be temporarily removed. This would, in our view, relieve pressures on beds and protect elderly and frail individuals who were currently trapped in environments which were detrimental to their health – a circumstance which has only become more extreme with the addition of

Covid-19. We believed that this should have applied to all frail elderly patients and not limited to instances where a complaint had been raised. We had been made aware that there may have already been examples of patients in these circumstances who had contracted Covid-19 and that this had led to poor outcomes. To meet the necessary safeguarding requirements, our view was that the Mental Welfare Commission could maintain a list and make contact with individuals remotely, following up once this crisis was resolved.

194. On 10 July 2020, the RCPsych in Scotland sent a letter to Minister Clare Haughey following the expression of views by the Equalities and Human Rights Committee and sent a similar letter to committee convener Ruth Maguire. In it, we emphasised that the powers of the new legislation must be permissive rather than obligatory and should allow clinicians to act to preserve the life of a person with mental ill health under exceptional circumstances, and that the parameters for triggering these measures would be very difficult to identify.

195. On 27 August 2020, the Chair of RCPsych in Scotland at the time, Dr John Crichton, gave evidence to the Equalities Committee on the necessity of retaining these provisions.

196. On 1 September 2020, we met with the Minister for Mental Health and Christine McKelvie MSP to discuss how the powers given in this emergency legislation should be triggered.

197. The RCPsych in Scotland was in agreement, as part of the Scottish Government Mental Health Legislation Oversight Group, to stand down emergency provisions when the time came.

Emergency powers: Wales

198. In Wales, as part of our work with the Mental Health Incident Group that was established by Welsh Government, we gave guidance with respect to the potential for enactment of the Coronavirus Act in Wales. A Declaration of threat to public health in Wales due to coronavirus was made by the First Minister of Wales on 29 March 2020 under Schedule 22 of the 2020 Act. This was required in order to exercise the powers

conferred upon the Welsh Ministers under that Act relating to events, gatherings and premises in Wales. Guidance has also been issued under the Coronavirus Act 2020. As part of our work with the Welsh Governments' Mental Health Incident Group, we shared RCPsych's views relating to the potential for enactment of the Coronavirus Act in Wales, receiving a regular picture of the demand and provision of mental health services.

Emergency powers: Northern Ireland

199. The RCPsych in Northern Ireland were consulted regularly by the DoH Mental Capacity Unit regarding matters related to emergency legislation, namely the development of the Coronavirus Act. We were contacted seeking advice on implementation, workforce, and the impact on service provision. We were also sent instructions on how to access the legislation once it was passed and we subsequently wrote to all members advising them of this change in law and directing them to official information sources.

200. On 19 October 2021, the RCPsych in Northern Ireland formally recommended to the DoH that the retention of certain emergency provisions of the Mental Capacity Act ("MCA"), namely the Coronavirus Act 2020 modifications, be retracted in line with the other three nations of the UK, and that only a full consultation with a broad range of stakeholders would suffice if the DoH was ever minded to retain any aspect of the emergency legislation in force. We communicated that a consultation process would capture consideration of the human rights aspects of this decision, which would require careful scrutiny.

Access to medication

201. On 25 March 2020, we became aware of an issue relating to pharmacies in England not accepting scanned prescriptions. There was considerable variation in practice nationally with some pharmacies accepting scanned prescriptions, while others would not and were only accepting posted handwritten prescription. We even heard of one pharmacy refusing a handwritten prescription as they felt it was an infection risk. Some psychiatrists were asking GPs to prescribe on their behalf. While this was normal practice for some, others found it added to the workload of GPs. Clinicians were struggling to get clinical commissioning groups ("CCGs") to resolve

this issue locally and, as a result, some teams put rotas in place where a doctor had to physically drive to the team base to handwrite prescriptions.

202. On this point, we liaised with Peter Pratt, Chief Mental Health Pharmacist at NHSEI, who escalated the issue with pharmacy colleagues. We were later advised that they would be taking forward the issue to address difficulties of patients getting their medication dispensed, and the reluctance of one pharmacy to handle a paper prescription. We acknowledged that while this might not be the best time to implement 'new' systems, there is value in electronic prescribing systems. As such, we asked if there was any way for the role of electronic prescribing across mental health, and community mental health teams in particular, to be accelerated in order to address these issues.

203. We consulted one of our patient and carer representatives, who is a lived experience expert on drug use and a volunteer member of a national social care and health charity, who witnessed in their professional capacity the ramifications of government decision-making on recovering drug users who required prescription access. This representative described a situation where drug users who were seeking to recover were not prioritised during the pandemic, in some cases to the point where they could not access their prescription medications at all as pharmacies were being overrun and were prioritising other patients. At the time, the charity this representative is a member of implemented new regulations, trusting people with methadone prescriptions with 14-day supplies of methadone rather than enforcing the usual supervised consumption of methadone onsite. We heard of the positive impact of this change, which is still in use today, and the amount of trust it built between the organisation and its clients. However, the representative noted that, to mitigate the detrimental impacts of the pandemic on drug users and people pursuing recovery from substance addiction who felt cast aside by the health system and the government, this work had to be carried out by a charity.

Clozapine

204. Regarding clozapine prescriptions specifically, the RCPsych became aware on 19 March 2020 of the effects the Covid-19 virus had on thrombocytopenia (for patients prescribed clozapine, this was already a risk factor). Clozapine is used in patients with

schizophrenia for whom other antipsychotic medications have not worked or have caused severe side effects. This medicine belongs to the group of medicines known as antipsychotics. We knew at that point that approximately 80% of people with Covid-19 would have a low white blood cell count, which would put patients taking clozapine who had contracted Covid-19 at further risk of thrombocytopenia and associated complications. We heard from members that manufacturers of clozapine would not be adjusting the blood cell count thresholds for Covid-19 positive patients, but advised that it could be prescribed off-licence. We also heard that while pharmacy teams did not generally support off label prescribing of clozapine, NHSEI said that they would expect them to engage positively in a process to ensure support for a sound clinical decision on this issue on case-by-case and individualised bases. We considered whether establishing a local panel of experts would be helpful in making these clinical decisions, while acknowledging the likely pressure on acute hospital services, and whether the acute cardiologists and haematologists would have the capacity to support such a panel.

205. On 25 March 2020, we received information from the three companies who supply clozapine that they had issued and had sent guidance about clozapine and Covid-19 to pharmacies who supply their respective brands. Subsequently, we posted this information on our website for members to access. The RCPsych also learned on this day that SLaM had developed guidance about clozapine monitoring in the Covid-19 era, both regarding the effect of the virus on full blood count, and on considering whether current monitoring intervals could be extended in some patients. We included this guidance on our website for our members to consider.

206. On 26 March 2020, the RCPsych received further notice from NHSEI, that prescribers must follow the license of the respective clozapine brand as far as blood testing intervals was concerned, noting that there was consistency across the three brands. Furthermore, each company published guidance on flexibility with respect to the number of days allowed outside of the weekly, fortnightly or monthly interval. Any use of clozapine outside of the licence would be off-label use and prescribers should follow the guidance for off-licence use set by their trust and in line with the respective clozapine brand and monitoring scheme. Furthermore, trusts were advised that they should consider their governance process to support off-label use of clozapine, as well

as a multidisciplinary medicines and ethics process for rapid consideration , which would be available to support off-label requests to the respective company, for example, if prescribers wanted to continue to use clozapine in the event of a clozapine patient with Covid-19 showing a confirmed red result (a red result from haematological monitoring indicates development of the blood dyscrasias and means that the patient must stop taking clozapine immediately). NHSEI advised that the three clozapine manufacturers were happy to work with their sites to find solutions to local problems, but that there was not currently an ability to waive the conditions of the licence insofar as monitoring was concerned.

207. On 26 March 2020, the RCPsych was contacted by Peter Pratt, Specialist Mental Health Pharmacist Advisor at NHSEI, who asked whether we were receiving any queries about the safety of near-patient testing machines which were being used to monitor patients prescribed clozapine. NHSEI had been told that information circulating indicated that these machines were not safe for analysing the blood of patients who had tested positive for Covid-19. At that time, Peter Pratt was drafting a response to this information, based on the assurances of the three drug companies that were supplying these machines, as well as the manufacturers of the machines, that they were closed looped and therefore did not pose any additional risks to operators. We included this information on our website.

208. On 3 April 2020, the RCPsych asked Peter Pratt whether clozapine medication would fall into the category of immunosuppression therapy and therefore, patients taking the medication should be considered clinically extremely vulnerable ("CEV"). While it was decided that clozapine cannot be described as immunosuppression therapy, it seemed in practice that the clinical advice was to not start a patient on clozapine unless they were an inpatient due to the need for close monitoring during the first six weeks.

Sodium valproate

209. Regarding sodium valproate, the Medicines and Healthcare products Regulatory Agency ("MHRA") asked professional bodies to remind members of guidance for the prescription of valproate-containing medicines during the current lockdown. Sodium valproate is used to treat epilepsy and bipolar disorder. If taken during pregnancy,

sodium valproate can cause problems for a baby's development, including birth defects and long-term learning difficulties. For this reason, sodium valproate is not recommended if there is a chance that the person could become pregnant. For women and girls of childbearing age who do need to take sodium valproate, their doctor will put them on Prevent, the valproate pregnancy prevention programme. Specifically, the MHRA announced temporary guidance for specialists on the use of valproate in patients of childbearing potential during the pandemic, covering initiating medication, annual reviews and pregnancy testing for pregnancy prevention requirements.

Access to medication: Northern Ireland

210. In the early stages of the pandemic in Northern Ireland, supervision arrangements for methadone and buprenorphine preparations were reduced due to pharmacies being unable to action them safely. Some pharmacies in Northern Ireland have since reinstated supervision of Opioid Substitution Therapies ("OSTs"), but this practice is not back to pre-pandemic levels. Additionally, inpatient addiction units in Northern Ireland closed during the first wave as addiction staff were redeployed to shore up mental health wards. As a result, there were no inpatient beds for Addictions for approximately five months. In January 2021, members in addictions services had an additional stressor with the abrupt closure of one of the addictions inpatient units with one day's notice. There were six inpatients in the unit and 23 patients on the waiting list. This was particularly worrying in the context of the emerging evidence that addictions patients had higher mortality rates during the pandemic.

Indirect harms of Covid-19: undelivered care

211. In early April 2020, we were becoming increasingly concerned about the level of non-Covid-related harm caused by the decline in presentations for serious health issues. We were also concerned that when patients were presenting, their needs were often more complex due to, for example, a lack of family support and reduced support in the community, and a decline in physical health.

212. On 5 April 2020, we received a message from the Academy which said that we needed to ensure that the NHS did not lose sight of patient groups for whom delay would lead to consequent harm. This point had previously been discussed on a call with the CMO for England who had asked for medical royal colleges to help take

forward work in this area. At this point, NHSEI had started a gap analysis of where we should be and where we actually were regarding common, or high-risk, diagnoses or conditions. To this end, the Academy asked each medical royal college to provide information on the top or most common diagnostic procedures and interventions, or appointments – according to specialty – required for them. Working with the Academy, the RCPsych sought to be involved in a three-pronged approach, comprised of short-term communication to the public to say that "the NHS is open"; a gap analysis of the mental health sector; and a recovery plan to address implications of unreceived care.

213. On 9 April 2020, the Academy approached the RCPsych about urgent work that was being led by NHSEI to deliver an immediate restoration of critical services to safe levels. Part of this work was aimed at delivering a plan for post-Covid-19 recovery by incorporating new models of care. We were involved in this work via the Academy and provided input accordingly.

214. As I have previously stated in paragraph 159 data from our own survey from the corresponding period of 17 April 2020 to 6 May 2020, indicated that in England, most respondents reported no change in their workload associated with emergency and urgent interventions/appointments, which are usually conducted within 4 hours and 72 hours respectively. Additionally, respondents indicated that the biggest decrease in their workload was associated with routine work. For interventions or appointments usually conducted within 4 weeks, 39.1% of respondents reported no change. 27.3% reported a decrease and 9.5% reported a significant decrease. 20.4% reported an increase and 3.7% reported a significant increase. For work usually conducted within three months or longer, respondents who reported no change ranged from 47.8–49.5%. Around 25.0% of respondents indicated a decrease and 13.5–14.6% indicated a significant decrease. Between 7.9–10.3% and 2.2–2.9% reported an increase or significant increase respectively.

215. Data from our second survey, from the corresponding period of 4 May 2020 to 26 May 2020 indicated a fairly similar pattern of responses. In England, 48.1% of respondents reported no change in their workload associated with emergency interventions or appointments, which are usually conducted within 4 hours. There had been an 8.8 and 2.1 percentage point increase in those that reported an increase and

significant increase respectively. There had also been an 8.4 and 2.3 percentage point decrease in those reporting a decrease or significant decrease respectively. At this point, routine work conducted within 4 weeks seemed to be increasing overall, but this data shows further decreases in activity for those interventions or appointments conducted within three months or longer. While this was useful in providing a national overview of how the workload had changed during the Covid-19 NHS response, we interrogated this data by speciality to identify specific services that were reporting decreases in workload associated with emergency or urgent appointments or interventions:

215.1. For perinatal mental health services, although a small sample size means that our data should be interpreted with caution, it appeared that workload associated with emergency and urgent cases had increased, with the second survey identifying workload above the England average. From the qualitative comments we received, one respondent highlighted that, due to reduced social contact and the use of PPE, the communal spirit of mother and baby units had completely changed and were no longer as therapeutic. It was also highlighted to the RCPsych that patient leave in this service is critical, however, if this were stopped, it would mean there would be a significant amount of time before patients could be discharged home.

215.2. For CYPMHS, 30.3% of respondents reported a decrease or significant decrease in workload associated with emergency interventions or appointments. Furthermore, 29.7% of respondents reported a decrease or significant decrease in workload associated with urgent interventions or appointments. By the time of our second national survey, this had dropped to 7.8% and 7.2% of respondents reporting a decrease or significant decrease for emergency or urgent work respectively; as such, levels of activity were being restored.

215.3. For general adult mental health services, the majority of respondents either reported no change or an increase in workload associated with emergency or urgent situations. Some also reported a reduction in more routine work, but feedback was mixed on this point across both surveys.

215.4. For older adult mental health services, it appeared that workload for emergency and urgent work was increasing, as well as for the work usually conducted within 4 weeks. For memory services specifically, we heard that routine assessments had been suspended and that clinicians were only responding to emergencies, regularly ringing around patients who were classed as red on their vulnerability scale – as a result, memory service waiting lists have been impacted. There were also reports of extra emergency assessments for people with advanced dementia who were in need of permanent 24-hour care, but whose families did not want to send them because of the risk of Covid-19. As a result, clinicians were trying to manage a significant number of people in the community who they would not usually. The other increase in need was from patients with chronic depression who usually attended regular groups in the community often run by psychologists; because all of these had stopped at this time, these patients were deteriorating.

215.5. For intellectual disability services, initially there were several reports of increases in emergency (32.4%) and urgent work (68.6%). During the time period of the second survey, emergency-related workload appeared to remain the same (31.7%) and urgent workload had somewhat reduced (41.9%), although it was still elevated. It also appeared, at this point, that routine work in this area was increasing. From the qualitative responses, one member working in forensic intellectual disability services said that discharge had essentially gone on indefinite hold due to the pandemic measures put in place. Another member said that CYPMHS' intellectual disability education services had not been provided in special schools which meant that families were really struggling to care for their children safely at home. Furthermore, when special schools did begin to open, initially for one day a week for only a handful of children, this led to an increase in crisis calls and prescribing for children with an intellectual disability and mental health needs.

215.6. For rehabilitation services, data from respondents indicated that there was initially a substantial increase in urgent work (55.6%) but that this somewhat reduced by the time of our second survey. Qualitative comments highlighted that the initial idea was for rehabilitation units to help create space in acute mental

health services but, as it transpired, acute admissions fell markedly, and rehabilitation units began assessing according to the usual criteria once again. We also heard that for admission and discharge of people from high-dependency rehabilitation, placements were not opening, and patients were in hospital for longer than necessary.

215.7. Liaison mental health services were one of the specialities that initially appeared to have had substantial reductions in workload, both for routine and emergency or urgent work. However, by the time of our second survey, this seemed to have changed rather suddenly, with the second survey identifying 63.3% of respondents reporting an increase or significant increase in emergency work and 72.3% reporting an increase in urgent work. Work usually conducted within 4 weeks also seemed to be increasing. Qualitative responses revealed that, initially, liaison mental health teams noticed a drop in patients presenting to the A&E or diverted area, but that patient numbers had started to rise by the time of our second survey. Although there was a lot of planning going on behind the scenes to divert patients who usually presented to A&E for both physical and mental health emergencies, the message from national bodies did not state that there were alternative Covid-19-free areas within their trusts that could support them with their emergency safely without them having to wait for many hours in A&E.

215.8. For eating disorder services, initially 55% of respondents reported an increase in urgent work and 19% reported an increase in emergency work. By the second survey, this had decreased, with between 63–70% of respondents reporting no change with urgent or emergency work. It is important to note, however, that this sample size was small, so data should be interpreted with caution.

215.9. For forensic services, responses did not vary greatly between surveys. More than half of respondents reported no change in workload across the five timeframes of activity. In the second survey, 26.4% and 23.4% of respondents reported an increase in activity for emergency and urgent interventions and appointments respectively. However, the qualitative responses revealed some

difficulties in delivering mental health services in prisons, delays to prison transfers into hospital with patients who should have been admitted staying in prison, as well as delays to discharges for those in inpatient services due to suspension of community leave, visitation and community placements with housing providers.

215.10. For addiction services, despite a small sample size of respondents, data indicated that there had been significant increases in emergency, urgent and more routine workload across both surveys. From the qualitative responses, it appeared that there had been an increase in patients starting opioid substitution treatment. However, there were reports that nearly all inpatient detox wards were closed with waiting lists increasing substantially. Psychiatrists reported having to make difficult decisions about who to admit. For example, some members described focusing on reducing burden on acute hospitals while also admitting those most likely to benefit from detox given the severe limitations on community services at the time.

216. In conclusion, from the first survey rehabilitation, liaison psychiatry, general adult and intellectual disability services reported an increase in emergency interventions or appointments above England's average. For urgent interventions and appointments, psychiatrists working in intellectual disability, rehabilitation, addictions, eating disorders, older adult and general adult services reported workload above England's average. By the second survey, psychiatrists working across liaison, addictions, perinatal and general adult services reported workload above England's average for emergency interventions/appointments. For urgent interventions/appointments, liaison, perinatal, addictions, older adult and general adult services were above England's average. Overall, across both surveys, psychiatrists working in CYPMHS and forensic services reported workload lower than England's average for emergency or urgent work. Routine work across the board was still reduced.

217. Our members who work in liaison services reported to us that in the early stages of the pandemic, patients were reluctant to attend A&E, which resulted in a reduction in referrals to psychiatrists working in these services. After the initial acute phase of the pandemic, however, referrals to liaison services began to rise once again to pre-

pandemic levels, with 45% of services in the Liaison Faculty survey reporting an increase in referrals. Liaison services subsequently noted an increase in the number and severity of presentations, including for patients with eating disorders; older people with anxiety and depression but especially first episodes of psychosis; patients with somatoform disorders; and school age children with increased anxiety and low mood being away from the structure of school.

218. On 21 April 2020, the *Clear Your Head* public mental health campaign was launched in Scotland. The RCPsych in Scotland had provided input into this campaign, and our members in Scotland were asked to support it.

219. On 23 April 2020, the RCPsych had a call with NHSEI about a new communications campaign they were launching. The point of the campaign was to communicate to the public that the NHS was 'open' and that mental health services would be available. This campaign, titled *Help us help you*, covered mental health services as part of its messaging, and was launched on 11 May 2020.

220. On 29 April 2020, the NHS entered the second phase of its response to Covid-19, in which it wanted MHIDA services to establish all-age open access crisis services and helplines and promote them locally, working with partners such as local authorities, the voluntary, community and social enterprise ("VCSE") sector, and 111 services. It also wanted MHIDA services to continue to ensure that existing patients known to mental health services, particularly those who had been recently discharged from inpatient services and those shielding, were contacted proactively and supported; to ensure that children and young people continued to have access to mental health services, liaising with local partners to ensure referral routes were understood, particularly where children and young people were not at school; to prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan; to continue to complete annual health checks for people with an intellectual disability; to ensure enhanced psychological support was available for all NHS staff who needed it; to ensure that inequalities in access to mental health services were taken into account; and to ensure that Care (Education) and Treatment Reviews continued using online or digital approaches.

Impact of undelivered care

221. On 8 July 2020, following widespread concerns about the impact of the pandemic, and measures to control its spread, on children's mental health and wellbeing, we were invited to attend a briefing meeting organised by NHSEI, ahead of the publication of the National Child Mortality Database programme summary report. The findings suggested that there were 26 likely child suicides during the 82 days before lockdown and a further 25 in the first 56 days of lockdown. Additionally, it also found that the proportion of cases under 15 years of age appeared higher, but that these differences did not reach statistical significance. In a similar proportion of pre-lockdown (33%) and post-lockdown (36%) cases, the child or young person was currently in contact with mental health or social care services. A diagnosis of autism spectrum disorder ("ASD") or attention-deficit hyperactivity disorder ("ADHD") had been recorded in six cases (25%) pre-lockdown and in six additional cases (24%) post-lockdown. Comparing 2020 with 2019 gave similar results: in 12 (48%) of the 25 post-lockdown deaths, factors related to Covid-19 or lockdown were thought to have contributed to the deaths. The report concluded that while there was a concerning signal that child suicide deaths may have increased during the first 56 days of lockdown, the numbers were too small to reach definitive conclusions. The authors argued that, amongst the likely suicide deaths reported after lockdown, restriction to education and other activities, disruption to care and support services, tensions at home and isolation appeared to be contributing factors. Previous research has highlighted an increased suicide risk in autistic people. We found a quarter of the likely suicides both pre- and post-lockdown were individuals with autism or ADHD. Although the finding of increased risk is not confirmed statistically, it was important that clinicians and services were aware of the possible increase and the need for vigilance and support.

222. On 20 August 2020, MBRRACE-UK's Covid-19 report on maternal health was published and found that four women who were pregnant or who had recently given birth had died by suicide during this three-month period. The authors found that changes to service provision as a direct consequence of the pandemic meant that women were not able to access appropriate mental health care, and that receipt of the specialist care they needed may have prevented their deaths. The lack of recognition of the negative impact of this change in support on their mental health may have been

exacerbated by the absence of face-to-face assessment brought about by Covid-19-related changes to practice. In one case, the report found that one of the women should have had a face-to-face assessment the same day she died, yet both the crisis and perinatal mental health teams seemed to have viewed the care of this individual as the other team's responsibility The report also found that earlier, face-to-face or, at the very least, video consultation, may have enabled the diagnosis of psychosis and prevented the woman's death.

223. MBRRACE-UK outlined two actions for the RCPsych and other bodies. These were:

223.1. Establish triage processes to ensure that women with mental health concerns can be appropriately assessed (face –to face, if necessary), and access specialist perinatal mental health services in the context of changes to the normal processes of care due to Covid-19. Perinatal mental health services are essential and face-to-face contact will be necessary in some circumstances. There is a clear role for involvement of the lead mental health obstetrician or midwife in triage and clinical review. This was to be actioned by the Royal College of Obstetricians and Gynaecologists ("RCOG"), the Royal College of Midwives ("RCM"), the Obstetric Anaesthetists Association and the RCPsych Covid-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; and Health Boards.

223.2. Ensure that referral with mental health concerns on more than one occasion is considered a 'red flag' which should prompt clinical review, irrespective of usual access thresholds or practice. This was to be actioned by the RCOG, RCM, the Obstetric Anaesthetists Association and the Covid-19 Guideline Development Groups; Local Maternity Systems; Mental Health Service Providers; and Health Boards.

224. We considered these actions with RCPsych's Perinatal Faculty who subsequently developed a response, which is outlined below.

225. Relating to the first action for the RCPsych, our view was that assessments carried out by perinatal mental health professionals should include an assessment of verbal and nonverbal information, which should typically include a family member or carer. Furthermore, any assessment should include a review of the relationship between the mother and child. The assessment is essential to understanding red flags and risks. Our view was that in order for this to be done to a high standard, the mother must feel safe, respected and not judged. We recognised that face-to-face assessments were necessary in some circumstances, but at that point in the pandemic, it was felt there was not enough evidence to help clinicians understand the impact of offering assessments face to face (digitally) or face to face (in person but wearing masks), and research was urgently needed to evaluate this impact. We concluded that each option would have some advantages and some limitations, but we had insufficient evidence to definitively recommend one or another at that time. However, we agreed that the 'Gold standard' and the most inclusive model, until we had evidence to support an alternative, would be a face-to-face assessment without a mask, if a Covid secure way of offering this could be found. We therefore recommended that NHSEI or PHE provided clarity around what is meant by 'face to face' in the perinatal context in any further guidance.

226. Relating to the second action for the RCPsych, we agreed that a patient referral on more than one occasion should prompt a clinical review across the system. We suggested that this recommendation needed to be understood as an action for all healthcare providers, including for health visitors, midwives, obstetricians and GPs. We said that all such health care providers should be able to offer women and families clinical review, information and treatment for a wide range of concerns and they should be escalated appropriately to specialist mental health services (including specialist perinatal mental health services where available), which would also need to review access thresholds where multiple referrals had been made.

227. Based on this response, we updated our joint perinatal Covid-19 guidance to reflect the MBRRACE report and the RCPsych's position, following discussion and approval with colleagues at RCOG, the RCM, Unite and the NHSEI MHLDA Covid-19 Response Cell. We then shared the report, our position, and updated clinical guidance with faculty members via email.

228. We also contacted the report's authors to let them know that this action had been taken, for their reference. We also discussed the report and our response with NHSEI's Covid-19 MHLDA Response Cell.

Conclusions and recommendations

229. **Based, then, on a considered assessment of the information known to us, with respect to capacity and collaboration across the health system, it is the RCPsych's position that:**

229.1. **NHSEI developed and disseminated guidance to providers and their clinical and non-clinical teams on how to manage capacity and demand across inpatient and community mental health services, but this was not developed in a timely manner nor was the response commensurate to that of other healthcare sectors. For instance, NHSEI's mental health guidance titled, *Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages*, was published on 26 March 2020. This can be compared to the standard operating procedures (SOPs) developed for primary care settings (general practice, primary dental care, community pharmacy and primary care optical settings), which were published by NHSEI on 27 February 2020; the SOP for Priority Assessment Service for Emergency Departments, Urgent Treatment Centres, Minor Injury Units and Walk-In-Centres, which was published on 6 March 2020; *Hospital discharge and community support guidance,* published by NHSEI on 17 March 2020; primary care guidance on adaptations to the NHS Diabetes Prevention Programme published on 19 March 2020; and the RCPsych's own suite of clinical guidance which were published on 20 March 2020.**

229.2. **In their contingency planning, NHSEI did not provide adequate support to providers of MHIDA services to allow them to manage a range of resource-constrained scenarios.**

229.3. **PHE adequately considered the impact of their public messaging on non-Covid services during the first wave of the pandemic, given a significant proportion of patients were not seeking help as usual. PHE also considered those who were digitally excluded and sought to address the barriers to accessing services.**

229.4. **DHSC adequately considered the impact of emergency legislation in relation to mental health legislation and detention, but NHSEI's legal guidance fell short of what was required for clinicians due to the time it took NHSEI to publish the guidance and the fact that helpful aspects of the guidance relating to application of the legislations across various scenarios had been removed in the final publication.**

229.5. **The dialogue between NHSEI and the RCPsych about the prescription and dispensing of psychotropic medication was sufficient and effective and allowed us to issue advice to our members in a timely way and answer any of their questions and concerns.**

229.6. **Working with providers, NHSEI adequately considered the indirect harms caused by the response to the pandemic and gave sufficient attention to restoring and recovering access to critical mental health services that had been temporarily stopped or deferred. However, NHSEI was unable to draw on real-time, valid and reliable data to monitor capacity across mental health, intellectual disability and autism services.**

229.7. **NHSEI successfully launched its 'Help us help you' campaign in May 2020, which included messages about the NHS being open for those with a mental illness; however, starting this earlier might have helped to avoid the significant drop off in presentations of children and young people to mental health services via A&E, primary care, and schools, for example.**

229.8. **NHSEI made RCPsych and other organisations aware of forthcoming publications and confidential datasets reporting the impact of undelivered**

care on mortality rates. This enabled us to take swift action – amending guidance, and cascading information to our members.

230. **Based on the positioning outlined above, the RCPsych makes the following recommendations with respect to capacity and collaboration in England:**

230.1. **During a comparable Level 4 Incident, NHSE must ensure that the national leadership response includes senior leaders from NHS mental health, intellectual disability and autism services; there is sufficient priority and resource provision within the MHLDA Directorate to enable the team to respond in a timely manner, and in a way that is commensurate with other healthcare sectors; there is sufficient priority and resource provision within the MHLDA Directorate at NHSE to enable the team to develop guidance that is relevant, valid and reliable to those that are working across the MHIDA sector (including NHS, social care and community and voluntary sector providers).**

230.2. **During a comparable Level 4 Incident, NHSE must request, collect and utilise SitReps reports from MHIDA settings, and should mandate all critical mental health data collections at the time to ensure quality and sufficient coverage in order to aid decision making.**

230.3. **NHSE campaigns and messaging about the NHS being 'open' might benefit from starting sooner.**

230.4. **Considering the main challenges identified through the information resources that were produced at the beginning of the pandemic, in future pandemics, clarity should be given on:**

230.4.1. Access to medications, and medication prescribing for people with mental health conditions and how this will continue while isolation and social distancing rules are in place.

230.4.2. Messaging about continuing treatment, i.e., not stopping medication without advice from your doctor and continuing to attend remote or in-person appointments where appropriate.

230.4.3. Situations where remote consultations might not be appropriate, such as with physical health checks.

230.4.4. Who is or is not in the 'clinically vulnerable' group. Where appropriate, ensuring that people with mental illnesses are not forgotten about when deciding on or communicating about these groups – including pregnant people with a mental illness, people with drug and alcohol dependency and people with eating disorders.

230.4.5. The importance of continuing to attend A&E and any agreed appointments unless informed otherwise.

Infection prevention and control ("IPC") and nosocomial transmission

Personal protective equipment ("PPE"): guidance, supply, and communication

231. The issue of infection prevention and control ("IPC") was one of the most significant areas of concern for our members during the pandemic, and subsequently. I will first discuss the issues surrounding personal protective equipment ("PPE") and IPC guidance, specifically within the first few months of the pandemic, before covering aerosol-generating procedures ("AGPs") and CPR, testing and visiting.

232. On 16 March 2020, our members began to share with us concerns about the lack of IPC guidance and implementation in MHIDA services. We heard that one mental health trust, for example, had banned the use of hand gel given the risk posed if ingested.

233. On 22 March 2020, the RCPsych sought to respond to our members' questions and concerns about the type of PPE required in MHIDA settings. We intended to reproduce information on our website that was aligned to national guidance at the time,

but this was not approved by the MHLDA Covid-19 Response Cell at NHSEI as they were intending to publish their own national guidance within the next few days. However, this was subsequently delayed. Given the pressure our members felt about a lack of information on appropriate PPE use, the RCPsych raised this issue with Claire Murdoch CBE, National Director for Mental Health at NHSEI, to identify the reason for the delay.

234. The following day, we learned that the PPE guidance previously sent out by the national IPC team was not going to be updated further, despite suggestions to the contrary. Therefore, the PPE required in MHIDA settings continued to be a fluid resistant surgical mask and an apron, to be worn when working in close contact (within 2 metres) of a patient with Covid-19 symptoms. We raised concerns with Emma Wadey, Head of Mental Health Nursing within the MHLDA Covid-19 Response Cell at NHSEI, that the current IPC guidance produced by PHE was unclear, particularly with respect to how it applied to MHIDA settings and scenarios. Our concern was that this setting and patient group is unique in that the nature of mental illness means that patients find it difficult to self-isolate or maintain social distance in an inpatient setting.

235. Emma Wadey, Head of Mental Health Nursing within the MHLDA Covid-19 Response Cell at NHSEI, advised that they had requested that future national guidance would reference individual healthcare settings to avoid confusion. Given the urgency of the situation, the RCPsych tweeted, "Current advice from @NHSEngland is that mental health staff wear a fluid resistant surgical mask, an apron and gloves when working within two metres of a patient with suspected or confirmed COVID-19 symptoms." This was the first time that staff working across MHIDA settings had been specifically referenced. However, confusion among our members continued to grow.

236. On 25 March 2020, the RCPsych asked NHSEI to clarify what was required for staff caring for patients in mental health settings who were not suspected of having Covid-19. The response from NHSEI was that PPE use for mental health staff was not required for those working with patients who were not suspected of having Covid-19. Rather, staff should follow universal infection control procedures which included being bare below the elbow and frequently washing hands.

237. On 26 March 2020, the Academy chair expressed concerns to the RCPsych about guidance – specifically on PPE – emerging from different bodies, including medical royal colleges and specialist societies. The issue of consistent advice at this point had become critical, and while the RCPsych's guidance was aligned with NHSEI at this time, there was recognition that some medical royal colleges disagreed with NHSEI guidance and were therefore recommending different approaches. We also heard about "panic usage" of PPE supplies, where PPE was used inappropriately or wastefully due to fears of infection or lack of clarity on where it was best utilised. The Academy Chair advised that they had been awaiting further clear and updated guidance from NHSEI/PHE and the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") since Monday 23 March, and that this delay has been "hugely frustrating".

238. The Academy recognised that communications and shortages around PPE had engendered anxiety but, for the sake of all frontline clinicians looking for clear advice and for the safety of patients, the advice was for medical royal colleges and specialist societies to ensure that: any guidance published aligned with and complemented, the national generic guidance from PHE/NHSEI with regard to asymptomatic patients, suspected and confirmed cases of Covid-19 in general circumstances; any specialty-specific advice indicated how national guidance should apply and be implemented within the individual specialty and not suggest alternative specific guidance, including indicating which procedures or circumstances fell into different categories like AGPs or high-risk clinical zones; discussions involved other specialties and organisations in formulating advice before publication to avoid contradictions; advice and guidance would be shared.

239. On 27 March 2020, the RCPsych was approached by NHSEI to say that they were seeking to improve communications on PPE given widespread concerns among NHS staff. The following day, we received a message from PHE via the Academy asking for urgent comments on their revised PPE guidance, which comprised of one set of guidance for inpatients and one for the community. Regarding the draft PPE guidance for inpatient settings, we asked that various amendments be made, including clarifying:

- that guidance covered inpatient psychiatric units and ECT suites

- whether nasogastric feeding, and spitting and biting, were considered AGPs
- whether "general ward environments" referred to mental health and intellectual disability inpatient settings
- whether an apron would also be required when mental health professionals were restraining a patient detained under the MHA, including when such patients were being transferred to acute hospital settings
- what healthcare professionals should do when unexpectedly coming into contact with suspected or confirmed Covid-19 patients
- whether, as liaison psychiatry services also conduct emergency and medical assessments in inpatient settings, they were subject to the same PPE requirements as other staff.

240. We also requested that an example relevant to mental health settings be added to the guidance to demonstrated that fluid-resistant masks should not be worn by patients if there is the potential for clinical care to be compromised, for example, if there is a risk of self-injury if a mask is worn.

241. On 31 March 2020, we received an update from the Academy to say that PHE had received over 1,000 responses, primarily from professional bodies, to the two sets of guidance. PHE had stated that they had gone through the comments in great detail, before feeding this work through to the Four Nations IPC Cell lead by NHSEI and then reviewing and refining the guidance with the four Chief Nursing Officers and Chief Medical Officers of the UK. The resulting document, PHE said, documented the consensus and highlighted the risk-based equitable approach across all sectors. PHE had added a new table to the guidance, which, with a risk-based approach highlighted the role of PPE at that time of uncertainty. Specifically, the guidance advised, "sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where Covid-19 is circulating in the community and hospitals. Where staff consider there is a risk to themselves or the individuals they are caring for, they should wear a fluid repellent surgical mask with or without eye protection for the single session."

242. On a call arranged by the Academy with PHE later that same day, we heard that the NHS did not have the right PPE equipment and that the updated guidance reflected

this situation. This was deeply concerning to the RCPsych at that time and remains so. It was our understanding that while PHE claimed to be sticking to 'the science', at the same time, its guidance was being compromised by a lack of supply. Additionally, many of our questions and concerns previously raised remained unaddressed in the final iteration of the PPE guidance, including whether there would be any specific information for clinicians working in MHIDA settings; whether guidance for acute hospital inpatient and emergency departments also applied to paediatric intensive care units, as well as mental health acute inpatient care, and secure care settings; whether an apron would be required when mental health professionals were restraining a patient detained under the MHA; what healthcare professionals do when unexpectedly coming into contact with suspected or confirmed Covid-19 patients; and when the reviewed AGPs guidance would be completed.

243. At this point, we feared that PHE was failing to take account of the significant loss of confidence in this area of guidance from NHS staff, and that communications associated with prospective guidance would be confusing and therefore fail to allay fears. It is at this point that the RCPsych considered diverging from PHE messaging out of concern that its guidance was not sufficient, despite the negative consequences that would arise from doing so.

244. Later that same day, Claire Murdoch CBE, National Director for Mental Health corresponded with Dr Susan Hopkins, Deputy Director of the National Infection Service, PHE, to say there had been differential application of the current IPC guidelines in MHIDA settings, which was making people anxious, and that supply issues had also contributed to this anxiety. It was suggested that PHE consider making a short educational video for the MHIDA sector to accompany the new guidance. This underlined our concerns that the guidance could be misinterpreted in MHIDA settings without some further educational material provided.

245. On 2 April 2020 in a call that the RCPsych was a part of, senior leaders at NHSEI acknowledged that there was still an issue with clarity in some areas of the guidance and that the relevant tables would be updated in light of this. Later that day, however, we were alerted to the fact that PHE had published revised guidance on PPE and IPC procedures and, despite previously advising that it would not include MHIDA settings

separately, the new table did. We also learned that the MHLDA Covid-19 Response Cell at NHSEI would be producing PPE posters that translated this guidance to various scenarios in mental health settings, and that these posters would subsequently be published as a PHE national resource. By 6 April 2020, NHSEI had sent the PPE posters to the RCPsych for comments with a quick turnaround. While the PPE posters were not finalised until 22 April 2020, the RCPsych was pleased upon review that they specifically mentioned ECT, restraint, rapid tranquilisation and depot medication.

246. On 17 April 2020, the RCPsych issued a press release presenting the findings of our first member survey. We warned that, without better protection from Covid-19, mental health units were facing a care home-style crisis. This warning came as our national survey found that only half of psychiatrists confirmed that they could access tests for themselves and patients, with this figure falling to 30% for family tests. We also found that nearly one in four psychiatrists in the UK (23%) did not have access to the correct PPE and were therefore putting themselves and patients at risk.

247. Specifically, we highlighted concerns that although thousands of psychiatrists and frontline staff were still treating people with mental illness face to face, both in the community and in inpatient settings (such as in specialist eating disorder units and liaison services) and were therefore at increased risk of contracting or passing on Covid-19; importantly, this figure was worse for Scotland (29%), Wales (28%) and Northern Ireland (26%). We made the point that not all our buildings were set up to withstand infection control and that we were hearing that frontline psychiatrists were fearful of putting themselves and their families in danger every time they went to work. We said that the Government must urgently address the need for PPE in mental health services to ensure staff and patients had the protection they needed from the virus.

248. Written responses to RCPsych's membership survey of psychiatrists included:

> "Last week we did CPR on a patient who had [attempted suicide] with no fit tested PPE."

> "There are extreme shortages of PPE and most of us are at risk. Only very limited supply is obtained and most of the time frontline staff are refused, risking their lives. Staff are terrified and afraid."

249. On 21 April 2020, the RCPsych was advised that PPE was in limited supply as a deal with a manufacturer based in Turkey had fallen through. Two days later, on a call with the CMO in England, we heard that the PPE shortage was continuing and that rapid testing of patients on admission was at least 4 weeks away. By 30 April 2020, we had received notice of a Central Alerting System ("CAS") alert that there was a severe shortage of PPE and that sessional use and reuse when there were such severe shortages of supply was required. Relatedly, on 30 April, the RCN advised that National Association of Psychiatric Intensive Care Units ("NAPICU") was going to change its guidance to recommend FFP3 masks for restraint; this diverged from PHE and NHSEI IPC Cell guidance.

250. On 9 June 2020, the NHSEI IPC Cell published guidance on the wearing of face masks in operational settings. Notably, Emma Wadey, Head of Mental Health Nursing within the MHLDA Covid-19 Response Cell at NHSEI had not seen the guidance beforehand. Together with Emma Wadey, we raised concerns relating to the safety risks of the masks, including, for example, metal being used for self-harm; ligature risk; and the respiratory risk of face coverings, directly to the IPC Cell. We also raised issues relating to the safety of alcohol gel, the need for more clarity on exemptions from mask wearing, and questioned what was meant by the term 'hospital' and whether there was an agreed risk-assessment tool to determine use. It was clear to the RCPsych that the MHLDA Covid-19 Response Cell at NHSEI had not been consulted prior to the finalisation of the guidance on face masks, despite working in the same organisation. It is our view that this provides further evidence of MHIDA being overlooked in NHSEI's IPC response.

251. On 22 June 2020, the RCPsych was invited to provide feedback on NHSEI proposed guidance for MHIDA settings and IPC, which was to be published alongside NHSEI's NHS Covid-19 workforce guidance that was also in development. The RCPsych identified a range of concerns with the current draft at that time, including a lack of information about testing, cohorting, patient leave, visitors, and the need for both initial isolation before test results, as well as age-appropriate language for child inpatients. We were concerned about the lack of guidance regarding what to do in a situation in which a patient could not understand the need to socially distance,

including, for example, young children, those with dementia, those with intellectual disabilities, and those with disinhibition.

252. On 20 August 2020, NHSEI sent the RCPsych its finalised mental health IPC guidance. This had been developed by the NHSEI IPC Cell in partnership with the mental health directors of Nursing and the RCPsych agreed to co-badge the guidance in partnership with NHSEI. While we were content with the final version, we were concerned that it had not been included as an annexe to NHSEI's NHS Covid-19 workforce guidance (as originally agreed) as that would have provided a greater opportunity to disseminate the information. As such, the mental health IPC guidance remained generic. It was also significantly delayed for no clear reason, with the final unchanged version published more than eight weeks after it was shared for comment. These delays in the context of a pandemic were unacceptable.

Aerosol Generating Procedures ("AGPs")

253. Alongside our work relating to IPC guidance, supply and communication, the RCPsych engaged extensively in conversations around AGPs. Given its complexity, particularly with respect to the administration of CPR, I have chosen to cover the ground of this issue separately.

254. On 23 March 2020, as part of the RCPsych's ongoing discussions with NHSEI's IPC Cell, we were advised that it had been determined that spitting and nasogastric feeding were not considered AGPs and therefore that the same level of PPE – apron, fluid resistant surgical mask, and additional eye protection if necessary – was sufficient for staff carrying out such care.

255. On 14 April 2020, the British Association of Parenteral and Enteral Nutrition ("BAPEN UK") contradicted PHE and NHSEI guidance and issued a statement which said that nasogastric tube insertion was, in fact, an AGP. BAPEN UK appeared to be advising that Level 3 PPE was used when inserting nasogastric tubes out of caution. This incongruity created conflicting information for staff about the type of PPE required. Our members advised the RCPsych that evidence on this issue appeared to be poor. On balance, our members were of the view that the insertion of a nasogastric tube was

potentially an AGP due to the induction of sputum (coughing), but whether transmission of aerosol was significant remained unclear.

256. Throughout April 2020, the RCPsych explored the impact of the IPC guidance on the delivery of ECT services. Given that clinicians working in ECT clinics around the country were confused about how PHE's infection control guidance and PPE requirements applied to their clinical setting, we wrote to PHE on 23 April 2020. Specifically, we sought to clarify whether ECT suites were considered higher-risk acute areas that fell into the 'wards with non-invasive ventilation' category. If they were deemed as such, then all staff present in that room or on that ward would be required to wear single-use gloves, a single-use apron, sessional gown/coverall, sessional FFP3 mask or equivalent, and sessional face/eye protection. If, on the other hand, ECT suites were to fall into either the 'inpatient wards' or 'acute assessment areas' categories, where direct care was provided within two metres, guidance would be for staff to wear single-use gloves, a single-use apron, sessional fluid resistant surgical mask, and sessional eye/face protection, except for those staff, such as anaesthetists and operating department practitioners, who were directly performing the single AGPs (non-invasive ventilation, intubation). Staff in the latter group would only be advised to wear single-use gloves, single-use gown/coverall, FFP3 (or equivalent) and single-use face/eye protection. We received a response from PHE and NHSEI and updated the RCPsych's webpages accordingly.

257. Outside of ECT services, nasogastric feeding, spitting and biting, the issue of the greatest concern to the RCPsych with respect to AGP guidance was in relation to chest compressions during CPR. At this point, PHE's guidance was clear that chest compressions were not aerosol generating. However, the Resuscitation Council UK ("RCUK") had issued guidance stating that chest compressions were aerosol generating. The divergence of opinion on this issue was the source of a great deal of stress and anxiety for our members and NHS staff more broadly, as it had significant implications for PPE requirements and protocols in place; this was the most frequently reported issue in the RCPsych question and answer website function, with our members asking the RCPsych to take a view on the matter. One psychiatrist working in a secure unit, for example, said that they had been told by their senior managers that their setting was classed as a 'community setting' in order to avoid the requirement

for FFP3 masks for chest compressions. We also heard of concerns about what to do should a Covid-19 positive patient arrest on an inpatient unit as a result of, for example, self-harm; specifically, there was a concern that mental health inpatients were being, or would be, denied resuscitation due to a lack of appropriate PPE such as FFP3 masks.

258. On 7 April 2020, the RCPsych contacted the RCUK to get clarity on their position on MHIDA settings. At this point, RCUK had guidance for acute hospital settings and the community. During that conversation, we became aware that the RCUK never intended for their guidance for acute hospital settings to apply to MHIDA inpatient settings and the RCUK subsequently recognised that this could be confusing.

259. Following our conversation, the RCUK began working on new guidance specifically for MHIDA settings. It was initially indicated that their guidance would say that full PPE was not needed for chest compressions in mental health settings, and only when intubation was likely, but that a mask would be needed to cover the mouth; then, on the arrival of the ambulance team, staff would be required to be in Level 3 PPE. RCUK's initial position, however, assumed that the risks associated with Covid-19 in MHIDA settings were not equivalent to the risks posed in acute hospital settings. We gathered feedback from members and arrived at the position that it could not be fair that what was considered activity requiring Level 3 PPE in acute settings was not deemed as such for MHIDA settings. After further discussion with the RCUK, we challenged their assumption that staff working in MHIDA settings did not require the same degree of protection, which they accepted and subsequently changed their guidance. We also alerted RCUK to the fact that mental health trusts had already developed plans based on their guidance for acute hospitals, and that any new guidance in development for mental health trusts could represent a downgrading of PPE required.

260. On 15 April 2020, the RCUK published new guidance for MHIDA inpatient settings, as well as for community hospitals. The guidance recommended that healthcare workers should not deliver chest compression or ventilation unless wearing Level 3 PPE (FFP3 mask, eye/face protection, fluid-resistant long-sleeved gown, gloves). It also stated that these procedures were considered to be aerosol generating and,

therefore, Level 3 PPE was required for all those in the immediate vicinity of the resuscitation attempt. While this was helpful for our members who were previously unsure whether to follow the RCUK's guidance for community settings or its acute general hospital guidance, the new information was still incongruous with the recommendations from PHE regarding whether chest compressions were aerosol generating. Concurrently to the publication of this guidance, the RCPsych learned from the CMO for England, that there was an AGP review underway.

261. On 21 April 2020, however, the RCUK published, what was in RCPsych's view, a particularly strong statement, stating deep concerns at PHE's "continued insistence on designating chest compressions as non Aerosol Generating Procedures" and that the "absence of high quality evidence for this should not be interpreted as the absence of risk." On 1 May 2020, the RCPsych signed up to, and published on its website, a statement by the Academy on the diverging views of PHE and RCUK; in this statement, the Academy stated that it was essential that health workers had the appropriate protection for the circumstances in which they were working and suggested that organisations and clinicians should agree, as soon as possible, on the local policy regarding the availability and use of PPE in resuscitation situations, in order to provide proper protection for staff.

262. On 6 May 2020, the Scottish Government agreed with the RCUK's advice regarding chest compressions being aerosol generating.

263. On 15 October 2020, an AGP Alliance was formed. While the RCPsych did not join as we felt we were able to effectively lobby on this topic in our own right, we acknowledged that there was a clear growth in the strength of feeling about AGPs and the associated use of PPE.

Testing

264. On 26 March 2020, the RCPsych became aware of our members reporting difficulties they and other mental health staff were experiencing in taking patient swab test material to be analysed at the designated acute hospital. This presented staff in mental health settings with a logistical challenge and resulted in prolonged periods of time away from the ward.

265. On 2 April 2020, during our regular call with NHSEI and PHE, we were advised that while PHE had been effective in its contact tracing early on in the pandemic, scaling up had been an issue. At this time, PHE and NHSEI were expanding contact tracing capacity from 10,000 to 25,000 patients, which was the first priority; we were also made aware that they were also building capacity for staff testing, and that the cap on testing had been lifted. We were also informed that a strategy for care homes in England was set to be published, as were new approaches in Wales, Scotland and Northern Ireland respectively; at the time, the consensus was that there needed to be more testing in care homes and that care homes had not been supported with infection control measures to the extent that they should have been. We have heard from members that the discharge of patients into care homes was a particularly pertinent issue in Northern Ireland; there was a lack of Covid-19 testing, and guidance for clinicians, patients and carers.

266. On 24 April 2020, NHSEI issued a letter to system leaders stating that testing should be expanded to all non-elective patients with a bed overnight, including for those in MHIDA settings.

267. On 1 May 2020, we were advised by NHSEI that many staff who had been testing positive for Covid-19 had been asymptomatic.

268. On 16 June 2020, the RCPsych received draft guidance from the MHLDA Covid-19 Response Cell at NHSEI on the testing and isolation of mental health patients. Subsequently, we consulted our members and sent back comments specifically relating to the issue of seclusion. It is particularly important that I reiterate at this point that we did not receive a first draft of this guidance until 16 June 2020, at which point every trust would already have had isolation and testing plans in place, rendering the guidance of limited practical use.

269. On 9 September 2020, the RCPsych made attempts to understand testing availability in mental health settings. For context, it appeared that NHS and PHE guidance did not preclude a mental health trust from being able to process Covid-19 tests, however, in practice some providers across the country might not have set up

capacity or capability to do so. The RCPsych had been made aware that the medical directors of mental health trusts had reported that they wanted to set up their own testing, but that the 'system' prevented them from doing so. We also heard frustrations that all the fast-testing machines had been given to the acute sector, despite the significant need for them in MHIDA settings also.

270. We were aware that DnaNudge's 'COVID Nudge', a rapid RT-PCR test for Covid-19, was to be rolled out from September 2020 to all urgent patient care and elective surgery settings, with further deployments in out-of-hospital settings, meaning that Covid-19 tests could come back within 90 minutes and also test for other viral illnesses such as flu. On 20 November 2020, the RCPsych sought to identify whether rapid lateral flow tests were being made available in mental health trusts and were told that they were being rolled out, albeit slowly.

271. On 15 March 2021, Claire Murdoch CBE, National Director for Mental Health at NHSEI, issued a letter to mental health system leaders outlining that timely access to Pillar 1 and Pillar 2 PCR test results, within 24 hours of the sample being taken, could be challenging in some MHIDA inpatient settings, particularly those without a laboratory site in close geographic proximity. The letter advised that pathology networks had been building capacity and resilience and encouraged the system to work together to ensure speedy access to tests for vulnerable patients. The letter also set out recommendations for acute and mental health trusts to support access to timely PCR testing for all NHS MHIDA inpatients in all settings, including both NHS and independent settings, serviced by Pillar 1 testing facilities. It stated that many NHS laboratories could that most samples were processed within 24 hours. For many MHIDA patients, self-isolating for longer than was necessary was detrimental to their recovery, adding to their distress. The letter noted that timeliness at each part of the testing pathway was crucial.

Visiting

272. On 8 April 2020, NHSEI published national visiting guidance, setting out that those admitted who had mental health conditions, dementia, an intellectual disability, or autistic people, could have visits. At this point, the RCPsych started considering the impact of visiting policies for relatives of those dying in hospital and we raised this

point with the Intercollegiate Ethics Forum. It was the RCPsych's position that the benefit of health and care staff attending dying patients to keep them comfortable outweighed the risk as it would be inhumane to withhold; additionally, to disregard the benefit of contact with close relatives also seemed to us to be out of line with offering patients the best care.

273. On 9 April 2020, NHSEI advised that its visiting guidance was being applied in a blanket fashion, which was concerning.

274. On 28 April 2020, Zoë Packman, Workstream Lead Clinical Cell and Head of Nursing Safety and Innovation at NHSEI, shared further draft visiting guidance with the RCPsych, asking for our comments. The draft guidance stated that there were exceptional circumstances in which one visitor – an immediate family member or carer – was permitted. These circumstances included where a person wanted to visit a patient who was receiving end-of-life care; the person was the birthing partner accompanying a woman in labour; the person was a parent or appropriate adult visiting their child; or the person was supporting a patient with a mental health issue, dementia, intellectual disability or autism, where not being present would cause the patient to be distressed. Following internal discussions, we shared concerns about the draft guidance. The RCPsych's view at the time was that the guidance would cause further confusion and misinterpretation as local trusts had already completed robust plans for visiting by this point. We also heard from members that confusion was arising in situations where a family was visiting someone who was Covid-19 positive and dying; in such situations, families had to wear PPE at all times but did not have clarity regarding how long they would have to self-isolate for afterwards. Some, for example, were worried that 14 days would impact on the support they could receive following a bereavement and funeral arrangements, and this concern was often being weighed against their decision to visit.

275. On 29 April 2020, NHSEI responded to the RCPsych by saying that this new guidance would provide further clarity that the health and safety of patients and staff was paramount; social distancing regulations, and, if required, PPE, would need to be adhered to; and that alternatives to physical visiting should also be available. NHSEI acknowledged the importance of physical visiting needing to be balanced with the risk

of infection, but that blanket restrictions could not continue. In relation to how the guidance was operationalised in each area, the NHSEI stated that this would be subject to local decision making. At this point, we also learned from NHSEI that separate end-of-life visiting guidance was already on hold, awaiting the publication of this central guidance.

276. On 23 October 2020, Ray James CBE, National Director for Learning Disability and Autism and Claire Murdoch CBE, National Director for Mental Health, NHSEI wrote to NHS system leaders[8] about visiting people in mental health, intellectual disability and autism inpatient services. The letter emphasised the importance of making the reasonable adjustments needed to ensure people could remain in contact with their loved ones and was clear that providers must take all steps possible to enable safe regular visits.

277. With longer inpatient stays, hospital and care home patients were left for long periods without contact with their families or loved ones, which only exacerbated feelings of loneliness and isolation. We heard from members working in liaison services that patients on the acute hospital wards were significantly impacted by not having visitors, leading to reduced hope, depression, and anxiety. Those who particularly suffered were people with dementia, intellectual disability and autistic people. There were some improvements when visiting restrictions were partly lifted but the extent of this varied across acute hospitals. The rules about visitors to the hospital to see loved ones had a detrimental impact on the mood and mental health of patients and carers, the impact of which is still being researched. There was, understandably, even more distress for those at the end of life who were not able to be with their loved ones. The role of psychiatrists working in liaison services was often to support these patients and their loved ones.

278. Given only off ward visits were permitted during the acute phase of the pandemic, patients in the Paediatric Intensive Care Unit were not able to have any visitors. One

[8] By system leaders, we mean mental health trust CEOs; CCG and STP mental health leads via regional teams; MHIDA provider settings; and regional specialised commissioning mental health leads.

young patient we heard from only had one visitor allowed throughout the course of their stay.

279. In some care homes in England, families were prevented from visiting their loved ones for extended periods of time. This had a detrimental impact on residents. Our members have emphasised to us the detrimental impact that lockdown has had on mental health, particularly on individuals who were already being treated by healthcare professionals.

280. The lack of transparent face masks significantly impacted communication for people with intellectual disabilities and patients with hearing impairment and/or who lip read. Communication through available PPE was often both quiet and muffled due to the constraints of the items used, seriously impacting staff's ability to connect with patients and make them aware of changes to their care.

281. From an Older Adults psychiatry perspective, there was a detrimental impact on those with dementia, with associated impacts on their carers. The acceleration of people's dementia was astounding as they lost routines, visitations with family members and friends, and even conversation, and one could say that lockdown measures were indeed a cause of death for some.

282. We heard from a patient and carer representative, who is both a patient and carer as well as an NHS worker, that they had witnessed their grandmother become ill with dementia while she was in a care home. It was their view that this was due to the lack of contact with family and friends, and the rigidity with which these rules were applied. Additionally, we heard that his mother's mental and physical health was negatively impacted by lack of contact with the world. When his mother had a stroke, she was not able to find sufficient mental or physical healthcare to support her recovery. We heard from this representative that he essentially lost contact with mental health services for over a year during the relevant period, and only had one telephone appointment with a consultant he had never met.

283. Some psychiatrists report being advised that they were restricted from carrying out family intervention therapy due to visiting rules. We have heard concerns from our

members on this point as this treatment is an intervention, and not necessarily about the visiting itself.

The MHIDA estate

284. Nosocomial transmission in MHIDA settings is an issue of particular significance to our response and, while it relates to the issues described in this section previously, I wanted to set this out separately.

285. On 17 March 2020, during the pandemic's early stages in the UK, the RCPsych wrote to the Health Service Journal outlining our concerns about nosocomial transmission of the virus in mental health care inpatient settings. We publicly called for PPE and testing for patients and staff to be made available.

286. That same day, Sir Simon Stevens and Amanda Pritchard wrote a letter to all NHS system leaders, covering next steps on the NHS response to Covid-19. It told MHIDA providers to plan for Covid-19 patients at all inpatient settings, and asked for them to identify areas where patients requiring urgent admission could be most effectively isolated and cared for. This might include, for example, single rooms, ensuites, or mental health wards on acute sites. The letter advised that case-by-case reviews would be required where any patient was unable to follow advice on containment and isolation and that staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, to ensure they were clear about triggers for transfer to acute inpatient care if indicated.

287. At this time, we heard from members working on an older person's inpatient mental health ward regarding cases of acutely unwell patients being sent to A&E to be assessed, as was the usual process at the time; these patients were being sent back to the ward, untested, without being seen, as it was assumed they had Covid-19. This led to situations whereby patients were returning to the ward, likely with Covid-19, where staff did not have sufficient PPE. This also presented a significant risk to other patients on the wards.

288. On 26 March 2020, the RCPsych was asked to review NHSEI's draft guidance on *Supporting patients of all ages who are unwell with coronavirus (Covid-19) in mental*

health, intellectual disability, autism, dementia and specialist inpatient facilities (covered further in the next section of this statement) and found the section on the prevention of transmission of Covid-19 to be inadequate. This was because it was based on the assumption that only symptomatic patients could transmit the virus. At the time, emerging evidence and the pattern of the pandemic showed this to be incorrect; asymptomatic people could, in fact, spread the virus. Furthermore, at that point we knew the virus could survive on hard surfaces for many days, which presented a major problem for inpatient wards where staff and patients would regularly touch various objects, doors and furniture. As such, we argued that we needed to learn from our Italian colleagues, who had recognised that hospitals could be major hubs for spreading the virus. The RCPsych was of the view that a proactive approach was necessary and believed making prevention the first priority would reduce morbidity, mortality and cost to the NHS.

289. On 3 April 2020, with further questions emerging from our members on the issue, we became concerned about how to care for patients who were CEV, including those vulnerable patients who were on wards and being cohorted.

290. On 31 July 2020, the third phase of the NHS response to Covid-19 outlined that all NHS providers should prepare for winter, alongside a possible Covid-19 resurgence, and continue to minimise nosocomial infections across all NHS settings.

291. Data from our second membership survey covering the corresponding period of 4 May 2020 to 26 May 2020 found that 32.9% of psychiatrists said that the quality of buildings and estates in their organisation has negatively or very negatively impacted upon the care provided to patients during the pandemic. Furthermore, 38% of members said that their organisations' estate has been unsuitable or very unsuitable for the cohorting of patients with suspected or confirmed Covid-19. Conversely, it is clear that where the mental health estate has been modernised, it has had a positive impact on both patients and staff during the pandemic.

292. Qualitive comments from the survey included:

"Mental health setting was basically a disaster waiting to happen when pandemic struck us."

"There has been a longstanding and acknowledged deficit in the quality of mental health estates in the NHS. Such deficits have only been notable during a time of significant systemic stress."

"Covid-19 spread rapidly on my ward in March. Six patients and multiple staff tested positive. Most patients were in bays. Only one side room has an ensuite."

"A Covid ward was identified within the organisation. However, this was done rather late, when virtually every ward in the organisation had anything between 2-6 patients who were unwell with Covid. My ward is an old-style ward on an acute hospital site with 4-bedded bays, and only 2 side rooms, so it became challenging to manage Covid positive unwell patients, and we had to quickly make other changes such as converting a communal quiet room into a third side room."

293. On 24 September 2020, ahead of the comprehensive spending review, the RCPsych published our representations to DHSC and HM Treasury. We strongly argued for the Government to ensure that mental health services were resilient, and clinicians were sufficiently prepared to manage patients with Covid-19 concurrently while they were receiving treatment and support for a mental illness. We made the following points:

293.1. The pandemic demonstrated that many mental health buildings were not fit for purpose, both across the community and inpatient estate, with many buildings designed to address safety concerns, such as fire, self-harming and violence, but not infection prevention and control. It was paramount, then, that mental health services prevented nosocomial transmission of the virus in inpatient settings, as well as the spread in the community.

293.2. People who have a mental illness are also more likely to have poorer physical health than the general population, which made them more susceptible to the virus. This group also has higher rates of smoking, respiratory disease (chronic obstructive pulmonary disease ("COPD"), asthma, chest infections), substance use disorders, as well as malnourishment caused by metabolic

problems or eating disorders. Protecting both patients and staff, then, required different ways of working from usual practices, which would prevent significant morbidity and mortality, and would reduce the pressure on acute physical health services.

293.3. Space was also required for the education and training of NHS staff, including for sessions about how to put on PPE, as well as to enable different types of research to be conducted. We pointed out that on NHS mental health sites, there was competition for clinic rooms for quiet spaces to do this work; and when reconfiguring or building new spaces for research and education, Covid-19 factors also needed to be considered, including those relating to interpersonal proximity, ventilation, and how to manage vulnerable or shielded participants or staff.

293.4. We recommended that NHS mental health trusts review their estate and repurpose vacant property, and/or procure and implement temporary modular facilities to increase real estate capacity during the pandemic if required. The purpose of this was to create cohorted wards to reduce the risk of contagion.

293.5. The estate was also an issue for mental healthcare professionals working in the community. While there needed to be sufficient and appropriate space for staff to socially distance, put on and remove PPE, and carry out hand washing, showering or changing clothing in order to follow IPC guidance, our members in some areas reported that this was not the case due to limited real estate capacity, or lack of strategic planning.

293.6. It was the RCPsych's position that a full assessment and remedial action were required in the community office and the community clinical estate, as well as in the inpatient and crisis environment. In response to Covid-19, NHS Property Services ("NHSPS") issued a Technical Guidance document to support the procurement and implementation of temporary modular units (prefabricated structures, with sections delivered on site to be assembled) on the NHS estate. In parts of the health service, NHS trusts commissioned modular buildings quickly.

Potential options included standard bedded wards, shell portacabins (for fit out by NHSPS for other use as required) and shower block/changing facilities.

293.7. In mental health settings specifically, it was not necessarily about increasing the total number of beds but increasing the number of buildings or sites in which those beds were located for cohorting. There would be special requirements for any modular build to be used in mental health settings, perhaps focusing predominantly on the fittings to be used, e.g., different doors, taps, and curtain rails. Alternatively, where immediate demand was required, NHSPS's designated taskforce could support mental health care providers to repurpose vacant property, which could potentially provide vital healthcare space quicker than the provision of modular units. This could also be helpful in the future when considering temporary decant facilities while construction was underway for other projects, such as eliminating dormitory provision.

294. The RCPsych published and presented our recommendations to HM Treasury, DHSC and NHSEI. Despite the compelling case for further investment across the mental health estate, while welcome, only funding to eliminate dormitory accommodation was announced.

295. On 17 November 2020, NHSEI published an update to its guidance, on *Managing capacity and demand within inpatient and community mental health, intellectual disability and autism services for all ages* which recommended that clinicians should separate, or cohort, patients into those with confirmed cases of Covid-19 and those without. RCPsych supported this position, but we were concerned that this would be challenging to implement given the limitations within the mental health estate, which was not set up for effective large-scale cohorting.

Impact of nosocomial transmission

296. By 20 October 2020, the QCOVID tool was published in the British Medical Journal ("BMJ"). This was a living risk prediction algorithm for risk of hospital admission and mortality from Covid-19 in adults and was instrumental in understanding the risk posed by Covid-19 to our patient group. The adjusted hazard ratio for people living in a

residential or nursing home and dying from Covid-19 was 3.61 for women and 4.28 for men.[9]

297. Prior to this, on 22 July 2020, we had written to the Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, and DHSC, HM Treasury and NHSEI officials outlining our concerns that many patients receiving assessment and treatment for a mental illness, chronic neurological condition, and/or intellectual disability were being cared for in residential settings or settings akin to care homes. We reiterated these points to the Rt Hon Matt Hancock MP further via:

- a briefing sent by email on 22 July 2020
- a briefing sent by email on 10 August 2020
- verbally during a MS Teams call on 15 September 2020
- verbally during a MS Teams call on 14 October 2020
- a briefing sent by email on 23 October 2020, and
- verbally during a MS Teams call on 17 November 2020.

We also reiterated these concerns in our subsequent discussions with the Rt Hon Matt Hancock MP, DHSC and NHSEI officials ahead of the publication of the Covid-19 vaccine prioritisation tool and deployment strategy. It remained our position that care homes, mental health/intellectual disability inpatient services, and residential settings shared similar challenges in preventing transmission of the virus to their patient/resident group for the following reasons. In both types of settings:

- patients/residents who were over the age of 65 were more likely to have comorbidities; one study that assessed Covid-19-associated deaths of 52 people over 65 years of age who using mental health services found that they had greater physical health needs or disability[10]

- patients/ residents were likely to have a long length of stay

[9] Clift AK, Coupland CA, Keogh RH, Diaz-Ordaz K, Williamson E, Harrison EM, Hayward A, Hemingway H, Horby P, Mehta N, Benger J. Living risk prediction algorithm (QCOVID) for risk of hospital admission and mortality from coronavirus 19 in adults: national derivation and validation cohort study. *bmj*. 2020 Oct 20;371.

[10] Boland B, Gale T. Mental and behavioural disorders and COVID-19-associated death in older people. *BJPsych Open*. 2020 Sep;6(5):e101.

- patients/ residents were often subjected to the provisions of the Mental Health Act or Deprivation of Liberty Safeguards

- there is a high reliance on temporary staff

- many buildings had not been designed in a way that enabled adequate IPC; many wards have dormitory accommodation which meant that patients could not be isolated or shielded; wards often had no place for putting on or removing PPE effectively, or facilities for hands-free handwashing as you would expect in acute hospitals.

298. We argued that this was undoubtedly leading to significant nosocomial transmission of the virus in these settings with severe consequences. We have outlined two of the most significant research findings below that were known at the time.

299. First, a retrospective observational study of older adults receiving care for a mental illness or dementia in five NHS Trusts in London published on 5 October 2020 found that of 344 inpatients, 38% were diagnosed with Covid-19 during the study period of 1 March to 30 April 2020. It also found that 15% of patients diagnosed with Covid-19 died (with their deaths determined to be Covid-19-related). The mean age of patients who had Covid-19 was 75.3 years; 52% were women, 36% were from ethnic minority groups, and 82% of patients were compulsorily detained. Of 56% of patients who had dementia, 18% had young-onset dementia. Researchers concluded that people living with dementia in inpatient or group settings are more vulnerable to infection from Covid-19 and more likely to die from the disease than people in the community.[11]

[11] Livingston G, Rostamipour H, Gallagher P, Kalafatis C, Shastri A, Huzzey L, Liu K, Sommerlad A, Marston L. Prevalence, management, and outcomes of SARS-CoV-2 infections in older people and those with dementia in mental health wards in London, UK: a retrospective observational study. *The Lancet Psychiatry*. 2020 Dec 1;7(12):1054-63.

300. Second, the Learning Disabilities Mortality Review ("LeDeR") programme reviewed the deaths of people with intellectual disabilities during the pandemic. The 2021 report stated that the majority of the 206 deaths were attributable to Covid-19 (79%). Over a third (35%) of those who died from Covid-19 lived in residential care homes, rising to almost half for those with Down's Syndrome. A quarter (25%) of those who died were living in supported living settings. It concluded that Covid-19 was the leading cause of death for people with an intellectual disability in 2021. It also shows that, during 2021, the rate of excess deaths was more than two times higher for people with an intellectual disability compared to the general population.[12] Additionally, it is also clear that inequalities in inpatient care for patients with intellectual disabilities could have contributed to excess avoidable deaths, as evidenced by a cohort study in the UK on understanding inequalities in Covid-19 outcomes following hospital admission for people with intellectual disabilities compared to the general population.[13]

301. We heard from one of our patient and carer representatives, who is an autistic person, that the frequent government rule changes were both confusing and upsetting. They felt that communication of the rules allowed for different interpretations – which was difficult for them to parse personally – and that this impacted public safety. The injustice they perceived with regard to how different people applied the rules, in combination with seeing government officials breaking these rules, affected their mental health significantly, to the point where they attempted to commit suicide in late 2020.

Clinically extremely vulnerable ("CEV") individuals and 'shielding'

302. On 17 June 2020, the RCPsych attended an urgent meeting with NHSEI and PHE about shielding and those who were determined to be CEV. While we were advised that there would be a communication to all those shielding, there appeared to be reluctance from NHSEI and PHE to issue central medical advice to the medical community on this matter.

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[12] White A, Sheehan R, Ding J, Roberts C, Magill N, Keagan-Bull R, Carter B, Ruane M, Xiang X, Chauhan U, Tuffrey-Wijne I. Learning from Lives and Deaths-People with a learning disability and autistic people (LeDeR) report for 2021.

[13] Baksh RA, Pape SE, Smith J, Strydom A. Understanding inequalities in COVID-19 outcomes following hospital admission for people with intellectual disability compared to the general population: a matched cohort study in the UK. *BMJ open*. 2021 Oct 1;11(10):e052482.

303. We heard from our members in England that it was difficult to implement shielding and navigate the impact of the pandemic on the clinically vulnerable in secure inpatient settings. A member told us about one patient who had to be repeatedly isolated in their room for extended periods of time. We heard of another patient who could not tolerate being isolated in his room and therefore had to be managed by three staff in a separate area of the ward. In community settings, this led to even higher levels of social isolation.

304. An unintended consequence of staff shielding or isolating was short staffing. While healthcare professionals who were shielding were able to support their colleagues in different ways, staffing was impacted, just as it was by sickness and family members who were unwell or poorly. It is also worth noting that shielding is likely to disproportionately affect women who are more likely to carry the burden of domestic responsibilities, and who are also more at risk from factors like domestic violence which was also significantly increased following Covid-19.

305. We heard from our South West Division in England that that there was not enough information about risk and decision making in relation to shielding. For example, although those who were clinically vulnerable were told to stay in isolation, there was little communication outside of that. It was important that people were supported to make their own decisions and understand the risks and benefits of shielding, and psychiatrists had a role in supporting people to make informed decisions where appropriate, but it is not clear that such a discourse on this matter was enabled.

306. We know that positive relationships and feelings of connectedness contribute to good health and wellbeing. With lockdown restrictions limiting social contact, both were inevitably affected by the pandemic. This also applies to staff who were shielding. One of our patient and carer representatives, who was a carer for his mother, recounted having no support with his care duties at all during the pandemic and experiencing stress, isolation, and severe depression. As a heart failure patient himself, he was doubly isolated and unable to delegate the care duties of his mother to any other person out of fear for her and his own safety.

Conclusions and recommendations

307. **Based on a considered assessment of the information known to us, it is the RCPsych's position that:**

307.1.1. PHE's and NHSEI's IPC guidance in the early stages of the pandemic and public messaging on the use of PPE in the community was, at least in part, driven by a lack of supply and stockpile, including a lack of supply in the health and care system.

307.1.2. PHE and NHSEI did not ensure that guidance on IPC policies and procedures were satisfactory in giving healthcare professionals working in mental health care settings adequate and timely information about the level of PPE required in different frontline scenarios, including home visits, inpatient settings and during rapid tranquilisation and restraint. Their guidance did not clarify what constituted an AGP and what the necessary IPC requirements were in such events, including for chest compressions during CPR, nasogastric tube feeding and dysphagia assessments. It also failed to cover the use of a hospital uniform. This had a profoundly damaging effect on the morale, confidence and safety of NHS staff working in these settings and led to avoidable harm.

307.1.3. PHE and NHSEI did not ensure that guidance on IPC policies and procedures were communicated satisfactorily to healthcare professionals working in mental health care settings, and decision-makers could have done more to resolve conflicting opinions and reduce confusion in a satisfactory manner, for example, with the deviation in guidance on chest compressions being AGPs.

307.1.4. PHE and NHSEI did not provide an appropriate level of PPE to healthcare professionals working in MHIDA settings (including in the community) which was commensurate with the national guidance at the time, including in cases where there was a deviation in opinion in the PPE required for AGPs.

307.1.5. PHE and NHSEI did not adequately consider and communicate the process for performing CPR across MHIDA services during the pandemic (including in the community, and in residential, inpatient and secure settings) and the requisite PPE that would be required, and did not mitigate any unintended consequences of conflicting advice.

307.1.6. PHE and NHSEI did not allocate and deliver Covid-19 tests to providers of MHIDA services throughout the pandemic, commensurate with need.

307.1.7. PHE and NHSEI did not adequately consider the extent to which people would be discharged from hospitals into MHIDA settings, residential care, care homes or nursing homes without testing for Covid-19, which led to avoidable harm.

307.1.8. NHSEI sought to ensure that guidance on visitation in mental health inpatient and residential settings was proportionate, evidence-based and regularly reviewed. However, in practice, there were concerns about 'blanket' use.

307.1.9. PHE and NHSEI did not adequately consider whether the pandemic would increase the risk factors for those with MHIDA, including in groups who were deemed CEV and advised to 'shield', nor did they provide sufficient resources to deal with increased associated risks.

307.1.10. DHSC, PHE and NHSEI, in their strategic and operational planning to prevent nosocomial transmission of Covid-19 across healthcare settings, did not adequately consider the provision of mental health care in inpatient and residential settings and the associated impact of those environments on patient experience, and morbidity and mortality from Covid-19, and specifically, the ability for providers of mental health services to reconfigure the inpatient estate to provide 'cohorted wards'; the ability of patients and healthcare workers to adhere to IPC guidance in these settings; the demographics of the patient population, including age, ethnicity and multi-morbidities; the

typical care episode, including length of stay; use of temporary staff; and the proportion of patients subjected to the provisions of mental health legislation, and the associated impact of being unable to self-discharge or avoid admission if deemed medically necessary. This led to avoidable suffering, harm and mortality.

307.1.11. Prior to the pandemic in March 2020, the Government, DHSC and NHSEI consistently did not prioritise efforts to improve the safety and quality of the MHIDA estate, including specialist services such as ECT clinics, in a way that was commensurate with other providers of NHS services.

307.1.12. NHSEI did not consider, in its strategic and operational planning, whether the space across the mental health estate was sufficient in enabling staff to adhere to national IPC guidance, and specifically, for staff to socially distance, don and doff PPE, and carry out hand washing, showering or changing clothing while working in the community.

308. Based on the positioning outlined above, the RCPsych makes the following recommendations with respect to infection prevention and control:

308.1.1. The Inquiry should review how the UK Government, PHE and NHSE developed IPC guidance in the early stages of the pandemic, its public messaging, and whether this was predominantly driven by a lack of supply and sufficient stockpile.

308.1.2. The UK Government, DHSC, UKHSA and NHSE should review the IPC, testing, and visiting policies they have in place for operating in the event of a contagious outbreak and seek to learn lessons from the Covid-19 pandemic.

308.1.3. In a comparable Level 4 Incident, UKHSA and NHSE must ensure guidance on IPC policies and procedures are communicated satisfactorily to healthcare professionals working in MHIDA settings;

provide an appropriate level of PPE to healthcare professionals working in MHIDA settings (including in the community) commensurate with national guidance; adequately seek to mitigate any unintended consequences of conflicting guidance and advice to NHS systems; and ensure tests are made available to providers of MHIDA services commensurate with need.

308.1.4. Early mobilisation and a coordinated response are essential to safeguard individuals from vulnerable groups during a pandemic. The UK Government, DHSC, UKHSA and NHSE should review their policies, processes and procedures for identifying individuals who are clinically extremely vulnerable in the event of a contagious outbreak and seek to learn lessons from the Covid-19 pandemic. There is also a need for a specific focus on, and surveillance of, vulnerable groups in future.

308.1.5. The UK Government, DHSC, UKHSA and NHSE should review their policies, processes and procedures for its strategic and operational planning to prevent and manage nosocomial transmission of contagious outbreaks across healthcare settings, and specifically on the points we have made about MHIDA settings.

308.1.6. The UK Government, DHSC and NHSE should prioritise MHIDA sites as part of any further NHS capital regime in order to address some of the most urgent safety issues, given that the 'high' and 'significant' risk maintenance backlog costs across mental health and learning disability sites had reached £185.655m in 2021/22. This was an increase from £121.594m during the time of the pandemic in 2020/21 (52.7% increase) and £92.060m in 2019/20 (101.7% increase). When looking at just high-risk maintenance backlog across mental health and learning disability sites, this was £48.286m in 2021/22. This has increased from £21.731m in 2020/21 (122.2% increase) and £16.171m in 2019/20 (198.6% increase). Immediate action is required, given that the situation has likely deteriorated further.

308.1.7. As soon as possible, the UK Government, DHSC and NHSE should introduce an investment standard for capital estate allocations to ensure funding is fairly apportioned to mental health redevelopment and improvement schemes – both across integrated care boards ("ICBs") and nationally.

308.1.8. Unlike other areas of healthcare, the vast majority of MHIDA providers were unable to reconfigure their inpatient estate to provide 'cohorted wards' during the pandemic owing to dormitory accommodation and a lack of single ensuite rooms. The UK Government must commit to providing a new Health Infrastructure Plan ("HIP") for mental health. Within this, we would want to see a commitment to a new building and redevelopment programme for mental health, in order to improve the therapeutic environment in mental health and learning disability/autism inpatient services by completing the work to eliminate dormitory accommodation, eliminating mixed sex accommodation, procuring ensuite facilities for all existing single rooms, minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities. We also want to see investment in new building and redevelopment schemes for community mental health facilities (which would include both clinical and office spaces), essential improvements to digital infrastructure, the completion of new building and redevelopment schemes for crisis mental health facilities (including the procurement of sufficient mental health ambulances or transport vehicles), age-appropriate mental health assessment spaces in A&Es and acute hospitals, and procurement of age-appropriate alternative forms of mental health crisis provision.

Supporting patients who are unwell with Covid-19

Supporting patients of all ages who are unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities

309. On 26 March 2020, the RCPsych received the first draft of the guidance from the MHLDA Covid-19 Response Cell at NHSEI for our review, *Supporting patients of all ages who were unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities* (LS/34 – INQ000410875). We then consulted with our RCPsych Covid-19 Advisory Group who, initially, were critical of the document, before working with NHSEI to make amendments to the draft. At this point, the narrative from NHSEI was that transfer to an acute facility might not be possible, and patients should stay in the mental health provider's care with supportive measures; the RCPsych raised significant concerns with respect to this approach. One of the key issues with the draft document was that it did not give equity to mental health inpatients accessing acute physical health care services. Therefore, as the guidance stood at that time, if a patient who developed respiratory distress was, for example, a 45-year-old with a diagnosis of schizophrenia being treated in the community or under the crisis team, then an ambulance and access to the trust's priority decision matrix would have been provided. This may not have been the case, however, if this same patient was on a mental health inpatient ward.

310. On 30 March 2020, we received the second draft of the guidance, *Supporting patients of all ages who were unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities* from the MHLDA Covid-19 Response Cell at NHSEI with a short timeframe for our review. We were pleased that many of our comments had been taken on board but remained concerned that 'Table 1: Considerations for patients with different levels of risk and symptom severity, and suggested actions' did not reflect our concerns about the risk of inequity in access to acute medical care if required. The following day, we had another conversation with NHSEI about the draft guidance. At that point, we felt satisfied that our suggested amendments had been accepted and that the guidance would be amended to state that a patient with risk Level 2 or 3 with Covid-19 positive symptoms would be transferred to an acute setting at the earliest opportunity, but also that those mental health trusts that had the capacity and capability to start with early supportive therapy

– oxygen, nebulisers, IV antibiotics, for example – could do so. We reflected that this was only likely to be possible in combined trusts that provided both community health and mental health services as they were more likely to have the staffing and support available to administer these interventions.

311. Anecdotally, we have heard from our members that with ambulance services overwhelmed, psychiatrists were often required to make their own plans for how to transport patients to an acute hospital in an urgent situation. The RCPsych's Psychiatric Trainees' Committee has noted the difficulty trainees experienced in managing patients with medical complications in psychiatric settings, particularly in light of slow ambulance times. They also shared that they were often the first person to see a patient face to face after the patient had had multiple interactions via the telephone with their GP, or community mental health team or third sector organisation (these interactions would have led to an MHA/MHO assessment, which is why the trainee would then be seeing them face to face). At times, trainees felt that this was unjust, both for the patient and trainee.

312. On 6 April 2020, the RCPsych received the final draft of the guidance from NHSEI, who advised that they had been given a clear steer from the Acute Covid-19 Response Cell at NHSEI that if, and when, beds would be required for acute hospital care, then transfer must and would be expedited. We reflected that we had, to that point, observed fairly wide variation in how mental health trusts were responding to this issue; some, for example, were having discussions about taking ventilated patients, while others seemed very unprepared to manage physical health needs associated with Covid-19 infection as the virus had been slower to spread to some mental health wards in more rural areas of the country.

313. On 8 April 2020, given its relevance to the yet-to-be-published guidance on supporting patients of all ages who were unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities, the RCPsych asked the MHLDA Covid-19 Response Cell at NHSEI if they had been involved in NHSEI's new guidance on monitoring physical health and decisions to admit. The team were unaware of this, and they had not been asked to review or contribute to said guidance. It is our view that this provides further evidence of the NHSEI National Covid

Response Cell not engaging and working closely with the MHLDA Covid-19 Response Cell.

314. On 30 April 2020, NHSEI published its first version of guidance, *Supporting patients of all ages who are unwell with Covid-19 in mental health, intellectual disability, autism, dementia and specialist inpatient facilities*. The RCPsych, at this point, started to think about updates that could be made in developing a future iteration of this guidance. Despite seeing a first draft on 26 March 2020, it was 5 weeks before the guidance was published. This represented a significant delay when compared to the guidance prepared for acute trusts, and there was no clear rationale for the delay. Undoubtedly, this delay would have had an impact on the delivery of care across MHIDA settings. On 24 January 2022, NHSEI published the second version of its guidance on managing acutely unwell patients. The RCPsych was not directly involved in this update.

Upskilling

315. On 14 April 2020, HEE asked for the RCPsych's advice on a list of resources they intended to offer to NHS staff to support their learning and development needs in light of Covid-19.

316. That same day, owing to concerns about poor access routes to acute medical care (as outlined in the previous section), we heard that one mental health trust in London was taking drastic steps to upskill mental health nurses to be ready to provide care to those dying of Covid-19 on mental health wards. Directors of nursing, we heard, were either commissioning local higher education institutions ("HEIs") or accessing local acute hospitals' training courses to provide these skills. While it was perceived nationally that there was good availability of intensive care beds, we heard that some acute trusts were reporting low capacity. We also heard that some acute trusts had closed access routes from mental health trusts. This forced directors of nursing to open medical wards to look after patients in their own services, requiring mental health nurses to complete physical health skills, refresher courses and prepare for redeployment. One London trust employed acute care nurses on the 'Bank', i.e., temporary staff who were already working for the trust or were hired externally, to support mental health nurses to undertake physical health care. While we heard that

demand was not likely to be high, we also heard that acute hospitals could refuse to admit mental health patients if they were deemed to be already in a clinical setting where they could access the care needed. The RCPsych was, and is, of the view that mental health patients deserve similar standards of care as physical health patients.

317. In April 2020, the RCPsych in Scotland engaged with NES and the Scottish Government following the halting of both new and refresher AMPs training across Scotland. On 2 April 2020, we asked if there was any new or amended advice for when there were returning retired consultants who had not completed refresher training in the last 5 years. NES stated that they had not heard any advice from the Scottish Government but advised that their understanding was that update training did not need to be completed until 31 December 2020. As such, it was NES's understanding that AMPs returning to work would be able to resume their duties, assuming they had completed initial training at some point in the past. The RCPsych in Scotland raised this point with the Scottish Government, asking if they were comfortable with the RCPsych updating the Scottish Covid-19 guidance to reflect this. Legislation officials were alerted for clarification. On 17 April 2020, the RCPsych in Scotland raised the issue with the NES once again, pushing for recommencement and highlighting the consequences of a pause in service provision.

318. In April 2020, the RCPsych set up a Covid-19 e-learning hub. Education and training for mental health staff in physical health skills, including the management of Covid-19 and deteriorating patients, had been beneficial and needed to continue as there had been many Covid-19 patients on mental health inpatient wards. The RCPsych worked with other medical royal colleges to create an e-learning hub with useful resources for clinicians which was free of charge.

319. For medical psychotherapy, Covid-19 outcomes for Annual Review of Competency Progression ("ARCP") were also developed, in parallel with the psychotherapy guidelines, recognising that aspects of training may be delayed by the pandemic. As such, these aspects needed to be carried over for future ARCPs where possible. The ARCP outcomes were designed specifically so that trainees could continue to progress through training without delay while still ensuring that they achieved their curricula psychotherapy competencies.

320. In May 2020, the Specialty Training Board in Scotland was suspended. The RCPsych raised concerns to NES and the Scottish Government about the impact this would have on psychiatry training.

Do not attempt cardiopulmonary resuscitation ("DNACPR")

321. On 24 March 2020, the issue of the clinical frailty scale was first raised to the RCPsych by one of our members. Their understanding was that NICE had called for health professionals to use the "fragility score" to decide who would require positive acute medical care. There was a concern, however, as this was not a scale which was validated in intellectual disability services and could easily and disproportionately impact a number of people with intellectual disabilities. We escalated this issue to NHSEI.

322. We subsequently heard members report the clinical frailty scale being incorrectly incorporated into decision trees relating to access to ICU treatment and ventilation. For patients with complex health needs who were at higher risk of Covid-19 mortality, advanced care planning was undertaken with patients – and, where possible, their families – to determine the ceiling of care. This issue had to be repeatedly raised to NHSEI, NHS providers and frontline clinicians by the RCPsych, other professional bodies and third sector agencies.

323. On 3 April 2020, following the issuing of a Covid-19 rapid guideline for critical care in adults by NICE, Claire Murdoch CBE, National Director for Mental Health, Dr Roger Banks, National Clinical Director for Learning Disability and Autism and Dr Nikki Kanani, Medical Director of Primary Care, a letter written by NHS England to the primary care distribution list, acute trust CEOs, and community trust CEOs clarifying that the clinical frailty scale and DNACPR should not be used as part of a blanket approach for younger patients, autistic patients, or patients with an intellectual disability. Instead, the letter stated that an individualised assessment was recommended in all cases where the clinical frailty scale was not appropriate. It was imperative, the letter said, "that decisions regarding appropriateness of admission to hospital and for assessment and treatment for people with learning disabilities and/or autism are made on an individual basis and in consultation with their family and/or paid

carers, taking into account the person's usual physical health, the severity of any co-existing conditions and their frailty at the time of examination" and that treatment decisions "should not be made on the basis of the presence of learning disability and/or autism alone."

324. The NICE guidance had made reference to assessment using the clinical frailty scale and was subsequently amended on 25 March to make it clear that it should not be used in younger people, people with stable long-term disabilities, intellectual disability, or autistic people. For further context, in May 2020, National Medical Director Professor Stephen Powis, stated that the terms 'learning disability' and 'Down's Syndrome' should never be a reason for issuing a DNACPR order, nor be used to describe the underlying, or only, cause of death.

325. On 7 April 2020, the RCPsych discussed the issue further with members of our Covid-19 Advisory Group and sought to consider the two issues – advanced decisions and availability of acute hospital care – separately as, at that time, we were concerned that these two issues were being confused in national Covid-19 planning. There was a risk that patients were being, or would be, put under direct or indirect pressure from the health system or their own support networks to make decisions on DNACPR they would not ordinarily make when system capacity was not an issue. There was already clear legislation and guidance on making advanced decisions that could be used when patients were considering what they wanted to happen with regard to their own Covid-19 treatment and, at that time, patient-facing advice from the NHS covered most eventualities. The RCPsych was keen to ensure that patients' wishes around advanced decisions were honoured and enacted. We also needed to ensure concerns from others regarding potential service capacity did not leak into patients' decision making.

326. Similarly in Scotland on 7 April 2020, the RCPsych sent a letter to the Scottish Government outlining the significant concerns psychiatrists had about the dissemination of guidance on the clinical frailty scale. In it, we asked that the Government make a statement drawing attention to the provisions and amendments of the clinical frailty scale to ensure there was awareness among clinicians that a blanket approach for younger patients, autistic patients, or patients with an intellectual

disability was not appropriate. Specifically, we were concerned that frontline emergency and clinical care staff would not be aware that this was in fact an error in the original guidance disseminated. We received immediate acknowledgement from the Scottish Government and an assurance that officials would investigate the matter straight away. Subsequently, we received confirmation that this issue had been addressed.

327. On 9 April 2020, we were advised on a call with the NHSEI Communications Team that DNACPR communications were still a concern.

328. On 4 March 2021, NHSEI issue another letter to system leaders regarding DNACPR for autistic people and those with an intellectual disability. This letter indicated further concerns about blanket notices being applied and stated that such policies were inappropriate whether due to medical condition, disability or age. The letter said that DNACPR orders should only ever be made on an individual basis and in consultation with the individual or their family, and that people should "not have a DNACPR on their record just because they have a learning disability, autism or both."

329. The RCPsych had been advised by trainees that decision making about the nature of healthcare to be provided to patients, including the use of DNACPRs, was a particularly difficult issue to manage in old age psychiatry. This was, at least in part, because care and emergency physicians were not as readily available to assist in the decision-making process due to their own clinical pressures from Covid-19. We heard that the main driver in whether these forms were completed was family preference. Psychiatrists working in liaison services told the RCPsych that DNACPR decisions were made through the liaison teams' acute trust colleagues and therefore did not impact liaison services as much as it did others.

330. We heard a range of experiences regarding the use of DNACPRs from members. Some psychiatrists in the South West of England said that the rationale behind the move towards incorporating the clinical frailty scale into decision making and the undertaking of advance care planning to determine the ceiling of care for patients, including whether to issue a DNACPR, had not been sufficiently communicated to staff. In London, we heard that difficult conversations had been had at the time, but

that they were necessary. In the North West of England, we were advised that individual risk assessments were completed and that there had been good communication with families and carers while they were carried out.

331. Members raised the concern that some patients who had DNACPRs issued during the height of the pandemic have not had those DNACPR orders removed from their records where it would be appropriate to do so.

Covid-19 deaths of hospital patients with pre-existing mental health conditions and patients in mental health, intellectual disability and autism inpatient facilities

332. In August 2023, the RCPsych independently decided to conduct a literature review to support the Inquiry's work. As part of this review, we investigated the number of patients with pre-existing mental health conditions who died in hospitals[14] in England, and the number of patients who died while detained or subject to the Mental Health Act 1983 in England during the pandemic, whose deaths had been attributed to Covid-19.

333. NHSEI reported the number of deaths of patients who died in hospitals in England and tested positive for Covid-19 and had broken this down based on the 'type' of a patient's pre-existing condition.

333.1. From 1 March 2020 to 29 March 2023, 2.6% (2,889) of patients who died from Covid-19 were receiving treatment for a mental health condition and 1.3% (1,558) had an intellectual disability and/or were autistic.[15] It should be noted that patients who died from Covid-19 may have had more than one pre-existing condition.

333.2. During the same reporting period, NHSEI also reported the number of patients who died in hospitals in England, including in mental health trusts, who had either tested positive for Covid-19 or had Covid-19 mentioned on their death certificate.

[14] Including acute, mental health, intellectual disability and autism settings.
[15] The term 'learning disability and/or autism' was included in the NHS England findings; RCPsych terminology has been adopted in this circumstance.

333.3. Between 1 April 2020 and 31 March 2021, 1,762 people died from Covid-19 in NHS mental health trusts in England. The figure dropped by 70.3% to 523 in 2021/22, but subsequently increased by 26.2% to 660 Covid-19 deaths in 2022/23.

333.4. In total, 2,991 deaths in mental health trusts were attributed to Covid-19 from 1 March 2020 to 29 March 2023, when NHS England's data collection ceased.[16]

334. Importantly, these figures do not include deaths that occurred outside of hospitals, such as those in care homes. When interpreting the data, it should be noted that the total Covid-19 death toll for the NHS mental health trusts would not include patients who may have contracted Covid-19 in an inpatient mental health setting, but were subsequently discharged or transferred to an acute hospital.

335. North Cumbria Integrated Care NHS Foundation Trust was the NHS mental health trust with the greatest number of Covid-19 deaths during the reporting period, with 965 deaths (32.2% of all Covid-19 deaths in England), followed by Somerset NHS Foundation Trust with 538 deaths (18.0%) and Isle of Wight NHS Trust with 340 deaths (11.4%). Conversely, there were no records of Covid-19 deaths in Black Country Partnership NHS Foundation Trust, Camden and Islington NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust, Devon Partnership NHS Trust, South West London and St George's Mental Health NHS Trust, Surrey and Borders Partnership NHS Foundation Trust, and Sussex Partnership NHS Foundation Trust. [17]

336. During the reporting period, the NHS England region with the greatest number of Covid-19 deaths in mental health trusts was the North East and Yorkshire (1,020 deaths, 34.1%), followed by the South West (782 deaths, 26.1%) and South East (546 deaths, 18.3%). In comparison, 1.1% of Covid-19 deaths in mental health trusts were in the North West of England (33 deaths in total).[18]

[16] NHS England, COVID-19 Deaths, 29 March 2023
[17] NHS England, COVID-19 Deaths, 29 March 2023
[18] NHS England, COVID-19 Deaths, 29 March 2023

337. Additionally, South London and Maudsley NHS Foundation Trust reported an excess of 1,109 deaths among people with pre-existing mental health disorders between 1 March and 30 June 2020 (out of a total of 2,561 deaths on their mental health register during this period). 63.8% of the excess deaths was attributed to Covid-19 and the remaining excess was accounted for by unnatural/unexplained deaths and neurodegenerative conditions. Please note that the study does not compare excess deaths among adults with SMI to those among adults with no SMI, nor does it account for the impact of comorbidities.[19-20]

338. Moreover, under the MHA 1983, all registered mental health providers must notify the CQC about the deaths of people who are detained or liable to be detained. Based on information included in notifications that providers sent to the CQC or that were obtained through the coroner's courts, as of November 2022, the CQC was notified that 196 people died from natural causes such as cancer, heart disease and Covid-19 while detained under the MHA, or while subject to a community treatment order ("CTO") between 1 April 2021 and 31 March 2022. This is a reduction of one third (33.6%) compared to numbers from the midst of the Covid-19 pandemic in 2020/21 (295 natural deaths) and an increase of 19.5% compared to numbers from before the pandemic in 2019/20 (164 natural deaths).

338.1. According to the CQC, between 1 April 2020 and 31 March 2022 there were 129 notifications of deaths that mental health providers indicated were attributed to Covid-19 – 26.3% of all natural deaths that occurred during this period – with 119 deaths recorded in 2020/21 and 10 deaths recorded in 2021/22.

338.2. The number of patients who were detained or subject to a CTO and died of unnatural causes in England increased substantially over the course of the pandemic, from 42 deaths in 2019/20 to 56 deaths in 2020/21 (an increase of one third or 33.3%) and 66 deaths in 2021/22 (an increase of 57.1%).[21-22]

338.3. It is important to note that there are often time lags in reporting and data cleaning and, as a result, there are often retrospective changes in overall

[19] OHID, Pre-existing mental health conditions, spotlight, 18 November 2021
[20] Stewart R, Jewell A, Broadbent M, Bakolis I, Das-Munshi J. Causes of death in mental health service users during the first wave of the COVID-19 pandemic: South London and Maudsley data from March to June 2020, compared with 2015-2019. *medRxiv*. 2020 Oct 27:2020-10.
[21] CQC, Monitoring the Mental Health Act in 2020/21, 21 February 2022
[22] CQC, Monitoring the Mental Health Act in 2021 to 2022, 1 December 2022

numbers. The cause of deaths in detention is usually determined through the coroners' courts, which can lead to a delay for accurate statistical reporting.[23]

Conclusions and recommendations

339. **Based on a considered assessment of the information known to us, it is the RCPsych's position that:**

339.1.1. NHSEI did not adequately consider in its strategic and operational planning in the early stages of the pandemic whether, if required, providers of mental health services and healthcare professionals would be sufficiently prepared to manage acutely unwell patients with Covid-19 in mental health inpatient settings, including considering whether they would have sufficient access to oxygen, oximeters and other vital equipment.

339.1.2. While NHSEI's guidance on managing acutely unwell patients with Covid-19 in mental health inpatient settings was comprehensive and sufficiently covered a range of scenarios, we found the delay in publication to be wholly inadequate and out of line with similar publications in other areas of healthcare. To reiterate, we received the first draft of the guidance for comment on 26 March 2020, but the guidance was not published until 30 April 2020.

339.1.3. Medical royal colleges worked well together to share free online continuing professional development ("CPD") resources to enable doctors to upskill themselves in areas of healthcare delivery that they felt necessary.

339.1.4. NHSEI successfully identified that guidance to patients and their loved ones about DNACPRs was at risk of being implemented in a way that was not proportionate and sought to ensure that this was communicated to providers of mental health services.

[23] CQC, COVID-19 Insight 13: Our data, 12 May 2022

340. **Based on the positioning outlined above, the RCPsych makes the following recommendations, with respect to supporting patients who are unwell in any future incidence of a pandemic of a contagious disease:**

340.1.1. The UK Government, DHSC, UKHSA and NHSE should review the policies, processes and procedures they have in place for operating in the event of a contagious outbreak and consider how best to prepare providers of mental health services and healthcare professionals to manage acutely unwell and contagious patients in MHIDA inpatient settings.

340.1.2. In the event of a comparable Level 4 Incident, NHSE should ensure the MHIDA sector has sufficient access to oxygen, oximeters and other vital equipment as required.

340.1.3. To prepare for future pandemics of any scale or nature, NHSE needs to ensure there is sufficient priority and resource provision within the MHLDA Directorate that enables them to respond in a timely manner, and in a way that is commensurate with other healthcare sectors.

Protection of doctors, nurses and other healthcare professionals

341. Some of our members have expressed that they felt respect increased for all health professionals at the time of the pandemic, with the general public having been happy to show their support and thank NHS workers for their dedication, particularly while in the midst of uncertainty. However, now that the relevant period has come to an end, members feel this has not translated into government priority and actions, a concern which we cover in more depth in the next section.

Guidance

342. On 26 March 2020, while awaiting national Covid-19 workforce guidance from NHSEI – which we knew at this point was under development – the RCPsych

published its own guidance for the workforce. This included information about team management and leadership, multidisciplinary teams, releasing clinical capacity for direct patient care, returning to practice, training and CPD, professional standards, staffing models and a list of NHS staff offers. Prior to publication, the RCPsych's guidance was approved by the NHSEI's MHLDA Covid-19 Response Cell.

343. It was not until 28 May 2020 that the RCPsych had sight of the final draft of the NHSEI's national Covid-19 workforce guidance. During the RCPsych's discussions with NHSEI, it became apparent that there was confusion within NHSEI about the out-of-date mental health information in this version; and we were advised by NHSEI's MHLDA Covid-19 Response Cell that they would try to find out more information.

Working outside of usual scope of practice

344. On 12 March 2020, a letter was issued by the Chief Medical Officers, NHSEI, and the GMC advising system leaders that as Covid-19 put pressure on services, doctors would have to work differently for their patients. The letter was endorsed by the Academy.

345. On 26 March 2020, the Chief Medical Officers, GMC and NHSEI issued a further letter to system leaders, setting out how doctors should continue to practice and how employers should adapt. The letter said that a significant epidemic would require healthcare professionals to be flexible in what they do, and that this "may entail working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients and the population as a whole." The letter said that all doctors were "expected to follow GMC guidance and use their judgement in applying the principles to the situations they face, but these rightly take account of the realities of a very abnormal emergency situation", and that GP practices, hospitals, trusts and health boards were responsible for ensuring that clinicians working in their organisations were supported to take a rational approach to varying practice during the emergency.

Redeployment

346. On 23 March 2020, the RCPsych was made aware that several mental health trusts in England had been asked to transfer all foundation year one doctors to acute

trusts amid worsening Covid-19 pressures. Some areas were able to manage, and in fact, some at a local level had transferred their foundation doctors to other areas and were planning to offer Core Trainees as well, noting that they had sufficient consultants and specialty doctors to cover mental health units. At this point, the RCPsych raised concerns over the impact this would have on mental health services. Professor Wendy Reid, the Executive Director of Education and Quality and National Medical Director for Health Education England said that HEE fully recognised the vital role mental health services play in supporting patients and, as such, that no psychiatry trainees had been asked to move.

347. Given that the approach to redeploying staff in Scotland was different to that of England, Wales and Northern Ireland, the Chair of RCPsych in Scotland issued a statement which reflected the different approaches across the Scottish territorial board. Many junior doctors, for example, had been redeployed at this point. Following the redeployment of Foundation Year 1 doctors in Scotland, concerns were raised at the RCPsych's Scottish Medical Managers meeting that roles would not come back.

348. In the field, between 18–26 May 2020, the RCPsych member survey asked our members how comfortable they were with the prospect of being redeployed to a general acute hospital if required. Across the UK, 16.7% of respondents confirmed that they were comfortable or very comfortable with the notion, whereas 68.9% were uncomfortable or very uncomfortable. For England only, the percentages were 16.8% and 69.1% respectively.

349. Some members expressed to us that they were worried about being deployed to Nightingale hospitals when they were not sufficiently skilled to work in them. There is a feeling among some of our members that trainees were, in a sense, donated to acute hospitals to staff urgent care departments and ICUs. We also heard from some members that many trainees were moved to acute services without the appropriate training, and that the damage to morale and resiliency that such experiences may have had on the younger parts of the psychiatry workforce should be recognised.

350. We have heard from members that there were more serious staff shortages in MHIDA settings than ever before, with reports of psychiatry losing many junior doctors

to acute settings. In turn, this placed pressure on senior psychiatrists, who were not all confident in carrying out junior medical work.

351. More generally, we have heard from members that while trainees and nurses were initially moved from mental health services to acute services, it was acknowledged later in the pandemic that this group was more vulnerable to Covid-19.

352. Additionally, some of our members found that a significant proportion of senior management had their focus shifted to acute settings. With what felt like the entire focus being on acute care, there was a shift by management away from their own trusts, and this left the next layer of leadership unsupported and unguided without leadership locally. This was indicative of Covid-19 not being seen to affect mental health and only acute care.

Support for NHS staff

353. On 19 March 2020, many members of the RCPsych's Advisory Group provided comments to past RCPsych president, Professor Sir Simon Wessely, for a paper on moral injury for the BMJ. The article outlined that moral injury can be defined as the psychological distress which results from actions, or the lack of them, which violate someone's moral or ethical code. Unlike formal mental health conditions such as depression or PTSD, moral injury is not a mental illness. The authors outlined that those who develop moral injuries are likely to experience negative thoughts about themselves or others – such as, "I am a terrible person" or "my bosses don't care about people's lives" – as well as intense feelings of shame, guilt or disgust. These symptoms can contribute to the development of mental health difficulties, including depression, PTSD and even suicidal ideation. However, it is also the case that some people who have to contend with significant challenges experience a degree of post-traumatic growth.

354. The RCPsych's Presidential Lead for Trauma and the Military also helped to develop a mental health plan for workers of the London Nightingale Hospital. In addition to the physical impact, it specifically covered the fact that Covid-19 was exacting an enormous societal toll. This would have a psychological impact, and those in healthcare faced the additional burden of managing a hitherto unknown virus. The

novel nature of Covid-19 exposed staff to the risk of moral injury. Without adequate support, there was a risk this would develop into mental illness. The mental health lessons from the London Nightingale Hospital were transferrable to many settings.

355. Many of our members working in medical psychotherapy led on their organisations' provision of psychological support to NHS staff across a wide range of settings, including through offering online reflective practice sessions to clinical teams and colleagues, as seen with ICUs and Great Ormond Street Hospital.

356. On 27 April 2020, working with the APPG on Mental Health, we ran a virtual session on Covid-19 and mental health for Parliamentarians and stakeholders. Professor Sir Simon Wessely, a past president of the RCPsych, talked about supporting the mental health of frontline workers and referring to our guidance and Dr Kate Lovett, former Dean at the RCPsych talked about how mental health services were coping with the crisis, referring to the findings of our survey.

357. On 28 April 2020, the RCPsych in Scotland submitted a response to the call for views on the NES crisis response wellbeing resource, emphasising the challenges faced by psychiatrists such as reduced staffing and the difficulties of meeting patient needs during social distancing.

358. On 7 May 2020, the RCPsych began a piece of work on staff wellbeing and a return to the 'new normal'. Ultimately, we called for a phased return to the new normal for NHS staff. We wanted both the Government and NHS providers to put NHS staff mental health – or psychological health – at the centre of their decisions during the 'return to the new normal after the initial peak' phase of the pandemic. We called on the Government to send a clear message to the public that it would take time for NHS services to return to 'normal', as NHS staff would need time to reset before embarking on their normal duties. We also called for NHSEI and HEE to send a clear message to NHS employers that they needed to give their staff sufficient time to reset after the initial peak as not doing so could cause serious psychological harm. Our calls, however, were not adopted.

359. Similarly, in May 2020 the Academy published a document with principles for reintroducing healthcare services, which the RCPsych supported. These principles included that there should be clear messaging to the public stressing the need to seek medical help for serious conditions whilst encouraging appropriate self-care; patients should be offered virtual or remote care where safe and appropriate; through a shared decision making process, patients should be offered evidence-based alternative management options where practical; patients must feel safe and be protected when they need to access direct healthcare in all settings; staff should be enabled, safe and protected to deliver equitable and clinically prioritised care; and staff should be supported and provided with training and education that would ensure adequate preparation of current and future staff to deliver services that meet the needs of the population.

NHS staff support: Scotland

360. Throughout the pandemic, the RCPsych in Scotland engaged with NES on NHS staff wellbeing plans, including through the influencing of general plans and pushing the need for a workforce specialist service in Scotland.

361. On 11 May 2020, the RCPsych in Scotland responded to the Scottish Government, MSPs, and stakeholders to the staff wellbeing announcement, welcoming the recognition of mental health needs for health and social care staff and pointing out that the health and social care workforce had already had significant mental health needs prior to the pandemic and that developing these resources would need to continue moving forward.

362. On 15 May 2020, the Chief People Officer at NHSEI authored a blog and document about freedom to speak up in the NHS. On 2 June 2020, our member survey showed that only 64.4% of all UK respondents, or 64.9% of all England's respondents, responded that they were 'confident' or 'very confident' to raise general Covid-19 concerns in their organisation. These percentages were 56.9% and 57.8% respectively for respondents from minoritised ethnic backgrounds and 69.6% and 70.5% respectively for those not from non-minoritised ethnic backgrounds.

RCPsych influencing

363. We have heard from members that staffing inpatient wards with a minimum number of nurses was challenging; staff anxiety about Covid-19 meant that absenteeism increased, which affected the delivery of both inpatient and community services. This was separate and in addition to the suffering from Covid-19 itself – and the anxiety arising from experiencing it – along with long Covid symptoms. Our members have said that the shortage of medical staff led to services not functioning optimally.

364. On 17 November 2020, the President of the RCPsych at the time, Dr Adrian James, gave oral evidence at a Health and Social Care Select Committee which was looking at increased pressures brought on by Covid-19 and the resilience of services to cope with high levels of staff stress. Dr Adrian James stressed that burnout was a patient safety issue as staff make mistakes when they are not at their best. He advised that mental health was understaffed even before the Covid-19 crisis, which added to pressures. Dr Adrian James stressed the need to expand medical schools and take other actions to increase the number of staff available to help patients.

365. On 21 February 2021, NHS staff mental health and wellbeing hubs had been set up across the country for the purpose of providing health and social care colleagues with rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer was confidential and free of charge for all health and social care staff in England. There was a clear demand for mental health hubs and most initial assessments occurred within a week. The RCPsych has called for more published data to measure the hubs' effectiveness, particularly given that they had different ways of working and varied staff profiles. We heard that many workers were not made aware of the hubs or were hesitant to seek them out. The RCPsych is of the view that the hubs should be embedded in the NHS and social care and standardised across England moving forward. On 27 March 2021, the Covid-19 Mental Health and Wellbeing Recovery Action Plan committed to £30m of funding for mental health hubs, which is equivalent to approximately £30 per NHS staff member. In July 2021, March 2023 and June 2023, we called on the Government to agree to a long-term commitment to fund the hubs, allowing the model to be adapted over time.

366. The RCPsych's Psychiatrists' Support Service ("PSS") increased capacity during the pandemic. This service provides free, rapid, high-quality, and confidential peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties. While we did not observe an increase in contacts with this service during the pandemic, there seemed to be more contacts in post-peak months.

367. We heard from one of our patient and carer representatives, who is both a patient and carer, as well as an NHS worker, who relayed an experience of his care seemingly coming to a halt. We heard how his husband was left in charge of manging his health and social care, which negatively impacted the mental health of both of them. This representative, who was also a carer for his mother, was not digitally literate, and found there to a be a lack of care for her during this time, which also meant increased pressures were placed on him.

368. In May 2022, the RCPsych held a Reflective Practice event with key partner organisations, led by the President at the time, Dr Adrian James, to reflect on the impact of the pandemic on staffing and what might be needed for recovery. A letter was sent to the Chief Medical Officer in England's team, NHSEI and the GMC but we have not yet received a response.

Staff in independent practice

369. To support members who worked in independent practice in England, the RCPsych's Private and Independent Practice Special Interest Group set up regular monthly drop-in meetings. During the first lockdown, the group facilitated two executive members of the SIG to be available at no cost to RCPsych members. The demand for these meetings was significant, and their main focus was to allow a space for independent practitioners to feel less professionally isolated and to provide them with advice on challenges they faced. For example, psychiatrists working in independent practice were not automatically considered as essential workers in some cases, and lacked the systems to confirm their services were as essential as any other in psychiatry. This meant, in some cases, that a child of a self-employed consultant psychiatrist working in independent practice did not automatically get to stay in school during lockdown, with schools advising that they needed confirmation from an employer.

370. We have also heard from members who worked in private hospitals that they experienced inequity in resource allocation. With PPE largely designated for the NHS, staff providing care for NHS patients in private hospitals were often not able to access it. RCPsych members in these situations have expressed the feeling to us that there was no understanding of the reliance of the NHS on the private sector for inpatient care of NHS patients, or the interconnectedness of the two sectors. Our members working as sole practitioners have told us that they had significant difficulty in accessing PPE and had to attempt to source it for themselves, often relying on donations and the goodwill of others, as well as their own creativity, to enable them to continue to see patients.

Minoritised ethnic groups

371. On 14 April 2020, the CMO for England advised medical royal college presidents that the number of people who had died from Covid-19 from minoritised ethnic backgrounds was striking, particularly those who were medical staff. It was suggested that there were likely multiple reasons for this and that more data from PHE was needed. We heard that relative risk looked reasonably high but that it was still unclear whether there was a difference between relative risk and absolute risk.

372. On 24 April 2020, the RCPsych wrote to NICE to ask about the vitamin D trial, which was being led by the Chief Medical Officer at the time. At this time, we were also exploring work with PHE and NHSEI on how primary care data on a patient's background – age, gender, ethnicity, deprivation, medical conditions – might alert us to an increased risk of serious illness from Covid-19.

373. By 29 April 2020, the Chief Medical Officer for England had indicated in our weekly call that it was clear that minoritised ethnic groups were overrepresented in the mortality data. We heard that this effect appeared to be less significant when morbidities had been taken into account, but that it was still there. It was unclear, at the time, whether the cause was genetic, economic, geographical, or another factor.

374. On 13 May 2020, the RCPsych published guidance on risk mitigation for minoritised ethnic staff, which was widely commended and used by other

organisations. On 2 June 2020, our member survey showed that 50.5% of all UK respondents expressed that they were 'confident' or 'very confident' in the processes outlined in the guidance. Minoritised ethnic respondents were less confident than those not from one of these groups, both in the UK (45.4% compared to 53.7%) and England (46.0% compared to 53.7%).

375. PHE's report, *COVID-19: review of disparities in risks and outcomes*, published on 2 June 2020, was widely criticised by minoritised ethnic groups for its lack of analysis and recommendations for action to protect the lives and mitigate risks for minoritised ethnic communities. We were also very concerned about the lack of any reference to mental health and disability more broadly within the review, including, but not limited to, the traumatic levels of grief and/or anxiety experienced by those groups more at risk of Covid-19, including minoritised ethnic communities. Alongside our partners across the Mental Health Policy Group, we called on the UK Government to urgently set out a clear action plan for protecting the lives of and managing the risks for minoritised ethnic communities in response to Covid-19. We also said that the Government should consider the specific impact of Covid-19 on people with mental health problems, including those in minoritised ethnic communities.

IT systems

376. At the pandemic's height, we heard frustrations from our members about the longstanding, unfit for purpose IT systems within the NHS. As such, rapidly switching to remote working and video conferencing was very challenging for many with poor connectivity, systems and hardware.

Conclusions and recommendations

377. **Based on a considered assessment of the information known to us, it is the RCPsych's position that:**

377.1.1. NHSEI and HEE did not provide timely guidance to the NHS given the 9-week delay between NHSEI beginning to develop national Covid-19 workforce guidance and its eventual publication. The reason for the delay was not explained to the RCPsych in our stakeholder meetings, despite us raising it continuously. This delay contributed to

a lack of clarity, direction and leadership for local systems during a critical decision-making period. Additionally, NHSEI and HEE did not include the PPE posters for mental health services in this set of guidance, which represented further misalignment between the NHSEI IPC Cell and the MHLDA Covid-19 Response Cell at NHSEI. Despite NHSEI outlining this as their intention, by the time the workforce guidance was published, the PPE posters were not going to have any added value to providers, given they had been managing the situation for more than two months. They needed and requested guidance within the first few weeks of the pandemic.

377.1.2. HEE and NHSEI did not adequately consider: during the early stages of the pandemic, the extent to which Core Training in Psychiatry (CT1 and CT2) junior staff were redeployed to medical wards; whether they received sufficient training to do so and, subsequently, the potential impacts this may have had on the future psychiatry workforce; whether junior staff were given the opportunity to catch up on psychiatry training missed; and any associated impacts resulting in gaps in skills, knowledge and experience.

377.1.3. HEE did not adequately consider the impact of the pandemic on the morale of trainees.

377.1.4. DHSC, NHSEI and HEE adequately considered the extent to which staff working in mental health care settings faced, and continue to face, workplace stress, domestic pressures, traumatic exposure and moral distress as a result of the pandemic, and whether steps had been taken to address this range of stressors.

377.1.5. NHSEI and HEE should consider whether they could have done more during the first wave of the pandemic to encourage NHS staff to speak up or 'whistleblow', given only 64.9% of all England's respondents of our member survey communicated that they were

'confident' or 'very confident' to raise general Covid-19 concerns in their organisation.

377.1.6. NHSEI adequately considered the wellbeing of staff (both mental and physical) and established NHS staff health and wellbeing hubs across the country with new funding. However, the sustainability of the hubs should have been considered from the outset, as funding for all the hubs has not continued.

377.1.7. PHE and NHSEI did not satisfactorily mitigate the risk of healthcare workers from minoritised ethnic groups becoming unwell and dying from Covid-19 while working in MHIDA settings. We were the first medical royal college to produce guidance on risk mitigation for minoritised ethic staff in mental health care settings.

377.1.8. The CMO for England identified the risks of Covid-19 for minoritised ethnic groups on 14 April 2020, but PHE's report, COVID-19: review of disparities in risks and outcomes, published on 2 June 2020, was widely criticised for its lack of analysis and recommendations for action to protect the lives and mitigate risks for minoritised ethnic communities.

378. **Based on the positioning outlined above, the RCPsych makes the following recommendations with respect to the protection of healthcare professionals:**

378.1.1. During a comparable Level 4 Incident, NHSE must ensure there is sufficient priority and resource provision within the MHIDA directorate that enables the team to respond in a timely manner, and in a way that is commensurate with other healthcare sectors, and to develop guidance that is relevant, valid and reliable to those that are working across the MHIDA sector.

378.1.2. NHSE should review their workforce and redeployment preparedness plans in the event of a contagious outbreak and seek to

learn lessons from the Covid-19 pandemic, specifically with regards to the points we have made about Core Training in Psychiatry (CT1 and CT2) junior staff.

378.1.3. NHSE should review the leadership and culture across NHS trusts and the whistleblowing policies and guidance, and specifically consider the points we have made about NHS staff feeling able to raise general COVID-19 concerns in their organisation.

378.1.4. The UK Government and DHSC should commit to funding the NHS staff health and wellbeing hubs in the immediate to short term, meaning that for 2023/24 to 2024/25, services provided by the hubs will continue to be developed as part of a national initiative, before they are devolved into ICSs and individual providers. In that way, the second phase of their development would be owned by local staff and services, and they could be further developed to reflect local patterns of need. Over time, we also want to see the hubs evolve in terms of their roles and responsibilities.

378.1.5. In any similar event, the UK Government should immediately set out a clear action plan for protecting the lives of, and managing the risks for, minoritised ethnic groups in response to Covid-19. It should also consider the specific impact of Covid-19 on people with mental health problems, including those in minoritised ethnic communities.

378.1.6. NHSE should ensure inequalities are considered proactively across all NHS settings and NHS organisations should work to embed a focus on equality and diversity in the workplace.

378.1.7. The UK Government, DHSC and NHSE should introduce, as soon as possible, an investment standard for capital estate allocations to ensure funding is fairly apportioned to mental health improvement schemes – both across ICBs and nationally – so that those working in

mental health settings have access to IT as well as the equipment they need to do their jobs effectively and efficiently.

Recovery and restoration of NHS services

379. When I first started my career, it was not uncommon for me to be working 110 hours a week. In my very first days of being a doctor, I can vividly recall being on call for five days in a row and not seeing my own bed once. I never thought that I would work like that again. The early days of the pandemic, however, were worse, and working on the frontline throughout this period was a relentless experience. On one hand, it felt as though we were working in a vacuum. On the other hand, the impact these experiences have had on psychiatrists and other healthcare staff are still being felt today.

Planning

380. On 7 May 2020, DHSC advised the RCPsych that it was setting up a group to develop a post-Covid-19 mental health strategy which was to be launched during Mental Health Awareness Week.

381. In May 2020, the College published a report, *Going for Growth*, an outline of an NHS staff recovery plan following the first outbreak of Covid-19. The plan noted that there was good evidence from scientifically conducted reviews that the most predictive risk factors for the onset of post-traumatic mental ill-health are those which operate after the traumatic incident is over. While efforts to prepare and sustain staff 'fighting' Covid-19 are important, the paper noted, dealing effectively with the period after the most intense Covid-19 work is likely to be more critical in terms of reducing the likelihood that staff will become unwell whilst increasing the likelihood that staff will experience post-traumatic growth. During this 'post' period staff may reflect on what has gone on and develop a narrative that makes sense to them which may in turn reduce the chance they will suffer with moral injuries which have been highlighted as a particular risk during the current crisis.

382. On 9 October 2020, DHSC issued a press release announcing the investment of £500m to end dorm accommodation.

383. On 17 November 2020, Dr Adrian James, the RCPsych President at the time, joined other medical royal college presidents in their regular catch up with Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care. Dr Adrian James was given the first slot at this meeting to talk about mental health, which allowed him to stress the link between the pandemic and the increasing demand on mental health. The Secretary of State seemed receptive to Dr Adrian James's points, including the proposal to extend NHSEI's existing hospital discharge programme to include mental health providers so that patients could benefit from health and social care support for 6 weeks post discharge.

384. That same day, Dr Adrian James presented to the aforementioned APPG for Mental Health on Covid-19 and mental health. At the meeting, Dr Adrian James talked about the experiences of our members during the first wave who reported a rise in urgent and emergency work, as well as recent NHSD figures that showed there had been more contacts with mental health services than ever before. He stressed the importance of investing in mental health services in the upcoming spending review.

385. On 1 April 2021, DHSC published its Covid-19 mental health and wellbeing recovery action plan, authored by the Rt Hon Nadine Dorries MP, Minister for Patient Safety, Suicide Prevention and Mental Health and the Rt Hon Penny Mordaunt MP, Paymaster General. The objectives for Covid-19 recovery in the plan were threefold:

- to support the general population to take action and look after their mental wellbeing
- to prevent the onset of mental health difficulties, by taking action to address the factors which play a crucial role in shaping mental health and wellbeing outcomes for adults and children
- to support services to continue to expand and transform to meet the needs of people who require specialist support.

386. This plan was backed by the £500m of funding announced at the previous Spending Review and included action on areas such as the acceleration of NHS service expansion, one-off initiatives to support groups which had been adversely impacted by the pandemic, and a continued focus on cross-government approaches to mental health. We understood £189m of this funding was to accelerate the delivery of key mental health commitments of the NHS Long Term Plan in 2021/22; £111m was for dedicated funding to support workforce growth; £170m was for action to tackle critical backlogs as a result of the pandemic; £15m was for early intervention and prevention; and the rest was reserved.

387. The plan was published alongside the National Suicide Prevention Strategy Progress Report and associated Cross-Government Workplan. This was the fifth progress report against the National Suicide Prevention Strategy for England and sets out data and trends on suicide and self-harm, progress against existing commitments, and crucially, further actions Government has and will be taking to reduce suicide and self-harm as far as possible. This includes £5m which will be made available to support the suicide prevention VCSE.

388. Comparatively, on 8 February 2022, NHSEI published a delivery plan for tackling the Covid-19 backlog of elective care. This plan set out a number of ambitions, including to eliminate the waits for elective care lasting longer than a year by March 2025. According to the plan, by July 2022, no one would wait longer than two years for elective care, with the following aims being to eliminate waits of over 18 months by April 2023, and of over 65 weeks by March 2024. Long-waiting patients would be offered further choice about their care, and over time, as the NHS brings down the longest waits from over two years to under one year, this would be offered sooner. Diagnostic tests would be a key part of many elective care pathways, with the ambition being that 95% of patients needing a diagnostic test would receive it within 6 weeks by March 2025. Within this plan, it is made clear that it does not extend to mental health services, which would be addressed by teams across the NHS and social care, and in other such plans. To support elective recovery the government planned to spend more than £8bn from 2022/23 to 2024/25, supported by a £5.9bn investment in capital for new beds, equipment and technology. This is in addition to the £2bn Elective Recovery Fund and £700m Targeted Investment Fund ("TIF") already made available

to systems to help drive up and protect elective activity. A significant part of this funding would also be invested in staff – both in terms of capacity and skills.

389. Similarly, on 9 May 2022, NHSEI published its delivery plan for recovering access to primary care. The plan's two central ambitions were to tackle the 8am rush and reduce the number of people struggling to contact their GP, and for patients to know on the day they that contacted their practice how their request would be managed. This plan was backed by £645m over two years to expand services offered by community pharmacy, a retargeting of over £240m of funding in 2023/24 for new technologies and support offers for primary care networks ("PCNs"), and £246m of the streamlined Impact and Investment Fund that would go towards improving access.

390. Furthermore, in January 2023, DHSC and NHSEI published their delivery plan for recovering urgent and emergency services. The aims of the plan were to increase capacity to help hospitals with increasing pressures, secure new beds and over 800 ambulances (including 100 specialist mental health ambulances) and to make urgent mental health support through the NHS 111 service universally available by April 2024. The Government backed this plan with £1bn to build urgent and emergency care capacity, £150m capital funding to support mental health urgent and emergency care and £1.6bn of additional social care discharge funding to be pooled into the Better Care Fund.

391. Therefore, while the publication of the *Covid-19 mental health and wellbeing recovery action plan* and the additional £500m invested in 2021/22 seemed to indicate the Government's understanding of the mental health impact of the pandemic, we felt this risked being a short-term sticking plaster in the face of an unprecedented increase in demand that would stretch far beyond the end of that financial year, and that one-off investments would not allow services to make longer-term plans.

392. As the Health and Social Care Select Committee raised at the end of 2021, there was no clarity as to whether any of the additional revenue funding announced for the NHS last autumn would be spent on mental health, despite around £7.5bn of "NHS recovery funding" still being unallocated. In this context, it is concerning to see that despite the Long Term Plan commitments, the overall proportion of the NHS budget going to mental health has fallen for three years running, with the total proportion of

NHS England's Revenue Departmental Expenditure Limit spent on mental health (CCG+NHSEI) having dropped from 11.10% in 2018/19 to just 9.94% in 2021/22.

393. Therefore, as it stands, it seems that the scale of the UK Government's ambition for mental health is failing to keep up with the scale of the post-pandemic challenge. Already at breaking point, the mental health workforce will be stretched even further as it struggles to meet increasing demand while also being asked to transform services without any additional funding other than the much-welcomed Long Term Plan funding, which is predicated on pre-pandemic predictions of need.

Wales

394. In Wales, from early 2021 until June 2021, the RCPsych in Wales issued a series of regular briefings to the Welsh Government's mental health and vulnerable groups division on the impacts of Covid and the opportunities to inform Covid recovery. We issued the following guidance with Technology Enabled Care ("TEC") Cymru in March 2021: *Home Working Guide: Promoting Mental & Physical Health.*

395. On 22 November 2021, the RCPsych in Wales wrote to the Chief Executive of Health Education and Improvement Wales ("HEIW") to highlight the need for the mental health workforce plan to take into greater consideration the impact that Covid-19 would have upon the workforce, and how this needed to be considered within the context of the development of the workforce plan. In December 2021, we submitted a report to HEIW in advance of the consultation for the development of the Strategic Mental Health Workforce Plan for Health and Social Care.

Scotland

396. In Scotland, in October 2020, the Scottish Government published their document titled, *Coronavirus (Covid-19): Mental health transition and recovery plan*. The plan outlined the Scottish Government's response to the mental health impacts of Covid-19 and addressed the challenges on mental health arising from the pandemic. The RCPsych in Scotland had been consulted by the Scottish Government on this plan and had provided feedback to ensure that mental health services were prioritised and funded.

397. In September 2021, the RCPsych in Scotland sent a letter about ongoing mental health service capacity issues caused by the pandemic to Scotland's Cabinet Secretary for Health and Sport, Minister for Mental Wellbeing and Social Care, Chief Nursing and Medical Officers, Principal Medical Officer, Chief Executive of the Mental Welfare Commission, NHS Health Board Chairs and Chief Executives, and IJB Chief Officers.

Referrals, admissions and hospitalisations

398. Only around one in three people with a mental illness were receiving some form of treatment even prior to the Covid-19 pandemic, and there has been a significant growth in demand since then.

399. Mental health services in England received a record 4.7 million referrals during 2021–22 as the pandemic continued to take a toll on people's mental health. This figure is substantially greater than the number of referrals for 2019-20 (4.0 million) and 2020–21 (3.9 million) by 17.5% and 20.5% respectively.[24] During this time, individuals were receiving treatment for conditions including addiction, anxiety, depression, eating disorders, and PTSD.

400. The particularly striking growth in referrals has been seen in CYPMHS, with 1.2 million in 2021–22 compared to 0.88 million in 2020–21 (40.6% increase) and 0.66 million in 2019–20 (87.0% increase).[25] 470,499 children and young people (aged 0 to 18 years) were in contact with mental health services in March 2022 compared with 339,850 in March 2019, the year before the pandemic, and 384,581 in March 2020, at the start of the pandemic. This equates to increases of 38.4% over three years and 22.3% over two years. The proportion of children and young people among the total number of people in contact with mental health services has increased from 26.5% in

[24] NHS Digital, Mental health referrals (by month and by year), 6 January 2023
[25] NHS Digital, Mental health referrals (by month and by year), 6 January 2023

March 2019 to 32.7% in March 2022.[26,27,28] Two surveys[29-30] conducted – one in April/May 2020 and the other in February/March 2021 – by the European Society for Child and Adolescent Psychiatry point out that, although specialist CYPMHS were not meeting clinical demand before Covid-19, waiting lists have only increased due to the rise in referrals.

401. The pandemic had a substantial impact on the perinatal mental health programme. In the year to March 2020, 30,625 women accessed specialist perinatal care in the community compared to the NHS Long Term Plan objective of 32,000, which equates to 96% attainment. Progress, however, stalled in the subsequent year and while access expanded again in 2021/22 there were 43,656 women accessing perinatal services, compared to the NHS Long Term Plan goal of 57,000 for that year (77% attainment). The most recently available data for the year to June 2022 showed a slight increase to 45,411, which equates to 80% of the expectation for 2021/22 or 69% of the expectation for the end of 2022/23.[31-32]

402. Regarding the NHS Talking Therapies/Improving Access to Psychological Therapies Programme ("IAPT"), from April 2020 to December 2022, the 50% recovery rate target was achieved in only five quarters for all patients and in only one quarter for patients of minoritised ethnic backgrounds. Only 1.248 million patients started treatment over the course of 2021/22 compared to the Long Term Plan goal of 1.6 million. Moreover, the number of patients commencing treatment in the first three quarters of 2022/23 (April-December) was 0.896 million compared to 0.926 million in

[26] NHS Digital, Mental Health Services Monthly Statistics, Final March, 13 June 2019
[27] NHS Digital, Mental Health Services Monthly Statistics, Final March 2020, 11 June 2020
[28] NHS Digital, Mental Health Services Monthly Statistics, Final March, 9 June 2022
[29] Revet A, Hebebrand J, Anagnostopoulos D. et al. ESCAP CovCAP survey of heads of academic departments to assess the perceived initial (April/May 2020) impact of the COVID-19 pandemic on child and adolescent psychiatry services. *Eur Child Adolesc Psychiatry.* 2022;(31):795–804.
[30] Revet A, Hebebrand J, Anagnostopoulos D. *et al.* Perceived impact of the COVID-19 pandemic on child and adolescent psychiatric services after 1 year (February/March 2021): ESCAP CovCAP survey. *Eur Child Adolesc Psychiatry*. 2023;(32): 249–256.
[31] NHS England, NHS mental health dashboard, 2020-2022
[32] NHS England, NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019

the corresponding period of 2021/22, implying that the gap against Long Term Plan goals (1.8 million for 2022/23) is set to widen further this year.[33-34]

403. For Early Intervention in Psychosis ("EIP"), the referral to treatment target for at least 60% of patients to commence treatment within two weeks has been consistently met for several years, however concerns remain about the NICE concordance of the care provided. The NHS Mental Health Dashboard confirms only 44% of EIP services were rated as concordant with NICE Level 3 in 2021/22, as opposed to The Five Year Forward View for Mental Health ("FYFVMH") objective of 60% by 2020/21 or the Long Term Plan objective of 70% by 2021/22 (rising to 95% by 2023/24).[35-36] The waiting time target also appears to be set too low to incentivise performance, given it hasn't increased since 2021 and isn't set to rise for the remainder of the initial Long Term Plan period.

404. The practice of inappropriate out of area placements ("OAPs") for adult patients in acute care was meant to have been eliminated from services by the end of March 2021. However, at the end of December 2022, 565 patients remained inappropriately out of area for their treatment and, over the three months from October-December 2022, 56,305 bed days were taken up with inappropriate OAPs (only 4.1% below the level of the same period in 2021).[37] The dataset that illustrates the scale of this problem is consistently missing responses from around a quarter of NHS mental health trusts, bringing the reliability of the reports into question. Moreover, there is still no data published on the scale of inappropriate OAPs for children and young people or a target date set for their elimination. The RCPsych has consistently advocated for robust capacity assessments in each ICS area, with targeted support provided to those areas with consistently poor performance, including additional inpatient beds where necessary, as well as enhanced community or social care support.

405. The measure for establishing the expansion of children and young people mental health access has changed during the NHS Long Term Plan period and is now based

[33] NHS Digital, Psychological Therapies, Reports on the use of IAPT services, 2020-2023
[34] NHS England, NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019
[35] NHS England, NHS mental health dashboard, 2020-2022
[36] NHS England, NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019
[37] NHS Digital, Out of Area Placements in Mental Health Services, 2021-2022

on only one contact with services. On this basis, in the year to June 2022, 691,935 under 18s received at least one contact with services, an increase of 177,971 on the baseline number for the planned expansion of 254,000 more 0–25-year-olds by March 2023.[38-39] 18–24-year-old access data is yet to be included in the Mental Health Monthly Statistics from NHSD.

406. For children and young people with eating disorders, performance against the 95% waiting time standards peaked in the first quarter of 2020/21 for urgent cases (87.8% started treatment within 1 week) and in the second quarter of 2020/21 (89.6% started treatment within 4 weeks). The Covid-19 pandemic period saw demand for children and young people eating disorder services increase substantially, with a concurrent decline in performance against both waiting time targets.

406.1. There were 2,632 completed urgent pathways across 2021/22 compared to 1,373 in 2019/20 (91.7% increase) and 9,825 completed routine pathways in 2021/22 compared to 6,661 in 2019/20 (47.5% increase).

406.2. Performance against the urgent and routine targets fell as low as 59.0% in Q3 2021/22 and 64.1% in Q4 2021/22 respectively. In the most recent complete data for Q1 2022/23, it was also reported that 102 out of 229 (44.5%) of those still waiting for urgent treatment had been waiting for more than 12 weeks.

406.3. This can be compared to the report that only 2 of 18 of those still waiting for urgent treatment had been waiting for more than 12 weeks in the quarter immediately preceding the pandemic (Jan-March 2020).[40]

407. The number of people with an SMI receiving a complete physical health check (comprising of alcohol, blood glucose, blood lipid, blood pressure, BMI weight and smoking tests) on a rolling annual basis fell as low as 110,530 over the 2020 calendar year in comparison to a FYFVMH target of 280,000 for the 2020/21 financial year. The provision of this full complement of physical health checks is an essential preventative

[38] NHS England, NHS mental health dashboard, 2020-2022
[39] NHS England, NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019
[40] NHS England, Mental Health: Children and Young People with an Eating Disorder Waiting Times, 2019-2022

tool for a patient group that typically dies up to 15–20 years earlier than the average. However, there has been substantial improvement in the performance of this programme, with the most recent data for the 2022 calendar year showing that 256,256 people received a complete set of checks. While this remains at 74% of the original NHS Long Term Plan target for 2022/23 of 346,000, the success in attaining a 132% increase in complete checks in just two years should be acknowledged.[41-42]

408. While the delivery of 'Core 24 services' was found to be slightly behind schedule prior to the Covid-19 pandemic (35% coverage in 2019/20 compared to the FYFVMH ambition for 40%, NHS England have reported that 64% of hospitals in England now meet the 'Core 24' standard in 2022/23, in line with the NHS Long Term Plan objective for this period.[43] 92% of general acute hospitals are also now offering adult liaison services on a 24/7 basis, compared to 78% pre-pandemic.[44]

409. Mental health social care is essential, but it is not well understood or recognised in a way that translates to appropriate levels of funding being invested. Mental health social care supports people of all ages who live with an SMI. It does this through advice, community support and social care crisis services, statutory roles including advocates and mental health social workers, and mechanisms including direct payments. Local authorities and mental health social care providers work with partners in the NHS to prevent unnecessary admissions and to reduce both the length of hospital stays and inappropriate OAPs. Failing to invest in social services is a false economy that harms patients. For example, according to NHS England data from July 2022, 57% of instances of delayed discharges in mental health hospitals were due to a lack of available social care provision. We are pleased that the *Better Care Fund policy framework 2023 to 2025* highlighted that mental health should be considered on an equal footing to physical health when decisions are made on the use of the funding.

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[41] NHS England, Mental Health: Physical Health Checks for people with Severe Mental Illness, 2020-2022
[42] NHS England, NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019
[43] NHS England, Report of the 4th Survey of Liaison Psychiatry in England, 16 July 2019
[44] Health Service Journal, Large hospital trusts still missing key crisis support in A&E, 23 August 2022

410. Based on recent data, NHSE have estimated that 1.395 million people were waiting for their second contact from community mental health and intellectual disability services at the end of March 2023, which is 10.8% more than a year prior.

411. NHSE have separately estimated that 222,000 people with an SMI are 'eligible but 'waiting for all 6 components of a physical health check in the last 12 months', as of the end of March 2023.

412. The mortality gap between those living with severe mental illness and the rest of the population is widening. Over a 3-year period from 2015 to 2017, adults with severe mental illness were 4.6 times more likely to die before the age of 75 than those without a severe mental illness; in 2018 to 2020, this increased to 4.9 times.

413. At the end of May 2023, there were 10,218.7 FTE psychiatrists (at all grades) in England, equating to 17.9 psychiatrists in post per population of 100,000 people, or 5,579 people per psychiatrist. Analysis of NHS workforce statistics shows a growth of only 6.3% (from 4,189 to 4,452) in the number of FTE consultant psychiatrists working in the NHS across England over a 10-year period between May 2013 and May 2023. In contrast, there was a 44.5% increase for all consultants in other specialties combined (34,952 to 50,512), 7 times greater than the figure for psychiatry. Over the same period, there was an 83.1% increase in both emergency medicine consultants (1,324 to 2,424) and respiratory medicine consultants (751 to 1,375) and a 70.7% increase in gastro-enterology consultants (893 to 1,524).

414. Based on NHSE targets to expand the workforce from 2016 onwards, there is a shortfall of 688.1 FTE consultant psychiatrists across England. As stated in the NHS's Step*ping forward to 2020/21: the mental health workforce plan for England* and the *NHS Mental Health Implementation Plan 2019/20–2023/24*, NHSE set a target to have an additional 910 consultant psychiatrists in post by March 2023. However, in the 7 years leading up to March 2023, only 221.9 FTE consultants were added to the workforce.

415. The latest NHS vacancy data for the quarter to June 2023 showed that 15.2% of mental health medical posts were vacant, the highest on record dating back to the start

of 2018/19. In comparison, the data for this quarter showed that 6.5% of acute sector medical posts were vacant. The disparity has grown markedly over the past five years, as demonstrated by the vacancy rates for the quarter to June 2018, which were 12.3% and 9.4% respectively.

416. Almost one in five mental health nursing posts were vacant across England in the quarter to June 2023 (19.1%) compared with the vacancy rate of acute nursing posts in this quarter, which was 8.6%. The South East has the highest rate at close to 1 in 4 (24.4%), followed by London (20.5%) and the East of England (19.4%).

Population level impacts on children and young people

417. For children aged 7 to 16 years, rates of probable mental disorder were 16.7% in 2020, 17.8% in 2021, and 18.0% in 2022. For young people aged 17 to 19 years, rates of probable mental disorder were 17.7% in 2020 and 17.4% in 2021, but increased to 25.7% in 2022. The Strengths and Difficulties Questionnaire was adopted by NHSE to identify children who were likely to have a mental disorder, i.e., children who may have had issues with their mental health to such an extent that it impacted their daily lives (the results of which can be found in their collection of mental health of children and young people surveys).

418. These issues may have included any difficulties with emotions, behaviour, relationships, hyperactivity, or concentration. Responses from parents and children were analysed to estimate the likelihood that the child had a 'probable mental disorder'.

419. Lockdowns, financial stress affecting families, and bereavement during the period were particularly impactful on children and young people. The closure of schools in particular, while a necessary public health measure during the acute phases of the pandemic, had a profound effect on children. Schools are an important source of support. They give children and young people the opportunity to see friends and trusted adults, and families are able to receive support from teachers.

420. The loss of contact with trusted adults and the sustained inability to access activities outside the home affected all children and young people during the period, but those more vulnerable were at a higher risk for developing clinical conditions, such

as anxiety and mood-based disorders, eating disorders and disordered eating, and self-harm and suicidality, with the effects of school closures and withdrawal of some vital support services during the pandemic still being felt.

421. Our members heard that parents and some young people felt that keeping such facilities open should be a priority because children with intellectual disabilities are already disadvantaged; the closure of such facilities further compounds the disadvantage, making it even more difficult for both young people and their parents. Finally, a high proportion of parents reported poor mental health to our members, as well as high stress and anxiety levels.

422. Both the physical and mental health and wellbeing of young people with special educational needs and disabilities ("SEND") were impacted by the pandemic and the associated measures put in place, including lockdowns. For parents, school closures removed one of the few respite opportunities they had to recharge and attend to their own needs, as well as those of other family members. We heard from our members that many parents of children with SEND felt they reached a breaking point during the first period of school closures in spring and summer 2020.

423. However, we also heard from our members that lockdown measures had some positive impacts with respect to education for some children; for example, those who found attending school stressful felt more at ease being at home and away from the pressure to adhere to strict measures. Additionally, those who found social situations with peers difficult were relieved at the prospect of learning from home, with older young people reporting that having more time to concentrate on their studies was a positive thing, particularly as extra-curricular activities were cancelled or postponed. Some of our young patients, particularly those with an intellectual disability and/or autistic children and young people for whom school can be stressful, found that lockdown made life easier. When school returned, however, we heard that there was an increase in the stress levels of these children. We are also aware of a significant number of children and young people who have not made it back to school since the lockdowns were eased. Our members have advised that many children with severe neurodevelopmental conditions have not fully recovered from the prolonged loss of routine, structure, and predictability, and that some support services have simply not

returned. It is important to note, however, that certain levels of anxiety are to be expected when a young person has not been in school for six months.

424. While pandemic and mitigation approaches, including lockdowns and school closures, are widely thought to have negatively impacted children and young people's mental health, the impact on those who have been clinically referred is less clear. In January 2023, some of our members published a Standardised Diagnostic Assessment ("STADIA") for children and young people with emotional difficulties in the *European Child & Adolescent Psychiatry Journal ('Mental health in clinically referred children and young people before and during the Covid-19 pandemic')*, which looked at the mental health of over 1,000 non-urgent, clinically referred children and young people. The study found that there were greater levels of mental health difficulties after these children and young people returned to school following lockdowns and school closures. The findings indicate that children and young people who had been clinically referred experienced higher levels of clinically significant difficulties after schools re-opened and thus may have had greater stresses in the adjustment period when re-starting school, in comparison with children who were not clinically referred.

Workforce growth

425. In the mental health sector specifically, being able to recruit enough skilled staff to meet the needs of patients was already an urgent and substantial challenge before the pandemic. The recruitment and retention of staff has been widely recognised as the most significant risk to the delivery of mental health commitments in the NHS Long Term Plan as well as to achieving parity of esteem. While the RCPsych recognises, and welcomes, the recent announcement of a Long Term Workforce Plan, the Government must continue to take the lead on building a sustainable mental health workforce across the mental health and social care sectors, which can deliver the mental health services we deserve. This requires commensurate additional funding and not just reallocations from existing stretched budgets.

426. CYPMHSs are predominantly staffed by women who often carry the main share of any caring responsibilities in their own lives. As such, staff working in these services during the pandemic were more likely to be affected by the requirement to homeschool children and look after elderly and frail relatives, in addition to attempting to continue

with their clinical work. We heard from our members that many staff working in CYPMHS opted to reduce their workload or leave the service during or in the aftermath of the pandemic. This has placed further workforce constraints and pressures on the service.

Post-Covid Syndrome

427. On 28 May 2020, the first Seacole Centre opened as the NHS expanded its Covid-19 rehabilitation services (which included increasing its number of mental health experts).

428. On 1 November 2020, NICE, the Scottish Intercollegiate Guidelines Network ("SIGN") and RCGP published the final scope for their guideline their final scope of guideline on Post-Covid Syndrome. While there was a member of the guideline committee with psychiatric experience, the College did have to push for such psychiatric involvement at the time.

429. On 17 November 2020, NHSEI advised the RCPsych of its plans to set up at least 44 Post-Covid Syndrome/Long Covid clinics around England (one for each ICS) and to have Systematized Nomenclature of Medicine Clinical Terms ("SNOMED CT") codes for 'Long COVID' available from early December so they can more easily track and analyse data. A representative from NICE said that they planned to publish guidelines on Post-Covid Syndrome between 14 and 18 December 2020.

430. In March 2021, a member delegation from the RCPsych in Northern Ireland attended a meeting on Long Covid with Public Health Agency Officials. The Officials were extremely receptive to the College's expertise in this area and expressed the need for the RCPsych in Northern Ireland to be involved in a Long Covid Reference Group which, at the time, was very encouraging as it showed that the role of psychiatry was regarded as having a valued place in this important discussion. However, following this initial meeting, we were not involved in the development of the Long Covid service in Northern Ireland, which was disappointing.

431. We have heard from members that sufficient and systematic longer term Long Covid monitoring has not been carried out for people with intellectual disability. This

is, in part, because Long Covid services did not explicitly consider the intellectual disability patient group when first implemented. Our members have, however, found that such services have been open to discussion on this matter when approached. While people with intellectual disability are not excluded from Long Covid services, the level of reasonable adjustment needed to support them effectively is not currently known. We have heard from our members that, much like the significant amount of funding that was initially needed for research into Covid-19, a similar investment is now needed for research into Long Covid, particularly for its impact on vulnerable and neglected groups.

432. We have heard from members that, given that many caught Covid-19 at work, thought should be given as to whether Post-Covid Syndrome – the symptoms of which include anxiety, tiredness and low mood – should be considered as an occupational illness.

Research agenda and funding

433. Research funding is a key input to the mental health ecosystem. By setting funding levels and designing funding programmes, policy makers and statutory, charitable and commercial research funders directly influence what kind of research is being done, where, by whom, and at what scale and pace. Existing analyses have generally concluded that mental health research is underfunded relative to the burden of disease and have found that considerable gaps exist in the funding landscape.

434. Randomised controlled trials ("RCTs") that our members were running or involved in had to be terminated due to the pandemic and associated difficulties in recruiting patients. One of our members, who was involved with the first ever RCT of clozapine which was looking at its use in the treatment of borderline personality disorder, said that this trial had to be terminated early due to poor recruitment. The trial had been funded by the National Institute for Health Research ("NIHR").

435. Mental health has had a decade of sub-par funding compared to its physical health counterpart, resulting in drag and lag in the development of new drugs, digital therapeutics, and clinical treatments for mental health conditions, as well as a paucity of high-quality research into social interventions.

436. The Covid-19 pandemic has highlighted the long-term value of research investment. Building on the Government's *Life Sciences Vision*, there should be prioritisation of research and innovation to drive advancements in public mental health and care. Allocating funding for research studies, clinical trials, and technology-driven solutions can facilitate the development of evidence-based practices, improved treatment modalities, and innovative interventions. Collaboration between academia, healthcare providers, and industry can accelerate progress in understanding mental health conditions and developing more effective interventions.

Conclusions and recommendations

437. **Based on a considered assessment of the information known to us, it is the RCPsych's position that:**

437.1. **There was early recognition from DHSC, after the first wave of the pandemic, that the mental health of the nation was going to be challenged and a strategy was needed. Work began quickly and the RCPsych was engaged throughout.**

437.2. **Since DHSC's publication of '*Covid-19 mental health and wellbeing recovery action plan'* in April 2021, we saw the publication of several other major government strategies, which set out plans for our recovery from Covid-19, including the NHS elective backlog strategy, and its strategies for primary care and urgent and emergency care. While the publication of the mental health and recovery plan and the additional £500m invested in 2021/22 seemed to indicate the Government's understanding of the significant mental health impact of the pandemic, we know now these actions risk becoming short-term sticking plasters in the face of an unprecedented increase in demand which would stretch far beyond the end of that financial year. Given the multi-year plans and financial commitments in other areas of healthcare, it is our view that this demonstrates a continued lack of parity of esteem between mental and physical health services.**

437.3. **NHSEI sufficiently included psychiatric expertise in the development of Post-Covid Condition pathways and clinics, but this was not initially forthcoming.**

437.4. **DHSC did not adequately consider the major logistical challenges in conducting mental health research and education during the pandemic and has not put a plan in place to mitigate the negative ongoing impact.**

437.5. **Just as with public health investment, we cannot say that a greater understanding and appreciation for mental health during the pandemic has translated into priority, resource provision and funding from the Government.**

437.6. **In fact, NHS MHIDA services are no better prepared now than they were in March 2020. For instance:**

437.6.1. NHSE have estimated that 1.395 million people were waiting for their second contact from community mental health and learning disability services at the end of March 2023, 10.8% more than a year prior.

437.6.2. The mortality gap between those living with severe mental illness and the rest of the population is widening. Over a 3-year period from 2015 to 2017, adults with severe mental illness were 4.6 times more likely to die before the age of 75 than those without a severe mental illness; in 2018 to 2020, this increased to 4.9 times.[45]

437.6.3. Based on NHSE targets to expand the workforce from 2016 onwards, there is a shortfall of 688.1 of FTE consultant psychiatrists across England. The latest NHS vacancy data for the quarter to June 2023 showed that 15.2% of mental health medical posts were vacant, the highest on record dating back to the start of 2018/19, while 6.5% of acute medical posts were vacant in this quarter. The disparity has grown markedly over the past five years, with vacancy rates being

[45] Office for Health Improvement and Disparities, Premature mortality in adults with severe mental illness (SMI).

12.3% and 9.4% respectively in the quarter to June 2018. Almost one in five mental health nursing posts were vacant across England in the quarter to June 2023 (19.1%) compared to 8.6% of acute nursing posts.

438. **Based on the positioning outlined above, the RCPsych makes the following recommendations with respect to recovery and restoration of MHIDA services:**

438.1. **The Government should establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation as part of the long-term recovery from the pandemic.**

438.2. **DHSC and NHSE need to publish a detailed statement outlining what achieving full 'parity of esteem' means in England. As part of this detailed roadmap to achieving parity of esteem, DHSC and NHSE should set out the trajectory for access and waiting time standards for mental health services, including recovery from the impact of the Covid-19 pandemic; increasing coverage of mental health services and services that prevent mental illness; improving service standards, staffing models and workforce requirements; data collection and reporting requirements; and funding requirements, both in terms of revenue and capital growth. DHSC and NHSE should publish this roadmap by early 2024, which should include both NHS and cross-government action. As part of their detailed statement for and roadmap to achieving parity of esteem in England, DHSC and NHSE should also outline publicly the extent to which the plan would enable the Government to achieve, or be on track to achieve, the following United Nations Sustainable Development Goals by 2030: delivering universal health coverage for the treatment of mental disorders, prevention of mental disorders and promotion of mental wellbeing; reducing premature mortality from mental disorders and illness by one-third (through prevention and treatment, and promoting mental health and wellbeing); and providing universal access to quality essential health care services so that and strengthening the prevention and treatment of substance abuse and harmful use of alcohol.**

438.3. **DHSC should follow through on its recent commitment to implement a 'mental health and wellbeing impact assessment tool'. This will support policymakers across government to consider the mental health and wellbeing impacts of all policies without undue burden. Initially, this will be used to develop cross-government policies for the major conditions strategy, before further policy roll-out.**

438.4. **The Government should appoint an Equalities Champion for Mental Health, Learning Disabilities and Autism to work across government, reporting to the Cabinet Office Minister and with dedicated staff and resourcing.**

438.5. **DHSC and NHSE should continue the Mental Health Investment Standard ("MHIS") to ensure that every integrated care board ("ICB") invests an increasing proportion of its spending on mental health services, and an even greater proportion on support for children and young people.**

438.6. **The UK Government should provide greater resource to OHID and ensure Public Health develops capacity and expands its focus on social determinants of mental health.**

438.7. **The UK Government should commit to a real terms increase in the Public Health Grant budget as part of a multi-year settlement, which will ensure local authorities can continue to work towards restoring total expenditure for adult substance use disorder services as a proportion of public health expenditure; restoring total expenditure for specialist drug and alcohol use disorder services for children and young people; and increasing the social care budget for children, young people and adults and with a ring-fence for early years funding.**

438.8. **For future pandemics, and now in the face of waiting lists, NHSE and OHID must ensure that there is clear communication around the importance of seeking timely advice for mental health problems to avoid further delays**

for young people in diagnosis and necessary treatment. Ensuring young people and their families are aware that CYPMHSs are open, and that there is a clear signposting to services and sources of support, is vital.

438.9. **The UK Government should grow the NHS mental health workforce in line with the Long Term Workforce Plan, including by increasing the number of medical school places to 15,000 by 2031 to help facilitate an initially sustained, and then growing number of psychiatrists.**

438.10. **The UK Government should do the following: expand the number of places available at nursing school (and we welcome the Workforce Plan envisaging doing this by 93%); urgently review the impact of tuition fees on mental health nursing; and work with secondary schools and universities to actively promote mental health career options. In line with commitments made in the NHSE Workforce Plan, with NHSE, the UK Government should also engage with stakeholders including MHPG members on improving workforce data and addressing trainee retention. It will be important for future iterations of the workforce plan to provide forecasts for growing specialties alongside further detail on workforce retention.**

438.11. **The UK Government should invest in retention and in mental health support for health and care staff. This should include at least one year of transitional funding for all NHS staff mental health and wellbeing hubs to provide either sufficient time for alternative funding to be identified or for services to at least be wound up in a more manageable way.**

438.12. **DHSC should increase the funding for mental health research to be 15% of the total UK research budget by 2030, drawing on the Roadmap for Mental Health Research in Europe ("ROAMER") priorities and research associated with Covid-19.**

438.13. **Researchers should seek to understand the impact of Covid-19 on levels of self-harm, suicidal ideation and suicide among children and young**

people in order for DHSC, NHSE and OHID to take mitigating action and ensure appropriate support is available.

438.14. **DHSC should allocate substantial capital funding to mental health trusts for research & development in mental health and dementia, including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry by 2024/25.**

438.15. **DHSC should commission regular prevalence surveys for adults and for children and young people.**

438.16. **NHSE should ensure the positive changes to clinical practice and services working together continue, for example, continuing with remote consultations and remote working in certain scenarios, the reduction of bureaucratic tasks so more focus can be paid to clinical care, new ways of working, wider system leadership, and the promotion of improved physical health skill sets of mental health professionals, and a greater understanding of prevention control etc.**

Concluding remarks

For many of us, the pandemic was a period of strife and difficulty unequalled in our lifetimes. Many of us lost treasured loved ones, or watched our loved ones lose people they love. Isolation, loss of routine, loneliness, financial strife, and fear for our safety permeated this multi-year ordeal. These hardships left none of us untouched, but they were not distributed equally. As we have seen in this report, the existing inequities of our society in the UK were deepened and widened by the pandemic and the measures taken to counteract it. Covid-19 and its many ramifications disproportionately impacted minoritised ethnic groups, people of low socioeconomic status, the elderly, the sick, and the vulnerable. Many of these groups continue to feel the ripple effects. In many ways, by many institutions and systems put in place to serve them, they were failed.

I offer this statement and the recommendations herein with the hope that we all can learn and grow from the experiences shared in this period. Parity, equity, dignity, and quality in healthcare, both physical and mental, is not only an imperative, but a fundamental right for all who reside in the UK and beyond. Lessons must be learned from the harrowing years of the pandemic. Chief among them, regardless of political affiliation, our government must be prepared to put the welfare of all governed people at the very forefront of healthcare decisions. Much of the strife we experienced firsthand and heard about in our compilation of this report came from decisions driven by political or economic factors, or made with good intentions but without consideration for society's most vulnerable. This cannot be permitted to happen again. Those with mental health problems are society's most vulnerable and must be thought of first rather than being an afterthought.

I want to take a moment to express my deepest gratitude to the RCPsych's members and all healthcare staff in the UK who worked in hazardous and changeable conditions, through staff shortages, vaccine shortages, PPE shortages, quickfire legislation changes, uncertainty, misinformation, burnout, and sorrow, at great personal risk to their own physical and mental health, to provide for us all. Their bravery and resilience have been astounding to witness and should motivate significant and immediate legislative action so they can be provided with better support – not only in the event of another pandemic, but right now.

Addressing the impacts of Covid-19 as they continue to negatively affect millions of people across the UK is vital. While the worst days of its spread may be behind us, Covid-19 has caused damage to our health systems, our care systems, our education systems, and ourselves. This damage is not, however, irreversible. We call for the immediate implementation of our recommendations. By identifying and adapting the hard lessons of the pandemic, we can all move forward, reinforced.

We wish to express thanks to the Inquiry for the opportunity to contribute, and the RCPsych would be happy to provide further assistance to the Inquiry as required.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 26 February 2024