Witness Name: Duncan Burton

Statement No: 1

Exhibits: DB1/01 – DB1/169

Dated: 1 August 2025

UK COVID-19 INQUIRY

FIRST WITNESS STATEMENT OF DUNCAN BURTON

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SECTION A - Introduction to the roles and responsibilities of NHS England

I, Duncan Burton, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

Background

1. I am the Chief Nursing Officer ("**CNO**") for England. I trained as a nurse at Swansea University between 1995 - 1998 and registered with the Nursing and Midwifery Council ("**NMC**") as a Registered Nurse (Adult) in September 1998. I also have a Bachelor of Nursing (Hons) degree from the University of Wales, Swansea (1998) and an MSc in Healthcare Practice from Bath Spa University College (2001-2004). I am a member of the Royal College of Nursing ("**RCN**").

2. From September 2019 to April 2021, I was the Regional Chief Nurse — South East England. I am employed by NHS England and before the merger I was jointly employed by NHS England and NHS Improvement. From April 2021 until July 2024, I was the Deputy CNO for England — Clinical Delivery, employed full-time by NHS England.

3. Since July 2024, I have been the CNO for England. The CNO role has existed in some form in England since 1941, pre-dating the creation of the NHS. The CNO post resided in the Department of Health and Social Care ("**DHSC**") until 2012 when, as part of the Health and Social Care Act 2012 reforms, it was moved to NHS England.

4. The role of the CNO is broad: I am employed by NHS England, but I am also an adviser to DHSC, Government and the wider NHS on nursing and midwifery related issues. Within NHS England, I am an executive director and I lead the Nursing Directorate. This means that I am responsible for the delivery of national programmes and policy areas that typically have a strong focus on nursing and midwifery. I also provide the nursing perspective and input into a wide range of clinical and operational issues that are the responsibility of other senior colleagues.

5. Before joining NHS England, I held the following roles:

Organisation	Role	Dates
Frimley Health NHS Foundation Trust	Director of Nursing and Quality	September 2017 – September 2019
	Director of Operations	July 2019 - September 2019
Kingston Hospital NHS Foundation Trust	Director of Nursing and Patient Experience	February 2013 – September 2017
	Chief Operating Officer	July 2015 – September 2015
University College London Hospitals NHS Foundation Trust	Deputy Chief Nurse Specialist Hospitals Board	September 2010 – February 2013
	Deputy Chief Nurse – Medicine Board	May 2009 – August 2010
	Divisional Senior Nurse – Emergency Services	2007-2009
	Matron – Infection and Pathology	2004-2007
	Deputy Charge Nurse then Charge Nurse Acute Admissions ward	2002-2004
	Junior Charge Nurse – Neurology Unit	2001-2002

Royal United Hospitals Bath NHS Foundation Trust	Staff Nurse – Respiratory Unit	1998-2001

Introduction

6. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The request received on 14 March 2025 pursuant to Rule 9 of the Inquiry Rules, specifically relating to Module 8 of the Inquiry (the "**Module 8 Rule 9 Request**") to NHS England is broad in scope and time period and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (both current and former NHS England employees) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

7. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England, references throughout to "NHS England," "our" and "we" represent the voice of the organisation. I have referred to all individuals (including myself) in the third person, by job title and, where appropriate, by name.

8. This statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement therefore provides a "high level account", and is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production, or if experience suggests that the Inquiry would wish to see a more detailed discussion of any particular issue.

Approach to the Module 8 Rule 9 Request

9. Following the period under investigation in Module 8, 30 January 2020 to 28 June 2022 (**"the Specified Period"**), NHS England merged with:

   a. NHS Improvement on 1 July 2022;[1]

   b. NHS Digital on 1 February 2023;[2] and

   c. Health Education England (**"HEE"**) on 1 April 2023.[3]

10. This statement refers to the legacy organisations above as is necessary to respond to the Module 8 Rule 9 Request.

11. NHS England welcomes the chance to assist the Inquiry to understand the key issues it has identified as in scope for Module 8 of the Inquiry (and in subsequent engagements with the Inquiry team).

12. The purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in understanding a range of matters as set out in the Module 8 Rule 9 Request.

13. The scope of Module 8 is focused on a range of issues relating to the impact of the pandemic on children and young people (**"CYP"**) in England, Wales, Scotland and Northern Ireland.

14. To ensure that this statement is as accessible as possible, material which is primarily required for contextual or reference purposes, including an overview of NHS England's commissioning responsibilities and broader legislative framework, and a list of key individuals and meetings, are contained within the annexes at the end of this statement.

15. In this statement I have referred to NHS England, the DHSC and the Secretary of State for Health and Social Care (**"SSHSC"**) in accordance with how they are

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[1] On 1 April 2016, the Trust Development Authority and Monitor were brought together to create "NHS Improvement".
[2] The statutory functions of NHS Digital were transferred to NHS England on 1 February 2023 pursuant to the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.
[3] The statutory functions of HEE were transferred to NHS England on 1 April 2023 pursuant to the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.

structured today, but such references include all predecessor organisations and roles as the context may require.

16. NHS Trusts and NHS Foundation Trusts are referred to collectively as "Trusts" in this statement unless otherwise stated.

17. Where we refer to a 'wave' in this statement, the following definitions apply (as there is no overarching definition in England)[4,5]:

Wave and dominant variant	**Dates (approx.)**
Wave 1 – Wuhan variant.	February – May 2020
Wave 2 – emergence of Alpha variant.	September 2020 to January 2021
Wave 2 - reducing and the emergence of Delta variant.	February 2021 to September 2021
Wave 3 – emergence of Omicron variant.	September 2021 to end of the Specified Period.

[4]There were regional variations regarding the impact of each wave.
[5] There is no overarching definition of each wave in England, the above represents the definition being used by NHS England for the purposes of the Inquiry. This definition is taken from the Technical report on the COVID-19 pandemic in the UK **[INQ000205650]**.

Roles and responsibilities

Commissioning of services for CYP

18. An overview of NHS England and, more broadly, the NHS in England can be found at Annex B of this statement.

19. The general functions of NHS England are set out in Section 1H to the National Health Service Act 2006 (the "**2006 Act**"), and confirm that NHS England:

    a. is subject to the same primary (concurrent) duty as the SSHSC to continue the promotion in England of a comprehensive health service;

    b. is required to:

        i. arrange the provision of services for the purposes of the health service in accordance with the 2006 Act; and

        ii. exercise functions conferred on it by the 2006 Act in relation to Clinical Commissioning Groups ("**CCGs**") so as to secure that services are provided for the purposes of the 2006 Act;

    c. does not have any duties relating to the health services provided in pursuance of the public health function, which are duties of SSHSC under Section 2A and Local Authorities under Section 2B of the 2006 Act respectively, unless there is a delegation in place under Section 7A (known as "**Section 7A Services**").

20. CCGs commissioned services locally in their area during the Specified Period, save for 149 specialised services directly commissioned by NHS England.[6] These specialised services support people with a range of rare and complex conditions (they are sometimes collectively described as 'specialised commissioning'). They include services within trauma, mental health, cancer and internal medicine. They range from treatments, such as chemotherapy, radiotherapy and kidney dialysis, to new procedures only carried out in small numbers or particularly complex mental health treatments. Ultimately, the responsibility for deciding which services should be commissioned as specialised services by NHS England lies with the SSHSC and DHSC. During the Specified Period, NHS England took on wider commissioning responsibilities including for diagnostic equipment and independent sector hospitals.

[6] Specialised commissioning has now been largely delegated to ICBs.

21. To assist NHS England's specialised commissioning role, there is a standing expert clinical advisory structure in place which includes a number of specialty based Clinical Reference Groups ("**CRG**"). The exact role of a CRG depends on its terms of reference. In general, a CRG is a group of advisers, independent of NHS England, who provide subject matter expertise and clinical advice to support specialised services. Increasingly CRGs are led by a National Clinical Director ("**NCD**") or National Specialty Advisors ("**NSAs**"). Further information regarding NCDs and NSAs is set out in Annex A.

22. Certain public health functions, including some specific health services for CYP, were commissioned directly by NHS England, acting on behalf of SSHSC, rather than CCGs.

23. The commissioning of public health services for children is undertaken by local authorities. This includes school nursing services and health visiting and family nurse partnership services. These health services have an integral role in safeguarding CYP.

Children and Young People's Mental Health Services

24. This section refers primarily to CYP Mental Health Services ("**CYPMHS**") rather than the traditional description of Child and Adolescent Mental Health Services ("**CAMHS**"). Both terms describe the same group of services, but CYPMHS is now the prevalent term, and the term adopted in this statement.

25. CYPMHS are commissioned by a number of different commissioning bodies, depending on the nature of the service. NHS England has a statutory role to arrange a number of mental health services and, through its Mental Health team[7] supports the commissioning of community services, via CCGs (now Integrated Care Boards ("**ICBs**")), providing guidance, support and direction as appropriate.

26. Commissioning responsibilities are set out in the 2006 Act and in regulations made by the SSHSC under the 2006 Act, namely the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the "**Standing Rules**").

    a. CCGs were given responsibilities relating to the commissioning of mental

[7] Each of NHS England's regions has an appointed Mental Health Lead.

health services unless NHS England had a duty to arrange provision.

b. NHS England is required (pursuant to the Standing Rules and Sections 3B and 6E of the 2006 Act) to arrange for the provision of services for rare and very rare conditions. These include certain specific mental health services for CYP such as:

i. medium secure in-patient services;

ii. child and adolescent mental health in-patient services; and

iii. mental health services for deaf children and adolescents.

27. Traditionally CYPMHS has been described by way of "tiers", with tier 4 being in-patient services, and ties 1-3 community-based services. Terminology is now focussed on whether the service is "in-patient" or "community" to focus on the needs of the young person themselves and the whole care pathway, rather specification-driven categories.

28. In-patient CYPMHS services (traditionally 'tier 4') are commissioned by NHS England through its Specialised Commissioning Team:

a. Specialist autism spectrum disorder services **[DB1/01][INQ000485246]**;

b. Tier 4 CYPMHS **[DB1/02][INQ000485247]**;

c. Tier 4 CYPMHS Psychiatric Intensive Care Units **[DB1/03][INQ000485249]**;

d. Tier 4 Child and Adolescent Low Secure Inpatient Service **[DB1/04][INQ000485250]**;

e. Tier 4 CYPMHS Adolescent Medium Secure services **[DB1/05][INQ000485251]**; and

f. Tier 4 CYPMHS General Adolescent Services including specialist eating disorder services **[DB1/06][INQ000485252]**.

29. NHS England's Specialised Commissioning Team also commission community forensic CYPMHS (including Secure Outreach) (tier 4) **[DB1/07][INQ000610874]**.

30. Community CYPMHS services (traditionally tiers 1-3) encompass:

a. specialist community multidisciplinary CYPMHS teams (including community mental health clinics and child psychiatry outpatient services) (tier 3);

b. targeted services, including youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third-sector providers (tier 2); and

c. universal services such as early years services and primary care (tier 1).

31. NHS England's Specialised Commissioning team coordinates a CRG for CYPMHS, covering secure and non-secure services, and services for children with learning disabilities, autism, and eating disorders. The CRG provides expert clinical leadership and support to services. During the Specified Period the CRG was chaired by NHS England's National Specialty Adviser for CYPMH. Membership of the group includes multiple clinicians from across the NHS, and patient and public voice representatives. The CRG's focus is on measuring and improving quality of care and value-for-money, reducing unwarranted service variation, effective commissioning of services, and developing new clinical models.

32. The work of the CRG was maintained during the pandemic without any changes in its structure or role. Following their introduction in October 2020, the clinical and operational leads for the 18 Provider Collaboratives (groups of providers of NHS commissioned services) started engaging in supporting the pandemic response through a variety of clinical and commissioning forums.

Other CYP services under the Standing Rules

33. Under the Standing Rules NHS England is required to arrange, to the extent it considered necessary to meet all reasonable requirements, the provision of:

a. community dental services and a range of prescribed dental services, including paedodontic/paediatric dentistry (Regulation 6 (dental services) and Schedule 2 (prescribed dental services)); and

b. services for prisoners and other detainees, which includes CYP detained in a secure children's home, a secure training centre, an immigration removal centre, or a young offenders institution (Regulation 10). Service provision includes community services (including dental), secondary care and rare and very rare services (Schedule 4).

34. In addition to CYPMHS, under Schedule 4 of the Standing Rules (services for rare and very rare conditions), NHS England is required to commission a range of acute specialist services for CYP. These range from gender identity development services through to specialist services for cardiac, cancer, dentistry, ophthalmology, diabetes and paediatric intensive care.

Section 7A Services

35. The SSHSC has delegated certain public health services (Section 7A Services) to NHS England on an annual basis by way of arrangements known as "Section 7A agreements".

36. These Section 7A agreements are set out in a letter from DHSC to NHS England and detail the nature and scope of the public health services delegated to, and to be commissioned by NHS England, the outcomes to be achieved, and details as to the ring-fenced budget to be provided by the SSHSC to NHS England to support the commissioning of these services.

37. Since 2012, a range of public health services have been commissioned by NHS England under Section 7A arrangements. For example, during the Specified Period, public health commissioning functions delegated by the SSHSC to NHS England included **[DB1/08][INQ000610919] [DB1/09][INQ000610920]**:

    a. national immunisation programmes, which includes child immunisation, for example the measles, mumps and rubella vaccine, and the seasonal influenza and Covid-19 vaccine immunisation programmes for both adults and children;

    b. national population screening programmes, including the newborn and infant screening programmes;

    c. public health services for adults and children in secure and detained settings in England;

    d. child health information services, which allow widespread maintenance of local and up-to-date clinical care records of all the children in an area, particularly regarding screening, immunisation, and where relevant, providing safeguarding information to local teams; and

    e. sexual assault services (Sexual Assault Referral Centres ("**SARC**")), which provide a safe space and dedicated care for anyone who has been raped,

sexually assaulted or abused. They offer a range of services, including crisis care, medical and forensic examinations, emergency contraception and testing for sexually transmitted infections. They can also arrange access to an independent sexual violence advisor, as well as referrals to mental health support and voluntary sector sexual violence support services. Services to meet the needs of CYP who are raped or sexually abused must be provided in ways that take account of the differences between adults and CYP **[DB1/10][INQ000610873]**.

38. Each year NHS England is required to report to the SSHSC on its achievement against the expected objectives set out in the Section 7A agreement. The reports for the Specified Period are exhibited at:**[DB1/11][INQ000610917][DB1/12][INQ000610915]** The report covering the period from 2017-2019 is exhibited at **[DB1/13][INQ000610916]**.

Clinical Commissioning Groups

39. Under the 2006 Act, CCGs were given responsibilities relating to the commissioning of health services. Section 3 of the 2006 Act required a CCG to arrange for the provision of certain services for persons in its area but not including services for which NHS England has a duty to arrange provision. CCG commissioned services include, but are not limited to, the following services in respect of both mental and physical health:

    a. hospital accommodation;

    b. such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the group considers are appropriate as part of the health service;

    c. such other services or facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness; and

    d. such other services or facilities as are required for the diagnosis and treatment of illness.

40. Section 3A of the 2006 Act provided CCGs with the power to arrange for the provision of such services as they considered appropriate for the purposes of the NHS that relate to securing improvement:

a. in the physical and mental health of the people in its area; or

b. in the prevention, diagnosis and treatment of illness in those people.

41. In practice this meant that during the Specified Period, CCGs were responsible for commissioning a range of children's services covering both physical and mental health. This included a range of community services and commissioner duties set out in Part 3 of the Children and Families Act 2014 (Children and young people in England with special educational needs or disabilities) and the Special Educational Needs and Disabilities ("**SEND**") Code of Practice (2015). To support CYP with SEND, including looked after children or children leaving care, local authorities and CCGs were required to commission services jointly (this is now an ICB duty).

Community Services

42. The term 'community services' is not clearly defined, and during the Specified Period covered a range of services commissioned by NHS England, CCG and local authorities. A table outlining the commissioning responsibilities in relation to community services is exhibited at **[DB1/14][INQ000421234]**.

43. Community services are delivered in a wide range of locations including the patient's home, school, at a clinic or in another clinical setting or remotely e.g., by telephone. Such services are crucial in supporting some of the most vulnerable children (children with Special Educational Needs/looked after children) and identifying safeguarding concerns.

Pandemic response structures

Pre-pandemic planning

44. NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 ("**CCA 2004**") and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the "**2005 Regulations**"). The CCA 2004 requires Category 1 Responders to assess, plan and advise, which includes a requirement to undertake a number of tasks, specified in section 2(1) of that Act.

45. NHS England, as a Category 1 Responder, has certain duties of co-operation under the 2005 Regulations. This includes co-operation with other general Category 1 Responders in connection with the performance of their duties and co-operation with relevant general Category 2 Responders (listed in part 3 of schedule 1 to CCA 2004,

and which included CCGs until July 2022) in so far as such co-operation relates to or facilitates the performance of the relevant general Category 1 Responder's duties.

46. There is a reciprocal duty on relevant Category 2 Responders to co-operate with relevant Category 1 Responders, as well as a duty for Category 2 Responders to co-operate with each other. Under the CCA 2004 and 2005 Regulations, responders have a duty to share information with partner organisations.

47. In England,[8] NHS England is responsible for setting a risk-based Emergency Preparedness, Resilience and Response ("**EPRR**") strategy for the NHS, ensuring there is a comprehensive NHS EPRR system, and leading the mobilisation of the NHS in the event of an emergency, working with partners where a joint response is needed.

48. In relation to EPRR, NHS England works with a range of national partners, including the devolved administrations and other Government departments and public bodies, as well as regional and local partners.

49. NHS England has had an EPRR team in place since 1 October 2012. The EPRR function is organised on a national and regional basis, to reflect the fact that planning, preparation and response can need different levels of co-ordination. The national EPRR team was part of the NHS England Chief Operating Officer's directorate during the Specified Period.

50. NHS England maintains an EPRR Framework (**[DB1/15][INQ000113172] [DB1/16][INQ000113334]**), together with a number of specific incident plans as well as a generic overarching 'Incident Response Plan' (**[DB1/17][INQ000113187] [DB1/18][INQ000113336]**), not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

51. In the years prior to the pandemic, working with partners, NHS England maintained standing plans for incidents relating to high consequence infectious diseases (which Covid-19 was designated as on an interim basis until 19 March 2020) and for pandemic influenza **[DB1/19][INQ000113189]** as directed by DHSC and the National

[8] As health is a devolved matter, there are four distinct health systems within the UK.

Risk Assessment.[9] The plans supplemented NHS England's overarching national EPRR Framework, and the NHS Core Standards for EPRR (the minimum requirements for NHS funded organisations) which every Trust and CCG were required to fulfil (**[DB1/20][INQ000113145]**).

52. As part of preparedness, NHS England would take part in exercises funded by DHSC and commissioned Public Health England ("**PHE**") to test existing plans. When involved in such exercises, NHS England would work with PHE to help plan for and design these. The theme would change each year depending on what was in the National Risk Assessment (e.g., terrorism, pandemic influenza etc.). NHS England would also itself commission exercises to test the operational response to specific scenarios, for example, Ebola. NHS England did not take part in all preparedness exercises that are organised by PHE.

53. There were no national pandemic preparedness exercises which NHS England was involved in that focussed on CYP. However, specialist and non-specialist children's providers, and non-specialist and specialist mental health providers would have tested their own preparedness for these groups through wider exercising (e.g., around pandemic influenza and other scenarios).

Covid-19 response structures

54. On 30 January 2020, NHS England declared a Level 4 incident (pursuant to its EPRR Framework), allowing NHS England to coordinate the response across the NHS in England. It is important to note that this is not the same as stepping into the shoes of NHS providers, who remained responsible for running their organisations.

55. NHS England's response evolved throughout the pandemic, but for much of the response it centred about NHS England's National Incident Response Board ("**NIRB**").

56. NIRB was formally established as a committee in common of the NHS England and NHS Improvement Boards on 1 April 2020, but many of its members had been meeting collectively since 18 February 2020.

[9] The Government assesses the most serious risks facing the UK or its interests overseas through the National Risk Assessment. NHS England commissions services for airborne high consequence infectious diseases via its specialised commissioning team, this includes paediatric services. No children were admitted to these services for Covid-19.

57. NIRB was a requirement of the NHS England Operating Framework for Managing the Response to Pandemic Influenza 2017 (referred to as the National Pandemic Influenza Incident Response Board – see Sections 7.3; 7.4.1 of that framework) and anticipated the longevity of an influenza pandemic response. It became collectively known as the Covid-19 NIRB (referred to only as "NIRB" generally throughout the arrangements). NIRB was to support the discharge of each organisation's respective duties and powers and their combined responsibilities by setting the strategic direction and providing oversight of the response to the Covid-19 incident **[DB1/21][INQ000269949] [DB1/22][INQ000269979]**. In addition, NIRB's role was to challenge and steer the Strategic Incident Director, the Incident Director, the EPRR team and national directors in relation to the pandemic response.

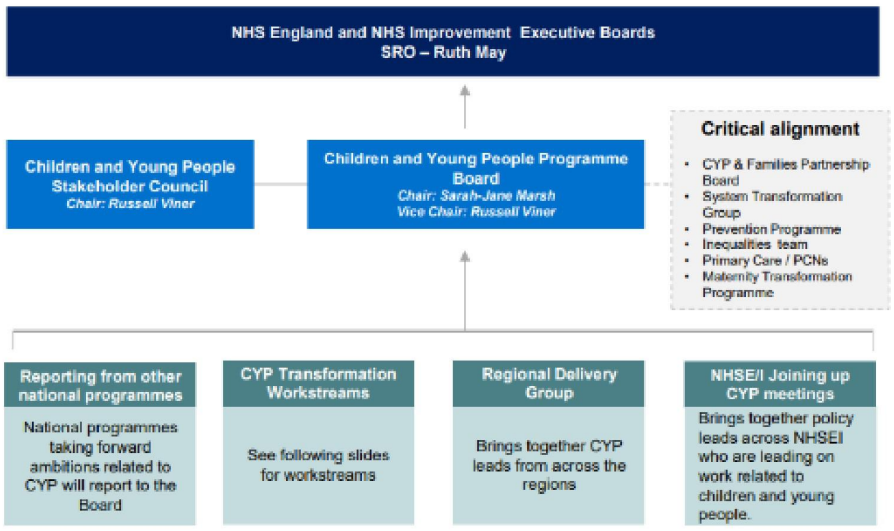
58. NIRB was supported by several structures, including a national cell structure. 'Cells' were set up by NHS England to give a focus to operational issues that arose during the pandemic, with a defined task and team allocated to each cell. The cells also became the building blocks of day-to-day management and record keeping of how each task was addressed. NHS England essentially reformed itself around the cell structure required to respond to the pandemic; many existing organisational structures, roles and workstreams were placed on hold to enable complete focus on pandemic response.

59. There was no specific pandemic response structure for CYP. As required, functions relating to services for CYP fed into the pandemic response structure described above, including into NIRB through CYP teams via national directors and others in attendance (see for example a paper taken to NIRB by regarding protecting services for CYP: **[DB1/23][INQ000610921]**). Further information about CYP teams is set out at Annex A.

Ways of working, communication with the system and monitoring

CYP Transformation Board

60. The NHS England CYP Transformation Programme Board (the "**CYP Transformation Board**") was established in April 2019. The Terms of Reference of the CYP Transformation Board refer to the Board's purpose as overseeing workstreams to facilitate the implementation of the commitments set out in the Long-Term Plan **[DB1/24][INQ000610875].** At the start of the Specified Period, it quickly became an important focal point to consider the impact of the pandemic on CYP, and for making decisions in a cross-sector stakeholder setting on CYP healthcare. The CYP Transformation Board during the Specified Period consisted of:



61. The CNO held (and continues to hold) executive responsibility for CYP in NHS England, and the NCD for CYP would often attend NIRB to update on CYP services (see for example a joint update between the NCD for CYP and the CNO on protecting CYP services ahead of the winter of 2020/2021.

62. In addition to the CNO's executive lead role over CYP in NHS England (which includes the CYP Transformation Programme and the CYP Transformation Board), the health of CYP in England falls within the scope of a number of other executive portfolios in NHS England – including Mental Health and Specialised Commissioning.

NHS England and clinical leaders on CYP issues

63. In addition to the CYP Transformation Board, NHS England's CYP team (who sat in NHS England's Medical Directorate during the Specified Period) would have regular meetings with stakeholders and clinical leaders on CYP issues, as well as reporting regularly to the NIRB. These included:

a. regular meetings with front line clinicians and commissioners through the Children's Hospital Alliance, Paediatric Leads and the Association of Chief Children's Nurses;

b. monthly briefings with the Clinical Directors of acute paediatric services in secondary and tertiary care;

c. regular briefings with Medical Directors and Chief Executives of the Children's Hospital Alliance;

d. regular briefings to the NIRB (either via the CNO or alongside the CNO);

e. invited briefings to the Chief Medical / Nursing Officer's Four Nations meetings;

f. briefings and webinars to multiple professional bodies including primary and secondary care;

g. attendance at a weekly Clinical Expert Group convened by the Royal College of Paediatrics and Child Health ("**RCPCH**") of leaders from paediatric emergency medicine; and

h. attendance at EPRR national intensive care capacity group (daily at peak times).

NHS England, the RCPCH and other CYP stakeholders

64. The CYP Transformation Board met every two months during the pandemic, with attendees from across NHS England, the NHS England Youth Forum, HEE, PHE, DHSC, the Young People's Health Partnership, Department for Education ("**DfE**"), the RCN and the RCPCH. The meetings covered a broad range of topics, from CYP-specific clinical updates on pandemic response, as well as the impact of the pandemic more broadly for CYP, for example on CYP Mental Health, Learning Disability and Autism.

65. From the early stages of the Specified Period onwards, NHS England worked together with a number of stakeholders, including:

a. three catch-ups a week with DHSC and PHE;

b. daily catch-ups with RCPCH, CYP Transformation, NCD, NSAs and PHE;

c. working as one team with specialised commissioning; and

d. weekly meetings across NHS England policy teams.

66. Across all teams in NHS England focused on CYP, there were two-way communication channels in place with local and regional systems and front-line clinicians. The focus was centred around five key areas:

a. **Voice** - including engagement with Youth Members to explore how young people feel about lockdown, and a parent stakeholder council;

b. **Capacity planning** - including working with the regions and Operational Delivery Networks ("**ODNs**") to clarify paediatric intensive care unit ("**PICU**") surge capacity, coordination across neonatal and adult critical care and managing capacity and demand in both in-patient and community CYP mental health;

c. **Data and evidence** - including daily interpretation of the latest evidence with the RCPCH and ensuring that feeds into planning;

d. **Communication and engagement** - involving the Covid-19 response cell on the FutureNHS collaboration platform in order for leads to share advice and learning (also open to the voluntary and independent sector) and use of shared learning and lessons; and

e. **Models of care –** which included a "hospital passport grab guide" to be used in conjunction with the clinical guidance about supporting people with a learning disability or autism; combining CYP mental health crisis services with adult services to expand additional support; crisis cafes and crisis houses; and access take up of digital assessment and treatment.

67. The CYP Transformation Board meeting in April 2020 focused on the impact of the pandemic on CYP. Two papers were presented to the Board relating to Covid-19 planning for CYP:

a. Understanding vulnerability to inform Covid-19 planning **[DB1/25][INQ000610887]**; and

b. Transformation programmes **[DB1/26][INQ000610888]**.

68. The former identified three high level categories of vulnerability for CYP, designed to provide clarity in the CYP response:

Clinically vulnerable	• Those that are **extremely clinically vulnerable**
	• Those that may have been impacted by **delay for planned / elective treatment** (i.e. CHD services) or reduced uptake of immunisation and early year support • NHS is working on bringing back services. we know that neuro-rehabilitation remains a challenge • CYP with **mental health needs** will require specific support.
Higher risk and have statutory entitlement for care and support	CYP who access statutory entitlement for care and support: • Those with a social worker; CYP up to age of 25 with education, health and care plan (EHCP); if they meet the definition in section 17 of the Children Act 1989; CYP with SEND needs (incl. SLCN); CYP be identified by mental health services; CYP with learning disabilities, autism, or both; Looked after Children and fostered and adopted children and children subject to special guardianship orders or wider kinship placements; those more at risk from exploitation, or admission to a psychiatric setting, family, or placement breakdown.
Higher risk due to wider determinants of health / other factors leading to poor outcomes	• Those who may **require multi-agency support** however do not meet statutory entitlement
	CYP who may be at **higher risk due to family and social circumstances** and may not be known to services • Wider determinants of health (poverty, worklessness, homelessness, poor housing etc) • Families with parental conflict, whose parents have mental ill-health, are alcohol/drug dependent, families within the Troubled Families Programme or families and young people in contact / on the fringe of the criminal justice system • CYP experiencing domestic abuse, violence and neglect; Young carers

69. The categories of vulnerability were intended to be fluid and not mutually exclusive. CYP that are vulnerable but are not included in formal/legal processes were the largest group, with an estimate of 2.3 million CYP having a vulnerable family background and 700,000 unidentified young carers in England. It was recognised that these CYP may be disproportionately impacted by lockdown. Note that the categories of vulnerability set out here are distinct from CYP considered clinically extremely vulnerable (though they form part of the first category above), discussed further below.

70. The paper identified different actions to be taken for the different groups of vulnerable CYP, with involvement of various stakeholders across health, care and education. A few examples of these are:

a. CYP identified as most risk by the NHS or their clinicians should be shielded and may have received letters from the NHS allowing better access to support, including home deliveries of medical supplies, equipment and food;

b. CYP with Education, Health and Care ("**EHCP**") plans were encouraged to stay in education following a risk assessment which concludes they will be safer in education than at home;

c. recognition that CYP with a learning disability, autism and/or behaviour challenges, looked after children or those with SEND needs may find adapting to living in lockdown difficult and will benefit from greater continuity and routine that education allows;

d. safeguarding plans should continue to be delivered; and

e. signposting to financial support and volunteer services and targeted services delivered virtually, including planning for a potential surge in mental health and safeguarding needs.

71. In May 2020, NHS England worked with NHSX[10] and NHS Digital to develop a CYP data and digital strategy. This was intended to support with understanding the impact of Covid-19 on CYP and to develop wider metrics to measure progress (e.g. around quality, integration and immunisation). National and local CYP dashboards were also built to measure progress against agreed metrics, enabling local benchmarking and identifying unwarranted variation.

72. Between July and October 2020, the CYP Transformation Board continued working with stakeholders across the health, care and education systems. The proposals for joint working were presented to the Board by the Head of CYP and NHS England's NCD for CYP. These included:

a. Working with HEE to improve the understanding of the CYP workforce across all regions, including identifying workforce gaps in CYP services, upskilling the workforce through training on effective digital consultations, and to develop a national career strategy for advanced clinical practitioners;

[10] NHSX was formed in February 2019 by the SSHSC as a joint unit of DHSC, NHS England, and NHS Improvement, with responsibility for setting national policy and best practice on technology, digital and data. It was not a legal entity in its own right, and its role was an advisory one such that it did not collect or otherwise disseminate data itself.

b. to co-develop integrated models of care with local health and care systems, both horizontally – across health, care and education, and vertically – across secondary, primary and community care;

c. to create a platform to facilitate a standardised and interoperable method of tackling and detecting acute deterioration in paediatrics, intended to adapt and expand the inpatient paediatric early warning system ("**PEWS**") into ED, community, ambulance and primary care; and

d. to test new ways of working by evaluating the impact of introducing paediatric expertise into NHS 111 (discussed further below). Including setting up an evaluation steering group with representation across NHS England, RCPCH, NHS Digital, Royal College of Emergency Medicine, Royal College of General Practitioners ("**RCGP**") and paramedic sciences to assess feasibility of the project.

73. A key joint-working project was the establishment of a task and finish group designed to help local areas develop digital solutions, with the ultimate aim of identifying and helping vulnerable CYP. This pulled together central teams across NHS England, DfE, PHE, DHSC and NHSX. The scope of work included:

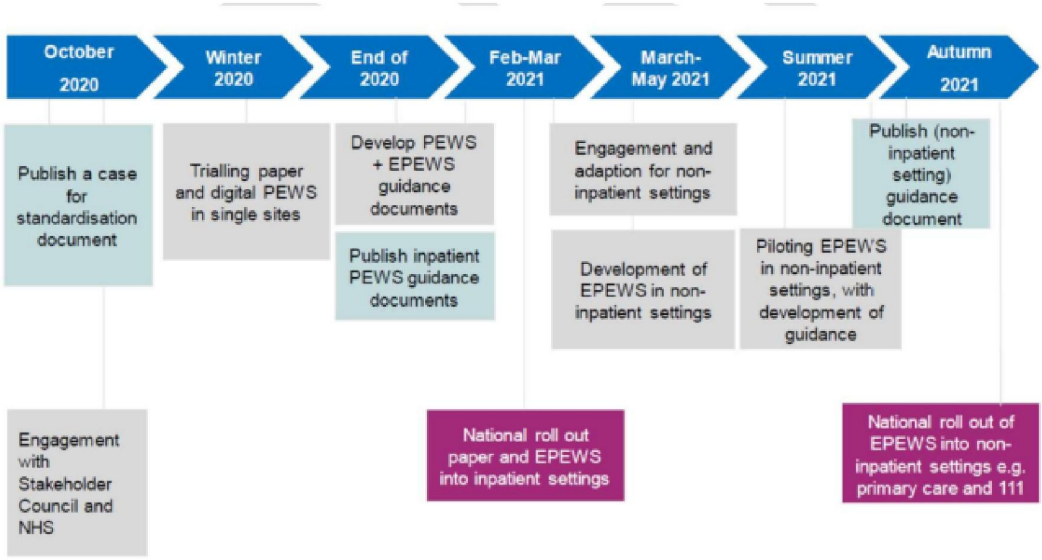
a. linking data across health, education and care to identify CYP who are known to services; and

b. understanding the benefits and limitations of predictive analytics related to the clustering of risk to identify CYP who may be vulnerable before they are known to services.

74. The project also considered opportunities to coordinate with other major programmes that seek to help children at risk and avoid poor outcomes, such as the "Troubled Families" programme led by the Ministry of Housing, Communities and Local Government.

75. Also in Autumn 2020, together with the RCPCH and the RCN, NHS England developed a CYP System-wide Paediatric Observations Tracking ("**SPOT**") Programme. This was already in the pipeline before the pandemic, but the programme was driven forward by the challenges of responding to the pandemic and to ensure CYP were assessed in a standardised and systematic way.

76. The SPOT programme aimed to standardise the way in which paediatric inpatients' physiological observations were measured, monitored and scored, which in turn would improve the early detection of deterioration in children, and in the context of the pandemic, to prevent, contain and supress the virus. Rapid trialling was proposed in Autumn 2020, with the aim of national rollout in Autumn 2021:



77. The NHS England CYP Transformation Programme supported pilot sites by providing a forum for all trial sites to interact. This involved frequent check ins with the national team, including participation in monthly meetings via the PEWS Oversight Group, which fed into the CYP PEWS Delivery Board. CYP, their families and relevant third sector organisations were also involved in the development where appropriate.

Communication to the system

78. Throughout the Specified Period there were various methods by which information was transferred between different organisations, such as the networks of meetings at regional levels, regular bulletins to system leaders and communications via the FutureNHS collaboration platform. As part of NHS England's pandemic response structure, a single point of communication ("**SPOC**"), was created as a mechanism for streamlining communication.

79. Key communication included several system letters that were drafted and published via the SPOC. During the Specified Period this included letters regarding service

prioritisation, which were relevant to NHS England's response and CYP services. These were:

a. the letter of 17 March 2020 from NHS England to the system confirming the position since the Level 4 declaration. This letter requested NHS bodies to enact urgent measures that were considered vital to free-up the necessary capacity to cope with the incoming wave of infections and prepare the NHS for the anticipated large number of Covid-19 patients in need of respiratory support (the "**Phase 1 Letter**") **[DB1/27][INQ000087317]**. As the position pivoted in March and April 2020, as per the Phase 1 Letter, non-urgent services were paused to enable the NHS to have the best chance to manage the anticipated number of patients with Covid-19. This included elective and community services for children (see below).

b. the letter of 29 April 2020 from NHS England to the system confirming the start of phase 2. This letter, amongst other matters, highlighted that the NHS continued to be at Level 4 and that NHS organisations needed to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter was to set out the broad operating environment and approach that the NHS would be working within for the foreseeable future (the "**Phase 2 Letter**") **[DB1/28][INQ000087412]**. This letter was clear that:

    i. essential community health services must continue, and other services phased back wherever local capacity is available;

    ii. home visits where there is a child safeguarding concern were to be prioritised;

    iii. CYP should continue to have access to mental health services, and that local partners should liaise to ensure that referral routes were understood, particularly where CYP were not at school;

    iv. Care (Education) and Treatment reviews should continue and annual health checks for people with a learning disability were also to be completed;

    v. newborn screening services were to be maintained; and

vi. providers and commissioners were to maintain good vaccine uptake and coverage of immunisations.

c. the letter of 31 July 2020 from NHS England to the system confirming the start of phase 3. This letter set out an update on the latest Covid-19 alert levels, priorities for the remainder of 2020/21 and an outline of the financial arrangements heading into autumn (the "**Phase 3 Letter**") **[DB1/29][INQ000051407]**. This letter was clear that:

i. service delivery should be restored, in primary care and community services, to usual levels where clinically appropriate, including addressing the backlog of childhood immunisations; and

ii. expanding and improving mental services and services for people with a learning disability and/or autism, including maintaining the growth in the number of CYP accessing care.

80. As part of implementing phase 3 of the response **[DB1/30][INQ000180768]**, it was acknowledged that:

Children and young people have been significantly impacted by COVID-19, through the disruption to multi-agency support and through the closure of schools and colleges. As schools prepare to welcome children and young people back, services should ensure that local access to pathways, consultation and advice is clearly advertised. They should continue to expand provision, focusing on the needs of the most vulnerable such as those with autism or neurodisability, making full use of the £47 million year-on-year uplift in 2020/21 CCG baseline funding for CYP mental health services (including crisis and eating disorders). The baseline funding uplift since 2018/19 is now £83 million. The National Quality Improvement Taskforce for children and young people's mental health, learning disability and autism inpatient services has resumed its work and will be getting in touch with providers in the coming weeks. Community and inpatient services should continue working to improve pathways of care across their services.

Data, Monitoring and Assessment

81. The National Child Mortality Database ("**NCMD**") is a national data collection and analysis system which records comprehensive data on the circumstances of

children's deaths. The programme has been commissioned since 1 April 2019 and is funded by NHS England.

82. During the pandemic, the NCMD was uniquely placed to gather data quickly from the whole of England and to pass that information to NHS England and PHE to inform national strategy for Covid-19. The NCMD issued at the start of the pandemic asking that clinicians in England inform them within 48 hours of any child death potentially involving Covid-19. This included:

a. children who die with symptoms of Covid-19, whether confirmed or suspected (recorded as potential cause of death);

b. those who die of any cause, but show signs of undiagnosed infection in the weeks leading up to death;

c. children known to have the virus but who might have died of something else;

d. any child who meets the criteria for a Joint Agency Response where the cause of death is unknown, but infection is considered as a significant possibility and the child or other member(s) of the household had a fever or cough within the preceding 14 days;

e. babies who are born and then die where the mother was known or suspected to have had Covid-19; and

f. child deaths where the pandemic might have contributed to the death (e.g. delayed presentation of other infectious diseases/sepsis, inflicted injury or child suicide).

83. Weekly monitoring data from the NCMD showed no increase in child mortality in 2020 as compared to 2019:

Figure 1: The trend of all child death notifications, by week beginning

84. It is important to set this data in context. An NCMD analysis of deaths of children in England from Covid-19 during the first two years of the pandemic tragically estimated that 88 CYP died of Covid-19 in England during the first 26 months of the pandemic. 80% of whom had a life-limiting condition, and 90% had an underlying chronic condition **[DB1/33][INQ000610918]**. That comparatively small number does not minimise the magnitude of that loss, for that child or young person, and the 88 families, friends and loved ones left behind.

85. It is important also to distinguish between the wider impact of the pandemic on child mortality, and the direct infectious burden of Covid-19 in CYP. In England, child mortality dropped to its lowest level ever recorded during the first year of the pandemic, with reductions in deaths from other infectious agents, substance abuse and from underlying chronic disease.

86. In order to assess and mitigate both direct and indirect consequences of Covid-19 in CYP, the NHS England CYP team took the following actions:

a. Obtained increased funding for the NCMD via the Healthcare Quality Improvement Programme ("**HQIP**") to permit 7 day data collection and early warning of emerging trends. There is an obligation for Child Death Oversight Panels to report a preliminary cause of child death within 48 hours to the NCMD. This mechanism meant that NHS England had a near real-time sight on child death trends enabling a rapid response when trends were determined.

b. Increased funds were also provided via HQIP to the National Neonatal Audit Programme to provide enhanced surveillance of the impact of Covid-19 infection on neonates.

c. Create linked datasets to assess the direct and indirect impact of Covid-19 on CYP. Secondary User Statistics ("**SUS**") data (on hospital admissions) were linked to the Paediatric Intensive Care Audit Network ("**PICANET**"), NCMD, PHE, Covid 19 serology and eventually vaccination data. This was supported by a National Institute for Health and Care Research ("**NIHR**") grant that allowed suitable support from academic epidemiologists, and mathematical modelling colleagues from PHE. Ultimately, this linkage enabled a joined-up view of hospital and paediatric critical care admissions, and child deaths, linked to Covid-19 infection. This enabled NHS England to identify the 'at-risk' child population and determine the overall risks of each wave of Covid-19

infection to CYP. This data was ultimately used to inform shielding and vaccination policy for CYP. In addition, monthly meetings with the audit teams from PICANET, NCMD and the National Neonatal Audit Programme were conducted.

d. There is a 6-week delay between discharge from hospital, and SUS datasets becoming usable (similar delays exist with PICANET). Recognising the inherent delays in using the above data sets, NHS England's CYP team funded a prospective cloud-based service evaluation hosted by the RCPCH which collected data on children admitted to hospital with a positive Covid-19 test. This was a short term project with the specific aim of early sight of the clinical characteristics of children being admitted to hospital. By May 2020 over 200 children had been registered by clinicians in 56 hospitals and an overall reassuring picture emerged on relatively small numbers requiring PICU admission.

e. The RCPCH maintained an evidence-based guide for management of children admitted to hospital and for treatment of non-hospitalised children at risk of severe disease. This was continuously updated as evidence increased.

SECTION B - Infection Prevention and Control ("IPC")

87. IPC is an integral part of health care practice, routinely implemented by healthcare workers to prevent and manage infection. Hospitals and other healthcare providers employ dedicated IPC and estates specialists who support the development of and implement protective measures based on organisation-wide and individualised risk assessments. Therefore, during the pandemic IPC measures were already well-established to address a wide range of infections.

NHS England IPC Cell

88. An IPC cell was initially established as part of NHS England's emergency response structure, after the first NHS England Wuhan Novel Coronavirus Incident Management Team meeting on 23 January 2020, following a request by NHS England's Strategic Incident Director on 22 January. This is not to be confused with the Four Nations IPC Cell (described below).

89. The NHS England IPC team within NHS England's Nursing Directorate, under the leadership of a Deputy CNO, led work to support the NHS in England with operational IPC issues, including the production of tools and operational guidance to support the implementation of Covid-19 UK IPC guidance and manage nosocomial infections in the NHS.

90. At a regional level, in the early part of the pandemic, each NHS England regional team built a regional IPC team (sometimes referred to as a cell). These teams/cells worked with Trusts to support implementation and best practice for IPC measures, along with supporting the handling of any outbreak issues, linking with Regional Chief Nurses and Medical Directors as appropriate, but they were not involved in setting policy.

Four Nations IPC Cell

91. As part of the Four Nations response to the pandemic, a UK-wide IPC Cell was introduced. The IPC Cell brought together IPC leads (with different qualifications) of the NHS (for operational input) and public health bodies (for scientific input) from the Four Nations to produce guidance. The IPC Cell started meeting in early February 2020. Membership of the IPC Cell included NHS England, PHE/UK Health Security Agency ("**UKHSA**"), Public Health Wales, Antimicrobial Resistance & Healthcare Associated Infection Scotland, the Scottish Government HAI Policy Unit, Public

Health Agency Northern Ireland, the Association of Ambulance Chief Executives and DHSC. As this group grew out of the NHS England cell structure, NHS England's IPC team hosted and administered the IPC Cell meetings. Example terms of reference from 2020 through to 2022 are exhibited at: **[DB1/34][INQ000489995] [DB1/35][INQ000489996] [DB1/36][INQ000348137][DB1/37][INQ000489988] [DB1/38][INQ000416768]**.

92. Standard practice before, and during the pandemic, was that IPC guidance was subject to Equality Health Impact Assessments ("**EHIA**"). An iterative EHIA was completed on the IPC guidance by NHS England on behalf of the IPC Cell **[DB1/39][INQ000492317] [DB1/40][INQ000492333]**. As guidance was based on the epidemiology of SARS-CoV-2, its purpose was to ensure safe and effective IPC measures to protect all patients, staff and visitors of all ages within any healthcare facilities.

93. The EHIAs considered potential positive or adverse impact for people who experience health inequalities, for example:

    a. looked after CYP, where consideration was given to the presentation of more than one guardian of a child; and

    b. those who were learning impaired or had a mental health condition, where consideration was given to the fact that those "who are learning impaired and or have a mental health condition may not be able to actively participate in the extended use of facemasks/coverings..."

94. Guidance was also issued for mental health and learning disability **[DB1/41][INQ000610890]**, which considered additional issues that may occur in specific mental health and learning disability settings such as:

    a. PPE ensemble when restraining a patient;

    b. direct personal care e.g., rapid tranquilization, depot administration and nasogastric tube feeding;

    c. risk assessments regarding the placement and storage of PPE, alcohol-based hand products and cleaning materials for reasons of patient safety; and

    d. adopting a trauma-based approach, including consideration of the effects of staff in PPE providing care and support to individuals, recognising the overall aim of reducing trauma.

95. The UK IPC guidance as published by PHE (and then UKHSA), was produced to provide minimum standards (based on the epidemiology of the pathogen – SARS-CoV-2), subject to local risk assessment and implementation (in accordance with health and safety law). Organisations need to consider the health and safety of staff, visitors and patients as part of business as usual (i.e., in non-pandemic times). In relation to CYP, healthcare organisations (including those delivering mental healthcare and learning disability services) would need to consider the implementation of the guidance, which would include after June 2020 (see below) the application of universal masking (as they would have to in relation to IPC measures during non-pandemic times).

96. The responsible IPC leaders within each Trust worked with their teams to implement these measures. Each Trust should have a named Director of IPC. This position is usually held by the Director of Nursing but could also be a lead microbiologist or the medical director.

97. It is recognised that the PPE ensemble being worn in healthcare settings during the pandemic was unusual for many staff, with very few staff previously wearing FFP3 masks for example. However, as usual health and safety requirements applied, risk assessments for items which could be used to self-harm or harm others, would need to be conducted in the usual way (and include the PPE ensemble and items such as alcohol-based hand rubs).

98. NHS England supported Trusts in implementing the IPC guidance published by PHE as part of its nosocomial infections programme. It also introduced an IPC intensive safety support programme in June 2020 consisting of a safety support team which worked in partnership with regional IPC colleagues to provide direct expert input for Trusts reporting high levels of nosocomial infection. As part of the nosocomial infections programme, NHS England designed a series of national resources to support implementation of IPC measures. This included an IPC Board Assurance Framework to support local leaders, IPC checklists, a series of ten IPC priority actions based on best practice and the Every Action Counts awareness campaign **[DB1/42][INQ000330908]**. Every Action Counts included the concern regarding staff being 'faceless' to patients, and asking Trusts to consider whether there is a way for photographs to be used to help reduce barriers.

99. It was confirmed in an IPC Cell meeting on 12 May 2021 that adult guidance was being followed for paediatric pathways **[DB1/43][INQ000398232]**:

The group discussed paediatric pathways asking if other countries are following adult guidelines as numbers are low in Scotland which causes issues around data. NI are trying to agree a regional approach as numbers also low. England are following adult guidance. Wales are also following adult guidelines.

100. Other examples of CYP issues discussed during IPC Cell meetings were:

a. whether there would be guidance for health visitors and school nurses (with the guidance applying) **[DB1/44][INQ000398170]**;

b. children with complex health issues relating to aerosol generating procedures **[DB1/45][INQ000398145]** (which involved PHE undertaking a pilot study as per the relevant minutes **[DB1/46][INQ000398176]**); and

c. social distancing concerns in paediatric settings **[DB1/47][INQ000398140][DB1/48][INQ000398141]**.

101. The first guidance, published by PHE on 10 January 2020 **[DB1/49][INQ000101202]**, was clear that visiting should be restricted and that visitors would need to wear personal protective equipment ("**PPE**"):

Visitors should be restricted to essential visitors only, such as parents of paediatric patients or an affected patient's main carer. This should be subject to a local risk assessment having been performed.

PPE must be made available to visitors, including instruction and supervision of correct usage and donning and doffing.

The hospital should be mindful of its responsibilities to persons who are not employees, under The Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999.

102. Risk assessment remained central to decision making, including in relation to advice on visitors and remote consultation.

Non-pharmaceutical interventions

103. Non-pharmaceutical interventions ("**NPI**"), such as social distancing and universal masking were introduced across the country in a range of settings, including within healthcare where practicable, to help reduce transmission.

104. Universal masking (from June 2020) required everyone visiting hospitals, primary or community care settings, or care homes (in any capacity i.e., patient or visitor) to wear a face covering or face mask (unless they were exempt) to reduce transmission. This was supported by NHS England.

105. There were exemptions to universal masking for:

a. young children under 11 years of age (UKHSA did not recommend face coverings for children under the age of 3 for health and safety reasons); and

b. those who could not put on, wear, or remove a face covering because of a physical or mental illness or impairment, or disability (this included CYP with autism or a learning disability).

106. The measures put in place to reduce transmission more broadly through NPIs also impacted children. This included an impact on immunisations provided in schools, as well as an impact on seasonal viruses that typically affect children.

Visitor guidance

107. Prior to the pandemic, hospital visiting policies were a matter for local organisations. These policies facilitated visiting at appropriate times and offered flexibility in specific circumstances, such as for patients approaching the end of life or patients who required additional or specialist support.

108. Trust visiting policies were at times applied differently as local organisations interpreted NHS England's guidance and principles in their own way (such as the definition of 'essential visitors') and necessarily took decisions on visiting based on their own circumstances, such as the layout of their hospital buildings or prevalence of the virus in the area at the time (as required for IPC risk assessment). Restrictions on visiting were tightened when areas needed to manage local outbreaks and/or to reduce the risk to patients when community prevalence was high. It is important to acknowledge that local flexibility was crucial, as no visitor guidance produced by NHS England could take into account the unique circumstances of every Trust.

109. The impact on patients and their families in the cases where visiting was not possible was deeply felt by patients, their families and NHS staff, particularly those on the front line.

110. During the Specified Period, visitor guidance was published by NHS England. The guidance impacted CYP as patients, and as visitors, however, it sought to ensure that they could be accompanied and visited in a safe manner wherever possible:

a. **16 March 2020**: CYP who needed to be accompanied were permitted. However, children under the age of 12 (immediate family members) were not generally permitted to visit patients without permission of the ward sister or charge nurse **[DB1/52][INQ000330806]**.

b. **25 March 2020**: visiting was suspended for everyone, except in the case of a parent or carer visiting a child, in which case only one visitor was permitted. Other situations which were permitted included where the visitor was visiting a patient receiving end of life care **[DB1/53][INQ000330814]**.

c. **8 April 2020:** visiting was suspended for everyone, except in the case of a parent or carer visiting a child, in which case only one visitor was permitted. Other situations which were permitted included where the visitor was supporting someone with a mental health issue, a learning disability or autism, where not being present would cause the patient to be distressed **[DB1/54][INQ000610886]**.

d. **5 June 2020:** this guidance provided greater discretion to Trusts and providers of NHS care to consider how they would permit visiting, subject to practical considerations (including IPC), and consideration of virtual visiting **[DB1/55][INQ000330865]**.

e. **12 June 2020:** NHS England and PHE both published guidance on the wearing of facemasks for hospital staff and face coverings for visitors, following the announcement of this measure by the SSHSC on 5 June 2020 **[DB1/56][INQ000339234]**.

f. **13 October 2020**: this guidance provided further advice in relation to visiting inpatient settings. In relation to CYP, it emphasised the need for a compassionate approach to allowing visitors (including CYP) to say goodbye to their loved ones who were dying. This involved local risk assessment to consider how rules could be relaxed safely. Where a child or young person was dying and a parent or carer was suspected of being positive for Covid-19, the guidance considered how adjustments could be made to permit a safe

visit. Information was also provided regarding approaches to virtual visits **[DB1/57][INQ000610895]**.

g. **23 October 2020:** further guidance for mental health and learning disability settings was provided in a message from the National Director for Mental Health and National Director for Learning Disability and Autism. It requested that all providers allowed families to visit their loved ones unless a risk assessment had been carried out which demonstrated that there were clear reasons it would be unsafe **[DB1/58][INQ000330964]**.

111. In October 2020, NHS England produced a YouTube video on face coverings information for people with a learning disability and autistic people,[11] covering why a face covering is important and why some people might not have to wear one.

112. The general visiting principles were further amended throughout 2021 and into 2022 to take into account wider developments, including hospital testing and PPE requirements.

Remote consultations

113. The use of technology also enabled the NHS to maintain care in a way that would not have otherwise been possible. As a result, the pandemic accelerated the adoption of digitally enabled remote appointments in outpatient services, significantly contributing to delivering this commitment. The same level of services could not have been delivered during the pandemic without the use of remote consultations due to IPC requirements.

114. NHS England published a number of guidance documents to assist with the adoption of remote consultations and remote working in secondary care **[DB1/59][INQ000470572]**, which included specific advice for remote consultations with CYP. NHS England also published a specialty guide on 27 March 2020 **[DB1/60][INQ000470427]** to mitigate against inappropriate use, including in relation to CYP. This offered practical guidance to clinicians and managers, including the following principles:

a. remote consultations are suitable for patients who do not need a physical examination or test, and can communicate by phone or video (with a

[11] https://youtu.be/lRf8_jt0nMU?feature=shared

preference for video if there is a benefit in seeing the patient or their surroundings);

b. a clinical risk assessment should take place in all cases in order to stratify services and individual patients, with remote consultation only taking place where there is a low risk of impact to patient safety and outcome;

c. consideration should be given to implementing remote consultations for all appointments except for those which meet local exception criteria. Examples of such criteria were patients with potentially serious high-risk conditions likely to require physical examination, or where an internal examination cannot be deferred; and

d. considerations for CYP:

   i. communication with CYP - be mindful that in a video consultation CYP may feel less able to communicate effectively with clinicians and defer to parents;

   ii. safeguarding - assess whether virtual consultation is appropriate in the context of safeguarding and make alternative arrangements if there are any concerns.

115. This statement covers guidance on the use of remote consultations in general practice, specifically, in paragraphs 123 to 133 below.

SECTION C - Primary Care

116. Primary care services in the NHS provide a local 'first point of contact' for individuals with health concerns. Primary care includes general practice, community pharmacy, some dental services, and optometry (eye health) services.

117. This section focuses on general practice and dental services. It outlines the steps taken by NHS England during the Specified Period which impacted CYP access to primary care services.

GP Services

Background and commissioning

118. NHS England has the statutory duty of arranging for the provision of primary medical services for the population of England. It discharges this duty by entering contracts for the provision of these services with primary medical services contractors (GP Practices). This section uses the general term "GP services" to describe healthcare services provided by general practices in England; it uses the term "general practice" to refer to all GP practices providing GP services in England. GPs and their practice staff are not employed by NHS England. GP practices are independent contractors responsible for their "business".

119. At the start of the Specified Period, NHS England had already delegated its statutory duty for arranging for the provision of GP services in their area to most CCGs. By 1 April 2021 every CCG in England had these delegated responsibilities. Each CCG had operational responsibility for the arrangements with GP practices. At the time of drafting this statement, NHS England retains accountability for the performance of primary medical services commissioning and seeks to ensure that consistent high quality services are available for patients.

120. GP practices must all offer core GP services, including diagnosing illnesses and treating conditions, for which they receive a payment based on a weighted sum for every patient on the practice list. The vast majority GP practices receive additional remuneration by participate in optional incentive schemes. Those of relevance to services provided for CYP include:

    a. the Quality and Outcomes Framework ("**QOF**"), typically related to the management of long-term conditions (e.g. asthma). QOF measures

incentivise GP practices to undertake these quality improvement activities; and

b. other enhanced services ("**ES**"), such as the vaccinations and immunisations enhanced services, and in particular the enhanced seasonal influenza vaccination programme. These services require GP practices to provide the relevant services with payment being linked to the amount of activity undertaken.

121. With respect to any child under the age of five, GP practices have specific obligations under the GP contract relating to child health surveillance, including:

a. monitoring the health, well-being and physical, mental and social development of the child; and

b. recording the responses (if any) to offers made to the child's parent for the child to undergo any examination.

GP Services during the Specified Period

122. During the Specified Period, NHS England took a range of steps to attempt to alleviate the pressures on GP capacity, and to support general practice to continue to deliver essential care to all patients including children. The following paragraphs in this statement explain NHS England's role in:

a. changes in how people accessed general practice services, including the shift to remote triage and remote consultations;

b. relaxing GP contractual requirements and the implications for the delivery of routine care for people with long term conditions including learning disabilities; and

c. guidance to GPs on referring patients to secondary care, including for urgent suspected cancer.

Changes in how people accessed general practice services

123. Pre-pandemic, general practice was already undergoing a digital transformation. The NHS Long Term Plan ("**NHS LTP**"), published in January 2019 **[DB1/65][INQ000113233]**, committed to every patient being offered digital-first primary care by 2023/24. Patients would be able to access most of their primary care

needs online, without having to make a face-to-face appointment. The digital transformation could increase patient choice, expand GP capacity, improve efficiency. Approximately 50% of GP practices had this capability before the pandemic.

124. NHS England became aware of the potential for viral transmission in GP practice settings early in the pandemic, including through face-to-face consultations. A briefing issued to primary care providers by NHS England on 18 February 2020 noted this **[DB1/61][INQ000049392]**. The briefing advised that those who met certain criteria were not to go to a GP practice and instead should call 111, for example those who had visited Wuhan in China in the last 14 days (regardless of the presence of any symptoms).

125. The pandemic accelerated the need for GPs to adopt digital tools and remote consultations, to help minimise the risk of Covid-19 infection and onward transmission to primary care staff or patients in GP surgeries.

126. NHS England's approach to enabling and facilitating GPs' use of digital infrastructure and tools took the form of:

    a. establishing the total triage model early in the pandemic through which GPs were to assess each patient's clinical needs by using consistent criteria, and then identifying both the appropriate health professional they needed to see and the mode of that consultation (whether by telephone, video or in-person). Where patients needed to be seen face-to-face, GP practices provided a consultation room in line with IPC advice. In some areas of the country, 'hot sites' were commissioned locally for people presenting with any flu or Covid-19-related symptoms; and

    b. disseminating guidance to assist GPs in making appropriate use of technology to meet patient needs. Funding was provided to GP practices to procure from the list of assured suppliers.

127. There are specific considerations around remote consultations for CYP:

    a. GP practices need to train and guide clinicians on identifying and escalating child and adult safeguarding concerns during a remote consultation. Patients identified as safeguarding risks should be followed up in a face-to-face setting unless doing so is not in the patient's best interests.

    b. Children, if they have capacity, are able to exclude a parent from remote

consultations. Children under the age of 12 years are unlikely to have capacity to make this decision.

c. Both adults and CYP may fail to attend planned appointments (online and in person), and for future appointments this is recorded on the patient record.

128. On 29 May 2020, NHS England published "*Principles of safe video consulting in general practice during Covid-19*", in conjunction with the RCGP **[DB1/62][INQ000470458]**. The key principles that GPs were expected to follow in relation to children under 16 years' old included:

a. If the child does have the capacity to consent to a phone or video consultation, then confirm whether they would they like another person (for example, parent or family member) present on the call or not.

b. If a competent child wishes to discuss a matter in the absence of a parent, all the usual principles apply in relation to confidentiality (the General Medical Council ("**GMC**") guidance is here).

c. Consider the voice of the child, even if children are unable to legally consent to an examination, ask the child if it is acceptable first, they should have as much involvement and say in their care as possible.

d. An opportunity to speak to adolescents alone may be more difficult if they are at home. Consider how you will still have these vital conversations.

129. If the young person did not have the capacity to consent to a video consultation, then consent would need to be sought from someone who had parental responsibility (or delegated parental responsibility), unless it was not in the child's best interests. Practices were expected to document the name and relationship of any adult and/or person(s) present. Clinicians were instructed to not "*just talk to the adult(s)*", but to make sure they saw the young person.

130. The guidance also advised on visible and audible cues clinicians should consider when consulting via video with young people: tone, interactivity, consolability, look, and speech for example. It also provided advice on undertaking remote tonsillar examinations in children.

131. The revised GP Covid-19 SOP published on 29 May 2020 specified that, for children experiencing Covid-19 symptoms, "*the threshold for face-to-face assessment in*

general practice and for referral to secondary care should not change during the Covid-19 pandemic" **[DB1/63][INQ000470459].**

132. NHS England also provided input into guidance issued by RCPCH "*Key Principles for intimate clinical assessments undertake remotely in response to COVID-19*", the first version of which was published on 1 July 2020 **[DB1/64][INQ000470487]**.

133. This guidance noted the pandemic had accelerated the adoption and utilisation of online and video consultations and provided advice on safeguarding, securing consent from patients, confirming patients' identities, processing and storing images, undertaking intimate assessments, record keeping, and receiving intimate images of people under 18. The guidance provided advice specifically on securing the consent of young people, noting the approach to video consulting and image sharing would be the same as for face to face interactions.

Delivery of routine and preventative care for CYP with long term conditions

134. At the start of the pandemic, GP practices needed to focus on preparing for and managing the Covid-19 outbreak, and on supporting patients at highest risk from Covid-19. On 19 March 2020, following publication of the Phase 1 letter, NHS England set out the routine activities that GPs could consider suspending if necessary, including new patient reviews, annual patient reviews, and routine medication reviews **[DB1/66][INQ000087325].**

135. NHS England recognised that management of long-term conditions in general practice needed to be maintained, to prevent the escalation of future health risks, and that GP practices would likely have a backlog of reviews and checks to undertake. GPs would need to prioritise these using their clinical judgement and a risk-based approach.

136. Whilst most long term conditions, and multimorbidity, are more likely to affect adults, children can be affected by (for example) asthma, epilepsy and diabetes. NHS England's 29 April 2020 Phase 2 Letter asked GPs to deliver as much routine and preventative work as possible. The GP SOP of 29 May 2020 advised GPs to focus on the restoration of routine chronic condition management and prevention. GPs were advised to assess and proactively address health needs that may have gone unmet, or increased or developed during the pandemic, and to accommodate changes in how patients wanted to seek health care – including support them with self-care and self-management.

Learning disability health check

137. People with learning disabilities face significant health inequalities compared with the rest of the population. Despite suffering greater ill-health, people with a learning disability, autism, or both often experience poorer access to healthcare.

138. The NHS LTP committed to improving uptake of annual physical health checks in primary care for people aged over 14 with a learning disability, to help tackle the higher rates of morbidity and preventable deaths. The aim was to ensure at least 75% of eligible patients had a health check each year by 2023/24.

139. NHS England guidance to GPs on 19 March 2020 had advised that annual patient reviews could be deferred if necessary. As the first Covid-19 wave subsided, NHS England recognised some practices might have a backlog of reviews and checks to undertake. It also recognised that people with learning disabilities had been disproportionately impacted by the pandemic: Covid-19 risked compounding pre-existing health inequalities.

140. The Phase 3 Letter instructed all GP practices to ensure everybody with a learning disability was identified on their register, and that annual health checks were completed. Phase 3 implementation guidance advised GPs should provide health checks to at least 67% those on the learning disability register by the end of financial year 2020/21. Each health check would attract an additional payment of £140 to practices. Updated QOF guidance, published in September 2020, clarified all practices should develop and implement plans to restore full operation of annual health checks for people with learning disabilities – and that virtual health checks may be clinically appropriate as determined on a case-by-case basis.

141. The proportion of eligible 14-17 year olds who had a health check increased from 38.7% in 2019/20 to 63.0% in 2020/21 (an increase of 24.3 percentage points), based on experimental official statistics in development. For 18-24 year olds, the proportion increased from 50.2% to 70.1% in the same period (an increase of 19.9 percentage points). The proportion of health checks delivered declined in 2021/22 – to 58.4% for 14-17 year olds, and to 67.0% for 18-24 year olds – but not to pre-pandemic levels.

Secondary care referrals

142. Where a patient presents with a condition that requires further examination or requires additional treatment, GPs can refer the patient to secondary care.

Depending on the type of care needed, a patient may be subject to diagnostic tests such as scans, referred to a local NHS hospital for ongoing treatment or given the opportunity to see a consultant to discuss a potential future procedure.

143. During the pandemic, there was no change to this approach. NHS England did not at any point in the pandemic advise GPs to halt or hold up any referral to secondary care that the GP considered was clinically necessary. In its preparedness letter on 19 March 2020 **[DB1/66][INQ000087325]**, NHS England considered it appropriate to emphasis to GP practices that where a patient was concerned about any symptoms related to suspected cancer, GPs should continue to refer them to diagnostic tests as normal.

144. This was reiterated in the GP Covid-19 SOP updates issued on 5 April 2020 **[DB1/67][INQ000470430]** and 6 April 2020 **[DB1/68][INQ000049958]**. The latter expressly stated that "*Access to urgent care and essential routine care should be maintained for all patients*". The former set out the position where a secondary care referral was appropriate for a person with symptoms of Covid-19. It stated:

"*For guidance on when to consider hospital admission for patients with symptoms of COVID-19, please refer to the NICE COVID-19 rapid guideline. If an ambulance is required, the call handler should be informed of the risk of COVID-19. If an ambulance is not required, the admission should be discussed with the relevant hospital team first, to inform them of the risk of COVID-19 and agree method of transport to hospital*".

145. The version of the Covid-19 SOP issued on 29 May 2020 **[DB1/63][INQ000470459]** contained more detail on secondary care referrals, specifically for children. It stated that, for children experiencing symptoms of Covid-19, the "*thresholds for face-to-face assessment in general practice and for referral to secondary care should not change*". It also referred to consultant hotlines as a means to using secondary care consultant advice in their management of children.

Data on Children's GP appointments and referrals

Children's GP appointment data

146. NHS England has been asked to provide data on the number of GP appointments attended by CYP during the Specified Period.

147. The NHS England GP Appointment Dataset ("**GPAD**") provide national data on the

number of GP appointments undertaken, the mode of consultation, and when appointments took place, but it does not provide data on patient characteristics such as age.

148. NHS England understands the Clinical Practice Research Datalink ("**CPRD**") collects data on children's contacts with GPs from a large representative sample of GP practices across the UK. The CPRD is delivered by the Medicines and Healthcare products Regulatory Agency ("**MHRA**"), with support from the National Institute for Health and Care Research ("**NIHR**"). Research based on CPRD data suggests GP contacts for children aged 1-14 years declined by over 50% in the first Covid-19 wave (March to June 2020), more than for young people aged 15-24. Face-to-face contacts for people under 25 fell by 88%, with a decline of over 90% for children aged 1-14. Mirroring the decline in face-to-face contacts, remote contacts more than doubled **[DB1/152][INQ000624813].**

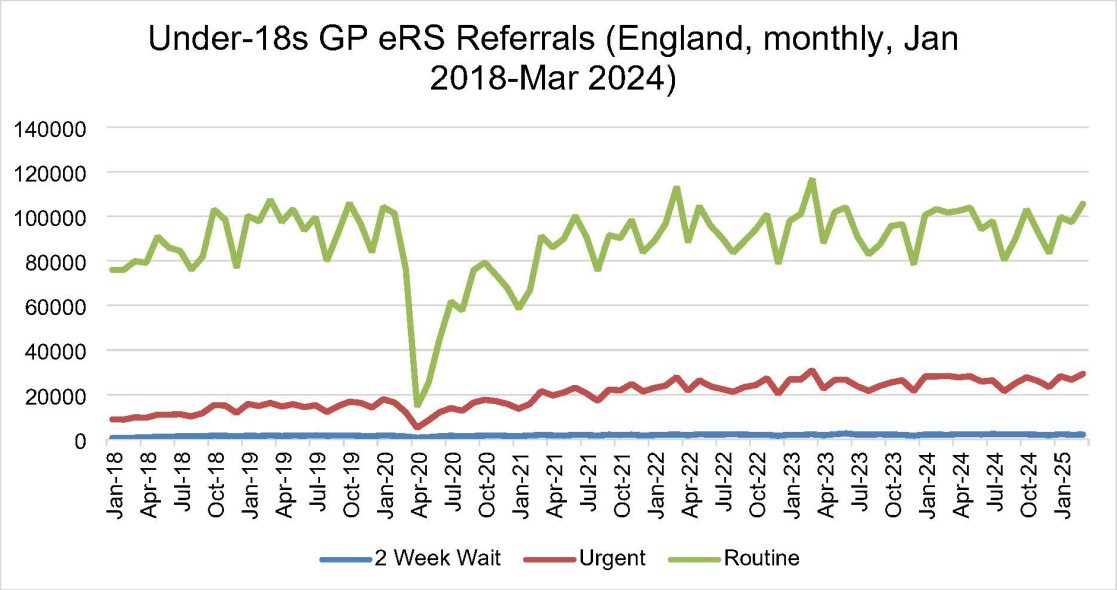
Children's GP referrals data

149. The NHS e-Referral System Dataset ("**eRSDS"),** collected by NHS England, provides summary data on GP referrals to consultant-led services, including on behalf of CYP.

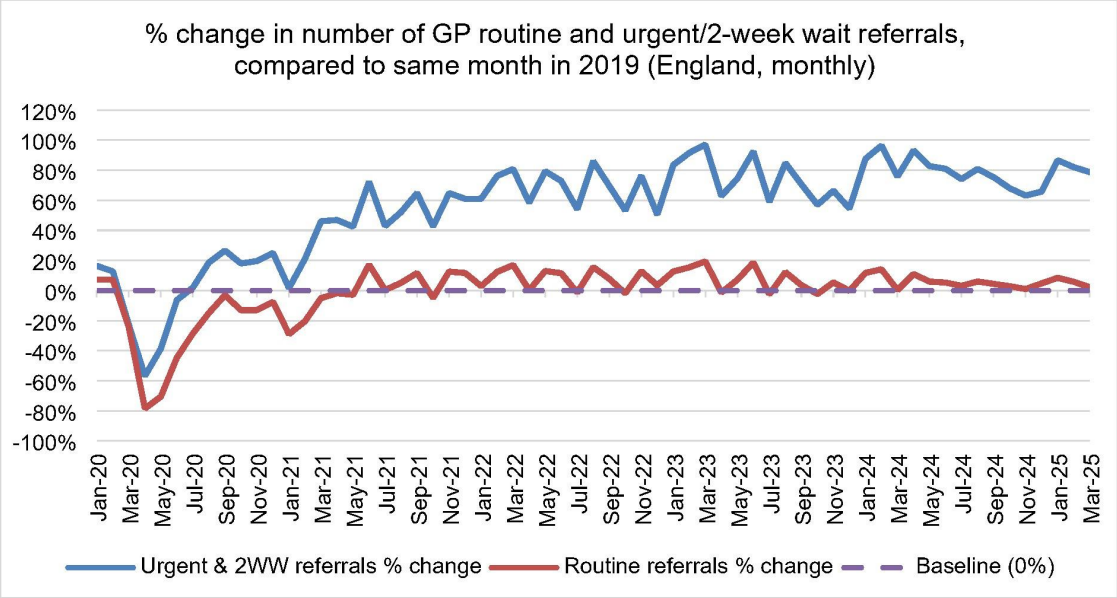
150. Under the NHS Standard Contract, all GPs in England use the NHS e-Referrals Service ("**e-RS**") to refer patients to secondary care. The eRSDS does not include patients whose referral, booking, or attempted booking has occurred outside of e-RS.

151. Most GP referrals are categorised as either 'routine', 'urgent', or (for suspected cancer, specifically) 'two-week wait'. A significant proportion of children's suspected cancer cases receive an urgent referral.

152. eRSDS data shows GP CYP referrals declined significantly following the onset of the pandemic (from 119,177 in February 2020 to 20,325 in April 2020), before recovering to above pre-pandemic levels by mid-2021. It is not possible to infer whether, or to what extent this decline was attributable to GPs referring a smaller proportion of CYP contacts to secondary care. GPs were instructed to continue referring patients to secondary care, including for suspected cancer, as normal throughout the pandemic. A more likely significant reason for the decline is that fewer patients were coming forward with symptoms, in the first instance.



153. The graph below shows the relative changes in numbers of routine and urgent referrals, from January 2020 until March 2025, compared to the same month in 2019. Data on urgent referrals also includes two-week wait referrals:



154. Following the initial decline in the first Covid-19 wave, numbers of urgent referrals recovered by July 2020. From this point on, urgent referrals consistently exceeded the 2019 baseline. In March 2023, there were 85% more referrals compared to March 2019. Routine referrals recovered by June 2021, and thereafter stayed consistent with pre-pandemic levels, until March 2025.

Dental services

Background and commissioning

Primary dental services

155. NHS England was responsible for commissioning primary dental services, via regional commissioners, from 2013 until 2023. Most primary care dentists were, and continue to be, 'high-street' independent contractors, working to a 'General Dental Services' ("**GDS**") or a 'Personal Dental Services' ("**PDS**") contract. There are around 11,000 independent dental practices in England. From April 2023, responsibility for commissioning dental services has been delegated to ICBs.

156. Around 85% of NHS primary dental care providers hold a GDS contract, covering 'mandatory dental services', i.e. routine and clinically necessary urgent treatments needed to keep the mouth, teeth and gums healthy and free of pain. PDS contracts make up around 15% of NHS dentistry contracts. These cover specialist primary services such as sedation, orthodontics, or home visits.

157. People should be able to go to any dental practice that holds an NHS contract for treatment, irrespective or geographical restrictions. Dental practices can choose whether to provide NHS treatment to new patients depending on whether they have capacity under the terms of their contract.

Additional dentistry services

Urgent dental care services

158. Urgent dental care delivered during normal working hours is provided by dental practices under GDS contracts. Other urgent dental care, including out-of-hours care, may be commissioned separately from other providers. Patients usually access this type of care by contacting NHS 111 for triage.

Community dental services

159. Community dental services ("**CDS**") provide dental care for adults and children with specialist needs that high-street contractors may not be able to cater for. These include adults and children with physical or learning disabilities, people with some medical conditions, people who are housebound, and people experiencing homelessness. CDS is provided in a range of settings, hosted by NHS acute Trusts, community Trusts or by community interest companies / social enterprises under a

PDS contract.

Secondary and tertiary care dentistry

160. Most specialist dental services are delivered in secondary and tertiary care settings, including acute hospitals, district general hospitals and (currently ten) specialist dental hospitals, funded under the standard NHS contract. Specialist dental services include, for example, oral and maxillofacial surgery, paediatric dentistry, and restorative dentistry (including endodontics, periodontics, prosthodontics, and implants).

Dental practice payments

161. Under GDS and PDS contracts, dental practices are paid an agreed annual contract value against which they are required to deliver a specified number of units of dental activity ("**UDA**") or units of orthodontic activity ("**UOA**"). The annual contract value to is paid to each dental practice in equal monthly payments. At the end of each financial year a reconciliation of the volume of activity delivered against the annual contract value is undertaken. Should the contractor fail to deliver 96% of the agreed volume of activity then recovery of non-delivered activity is undertaken. The indicative UDA or UOA value varies between practices.

162. During the Specified Period, dental treatments were categorised according to one of three treatment 'bands'. Each band attracted a different number of UDAs, based on the complexity and cost of providing the treatment. The three 'bands' were summarised as follows:

    a. Band 1: Clinical examination, radiographs, scaling and polishing, preventative dental work, such as oral health advice (worth 1 UDA).

    b. Band 1 (urgent): Treatment including examination, radiographs, dressings, recementing crowns, up to two extractions, one filling (worth 1.2 UDAs).

    c. Band 2: Simple treatment, like fillings, including root canal therapy, extractions, surgical procedures, and denture additions (worth 3 UDAs).

    d. Band 3: Complex treatment, which includes a laboratory element, such as bridgework, crowns, and dentures (worth 12 UDAs).

163. Patients typically make co-payments for dental treatments, which increases according

to the treatment band. People under 18, or under 19 and in full-time education, and some other patients in respect of benefits, are not liable for patient charges. There are no patient charges for secondary or tertiary care dentistry.

CYP dentistry before the Specified Period

164. Tooth decay has been recognised as a public health concern amongst young children in England since before the pandemic. PHE survey data suggested rates of tooth decay amongst 5-year-olds had been falling since the 1980s, but in 2020 23.5% of children aged 5 years experienced obvious signs of dental caries.

165. In the 12 months leading up to June 2019, almost one in three 5 to 9 years olds in England had not visited an NHS dentist. In 2018-19, tooth decay was the leading reason for hospital admissions amongst the same age group (25,702 hospital admissions, compared to 26,111 the previous year).

166. In September 2019, NHS England published a dental access and prevention framework, "*Starting Well Core*", to support local health commissioners improve oral health for children aged 0-2, with the aim to **[DB1/69][INQ000610877]**:

    a. increase dental access and attendance for children aged 0-2 years;

    b. deliver evidence-based preventive care in practice; and

    c. raise public and professional awareness to promote early-years dental attendance, and support campaigns led by professional bodies.

167. The scheme incentivised dental practices to deliver units of dental activity in excess of 102% of their contract value, up to a maximum of 104%, attributable to eligible children aged 0-2 years.[12] These incentives encouraged practices to potentially exceed commissioned capacity to provide dental checks with preventive care for children aged 0-2 years. The NHS LTP recognised Starting Well as supporting 24,000 dentists in England to help young children develop good oral health habits.

<u>Steps taken by NHS England during the Specified Period</u>

168. NHS England's approach in the early pandemic was to suspend all routine and non-urgent dental care, to help minimise the spread of Covid-19. From June 2020 until the

[12] Under GDS and PDS contracts, dental practices are paid for individual units of dental activity ("UDA") or units of orthodontic activity ("UOA"), up to a maximum agreed annual contract value

end of the Specified Period, as IPC and social distancing measures were relaxed, NHS England agreed temporary contract arrangements to incentivise dental practices to resume as much activity as was safe – whilst recognising a significant amount of activity undertaken during the pandemic (e.g. remote triage) was not measurable or remunerable under the GDS and PDS contracts. In the context of severe capacity constraints, NHS England encouraged dental practices to prioritise vulnerable patients, or patients likely to experience oral health inequalities (including children) for treatment.

Suspension of routine dental care

169. In recognition of the new social distancing measures and the wider NHS pandemic response, NHS England wrote to general dental practices and CDS on 20 March 2020, asking them to "*radically reduce the number of routine check-ups by cancelling patients from vulnerable groups (and offering cancellation to anyone else who wishes to do so) to reduce the need to travel and have close contact with others in waiting rooms and surgeries*" **[DB1/70][INQ000610881]**. This was intended to help free up capacity for urgent care that could not be delayed.

170. Guidance from NHS England to dental services impacted adults, CYP alike.

171. On 25 March 2020, NHS England wrote to dental practices and CDSs advising that:

    a. all routine, non-urgent dental care including orthodontics should be stopped and deferred until advised otherwise;

    b. all practices should establish (independently or by collaboration with others) a remote urgent care services, providing telephone triage for patients with urgent needs during usual working hours, and whenever possible treating with:

        i. advise;

        ii. analgesia; or

        iii. antimicrobial means where appropriate;

    c. if a patient's condition could not be managed by the above means, they would need to be referred to a local 'Urgent Dental Care' ("**UDC**") system. UDCs were new arrangements, whereby providers would work with defined groups

of patients and manage urgent dental care needs only, with appropriate separation arrangement in place; and

d. all community outreach activities (e.g. the Starting Well Core programme for children) should be stopped until advised otherwise.

Restoration and prioritisation of dental services during the Specified Period

172. During April and May 2020, NHS England planned for the gradual resumption of dental service delivery. There was a concern that private dental services would resume ahead of NHS services, which might exacerbate inequalities in care access. NHS service restoration would be contingent on the ability of practices to meet IPC and PPE requirements, including the additional requirements to undertake aerosol generating procedures.

173. From June 2020 until June 2022, NHS England offered to pay dental practices the full value of their pre-pandemic contracts, on the condition they delivered a specified proportion of normal activity volumes. This proportion increased gradually over the course of the Specified Period, as IPC constraints were eased, and in accordance with clinical advice about realistic expected levels of dental activity.

174. On 4 June 2020, NHS England published an updated SOP to support the phased transition to the full resumption of dental services, as well as an updated UDC SOP. The SOP advised practices that every CYP should continue to receive tailored oral health advice, remotely, in line with government guidance **[DB1/71][INQ000610893].** The dental services SOP was subsequently updated at intervals throughout the Specified Period, to reflect the changing government guidance on IPC and PPE requirements.

175. On 15 July 2021, NHS England published a revised dental practice SOP with a renewed focus on health inequalities. It stated practices should prioritise patients with the greatest clinical need, attend to incomplete care plans, and re-call those patients whose oral health needs may have increased or gone unmet during the pandemic (including children) **[DB1/72][INQ000610899].** The SOP acknowledged some vulnerable patients, including looked after children, may have been displaced or relocated due to measures applied by local authorities; dental practices were expected to ensure they provided flexible access to these groups.

176. On 14 September 2021, NHS England published guidance for dentists on the

prioritisation of recalls for children. The guidance was intended to support the implementation of existing National Institute for Health and Care Excellence ("**NICE**") guidance on assigning recall intervals between oral health reviews **[DB1/73][INQ000610901]**. The NHS England guidance advised, for example, child with known safeguarding concerns, children under the age of 2 years, or children with a medical condition where a dental infection may have an impact on their health, should be prioritised for recalls.

177. NHS England confirmed on 28 June 2022 that usual contracting arrangements would resume from the second quarter of 2022-23.

Monitoring of dental service activity

NHS Dental Statistics("**DS**")

178. NHS DS provide information on NHS dental activity in England, including clinical treatments and numbers of patients seen. NHS Digital oversaw the DS collection until 2023; it has since been overseen by NHS England.

179. The graph below shows numbers of treatments by 'band', provided to children, from 2018-19 to 2022-23:

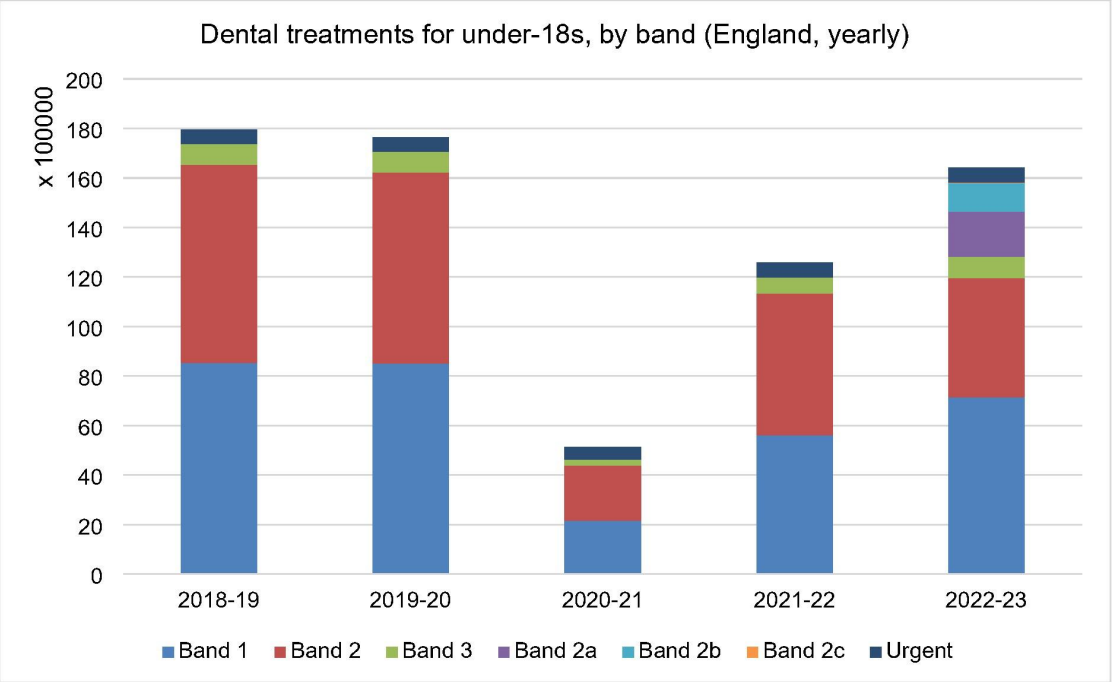
    a. In 2019-20, 17,642,120, courses of treatment were provided; this fell by over 70% to 5,144,304 in 2020-21.

    b. Treatments increased back to 12,599,712 in 2021-22, and to 16,439,589 in 2022-23, as services recovered from the pandemic.

    c. The number of urgent treatments remained stable during the period.

    d. This data excludes activity not measurable in UDAs, so it does not account for all activity delivered by dental practices during the pandemic (remote triage, for example).

    e. Bands 2a, 2b, and 2c were introduced only in 2022-23, so are not reflected in previous years.

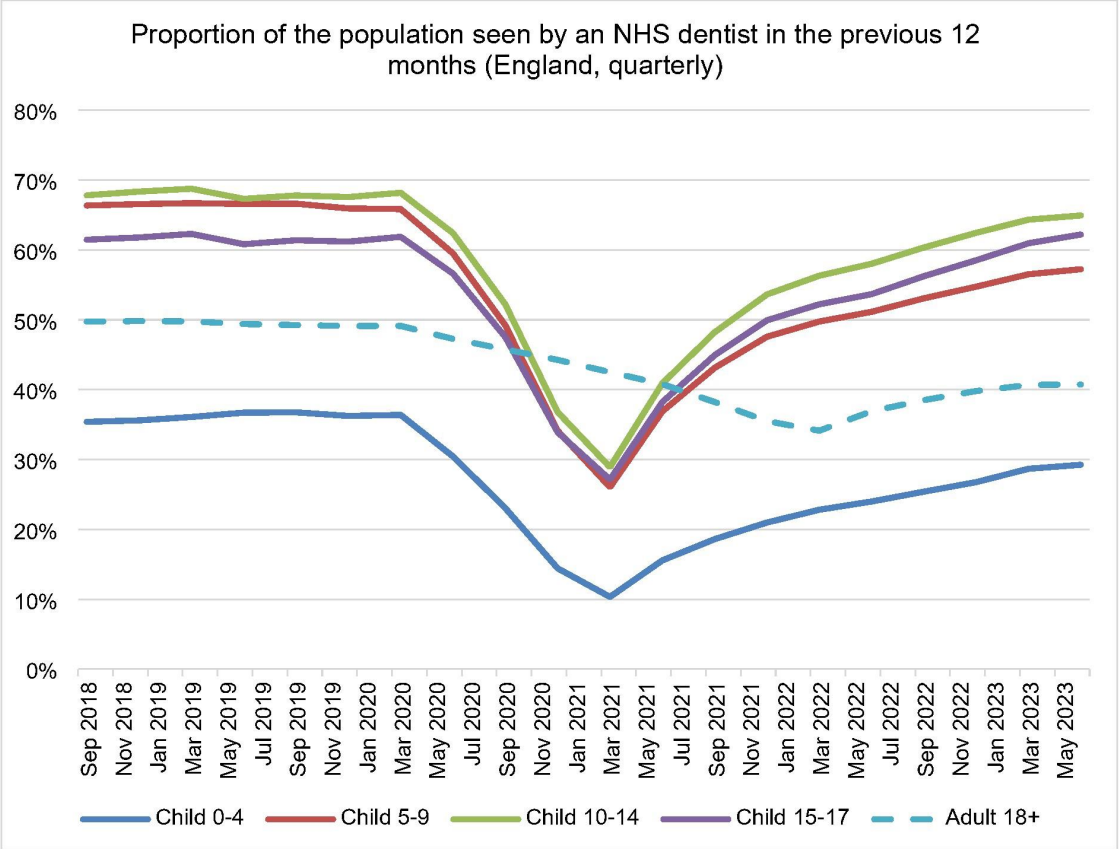


180. The graph below shows the proportion of the child population seen by an NHS dentist in the previous 12 months (by age group), compared to the adult population. It shows children's access to dental care was disproportionately impacted during the pandemic:

a. The proportion of all children seen by an NHS dentist in the previous year was 58% as of March 2020.

b. This declined to 22% by March 2021, recovering to 52% by June 2023.

c. 49% of adults had seen a dentist in the previous 12 months in March 2020; this declined less, to a low of 34% in March 2022.



181. Dental activity was monitored by the NHS England Board. In June 2021, it was noted that children up to age 15 had experienced the largest reduction in unique patients seen by dentists in 2020-21. This was considered likely due to dental practices recalling fewer children for routine fluoride varnishes. NIRB noted in July 2021 that children may have been more greatly impacted by adults because their needs were typically more routine, and the focus during the pandemic was on more urgent care.

Community Dental Services Waiting Lists ("**CDS WL**")

182. NHS England started collecting national data on CDS WL in April 2021, via quarterly surveys, to better understand and manage CDS care backlogs. CDS became a key focus given CDS' treat vulnerable people, including children with learning disabilities.

183. The CDS WL data are not published official statistics, and have several data quality issues:

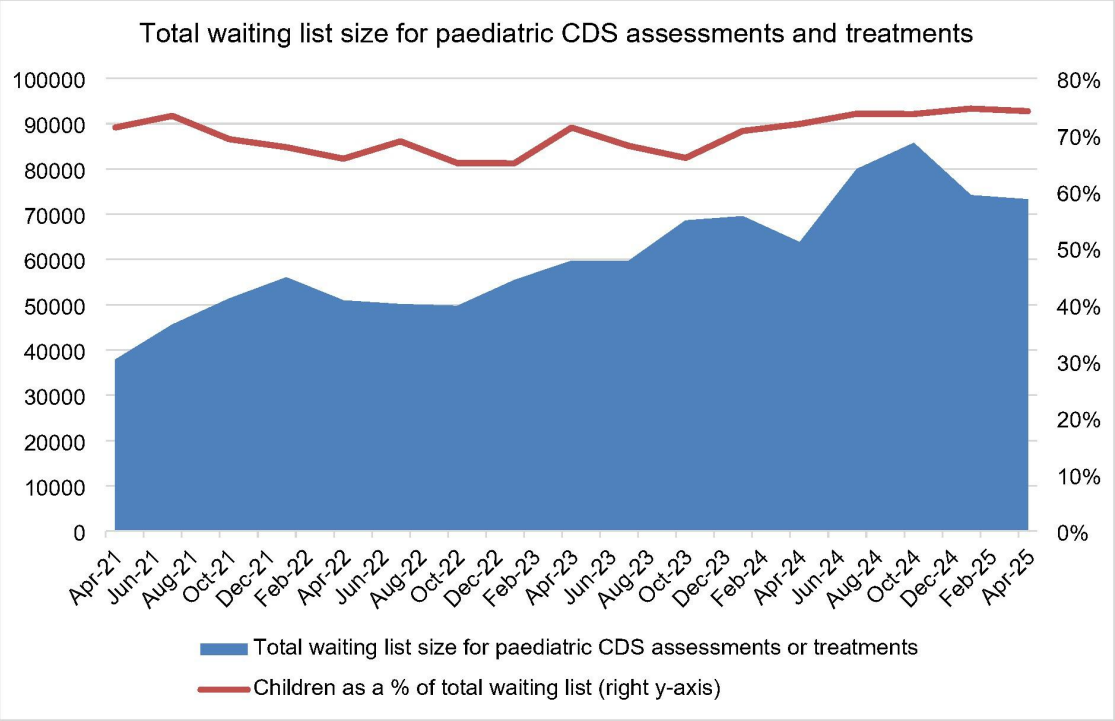
    a. providers receive and process referrals differently, so the data cannot always be split consistently across providers (e.g. between different types of treatment);

b. not all providers complete every survey, so reported waiting list sizes are likely to be under-estimates; and

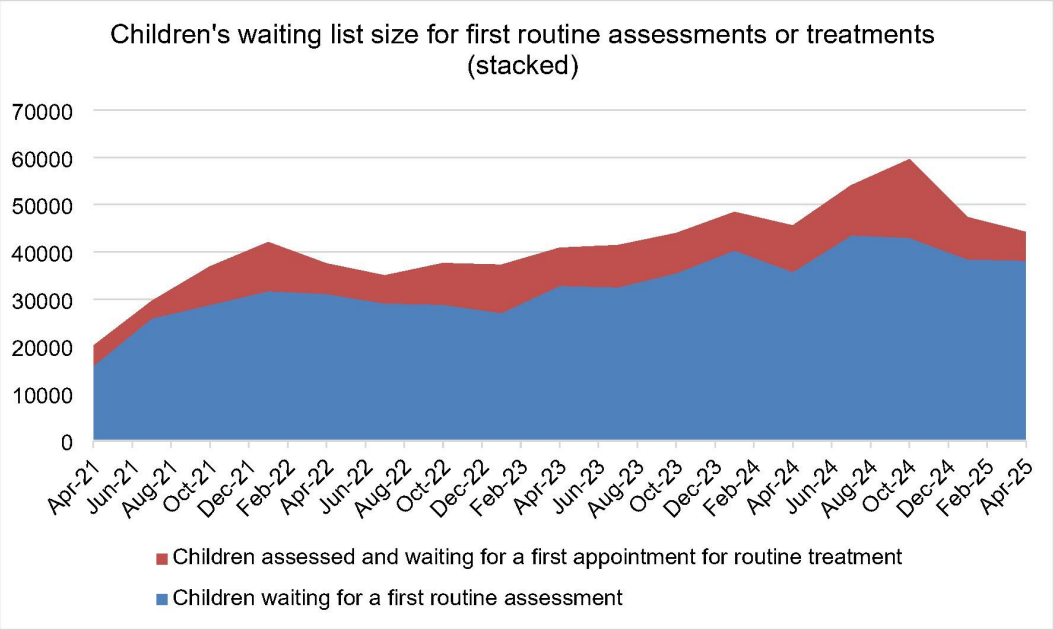
c. some providers provide multiple data entries for the same survey period.

184. The graph below shows the total waiting list size for paediatric CDS assessments and treatments (including routine treatments and treatments under general anaesthetic or sedation). It also shows the proportion of the list occupied by people under 18. The children's waiting list appeared to increase from almost 38,000 in April 2021 to over 50,000 in July 2022 (the end of the Specified Period) and subsequently increased further. April 2021 data is likely to be an underestimate, as it excluded data from the Yorkshire region.

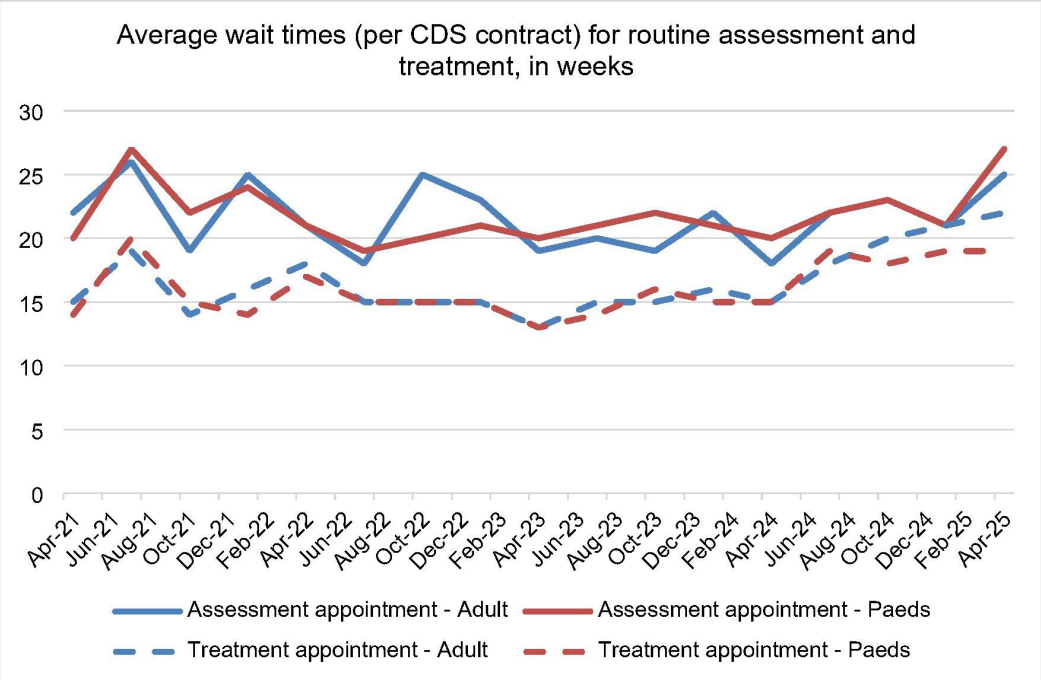
185. Children made up the majority of the CDS WL during the same period (between 65% and 75% from April 2021).

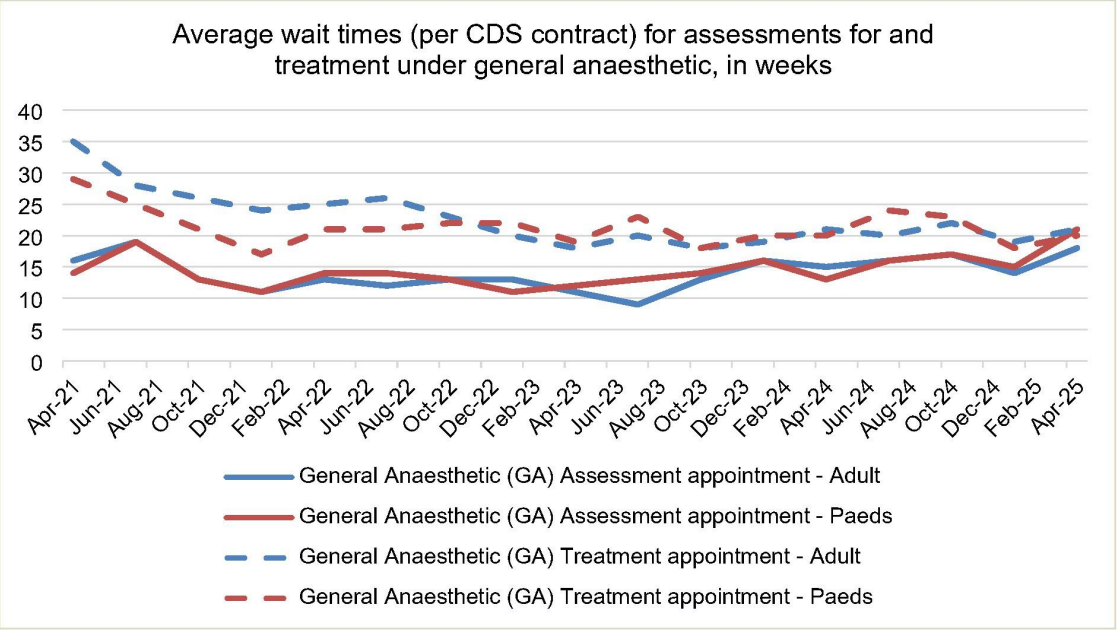


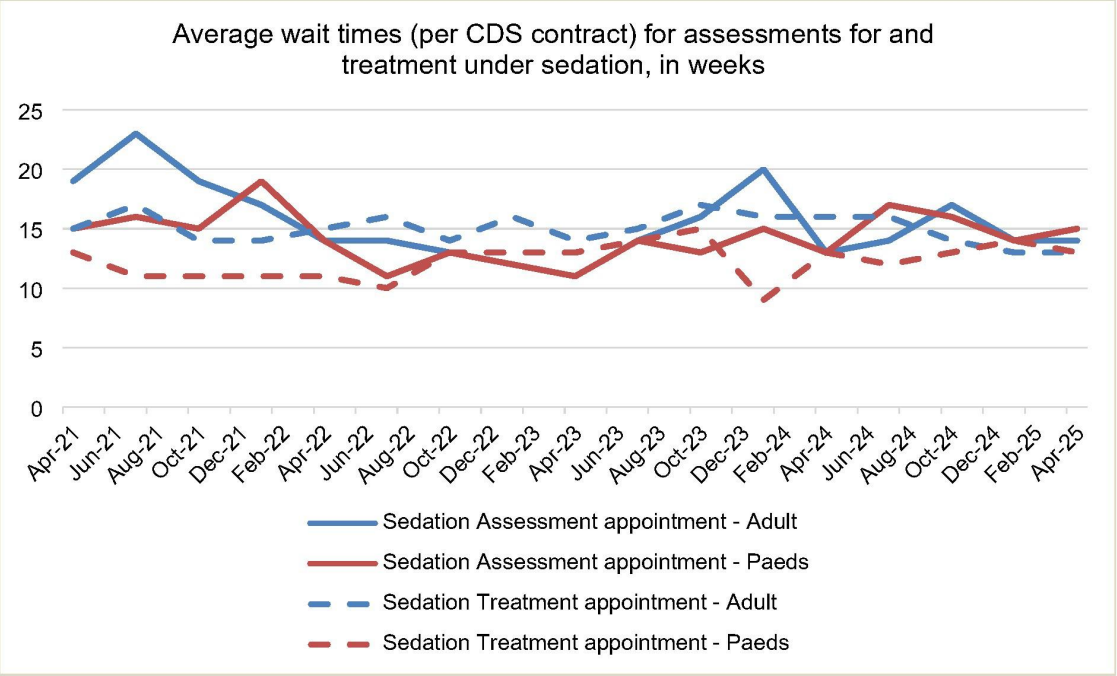
186. Most children's waits were for routine assessments, or a first routine treatment following assessment:



187. Graphs below show average wait times in weeks for assessments and treatments. Providers report average wait times for their patients; national data represents the 'average' waiting times across all CDS contracts. The graphs suggest children and adult wait times have been broadly similar, for all assessments and treatments, from April 2021 until early 2025. Average wait times for children's routine assessments fluctuated between 19 and 27 weeks in the same period. Average wait times for routine treatments fluctuated between 13 and 20 weeks.



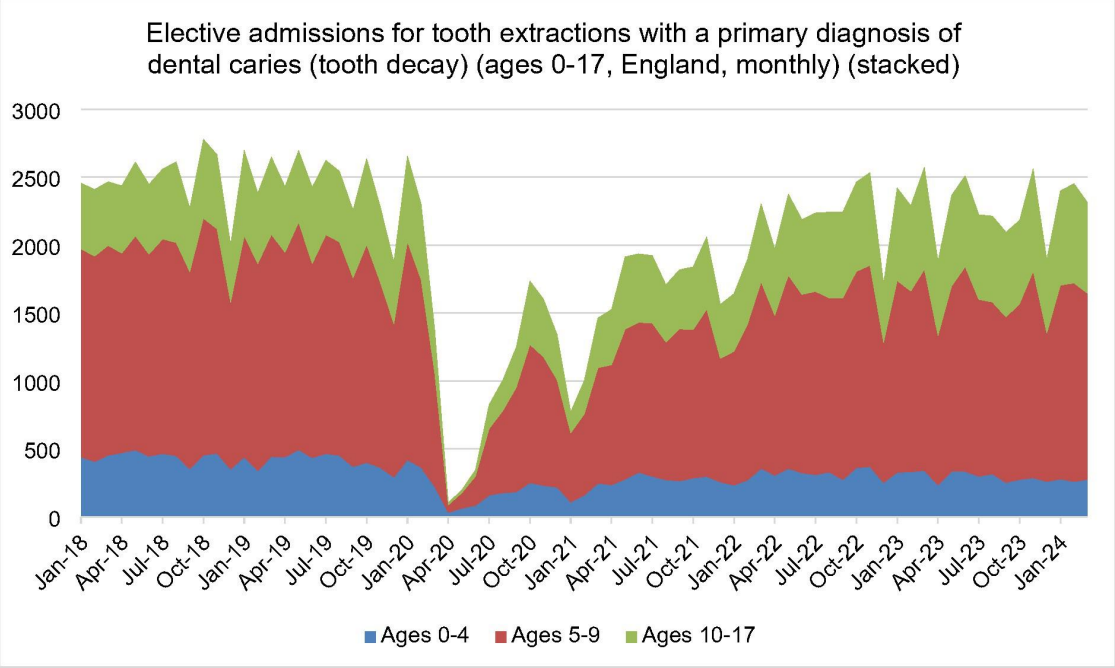




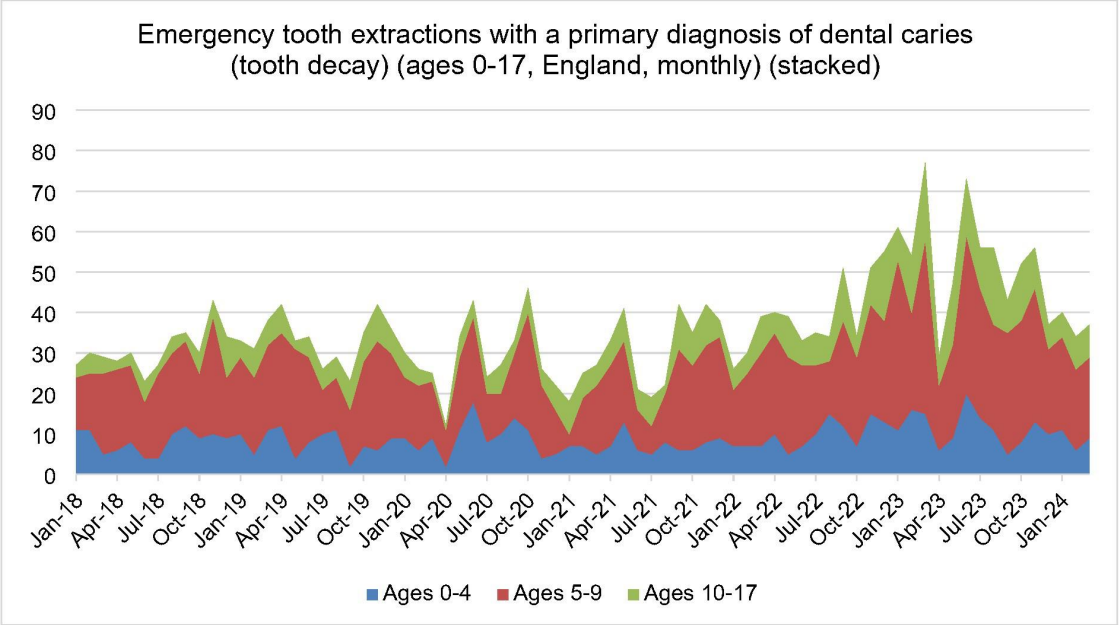
Secondary Care Dentistry

188. Tooth decay is the leading reason for hospital admissions amongst children aged 5 to 9; rates of tooth decay are nearly three and a half times higher amongst children living in the most deprived areas, compared to children living in the most affluent communities. Most children admitted to hospital with tooth decay undergo tooth extraction under a general anaesthetic.

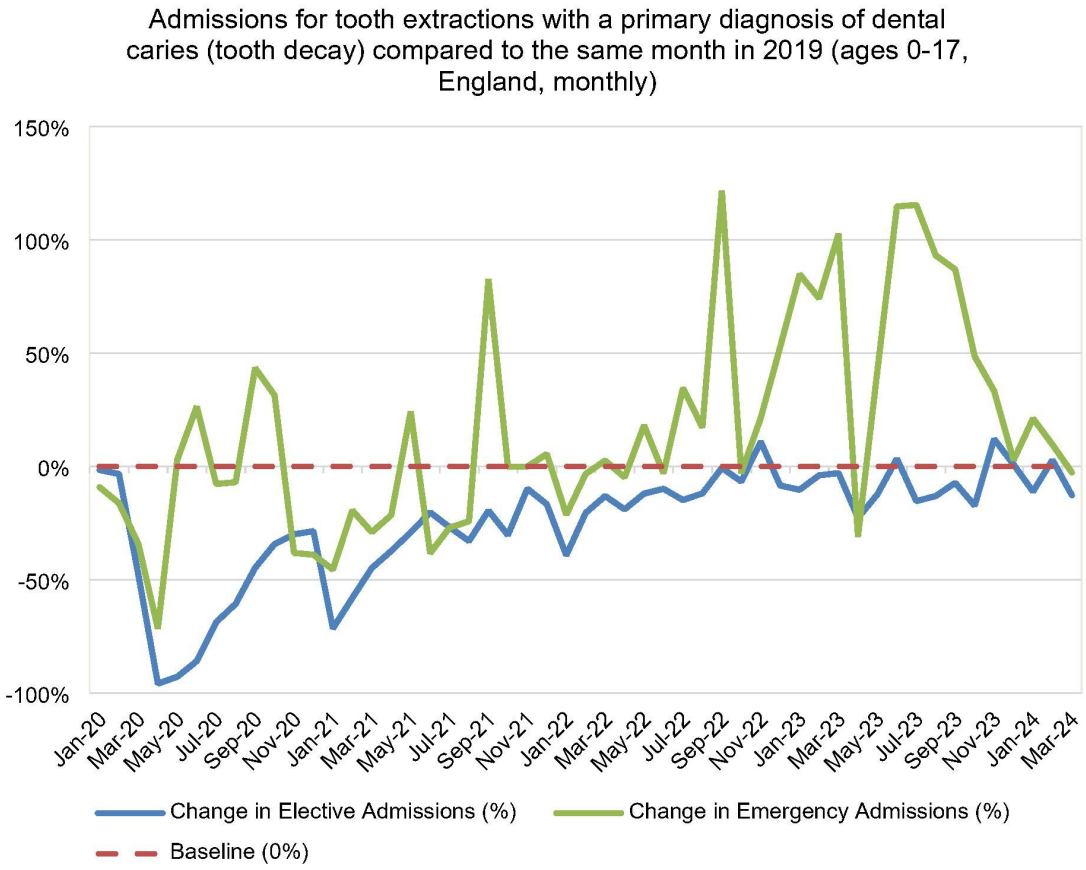
189. HES Admitted Patient Care ("**APC**") data provides information about dental activity provided in hospitals undertaken in England. The graph below shows elective admissions for tooth extractions with a primary diagnosis of dental caries (tooth decay) for children. There were 2,304 elective admissions in February 2020, falling to 103 in April 2020 after the onset of the pandemic and the suspension of routine elective services. Services recovered gradually with declines in the winters of 2020-21 (during the second Covid-19 wave) and 2022.



190. Emergency admissions for tooth extractions are less common than planned procedures. Prior to the Specified Period, there were typically under 40 admissions per month for emergency children's teeth extractions. Following the immediate onset of the pandemic, emergency admissions recovered quickly. There appeared to be a significant increase in emergency admissions after the end of the Specified Period, lasting until early 2024.



191. The graph below shows elective and emergency admissions for tooth extractions, with a primary diagnosis of tooth decay, as a proportion of treatments in the same month in 2019 (prior to the pandemic). It indicates the numbers of elective tooth extractions for children had largely recovered by summer 2023:

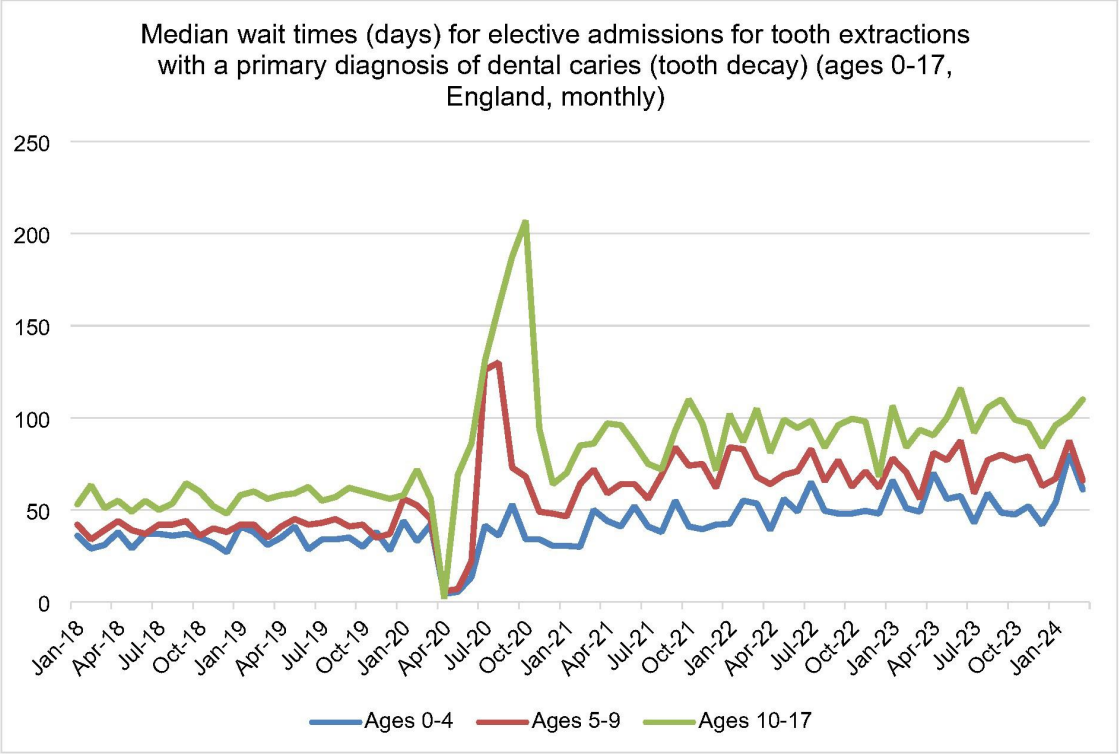


192. The suspension of elective services created a demand backlog, which increased average wait times. The graph below illustrates this:

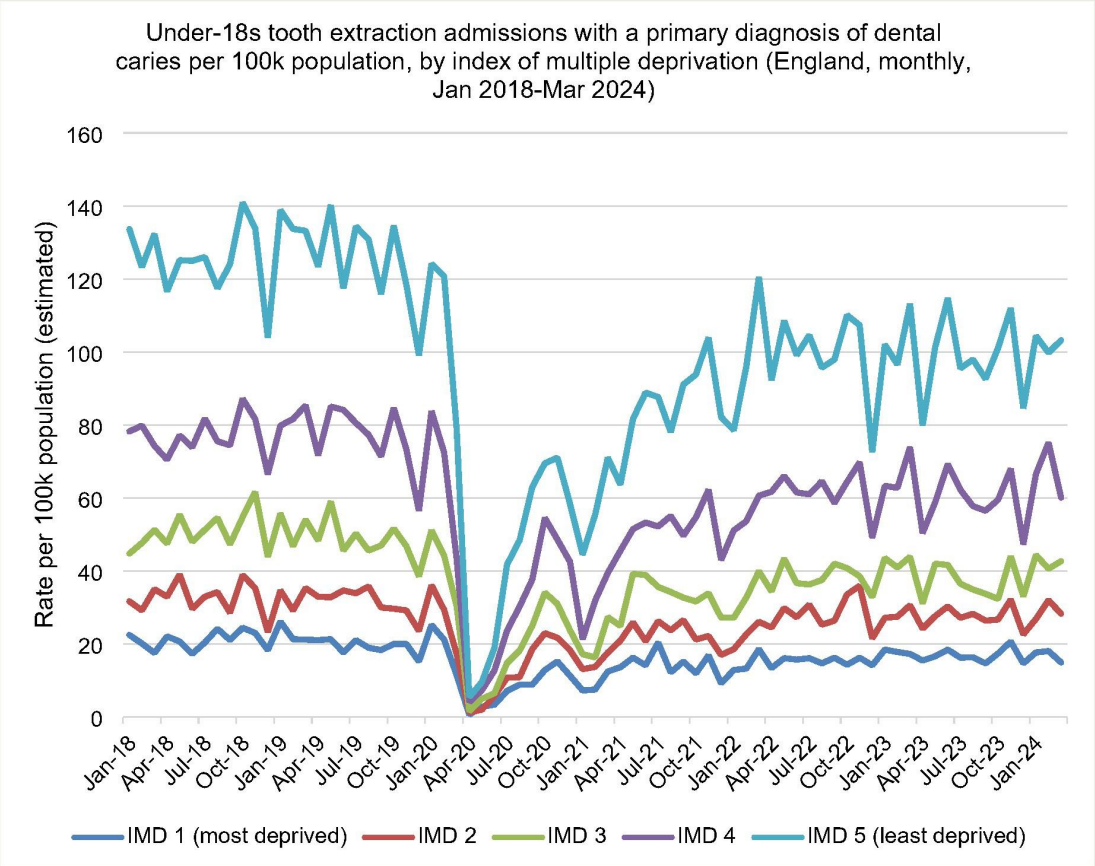
a. Prior to the pandemic, children up to the age of 10 waited on average less than 45 days for an elective tooth extraction, following a decision to admit. Children aged 10 or over waited on average less than 65 days.

b. During the latter half of 2020, as elective services recovered from the initial Covid-19 response, average waits increased to a peak of 130 days (for 5–9-year-olds) and 188 days (for 10–17-year-olds).

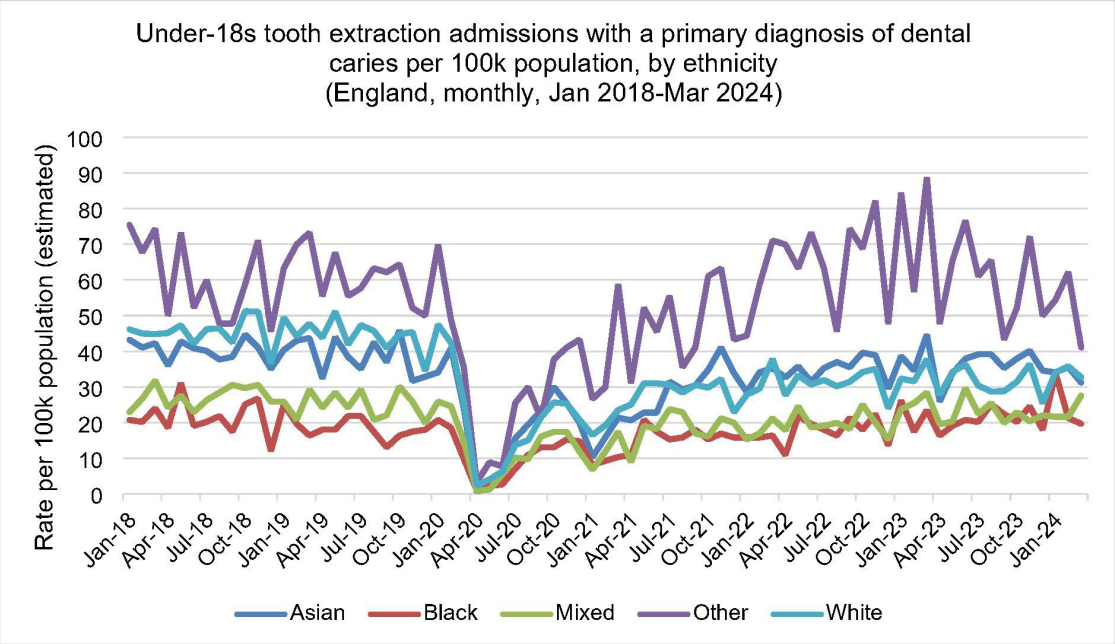
c. Wait times subsequently decreased and stabilised, but they had not recovered to pre-pandemic levels by early 2024.



193. The estimated rate of hospital admissions amongst children living in the least deprived areas were consistently higher than those living in more deprived areas, before, during, and after the Specified Period. Typically the admission rate for children in the least deprived areas was at least six times greater, per estimated 100 thousand population, than for children in the most deprived areas. Note this observed variation in access to hospital care, amongst different groups, may not necessarily reflect different groups' need or demand for healthcare.



194. Rates of admissions were also consistently higher amongst white or Asian children, compared to black or mixed-race children. Children from 'other' racial backgrounds had the highest admission rates overall, although these children represent a relatively small population. As above, estimates of variation in healthcare access amongst different population groups do not necessarily reflect variation in healthcare need. Estimates of population sizes are based on 2021 census data, and the data excludes a significant proportion of admitted patients for whom no ethnicity was recorded:


Under-18s tooth extraction admissions with a primary diagnosis of dental caries per 100k population, by ethnicity
(England, monthly, Jan 2018-Mar 2024)
Rate per 100k population (estimated)
100
90
80
70
60
50
40
30
20
10
0
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Asian
Black
Mixed
Other
White

SECTION D – Urgent and Emergency Care

Introduction

195. This section focuses on CYP access to Urgent and Emergency Care ("**UEC**") during the Specified Period. From as early as the Phase 1 Letter in March 2020, there was a clear message to secondary care providers that emergency admissions should continue unaffected. This applied to adults and CYP equally.

196. Emergency care involves life-threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department (A&E). Urgent care involves any non-life threatening illness or injury needing urgent attention which might be dealt with by phone consultation through NHS 111, pharmacy advice, out-of-ours GP appointments, and/or referral to an urgent treatment centre.

197. NHS England's elective and emergency care directorate provides national guidance and support in elective, UEC services across the NHS. It works in partnership with other NHS organisations, system leaders, frontline staff, patient and key stakeholders (such as Royal Colleges) to design, develop and implement best practice models of care that ensure patients are cared for appropriately. The National Director for Urgent and Emergency Care was a standing member on NIRB.

999 and the ambulance service

198. Upon calling 999, the call will be answered by an initial 999 call centre service (provided by BT Group Plc), which in turn directs the call to the appropriate emergency service.

199. Once the call is transferred to the ambulance service its outcome becomes the responsibility of one of the 11 NHS ambulance Trusts. The 999 call may result in the dispatch of an ambulance, but can also be managed without an ambulance being dispatched (such as health advice over the phone from a clinician).

200. NHS England's main role in respect of ambulance services is to provide national leadership and support to commissioners of ambulance services (ICBs). NHS England also brings together key stakeholders across systems to ensure that ambulance services are represented in wider national and regional strategic discussions across the breadth of work on UEC, including highlighting the impact on ambulance services handover delays.

201. Some specific safeguards applied to CYP in respect of 999 calls. During the pandemic, ambulance services started to receive increasing amounts of calls requesting Covid-19 "advice only". These increased call volumes were putting 999 services under strain with high call waiting times.

202. In response, BT implemented a filtering mechanism between the end of March 2020 and early June 2020 to protect the 999 service from non-emergency Covid-19 related calls. The filter enabled identification of patients who were calling for advice, who would then be referred to NHS 111 online for further advice. Initially this excluded children under the age of 5, and was subsequently extended to include young people under 16s in late April (decision agreed by Emergency Call Prioritisation Advisory Group 20 April, implementation date by BT not available). These calls were passed to the ambulance service; in any case of uncertainty the default was always to connect the caller to the ambulance service so there was no risk to patient safety.

NHS 111

203. NHS 111 is a nationally mandated service which makes it easier for the public to access urgent healthcare services. It is a free-to-call number available 24/7 every day of the year, first introduced in August 2010 alongside the NHS 111 website, to respond to people's healthcare needs when they:

    a. need medical help fast, but not a 999 emergency;

    b. do not know who to call for medical help or do not have a GP to call;

    c. think they need to go to A&E or another NHS urgent care service; or

    d. require health information or reassurance about what to do next.

204. Initially, NHS 111 was not intended to be a clinical service. It was an assessment and referral service provided by trained advisors, supported by nurses and paramedics. Following reform to the service in 2017, NHS 111 was expanded to include a "consult and complete" model which allowed users to be connected directly with a multidisciplinary clinical team (overseen by GPs) and offered clinical consultation direct over the phone.

205. The expansion to a "consult and complete" model led to the development of the Integrated Urgent Care ("**IUC**") Clinical Assessment Service ("**CAS**"). These were clinician delivered services, aimed at providing care closer to home, as well as

helping to tackle the increasing demand on urgent care services.

206. On 27 January 2020, NHS 111 was identified by the SSHSC as a critical part of the NHS infrastructure for dealing with the Covid-19 outbreak as it was positioned as a key point of access to the healthcare system for patients with Covid-19 symptoms.

207. Calls into NHS 111 started to increase from 27 January 2020. By the end of February 2020, the NHS 111 service started to experience a further significant increase in demand driven by callers with potential Covid-19 symptoms. It became clear there was not enough capacity within the core NHS 111 to manage the additional scale of demand.

208. Capacity was expanded at pace as a result of the National Pandemic Flu Service Framework (the "**NPFS**"), which was designed to lay dormant until needed. Under the NPFS, PHE would commission NHS England to contract manage and technically assure the additional NHS 111 telephony solution. NHS England led on mobilising additional operational capability.

209. The mobilisation of the contact centre capability contracts secured under the NPFS framework resulted in the core NHS 111 telephony service being complemented by an additional PHE helpline and a Covid Response Service ("**CRS**") (funded by PHE during the first two Covid-19 waves, and by NHS England during the third wave).

210. Three clinical queues were also stood up by NHS England to be able to assess and triage patients to support 111 core services and the CRS:

    a. The Covid-19 Clinical Assessment Services ("**CCAS**");

    b. The Dental Clinical Assessment Service ("**DenCAS**"); and

    c. The Pharmacy Clinical Assessment Service ("**PharmCAS**").

211. Calls relating to children under 5 were retained within the core NHS 111 service and not referred to CCAS. From 9 April 2020 onwards, all calls relating to people under 16 were retained within the core NHS 111 service, given the increasing awareness of the complexity of Covid-19 symptoms and how Covid-19 might present differently between children and adults.

212. There was an unprecedented increase in the volume of calls to NHS 111 at the start of the pandemic. Of the calls triaged, it is estimated that 25-30% of which were in

relation to children.

213. NHS England's CYP Transformation Programme and IUC teams, working closely with the RCPCH, piloted a programme of re-deploying paediatric clinicians who were shielding or returning/retired into NHS 111 services to assist by responding to paediatric NHS 111 calls.

214. One of the key drivers behind the project was to help divert avoidable emergency department presentations by offering paediatric advice to parents and/or carers contacting NHS 111. The aim of the pilot was two-fold:

    a. to support NHS 111 providers taking part in the project in responding to paediatric calls during the pandemic; and

    b. to test new ways of working, assessing the feasibility including paediatric expertise within NHS 111 and its impact on service delivery and patient pathway.

Pilot NHS 111 paediatric initiative

215. A pilot scheme for a paediatric NHS 111 initiative was stood up initially during spring 2020 by NHS England's CYP transformation team, and was staffed by re-deployed paediatric clinicians who were shielding and/or returning into NHS 111 services to assist pandemic response by responding to paediatric NHS 111 calls.

216. An expression of interest form was circulated by the RCPCH to its members, directed specifically at post membership paediatricians and paediatric Advanced Nurse Practitioners. Following the completion of an on-boarding process (including HR checks, contractual arrangements, IT set-up and a 4 hour induction session), clinicians were allocated to one of 5 provider sites.

217. The initial phase involved over 70 paediatricians responding to NHS 111 calls.

218. Although there was no national funding provided for the initial phase of the work, this was later secured through the CYP Transformation team ahead of the service's national launch in 2021. Paediatricians involved in the first phase of the pilot volunteered their time for the first few months.

219. A data framework was developed to evaluate the impact of the paediatric NHS 111 initiative. The results showed that calls handled by paediatricians were less likely to

result in avoidable attendances to primary care / ambulance call outs than those handled by non-paediatric clinicians **[DB1/75][INQ000610912]**.

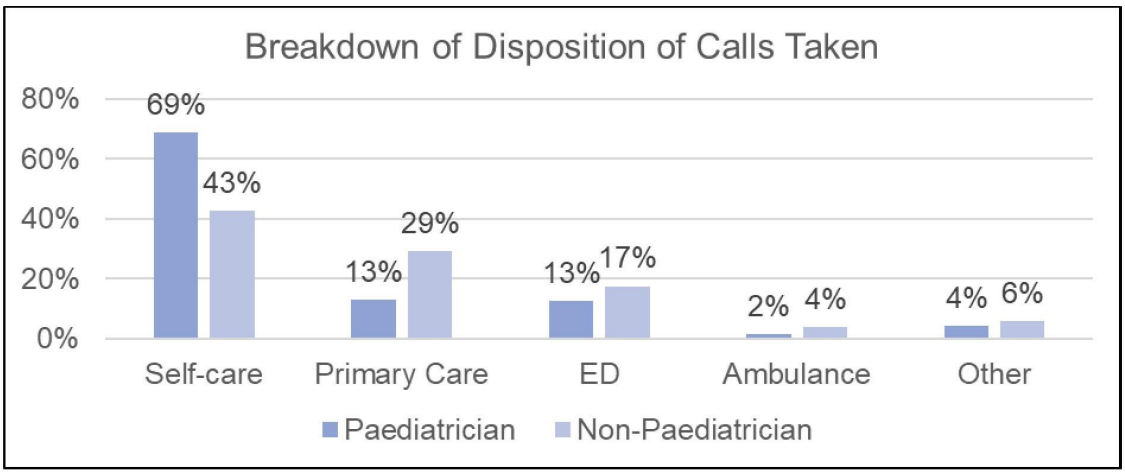


Figure 1. Final dispositions of calls responded to by paediatric clinicians, compared to other clinical groups (GPs, ANPs and ACPs). Source: NHS111 provider data

220. Based on the success of the pilot paediatric NHS 111 initiative, national funding was secured to establish the Paediatric Clinical Assessment Service ("**PCAS**") within NHS 111 to formally assess the feasibility and impact of a paediatric CAS.

Paediatric Clinical Assessment Service

221. The PCAS went live on 3 August 2021. It was hosted by a single provider (Integrated Care 24), and accepted referrals from all NHS 111 providers through a national clinical queue. Data was used from the pilot scheme to ascertain which clinical presentations are likely to benefit most from specialist paediatric input. These were:

a. a skin complaint or rash;

b. a cough;

c. a head, facial or neck injury;

d. toxic ingestion / inhalation / overdose, subsequently replaced by abdominal pain; and

e. unwell infant under 1.

222. When a call matched one of the chosen PCAS pathways (above), then it could be directed to the PCAS. When a call relating to a CYP fell outside the PCAS pathways,

they would be handled under one of the other NHS 111 services.

223. A senior paediatrician would provide on-shift supervision, and there was a medical director on-call to provide support across all five sites. Clinical forums and regular webinars were established to discuss clinical and operational matters.

224. A monthly PCAS Delivery Group was established in May 2021, consisting of NHS England's CYP and Integrated Urgent Care teams, IC24 (the service provider), NHS 111 Pathways and Director of Services leads.

Legacy of the PCAS

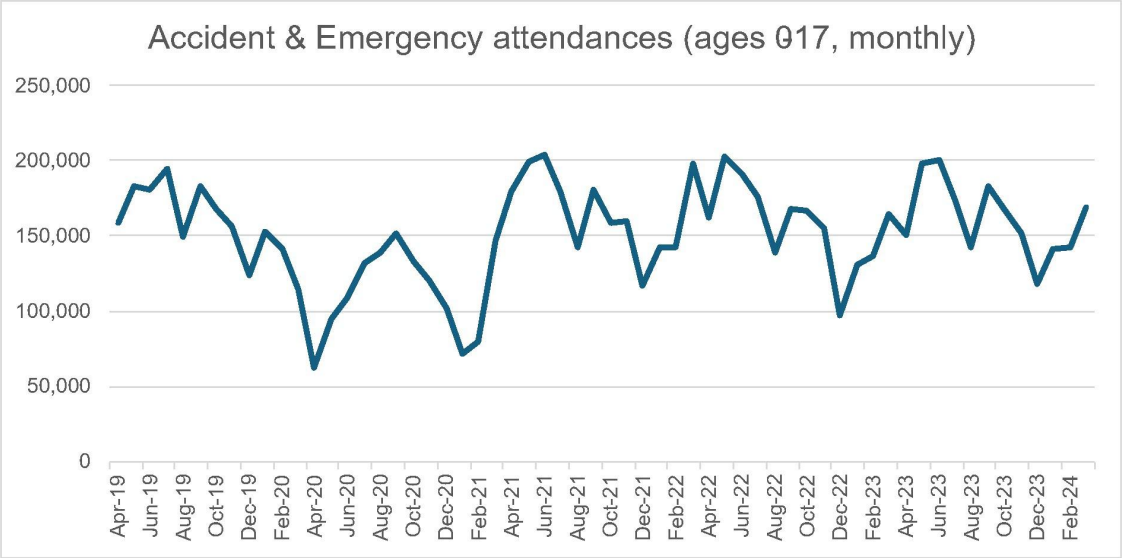
225. The launch of PCAS during the pandemic clearly demonstrated the benefit (in respect of both the child and appropriate use of health service resources) of having specialist, paediatric clinicians assessing children via PCAS (rather than the whole-population CAS).

226. In January 2023, NHS England launched a blueprint for the expansion of NHS 111 to transform patient access. The blueprint included a permanent role for PCAS as part of the NHS 111 family of services.

227. Parents and carers seeking health advice for CYP using NHS 111 online or by calling NHS 111 will now have increased access to specialist advice, including direct booking of a same-day appointment with a specialist rather than attending A&E, avoiding hundreds of avoidable hospital admissions.

A&E

228. As with all age groups, there was a decrease in the number of A&E attendances at the beginning of Wave 1.



229. On 19 May 2020, the CYP Transformation Board noted that protecting the health and well-being of CYP had been a focus across a number of issues, including reducing delayed presentations to primary and emergency care.

230. As part of a 10-point UEC action plan released in September 2021, NHS England released guidance to systems working together to ensure UEC services were maintained during winter 2021/22. There were specific concerns about a potential surge in respiratory syncytial virus ("**RSV**") amongst children, after RSV hospitalisations had been lower in the previous winter (due to social distancing measures). The UEC 10-point action plan committed NHS England to:

a. working with PHE / DHSC on national targeted messages, alerting parents to symptoms and appropriate management for common seasonal illnesses;

b. with DHSC, providing a £1.8 million fund for Voluntary, Community and Social Enterprise ("**VCSE**") organisations to support self-management and provide tailored information to targeted groups of children, young people, families and carers (including the most vulnerable) and carers with seasonal illness;

c. issuing guidance and case studies to support CCGs / ICS' who wished to establish and adult and paediatric out of hospital Respiratory Clinical Assessment Services ("**RCAS**") to manage the likely increase in respiratory infections;

d. working with the Joint Committee on Vaccination and Immunisation ("**JCVI**"), partners and palivizumab manufacturer to mobilise an early programme to

identify and protect those at risk of severe complications from RSV;

e. developing the role of the paediatric workforce to reduce pressure on UEC service by piloting a national paediatric clinical assessment service in 111; and

f. establishing a National Cell specifically to managed actions for CYP. **[DB1/74][INQ000470549_0015]**.

231. NHS England's role in anticipating, and preparing for, potential RSV surges amongst CYP is covered in more detail in paragraphs 283 to 294 below.

SECTION E – HOSPITAL CARE

232. Hospital care can be 'elective' (planned) or 'non-elective' (un-planned). Children requiring surgery or care may be admitted to hospital wards (including general paediatric wards or PICU). Alternatively they may receive outpatient care or diagnostic tests without needing hospital admission.

233. In addition to acute paediatric hospital admissions due to Covid-19 and its consequences (such as children with PIMS-TS), hospitals were also faced with unseasonal outbreaks of other diseases which surged once measures to reduce social interaction were eased (such as RSV).

234. Delivery of elective care, including planned surgery for CYP, was impacted significantly by the pandemic, as most non-urgent hospital care was suspended to free up hospital capacity for an anticipated surge in Covid-19 patients.

235. Emergency in-patient admissions also declined following the onset of the Covid-19, as fewer people presented to emergency departments and GPs. Delivery of planned outpatient care was less significantly impacted, as many appointments could be delivered remotely via telephone or video.

236. The subsequent recovery of routine in-person hospital care was constrained by multiple factors, including IPC restrictions, availability of PPE, and the redeployment of clinicians to support critical care.

237. Towards the end of the Specified Period, NHS England recognised recovery of children's elective services had been slower than for adults. Children also experienced a disproportionate increase in elective wait times. NHS England subsequently took steps to improve monitoring of children's service restoration, and to ensure local providers restored services equitably.

Scope and Definitions

Elective Care

238. 'Elective care' refers to planned non-emergency treatments led by a medical consultant. It can include non-urgent surgical operations, outpatient appointments, or diagnostic tests, which are typically undertaken following a referral from a patient's GP or community health practitioner to a hospital consultant. Elective care for children, including surgery, can include non-specialised, specialised, and highly specialised

services.

239. Patients in England, including children, should not normally wait longer than 18 weeks to start elective treatment, after having been referred to a consultant – as per NHS referral-to-treatment ("**RTT**") standards for all non-emergency consultant-led care.

Non-Elective Care

240. 'Non-elective care' refers to unplanned, and typically urgent, care – including surgery – required to address acute health conditions, some of which may be life-threatening. Children are often admitted to hospital for non-elective care after having first attended, and been assessed in, a hospital emergency department.

Paediatric Critical Care

241. Children requiring an enhanced level of observation, monitoring, or intervention, may be admitted to a Paediatric Critical Care ("**PCC**") Unit. Children in PCC are often medically unstable, and require intubation or ventilation, as well as single or multi-organ support. PCC supports children who have become acutely unwell or had an accident, and children who need intensive support after major (planned or unplanned) surgery.

242. PCC is categorised according to three levels:

a. Level 1 PCC is located in all hospitals providing inpatient care for children and focuses on more common acute presentations and clinical scenarios. Level 1 PCC is not a specialised service.

b. Level 2 PCC refers to more complex activity and interventions that are undertaken less frequently. Level 2 care is typically provided on a Paediatric High Dependency Unit ("**PHDU**") in tertiary (specialist) hospitals and a small number of district general hospitals.

c. Level 3 PCC refers to care in a PICU, provided for the most unwell children who need a ventilator. PICUs are usually located in tertiary centres or specialist hospitals.

243. Additionally, specialist neonatal critical care ("**NCC**") services, including neonatal intensive care units ("**NICU**"), provide care to newborn babies requiring specialist medical and surgical in-patient care after their birth.

Pre-pandemic background

244. In 2019, an NHS England review of children's surgery and paediatric critical care highlighted there had been a gradual decline, over twenty years, in numbers of children undergoing surgery in local District General Hospitals ("**DGH**") **[DB1/76][INQ000610878].** There had been a corresponding increase in waiting lists at specialist centres, even for non-specialised surgery. Specialist centres are often further away from a child's home.

245. Children receiving specialised surgery often need a paediatric critical care bed in which to recover. Capacity challenges in paediatric critical care made it difficult to balance demand for elective and emergency care, especially in winter – meaning elective surgery for children was sometimes postponed, or patients needed to travel further from home.

246. NHS England committed to establishing paediatric ODN in the NHS LTP, to oversee coordinated local approaches to ensuring CYP accessed services as close to home as possible – and could access specialised and non-specialised services whether for elective, urgent, emergency, or planned needs. NHS England commissioned 10 Surgery in Children ("**SIC**") ODNs in 2019 and subsequently published a SIC Clinical Network Specification in 2023.

247. SIC Networks also support local implementation of recommendations published in 'Getting it Right First Time' ("**GIRFT**") National Specialty reports. GIRFT is a national programme which has been hosted by NHS England since July 2021, and which aims to improve the treatment and care of patients through in-depth service reviews, benchmarking and presenting a data-driven evidence base to support change.

248. From 2021 onwards, GIRFT took more of a role in improving efficiencies/productivity, expanding from its earlier focus on clinical quality audits.

249. During the Specified Period, GIRFT published several National Specialty Reports for children's health services, including on paediatric general surgery and Urology (February 2021) **[DB1/77][INQ000610900]** and paediatric trauma and orthopaedic surgery (April 2022)**[DB1/78][INQ000610904]**.

Early pandemic response

250. NHS England's approach to delivering children's elective care during the Specified Period reflected its phased approach to non-urgent care more generally.

251. Early expert modelling in February and March 2020 predicted NHS capacity would be significantly overwhelmed (even with surge capacity) by a large influx of Covid-19 patients if no mitigations were put in place. Informed by this modelling, NHS England's early priority was to urgently free up the necessary capacity for Covid-19 patients, whilst maintaining essential care, including emergency and cancer care, for all patients who needed it.

252. On 16 March 2020, NHS England published the first iteration of a "*Clinical guide for the management of paediatric patients during the coronavirus pandemic*" **[DB1/79][INQ000610880]**. Paediatric services were advised to maintain delivery of high-quality care for emergency admissions during the Covid-19 response. They would need to plan to support a potential surge in Covid-19 hospital admissions, by planning to admit young and older adults, whilst also complying with IPC and PPE requirements. To this end, NHS England advised paediatric services to:

a. keep children out of the healthcare system, unless essential;

b. use telemedicine and other non-direct care, when appropriate; and

c. plan for stopping elective procedures and treatments, especially those that may consume critical care and ward resources.

253. The Phase 1 letter, published 17 March 2020, confirmed health systems should assume they would need to postpone all non-urgent elective operations from 15 April 2020, for a period of at least three months, to help free up the maximum possible in-patient and critical care capacity. Systems also had full discretion to wind down elective activity earlier than this. Emergency admissions, cancer treatment, and other clinically urgent care was expected to continue unaffected. It was anticipated paediatric staff freed from elective commitments might be able to support intensive care functions. Trusts were asked to consider how junior medical and nursing staff might be redeployed to adult services. Trusts were also required to consider the safeguarding implications of accommodating young adults in children's hospitals and wards.

254. On 26 March 2020, NHS England published a "*Clinical guide for the management of paediatric critical care patients during the coronavirus pandemic*", advising hospitals to prepare for a surge in demand for paediatric critical care medicine **[DB1/153][INQ000624808]**. By this time, it was acknowledged the number of paediatric patients admitted with Covid-19 may be low, so paediatric departments

were advised they may be asked to support adult services by providing staff to support adult clinical and non-clinical services, and admitting adult patients (initially up to 25 years of age), in the event adult units became overwhelmed.

255. On 8 April 2020, NIRB approved regional surge plans to protect local access to paediatric critical care capacity and access to co-located speciality services, in the event of severe operational and capacity pressures **[DB1/154][INQ000624806]**.

256. In April 2020, with input from RCPCH, NHS England published an updated version of its "*Clinical guidance for the management of paediatric services*" **[DB1/80][INQ000610894]**. This guidance reiterated non-elective patients continued to need access to high quality care, despite elective services being curtailed. Outpatient appointments were expected to continue using telemedicine and other non-direct care, where appropriate.

257. NHS England also published guidance on the management of patients within a number of sub-specialties. For example, guidance published 11 April 2020 set out the musculoskeletal conditions in children (under 16) which still required urgent onward referral and treatment in secondary care (including children showing signs of non-accidental injury) **[DB1/155][INQ000624807]**.

Redeployment of the Paediatric Workforce

258. The 16 March 2020 clinical guide for the management of paediatric patients recognised elective CYP care may be curtailed, and resources could be diverted to clinical areas under greater pressure. Trusts were advised to consider how their paediatric services could be 'exclusively consultant-led' in the event junior paediatric staff were redirected to adult services. The same consideration was to be given to the redeployment of students and newly-qualified nurses.

259. On 26 March, NHS England published more detailed guidance on the redeployment of acute paediatric staff, to be read alongside the 16 March 2020 guidance. Acute paediatric services were advised that, where possible, community paediatric doctors could be redeployed to support acute paediatric services and paediatric emergency departments, although essential community services for keeping children safe and well at home should continue. This followed the 19 March 2020 publication of guidance on the prioritisation of CYP community services, which advised some services could be stopped or partially stopped **[DB1/116][INQ000269920]**.

260. Where staffing of acute paediatric services was sufficient, Trusts were advised they

could redeploy foundation year ("**FY**") doctors and General Practice Specialty Training ("**GPST**") doctors to other services. With respect to paediatric critical care services, units could consider either increasing the age for admission to PICU, or PICU staff might be redeployed to support adult critical care, if current services were sufficiently well-staffed.

261. NHS England set out plans to restore all CYP community services on 3 June 2020 **[DB1/14][INQ000421234]**. The 26 March 2020 redeployment guidance was subsequently updated on 9 July 2020, stating community paediatric doctors should only be redeployed to acute paediatric services 'if required', and only if they had 'recent acute experience'. Acute paediatric services could now consider redeploying paediatric trainees, if they had recent experience working in adult services.

262. Key to the NHS England redeployment guidance was the principle that secondary care staff should be redeployed only in exceptional circumstances, and that local discretion should determine the extent to which redeployment measures should be implemented.

Clinical prioritisation

263. Clinicians use their professional judgement to determine, on a case-by-case basis, the urgency of a patient's needs and which patients should be prioritised for treatment – supported by clinical guidelines such as those developed by NICE and the Royal Colleges.

264. Throughout the Specified Period, including when elective capacity was constrained, clinicians were expected to prioritise patients with the most urgent needs.

265. To support clinical decision-making, on 11 April 2020, NHS England published (with Royal Surgical Colleges) a "*Clinical guide to surgical prioritisation during the coronavirus pandemic*" **[DB1/81][INQ000226460]** (**"Prioritisation Guidance"**).

266. The Prioritisation Guidance covered a range of paediatric surgical procedures, classifying each procedure in one of the following groups:

    a. Priority 1a Emergency – operation needed within 24 hours.

    b. Priority level 1b Urgent – operation needed within 72 hours.

    c. Priority level 2 – Surgery that can be deferred for up to 4 weeks.

    d. Priority level 3 – Surgery that can be delayed for up to 3 months.

e. Priority level 4 – Surgery that can be delayed for more than 3 months.

267. At NHS England's request, the Federation of Surgical Specialty Associations (**"FSSA"**) produced further versions of the Prioritisation Guidance as the pandemic progressed **[DB1/82][INQ000226461]** in addition to a 'Recovery Prioritisation Matrix' to support decisions to move patients between different priority levels. These guidance documents were developed with input from the NCD for CYP.

Phased re-introduction of elective care

268. By late April 2020, the number of Covid-19 patients in English hospitals was decreasing. On 29 April 2020, NHS England sent the Phase 2 Letter to all NHS providers and commissioners, encouraging Trusts to consider whether they had the capacity to resume some non-urgent elective care. By this stage, it was evident the complete cessation of elective surgery was no longer sustainable given Covid-19 remained prevalent, and it was likely to remain prevalent over the summer of 2020. Pathways to allow the safe resumption of elective surgery whilst minimising the risk of the patient and staff had to be developed at pace.

269. In May 2020, NHS England issued an "*Operating framework for urgent and planned services in hospital settings during COVID-19*" **[DB1/83][INQ000470457]** advising Trusts to plan, schedule, and organise elective care according to the following principles:

a. patients should only be required to attend hospital where clinically necessary; opportunities for remote, multi-professional virtual consultations should be maximised;

b. Trusts should only admit patients who remained asymptomatic having isolated for 14 days prior to admission and, where feasible, test negative prior to admissions;

c. only asymptomatic patients should attend outpatient appointments, and they should comply with normal social distancing requirements;

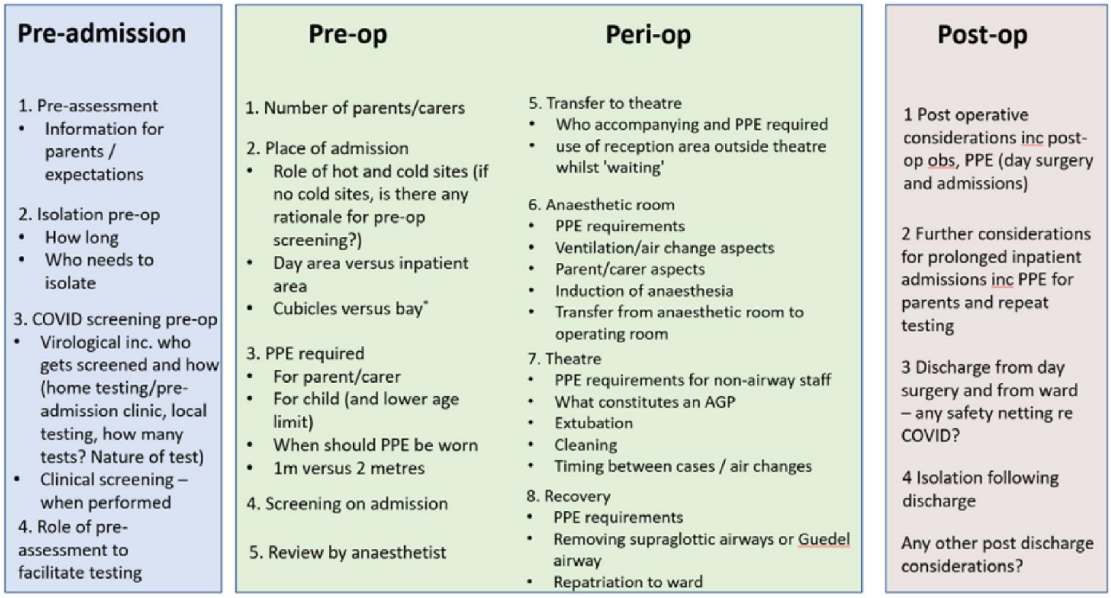
d. Trusts should undertake enhanced planning, and implement protection, for clinically extremely vulnerable (shielded) patients; and

e. patients who subsequently tested positive, or who showed symptoms, should be immediately isolated.

270. In April 2020, there were approximately 29,500 fewer elective paediatric hospital

admissions compared to April 2019 (a decline of around 72%). A considerable backlog of children who needed elective operations, some of whom were waiting longer than recommended by clinical guidelines, had began to develop. A significant proportion of the backlog comprised treatments which were age-critical in terms of a child's development.

271. On 17 July 2020 RCPCH published, with input from NHS England and other clinical stakeholders (including PHE), the "*National guidance for the recovery of elective surgery in children*", which advised services to implement the children's elective surgical pathway below **[DB1/156][INQ000624809]**:



272. An expert clinical steering group, comprising colleagues from RCPCH, NHS England, PHE, ODNs, and academia, continued to meet to develop updates to the RCPCH elective recovery guidance throughout the Specified Period, in light of changes to the national IPC guidance (including in September 2020, November 2021, and June 2022). The guidance aimed to increase patient flow and efficiency, by suggesting hospital providers rely on weekly regional Covid-19 prevalence data to determine the level of required pre-operative Covid-19 testing.

273. In the same month, NHS England, through its National Medical Director, commissioned NICE to produce a rapid guideline to assist with planned care (elective surgery (day surgery and inpatient stays), interventional procedures, diagnostics and imaging) whilst minimising the risk of Covid-19. On 27 July 2020, NICE published the COVID-19 rapid guideline: *arranging planned care in hospitals and diagnostic services (NG179)* **[DB1/157][INQ000309071]**. For CYP having elective surgery,

NG179 advised that the RCPCH guidance for the recovery of elective surgery in children should be followed.

274. By late July 2020, Covid-19 in-patient numbers had fallen to around 900 per day from a peak of 19,000 per day. In its Phase 3 Letter of 31 July 2020, NHS England instructed Trusts to recover the maximum possible elective activity between then and winter 2020/21. Trusts were expected to deliver:

    a. in September 2020, at least 80% of the previous year's activity for both overnight elective and outpatient/day-case procedures, rising to 90% in October 2020 (whilst aiming for 70% in August 2020); and

    b. from September 2020 until the end of the financial year, 100% of the previous year's activity for outpatient attendances, including first appointments and follow-ups (aiming for 90% in August).

275. In preparation for Wave 2, NHS England distributed an actions checklist to regional colleagues, to support them to discuss specialised service protection plans with local Trusts and networks (including paediatric surgery and paediatric intensive care), as Covid-19 admissions increased. From November 2020 onwards, NHS England also collected management daily data from PCC units in England, to monitor bed occupancy and operational strain in a dashboard accessible to all paediatric critical care units, as well as regional and national NHS England teams.

276. Unlike in Wave 1, it was anticipated for Wave 2 that routine elective surgery would be maintained where possible, and that paediatric staff would not be redeployed to the same extent as during the first wave. NHS England reiterated to health systems on 23 December 2020 they should continue to recover non-Covid services where possible, with a view to reducing variation in access and outcomes, whilst also responding to emergency demand and managing seasonal pressures, treating Covid-19 patients, and implementing the Covid-19 vaccination programme **[DB1/158][INQ000624816]**.

277. On 25 March 2021, NHS England published 2021/22 operational planning guidance instructing local health systems to plan to undertake highest possible level of elective activity in that financial year **[DB1/84][INQ000470529]**. Systems were required to draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) from April 2021 to September 2021. Trusts were expected to prioritise the clinically most urgent patients. Systems delivering 70% of 2019/20 baseline activity by April 2021 (rising month-on-month to

85% by July 2021), would be able to draw from an additional £1 billion Elective Recovery Fund provided by the Government.

278. On 30 September 2021, NHS England published the updated 2021/22 operational planning guidance for the second half of the financial year. It was expected children, young people and adults should continue to be treated according to clinical priority. The aim for systems was to:

a. eliminate waits of over 104 weeks by March 2022 expected where patients chose to wait longer;

b. hold or where possible reduce the number of patients waiting over 52 weeks; and

c. stabilise waiting lists around the level seen at the end of September 2021.

279. By November 2021, over 63,000 children were waiting for an inpatient procedure. This included over 5,960 waiting for dental procedures, 6,000 waiting for specialised surgery, 7,300 waiting for trauma and orthopaedic surgery, and 35,000 waiting for general surgical procedures.

280. In February 2022, NHS England published its delivery plan for tackling the elective care backlog as well as its 2022/23 operational planning guidance **[DB1/85][INQ000369624] [DB1/86][INQ000087534] [DB1/87][INQ000113282]**. Supported by £2.3 billion of elective recovery funding, systems were asked to:

a. eliminate waits of over 104 weeks as a priority by July 2022; and maintain this position through 2022/23 (except where patients chose to wait longer);

b. eliminate waits of over 78 weeks by April 2023; and

c. develop plans to support an overall reduction in 52-week waits where possible, with an ambition to eliminate them by March 2025.

281. Systems were expected to analyse their waiting lists data by relevant characteristics, including age, deprivation, ethnicity, and specialty, with the aim of better understanding local variation in access to and experience of treatment – and to ensure treatment was prioritised based on clinical need.

282. In June 2022 the "*National guidance for the recovery of elective surgery in children*" was updated with the following advice:

a. pre-operative Covid-19 testing was no longer required prior to elective surgery in children, irrespective of vaccination status and irrespective of whether children required overnight admission. Multiplex PCR testing should be considered if a symptomatic child was admitted to a critical care unit or was likely to be in close contact with extremely vulnerable children following surgery;

b. all children undergoing elective surgery should have symptom-based pre-operative screening performed in the 72 hours prior to surgery; if this identified symptoms consistent with a respiratory tract infection, a decision needed to be made by the anaesthetist about the safety of anaesthetising the child for surgery;

c. elective surgery did not need to be deferred in children following asymptomatic or mild Covid-19 infection **[DB1/88][INQ000610905]**.

Respiratory syncytial virus

283. RSV is seasonal, usually appearing in winter and generally has mild symptoms, but can lead to serious illness in children under two years of age. On average, around 33,500 children in the UK require hospital treatment due to RSV each year.

284. Due to measures taken during 2020 by the Government to reduce social interaction, the number of RSV-related hospitalisations in winter 2020/21 was far lower than usual. NHS England's NCD for CYP first raised the potential for a surge in cases as a risk in February 2021. Modelling from PHE/UKHSA in April suggested that there would be a significant surge in RSV cases in 2021 **[DB1/50][INQ000610898]**.

285. The CNO wanted to ensure that the NHS was prepared to manage this and worked with NHS England's NCD for CYP and Specialised Commissioning colleagues to highlight this issue to the NHS England executive in April 2021. Work commenced on resilience plans for paediatric intensive care to manage a surge of RSV related illness, with regions asked to draw up plans. NHS England also offered additional funding to Trusts hosting PICUs, to incentivise them to accelerate the recruitment of international PICU nurses in advance of a potential RSV surge in winter 2021/22 (equivalent to £7,000 for each nurse recruited) **[DB1/159][INQ000624810]**.

286. On 23 July 2021, the CNO updated NIRB on an increase in rates of RSV, particularly in the North West region, and on the preparatory actions in terms of planning, training

as delivered by PHE and the moving of the NHS England RSV group into the current incident structure with the establishment of a Paediatric Cell.

287. To help to communicate the risks of RSV more widely and effectively, a webinar was set up by NHS England's Director of People and Communities on 30 July 2021. This involved both national and local children's charities, utilising the structure of the VCSE Health and Wellbeing Alliance and other networks to reach a wide range of different charities. Charities were asked to share the information provided in the webinar with parents of children that might be at risk of RSV.

288. On 3 September 2021, NHS England published a framework to support the redeployment of nursing staff to support children's in-patient care, including critical care, in anticipation of increases in RSV admissions. Trusts were advised to aim to maintain national recommended nurse-to-patient ratios, working with partners across systems to deliver mutual clinical aid. Only after mutual aid options were exhausted could Trusts consider deploying non-critical care trained paediatric staff, or non-paediatric staff, to PCC areas, under the supervision of PCC-trained nurses **[DB1/160][INQ000624811]**.

289. NHS England also supplied 4,000 paediatric pulse oximeters to primary care practices, to support them to assess children with respiratory symptoms. Previously, most primary care settings could only assess oxygen saturation in adults.

290. RSV cases continued to increase into autumn 2021, and NHS services implemented local surge plans. By the time the peak had passed, there had been twice as many cases as in a normal RSV season. However, NHS services were able to manage this through their resilience plans.

291. In December 2021, NHS England published guidance for systems to support the development of local adult and paediatric RCAS hubs for acute respiratory infections **[DB1/161][INQ000624812]**. These hubs would be situated outside of hospitals, but would have access to advice from paediatric and acute clinicians. Many CCGs and ICSs had already put these models in place. The aims of RCAS hubs were to:

    a. reduce ED attendance and hospital admission from patients who could be appropriately managed in the community;

    b. support general practice by providing access to specialist advice;

c. reduce nosocomial transmission of Covid-19 and other infection conditions; and

d. support elective recovery in hospitals by relieving pressure on bed capacity.

292. NHS England updated its advice to local systems on the management of acute respiratory infections in October 2022, to design hub models to help manage demand and relieve pressure on primary and secondary care **[DB1/162][INQ000624814]**.

293. A lessons learned report on the paediatric respiratory surge response was presented to NHS England's Operational Response and Delivery Group on 8 June 2022, stating that the coordinated whole system approach enabled by senior leadership was important in managing this issue. The work done in 2021 helped to support local management of future RSV increases **[DB1/51][INQ000421236]**.

294. From 1 September 2024, pregnant women have also been entitled to receive a free vaccine to protect their babies against RSV.

Paediatric Inflammatory Multisystem Syndrome

295. A small number of CYP developed Paediatric Inflammatory Multisystem Syndrome temporally associated with SARS-CoV-2 ("**PIMS-TS**"). PIMS-TS develops weeks after contracting Covid-19. PIMS-TS is rare, affecting about 1 in every 3,000 children infected with Covid-19. It is a distinct condition from Long Covid. This was a new disease entity specifically related to Covid-19 infection.

296. PIMS-TS is caused by the immune system over-reacting to the virus, causing a widespread inflammatory response throughout the body. All cases require hospital admission, with a high proportion requiring admission to PICU. Symptoms of PIMS-TS included shock requiring inotropic support, cardiac dysfunction, high temperature, stomach pain, diarrhoea, vomiting, bloodshot eyes, dry/red lips, red rash, peeling skin on fingertips and toes and swollen neck lymph glands.

297. The first cases of PIMS-TS were identified in England in April 2020, during the first Covid-19 wave. Early intelligence was shared between the newly formed paediatric critical care ODNs and reported to the NCD for CYP, reflecting the key role of networked care in detecting early disease patterns.

298. A working group was formed between NHS England, the RCPCH and paediatric specialists from across leading children's hospitals in England in May 2020. A rapid

Delphi process was conducted with 78 clinical experts from, across various disciplines, including paediatrics, infectious diseases, rheumatology, cardiology and haematology, to reach consensus on the most appropriate diagnosis and treatment of children suspected of having PIMS-TS. This consensus was used as the basis for a World Health Organisation case definition of PIMS-TS.

299. The Delphi process led to the publication of a national consensus management pathway for PIMS-TS, published online in May 2020 and in a peer reviewed journal in February 2021. The process also supported the development of a RECOVERY trial protocol, the first formal randomised controlled trial of PIMS-TS therapies.

300. In September 2020, a new ICD-10 code was introduced to allow monitoring of admissions to and discharges from hospital following a PIMS-TS diagnosis. The purpose of having an ICD-10 code was to enable consistent, accurate and uniform coding, which in turn supported data collection and comparison of local and national data across time.

301. From November 2020, NHS England collected management data daily from PCC units in England, including on the number of children admitted to PCC wards with suspected PIMS-TS. The total number of affected children during the period under investigation was around 2000. Monitoring by NHS England and PHE suggested the risk of developing PIMS-TS following Covid-19 infection reduced with each new variant.

Long-term Impact of the pandemic on paediatric elective care

302. As local health systems restored routine hospital care, the CYP Transformation Board continued to monitor children's elective services. By June 2022, backlogs in paediatric services did not appear to have been addressed at the same as pace as adult services. This disparity may have been due to:

a. the relatively small size of the CYP waiting list, compared to the adult list (so CYP waits were less visible overall);

b. local health systems prioritising high throughput and low-cost elective procedures for adults, to meet national targets; this came at the expense of higher-cost and less routine paediatric care;

c. a lack of visibility of CYP-specific information in routine data reporting;

d. children's procedures being seen as less of a priority compared to, for example, adult cancer treatment;

e. children's services not benefitting as much as adults from investment in new care models; and

f. elective activity moving from secondary to more specialised tertiary settings, as some secondary providers had not yet restarted elective paediatric surgery **[DB1/89][INQ000610906]**.

303. In August 2022, further data suggested the children's waiting list size was increasing at twice the rate of the adult list **[DB1/90][INQ000610907]**.

304. NHS England subsequently published a '*Children and young people's elective recovery toolkit*' in May 2023, setting out actions that local regions, system, and providers should take, to accelerate the recovery of children's elective services, and to ensure parity between children's and adults' services **[DB1/91][INQ000610923]**. These included:

a. establishing dedicated CYP elective recovery oversight groups, at regional level;

b. disaggregating data on CYP elective recovery, as part of wider NHS performance reporting arrangements;

c. making use of a new national CYP elective recovery dashboard, to identify challenges across paediatric specialties and pathways, and to support CYP elective recovery;

d. ensuring nationally-funded local schemes to accelerate elective recovery were designed to benefit children as well as adults (including surgical hubs, for example); ICBs were expected to quantify the impact of these schemes on paediatric activity and maximise the benefits for children;

e. validating CYP waiting lists, in line with national guidance, taking into consideration clinical risk, age, the impact of waits on development and education, potential harm or long term consequences, and how/if digital technology would best suit the child;

f. addressing CYP health inequalities;

g. ensuring compliance with Evidence Based Interventions standards;

h. adopting learning from examples of best practice;

i. coordinating efforts between providers, systems, and regions, using mutual aid principles; and

j. maximising the proportion of CYP surgery admitted as day-cases.

305. Regions, systems, and providers were expected to have in place plans to recover CYP elective activity to a minimum of 2019/20 rates, dependent on previous delivery and baselines, as well as to ensure the CYP waiting list declined.

306. The CYP targets formed part of NHS England's broader 2023/24 elective care priorities for all acute Trusts, which included reducing 78 week waits and virtually eliminating 65 week waits for all patients **[DB1/92][INQ000226890]**.

307. GIRFT published additional guidance on reducing waiting times for CYP in August 2024 **[DB1/93][INQ000610913]**. In January 2025, DHSC and NHS England co-published an updated plan for reforming elective care, commitments in which included:

a. standardising referrals information, to enable better prioritisation of CYP for treatment;

b. publishing children's elective performance metrics;

c. reviewing waiting list prioritisation tools for CYP; and

d. undertaking quarterly review of local waiting list data on children **[DB1/94][INQ000610914]**.

Availability of NHS England data on CYP hospital activity and waiting times

Waiting List Minimum Data Set (**"WLMDS"**) Data

308. Patients in England, including children, should not normally wait longer than 18 weeks to start elective treatment, after having been referred to a consultant – as per NHS referral-to-treatment (**"RTT"**) standards for all non-emergency consultant-led care.

309. The operational target in England is for at least 92% of patients to wait less than 18 weeks for planned treatment to start. This standard leaves some tolerance for patients for whom starting treatment within 18 weeks would be inconvenient or clinically inappropriate.

310. The WLMDS is a weekly data collection relating to demand, activity, and waiting lists for elective care. NHS service providers began submitting WLMDS data weekly in April 2021, and published time series including data from September 2021.

311. WLMDS data provides information on:

a. RTT open (incomplete) pathways (i.e. RTT waiting list sizes);

b. RTT 'clock starts' (where patients are referred for elective care); and

c. RTT 'clock stops' (where pathways are completed, either because patients began elective treatment, or because it has been agreed treatment will not go ahead).

312. WLMDS data can be disaggregated by age and specialty. However, it is considered management information and is subject to less validation than official monthly RTT statistics. Official RTT statistics cannot be disaggregated by age.

Hospital Episode Statistics ("**HES**")

313. HES data provides more granular information about treatments and care undertaken in hospitals in England.

314. HES data does not support direct patient care; it is intended for the use of healthcare providers and commissioners for 'secondary' purposes (i.e. healthcare planning, commissioning, and policymaking).

315. HES data provide information about hospital inpatient admissions, outpatient appointments, and the wait times between a decision-to-admit and admitted inpatient care.

316. HES is a more authoritative data source than WLMDS and RTT waiting times statistics for information about NHS-funded activity. However, it cannot be used to assess performance against RTT waiting time standards (i.e. the 18-week standard) because it does not measure the length of time between a referral and the start of elective treatment.

Activity and waiting times data for CYP hospital care

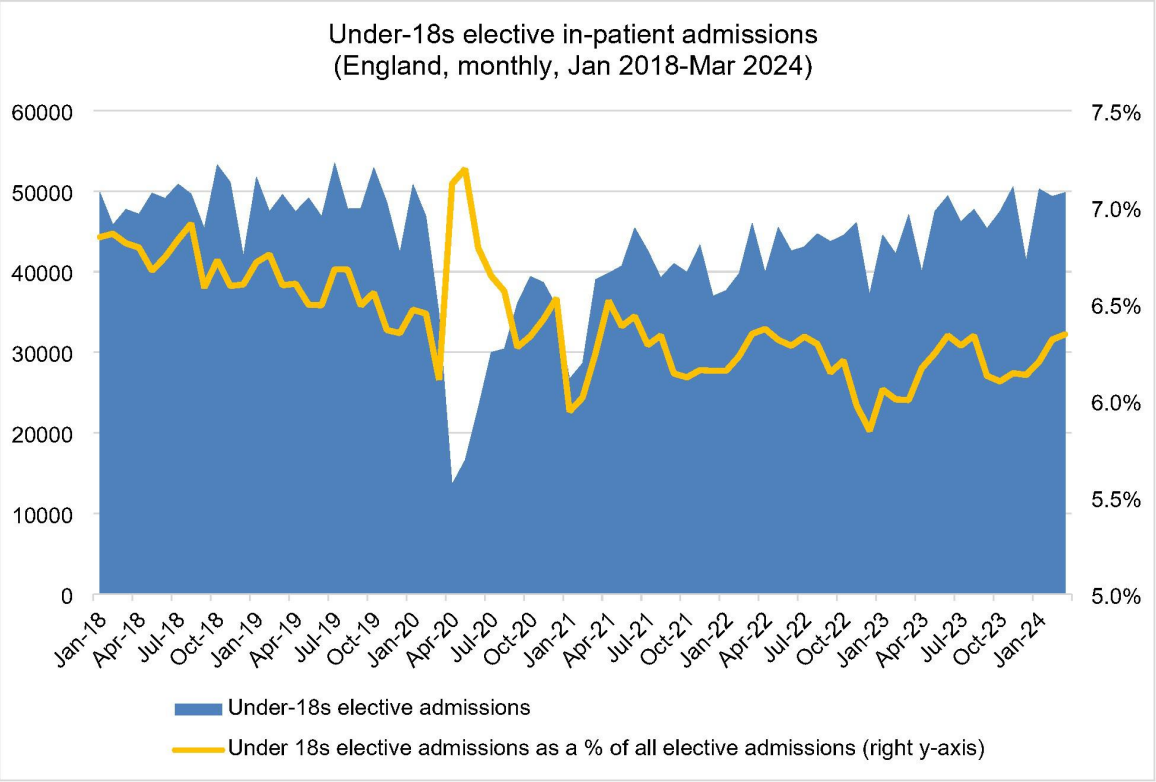
In-patient admissions

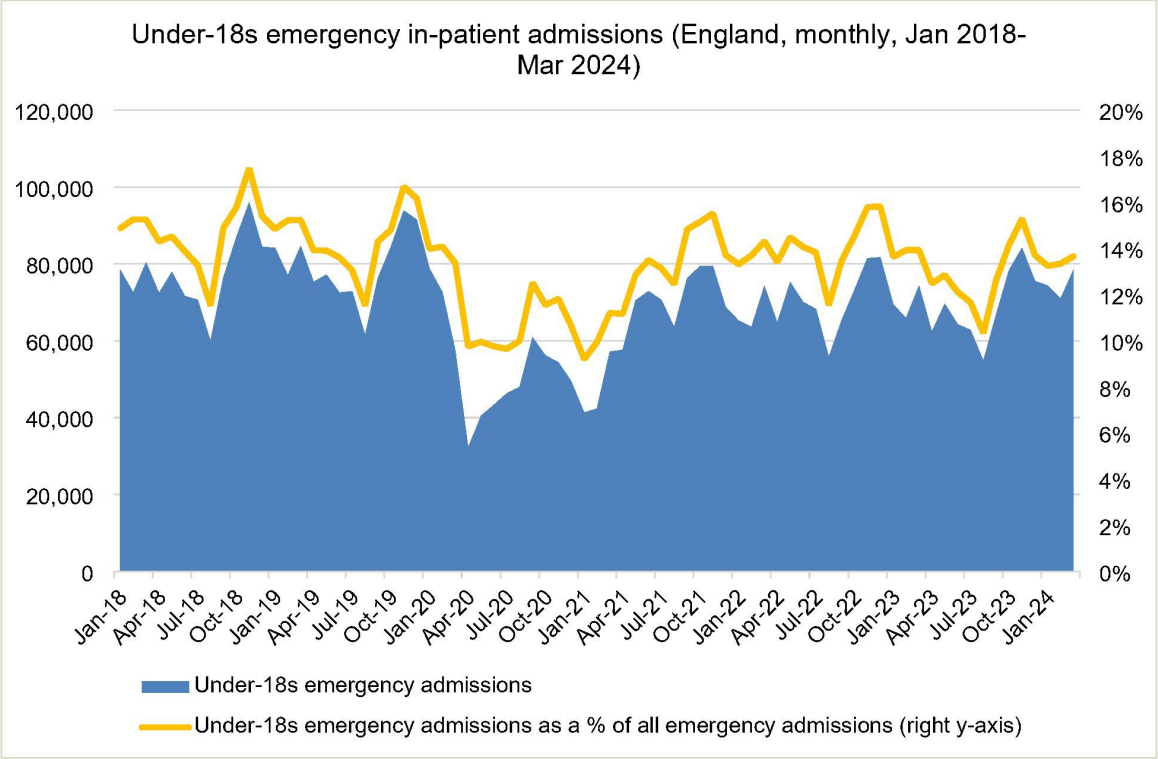
317. HES data shows children's elective in-patient admissions declined steeply following the suspension of routine elective services in March 2020, from 167,570 in February

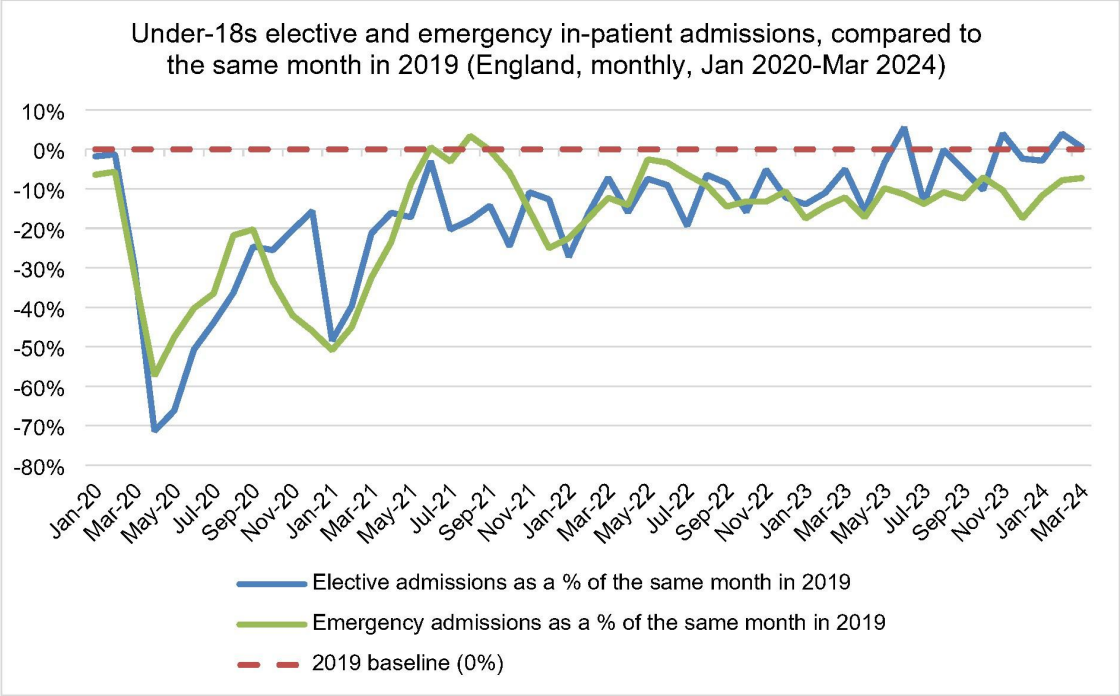
2020, to 94,264 in April 2020. There were 70% fewer elective admissions in April 2020, compared to the same month in 2019. Un-planned emergency admissions declined steeply, by 57%, in the same period, likely due to fewer people presenting at emergency departments.

318. Both elective and emergency admissions subsequently recovered over the course of the Specified Period, declining briefly during the second Covid-19 wave (winter 2020/21). Elective in-patient admissions recovered fully to pre-pandemic (2019) levels by summer 2023. Emergency admissions had not recovered to pre-pandemic levels by March 2024.

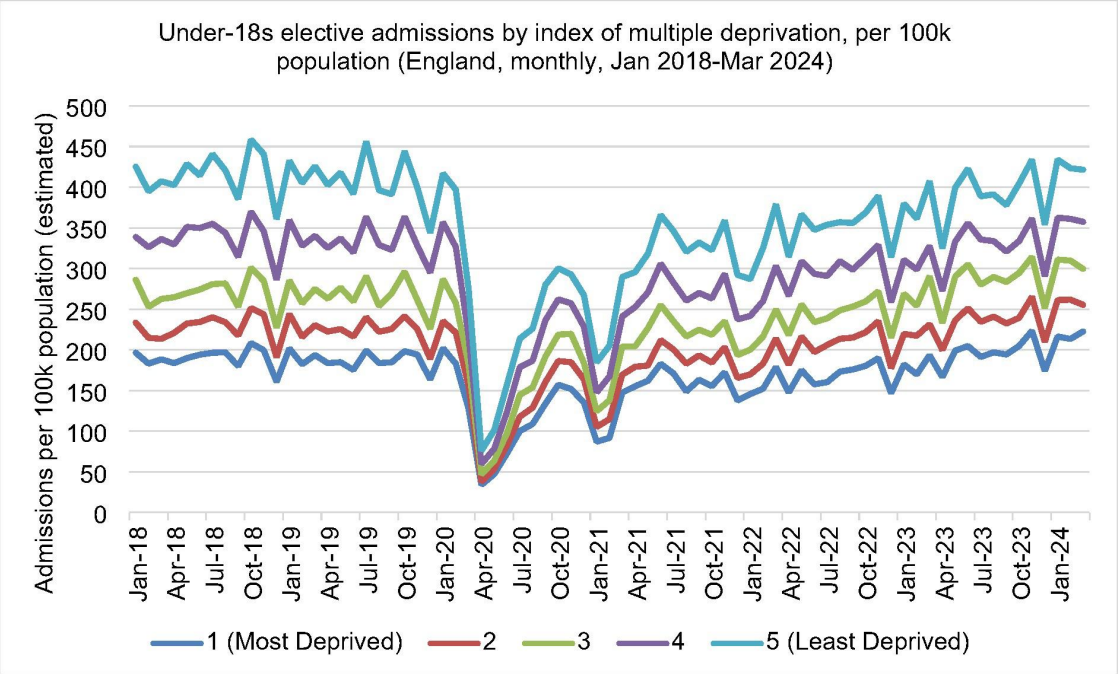
319. For the purposes of the data below, an elective admission is any admission that has been planned (i.e. time has elapsed between a 'decision-to-admit' and admission). An 'emergency admission' is an admission that is unpredictable and occurs at short notice because of clinical need. A small number of admissions, such as maternity admissions or hospital transfers, are not easily categorised as either elective or emergency, and are not included in the data below.

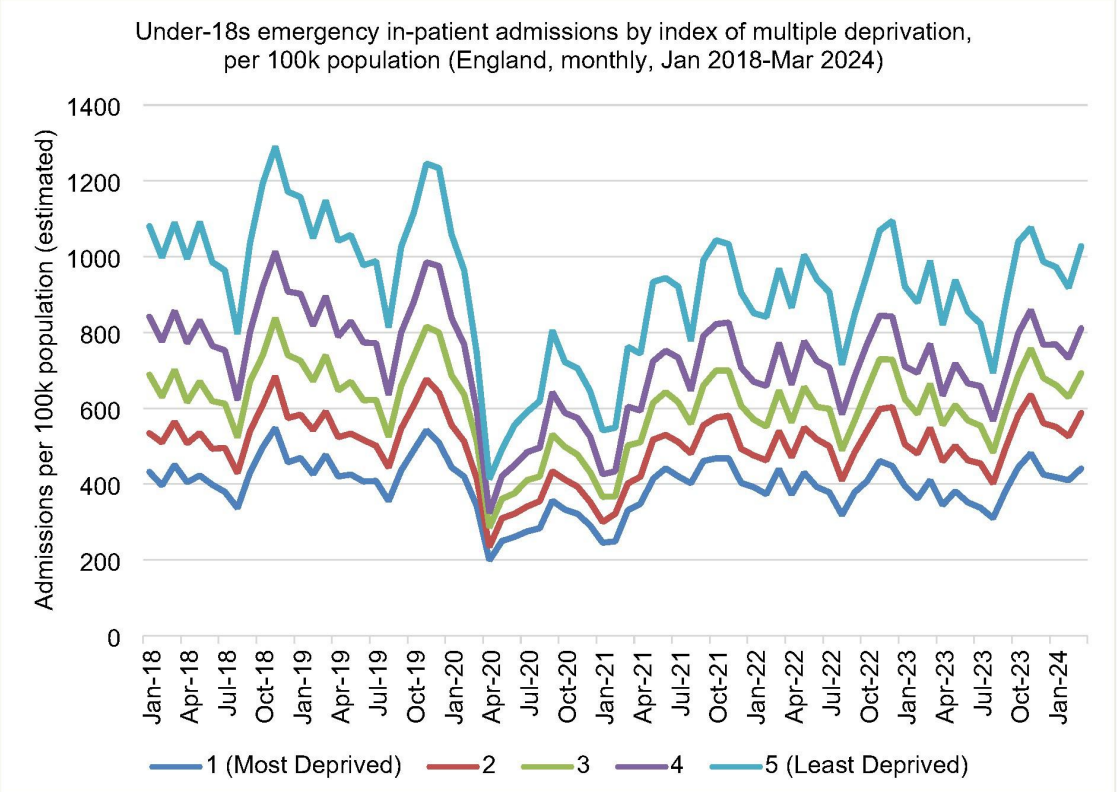






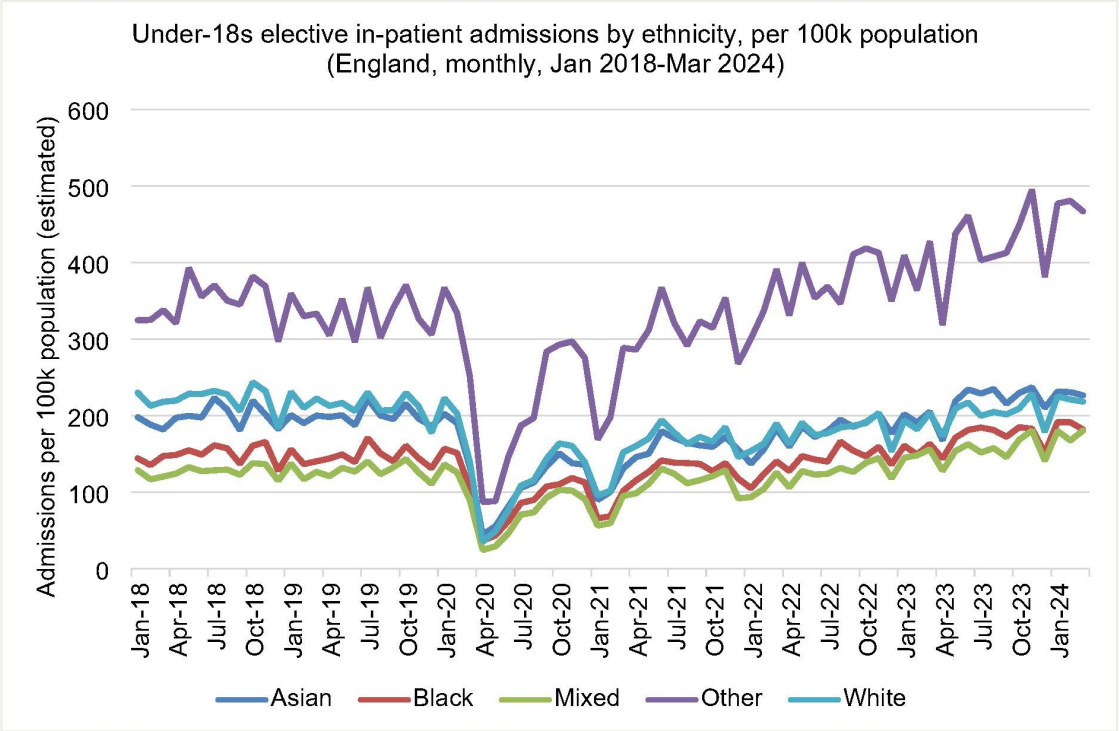
320. The rate of elective and emergency in-patient admissions amongst children living in the least deprived areas were consistently higher than those living in more deprived areas, before, during, and after the Specified Period:

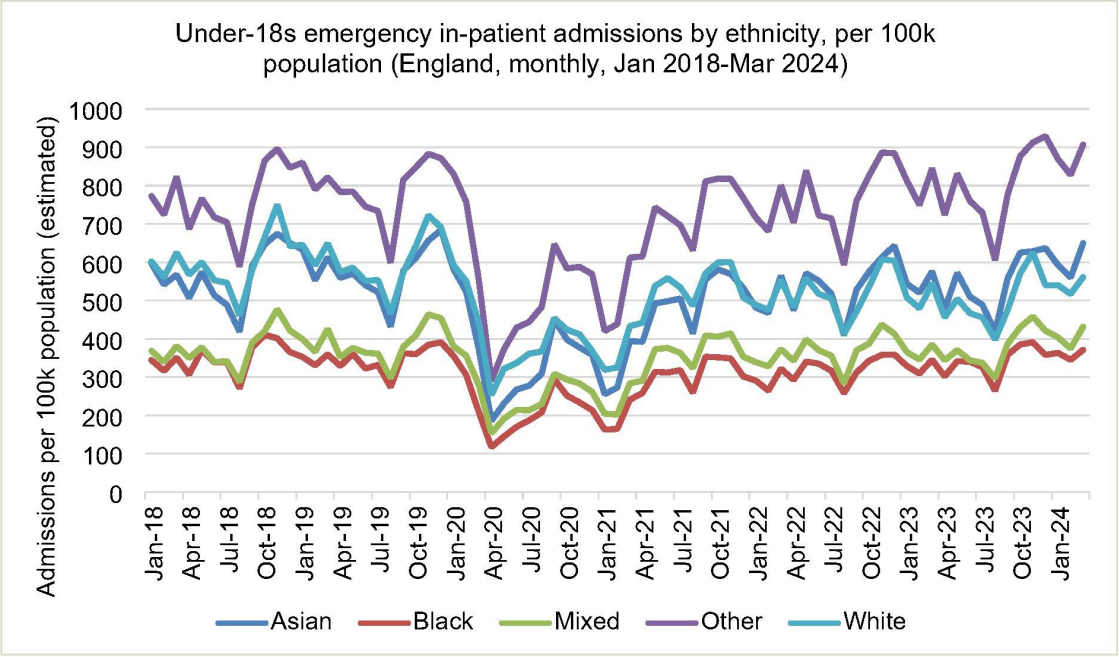




321. Rates of children's elective and emergency in-patient admissions were also consistently higher amongst white or Asian children, compared to black or mixed-race children. Children from 'other' racial backgrounds had the highest admission rates overall, although these children represent a relatively small population. For the

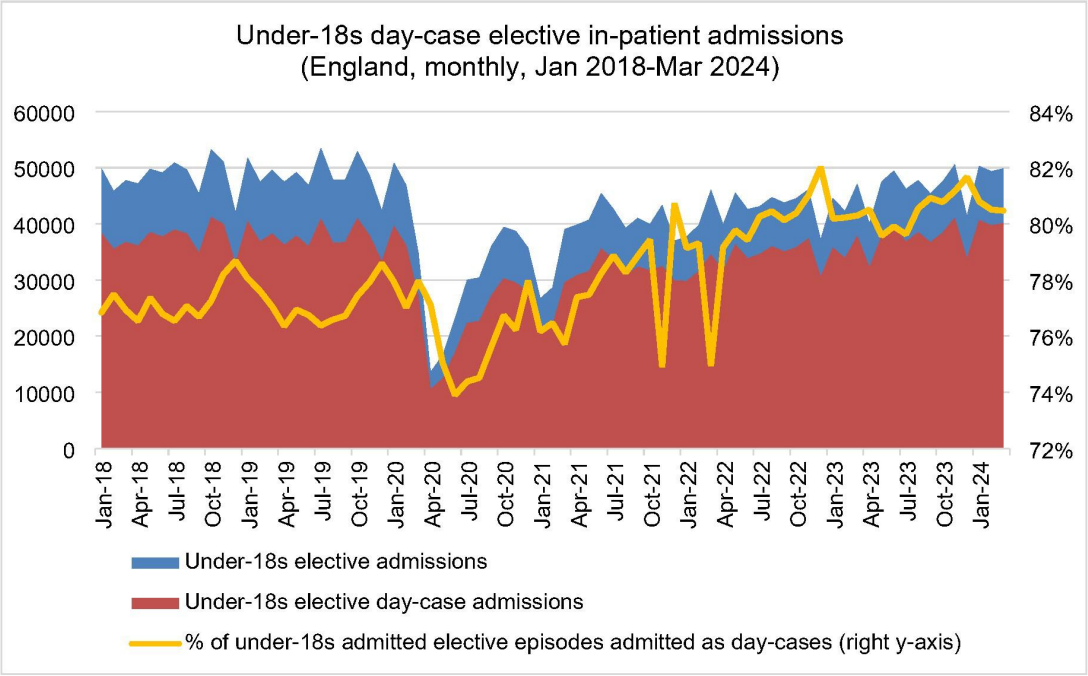
purposes of the data below, estimates of population sizes are based on 2021 census data:





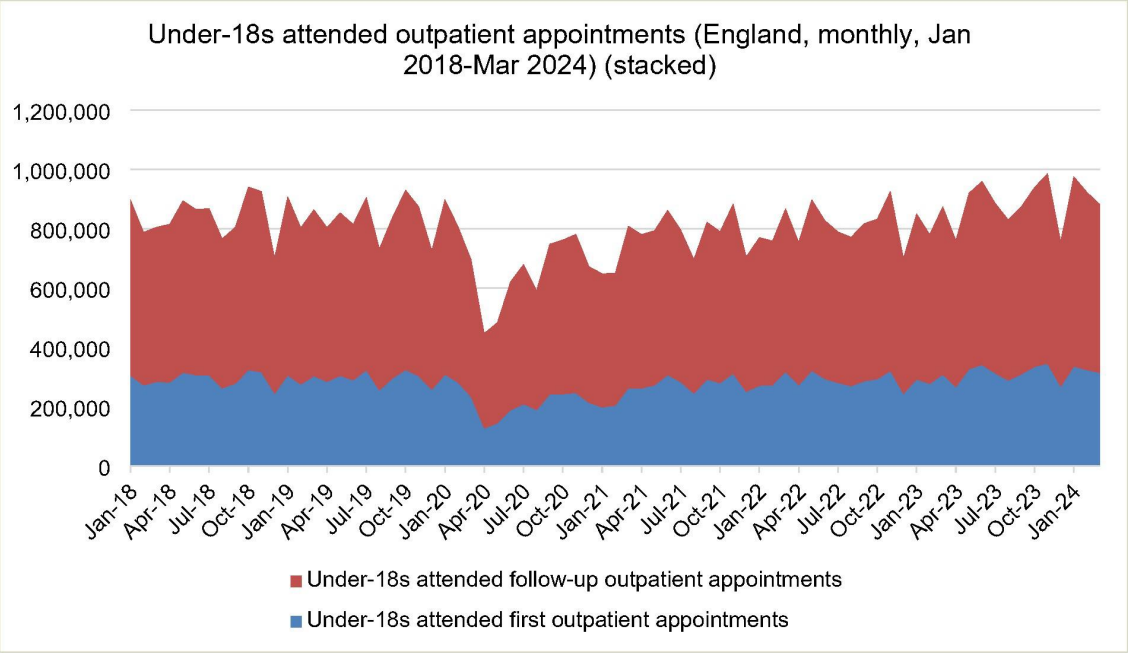
322. In 2018, day-cases made up just over 75% of under-18s elective inpatient admissions. As services recovered from the pandemic, following the cessation of routine care, day-case rates subsequently increased to above pre-pandemic levels

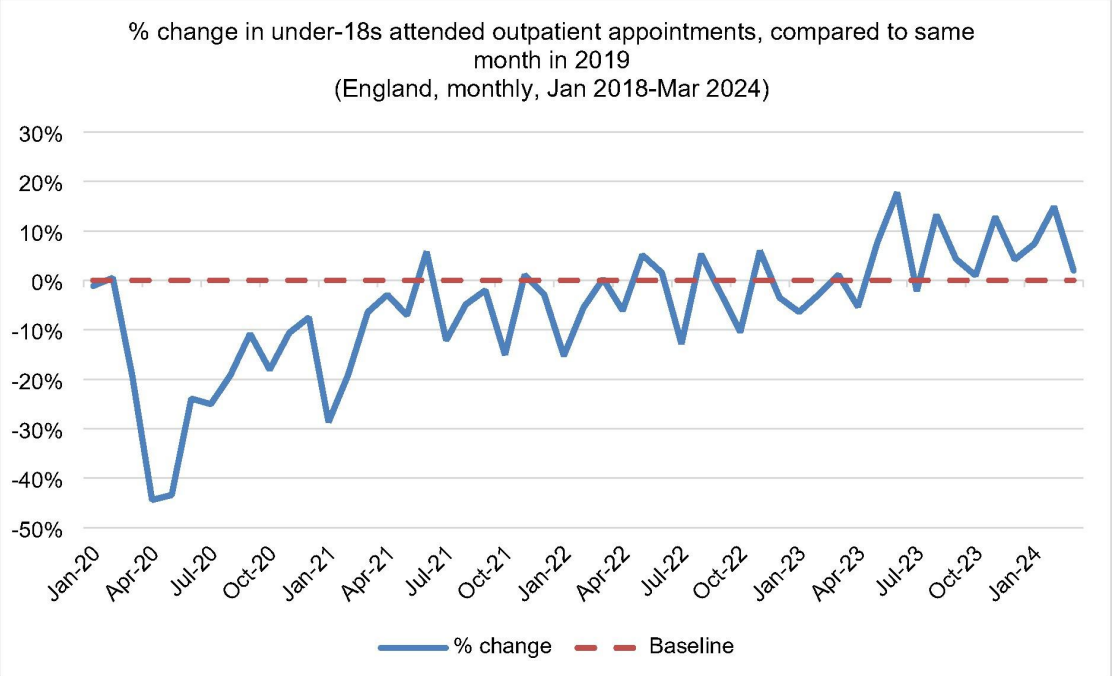
(consistently over 80%) from autumn 2021 until March 2024.



Outpatient appointments

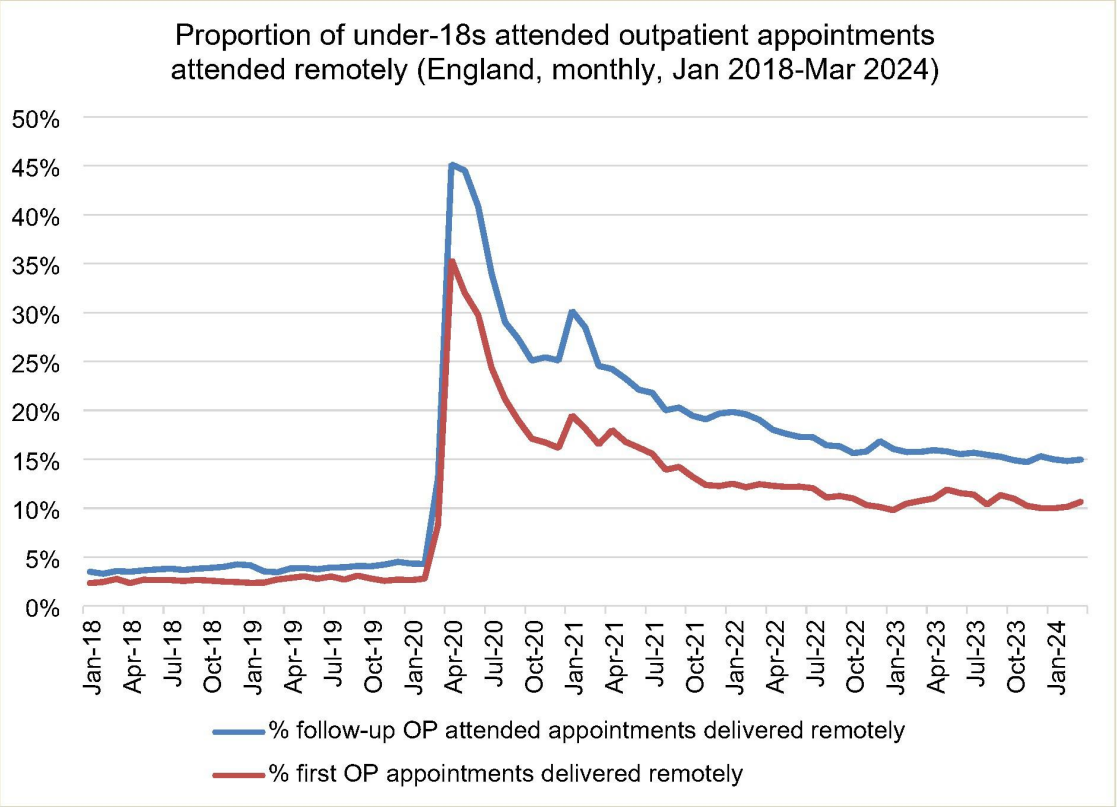
323. Following the suspension of routine elective services, the number of attended under-18s outpatient appointments declined less steeply than in-patient admissions, and recovered more quickly, largely because some outpatient appointments could be delivered remotely by telephone or video. There were 807,578 under-18s who attended outpatient appointments in February, declining to 446,941 in April 2020. There were 44% fewer outpatient appointments in April 2020, compared to April 2019, but appointment volumes recovered to 2019 levels by early 2021.



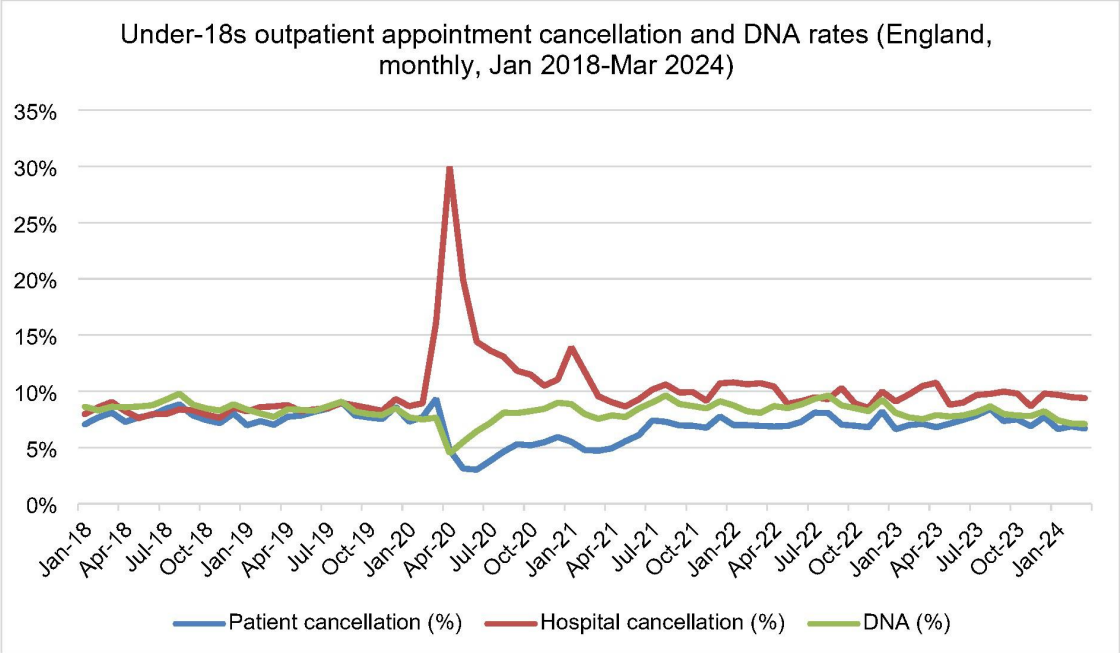


324. Prior to the pandemic, fewer than 5% of outpatient appointments were delivered remotely. In April 2020, immediately following the onset of the pandemic, this increased to 35% for first outpatient appointments, and to 45% for follow-up appointments. The proportion of appointments delivered remotely subsequently declined over the Specified Period, but remained significantly above 2019 levels (around 11% of first appointments, and 15% of follow-up appointments, in March

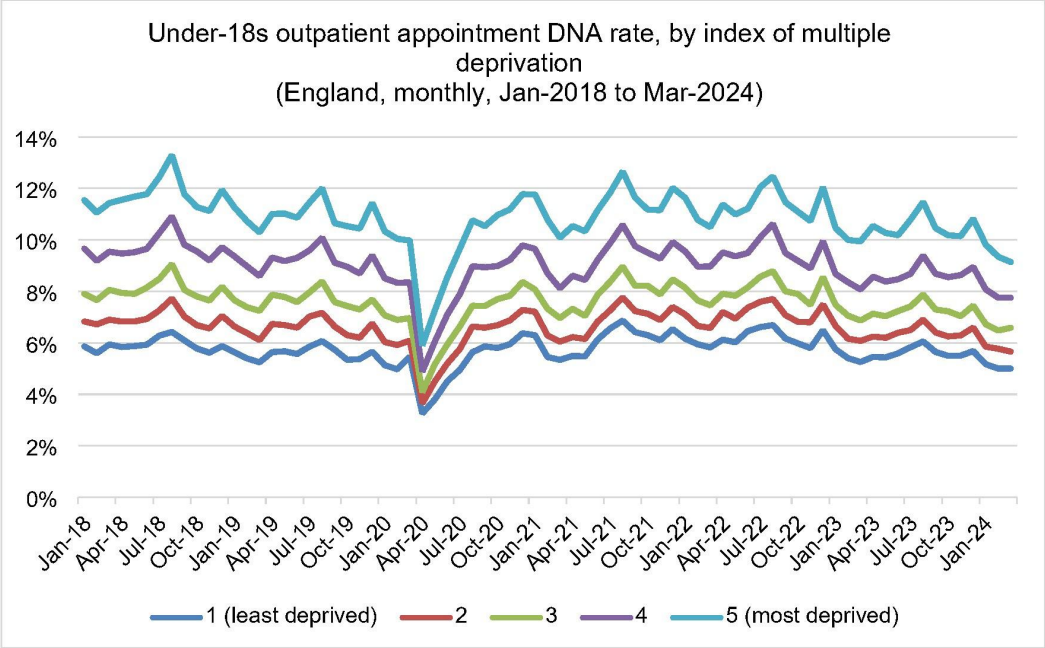
2024).

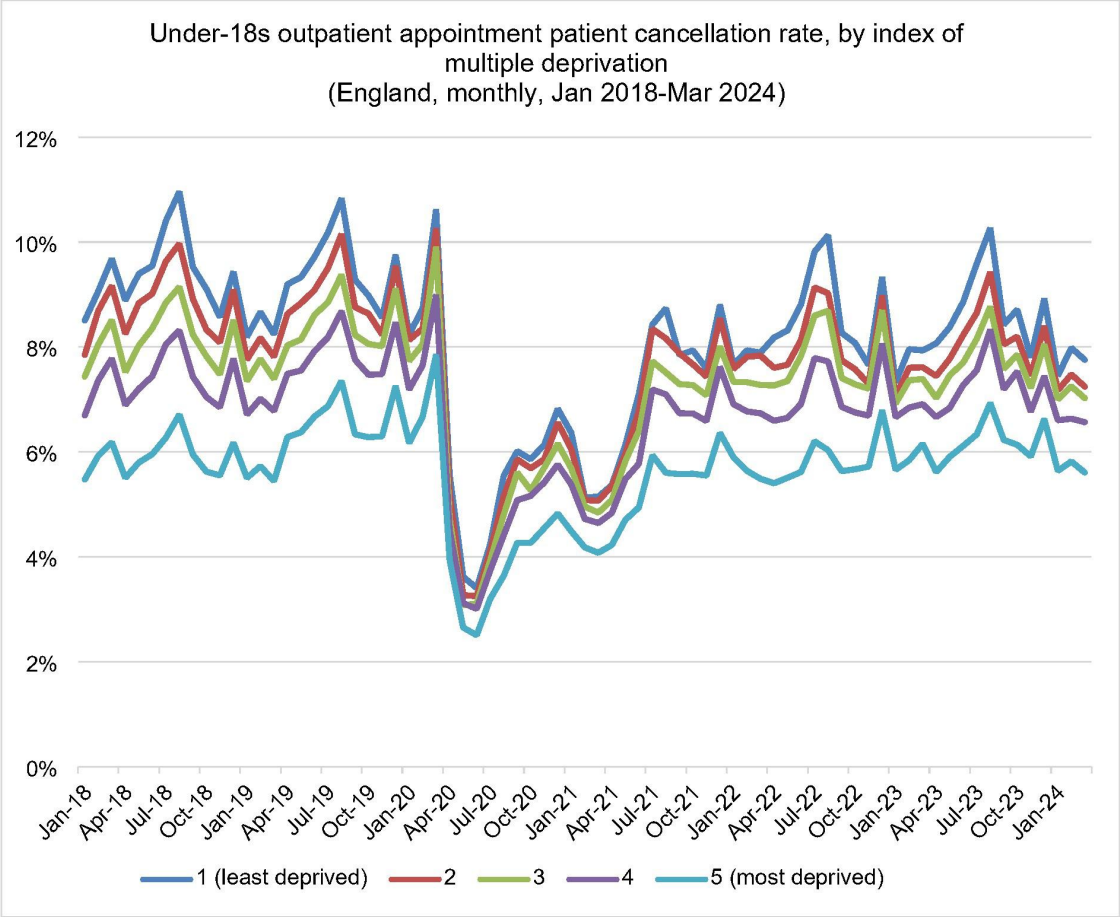


325. Prior to the pandemic, the rate of under-18s outpatient appointments cancelled by hospitals was 8-9%. Following the suspension of routine care in March 2020, this increased sharply to 30%. The rate subsequently decreased to under 15% by June 2020 and remained stable at around 10% from early 2022 until early 2024 (higher than in the pre-pandemic period). Patient cancellations and 'Did Not Attends' ("**DNA**") declined during the first pandemic wave but recovered by June 2021 and remained stable until 2024.

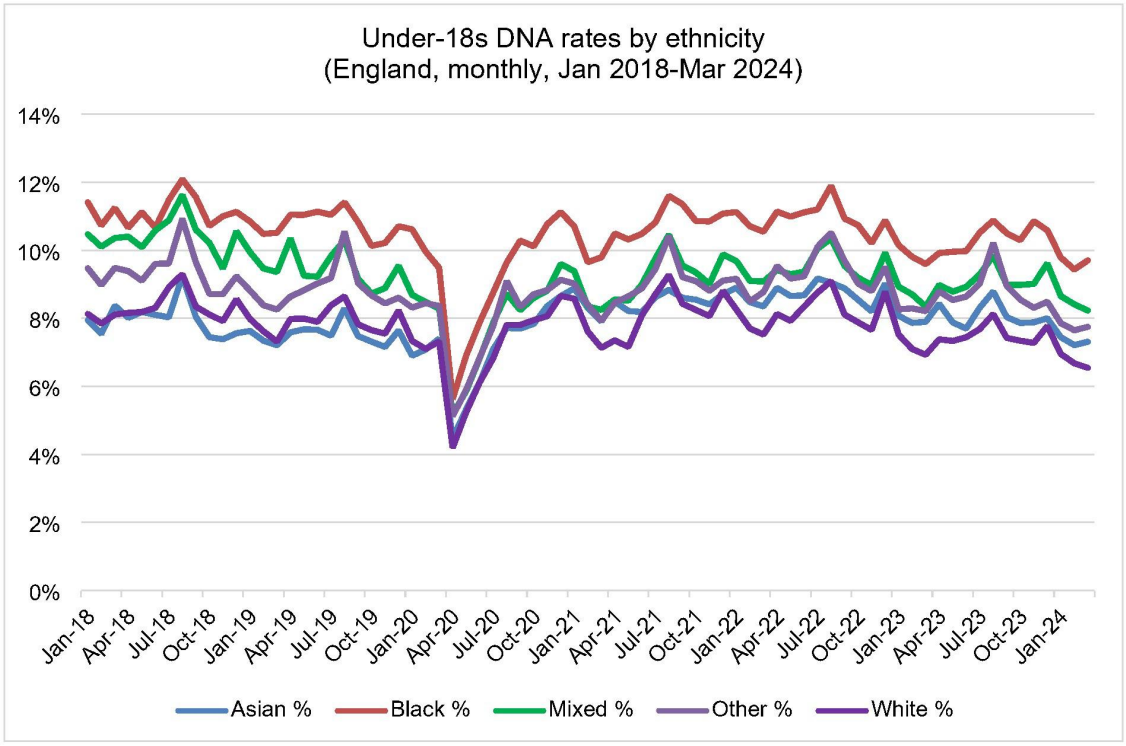


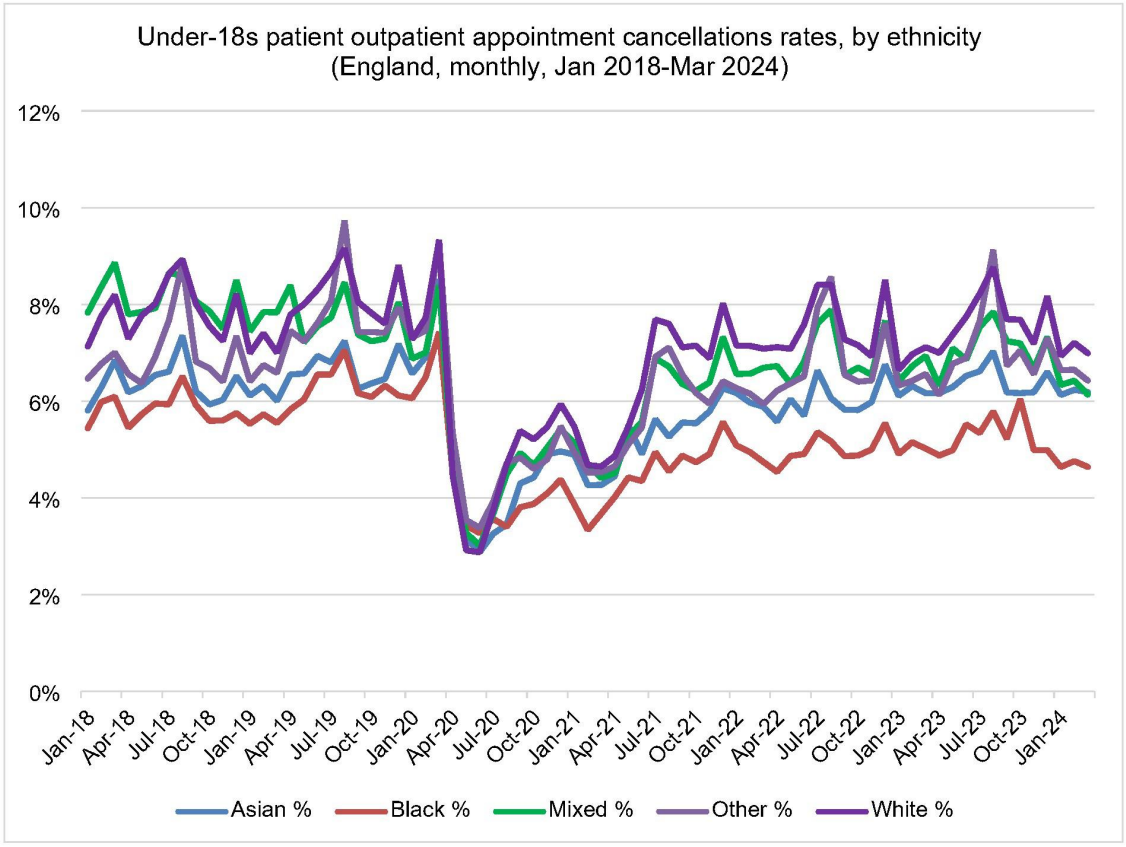
326. The outpatient DNA rate was consistently highest amongst under-18s living in the most deprived areas, and consistently lower amongst those living in the most affluent areas. The converse was true for patient cancellation rates:





327. Outpatient DNA rates were consistently highest amongst black children, and lowest amongst white and Asian children. Patient cancellation rates were lowest amongst black children and generally highest amongst children from white or other backgrounds:

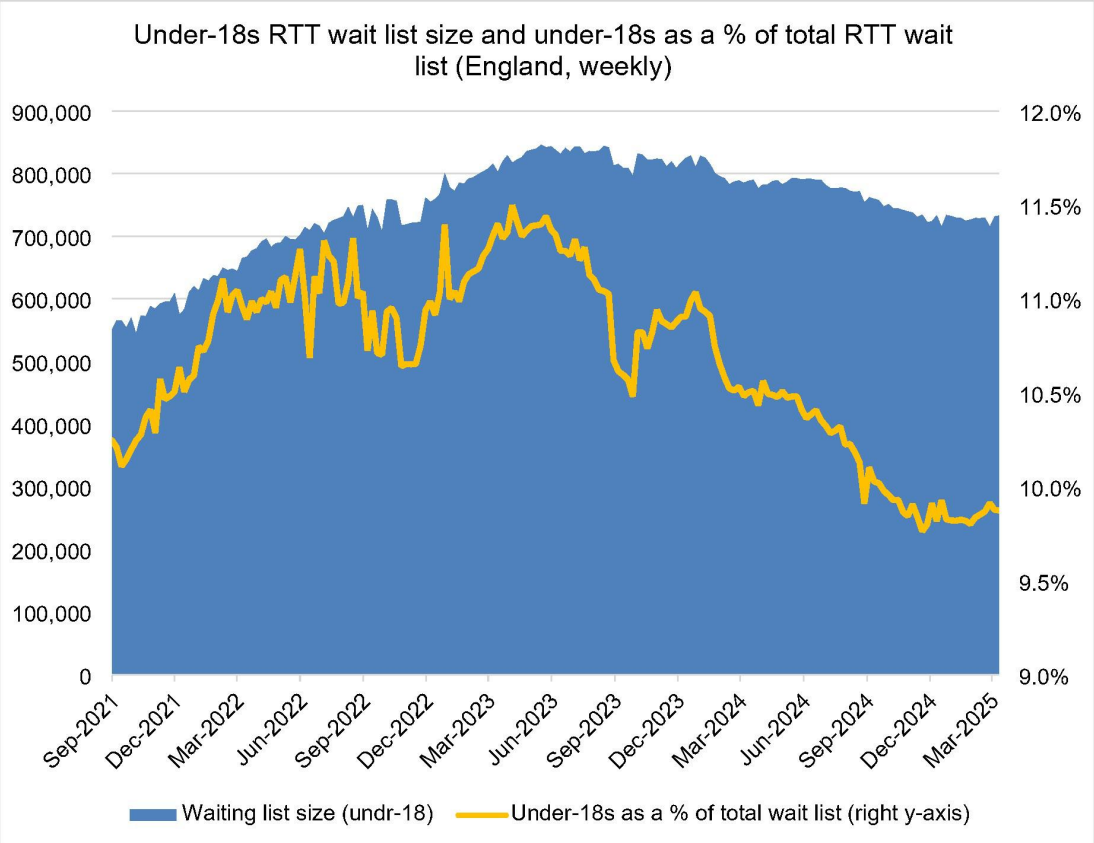

Under-18s DNA rates by ethnicity
(England, monthly, Jan 2018-Mar 2024)
14%
12%
10%
8%
6%
4%
2%
0%
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Asian %
Black %
Mixed %
Other %
White %


Under-18s patient outpatient appointment cancellations rates, by ethnicity
(England, monthly, Jan 2018-Mar 2024)
12%
10%
8%
6%
4%
2%
0%
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Asian %
Black %
Mixed %
Other %
White %

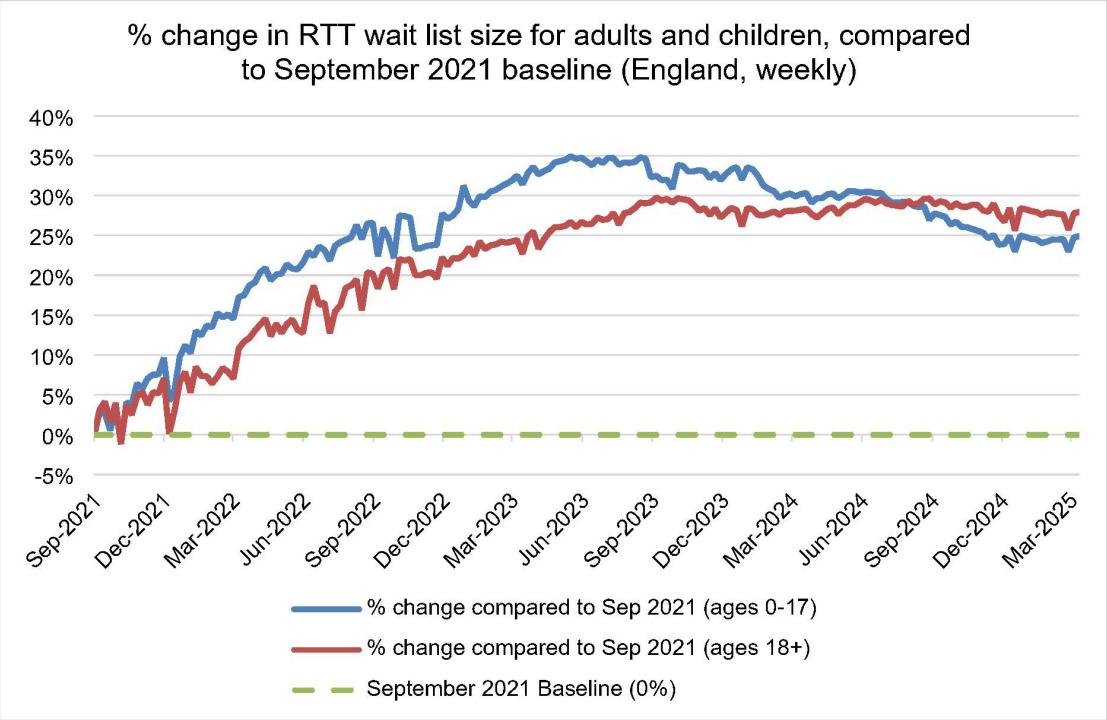
Waiting list for elective CYP care

328. WLMDS data on RTT waiting list sizes is only available from September 2021. Incomplete children's RTT pathways increased weekly, from 550,291 in September 2021 to 845,598 in June 2023. The wait list subsequently declined to 732,828 by March 2025 but note this may be largely due to community services being removed from the RTT wait list in February 2024.

329. During the same period, children's pathways increased as a proportion of the total RTT wait list, from 10.2% in September 2021 to a peak of 11.5% in April 2023, before declining to 9.9% by March 2025 (again likely due to the removal of community pathways from RTT data).



330. From September 2021 until June 2023, the children's RTT wait list increased faster than the adult waiting list. This trend was subsequently reversed, from September 2024 until March 2025:



Wait times

331. Before the pandemic, children typically waited longer for elective admission following a decision-to-admit ("**DTA**"), compared to young and older adults. This disparity increased after the first pandemic wave, as routine services recovered.

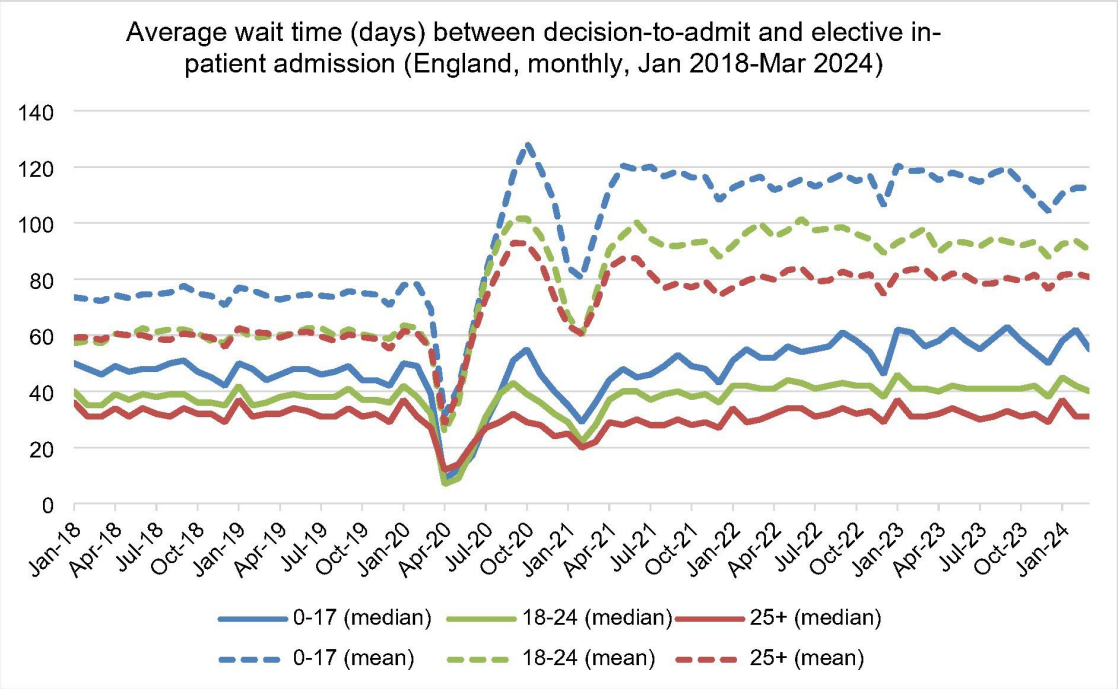
332. During the peaks of Covid-19 activity, in early March to summer 2020, and in winter 2020/21, average wait times for admission appeared to decline for all age groups – likely because a significant proportion of less urgent admissions were cancelled or postponed. Wait times increased to above pre-pandemic levels as non-urgent activity was restored, whilst hospitals simultaneously tackled care backlogs whilst working under IPC and other pandemic-related constraints.

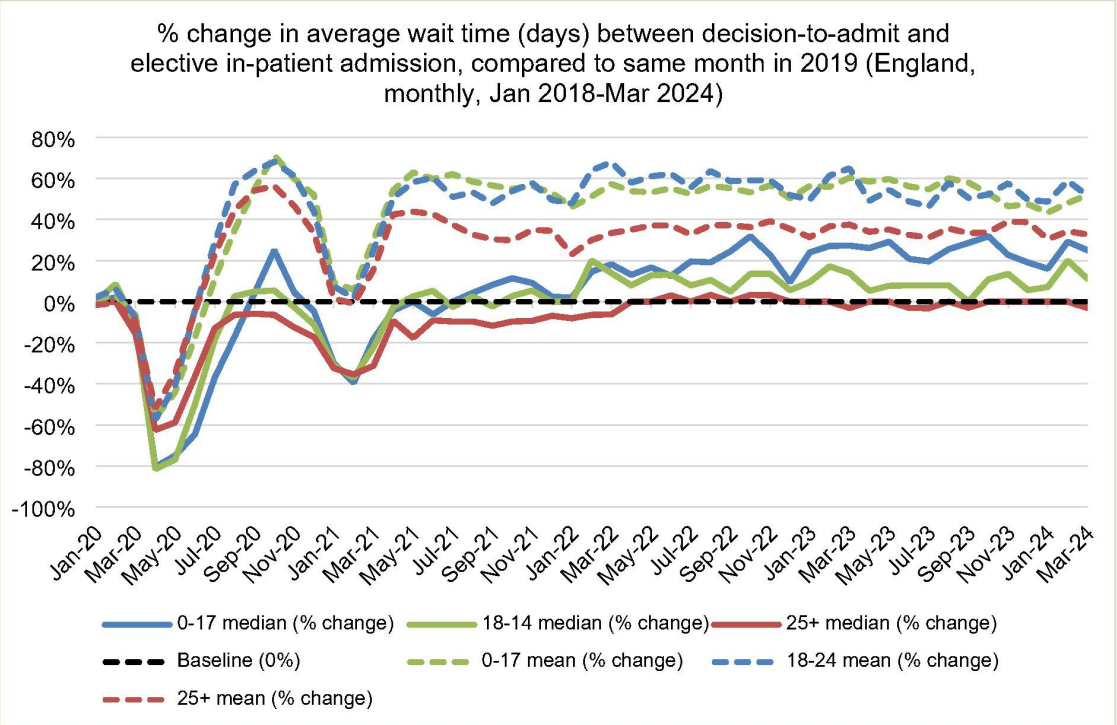
333. From January 2018 to January 2020, the median wait time for children was typically under 50 days (with a mean under 70 days). Towards the end of the Specified Period, from early 2022, until March 2024, the median was consistently over 50 days (and the mean was greater than 100 days).

334. The median wait time for adults over 24 returned to pre-pandemic levels (around 30 days) by April 2021. The mean, which is typically greater than the median due to the presence of outliers, stabilised at 80 days.

335. From early 2022 until March 2024, mean wait times for under-18s were consistently

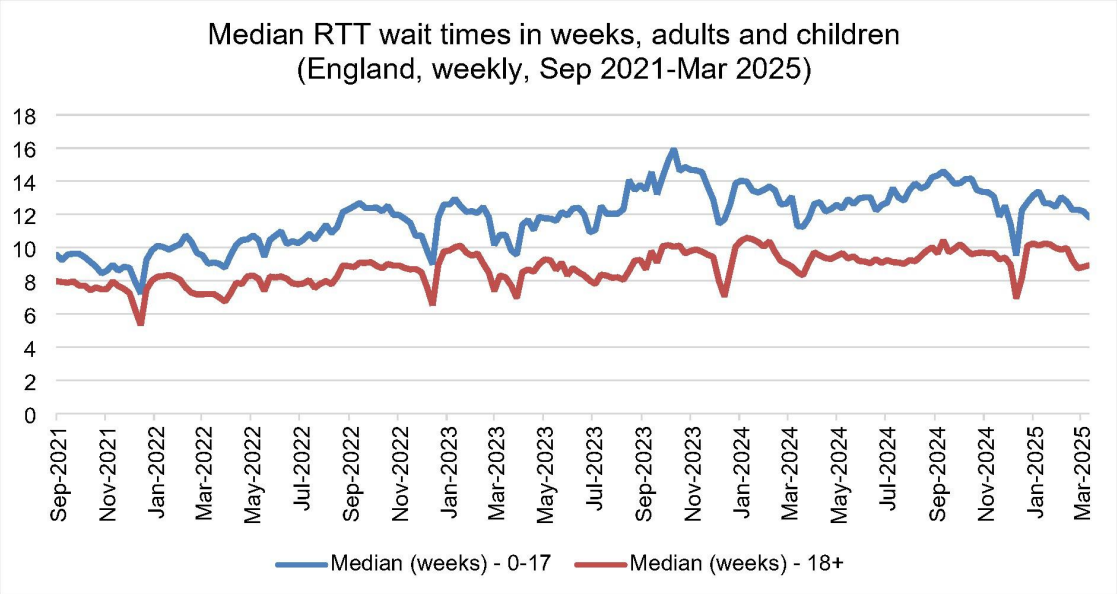
45-60% greater than in 2019. For over 25s, the mean wait time was consistently 30-40% greater than in 2019.



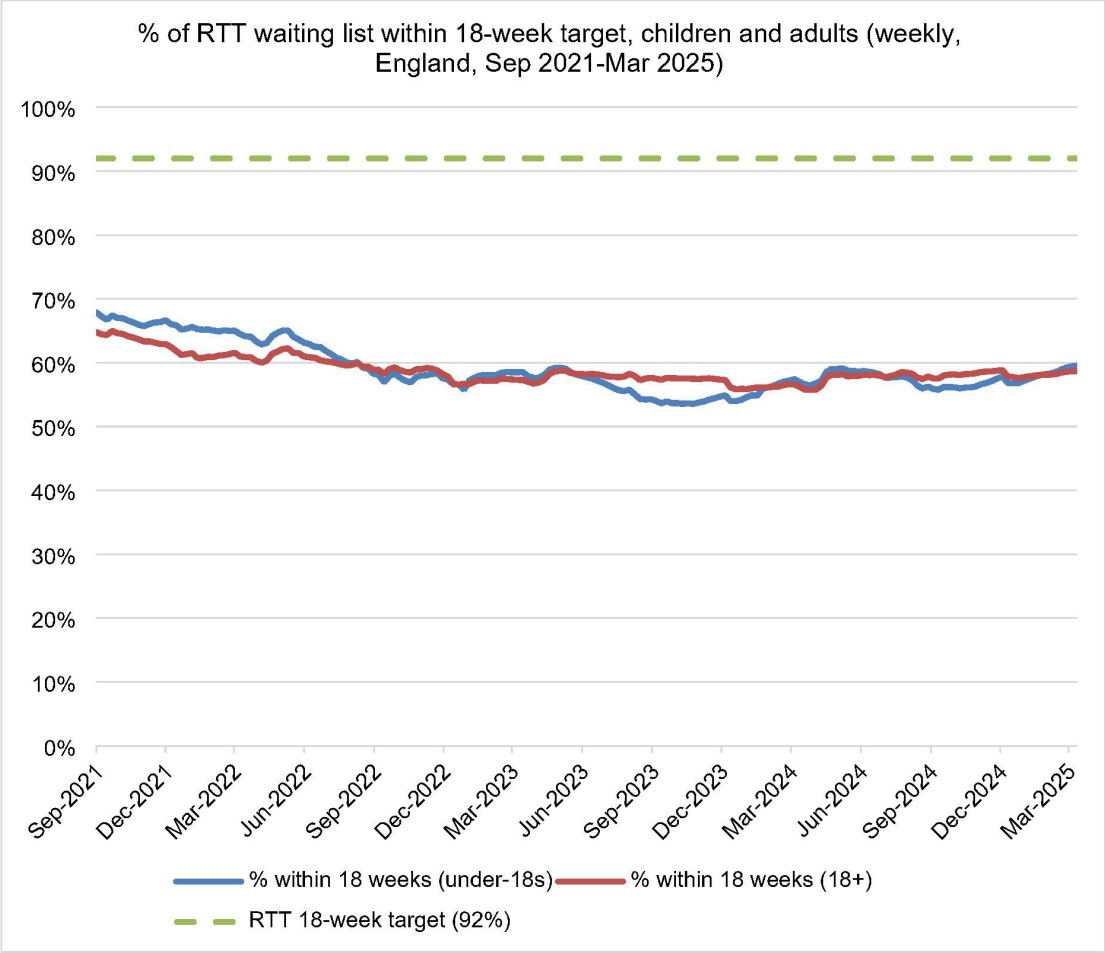


336. WLMDS RTT wait times data reflects trends seen in HES data. From September 2021 to March 2025, median wait times between referrals and RTT 'clock stops' were

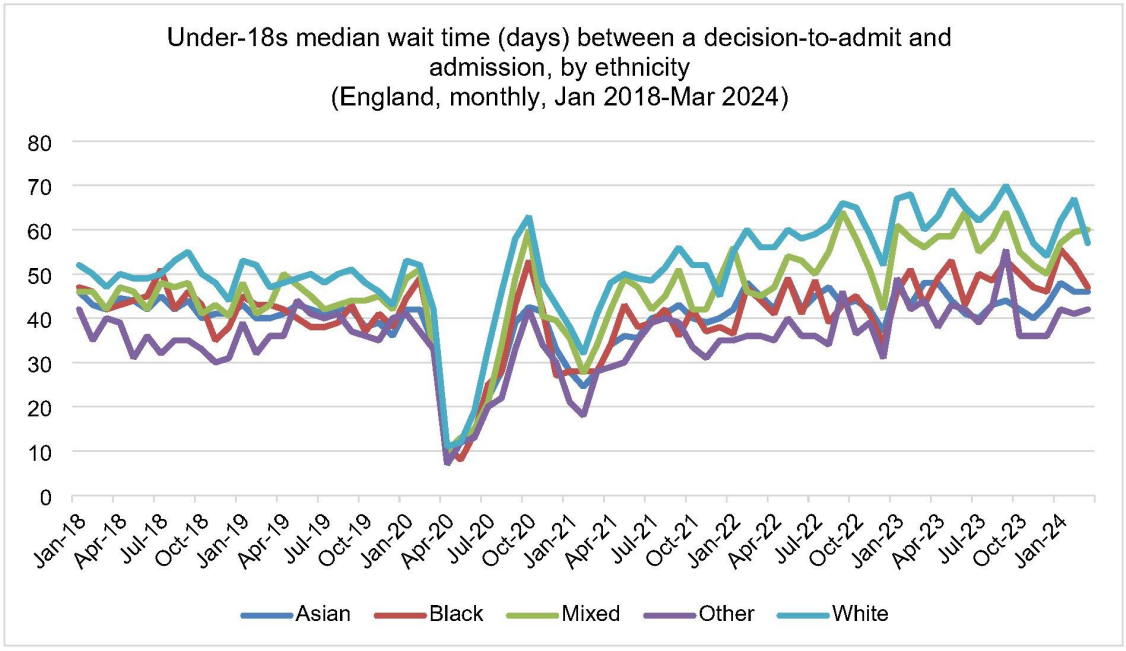
consistently higher for children than for adults. The median RTT wait time for children increased at a greater rate than for adults between September 2021 and October 2023 (from 9.6 weeks to 16 weeks in October 2023), before declining to 11.5 in March 2025.

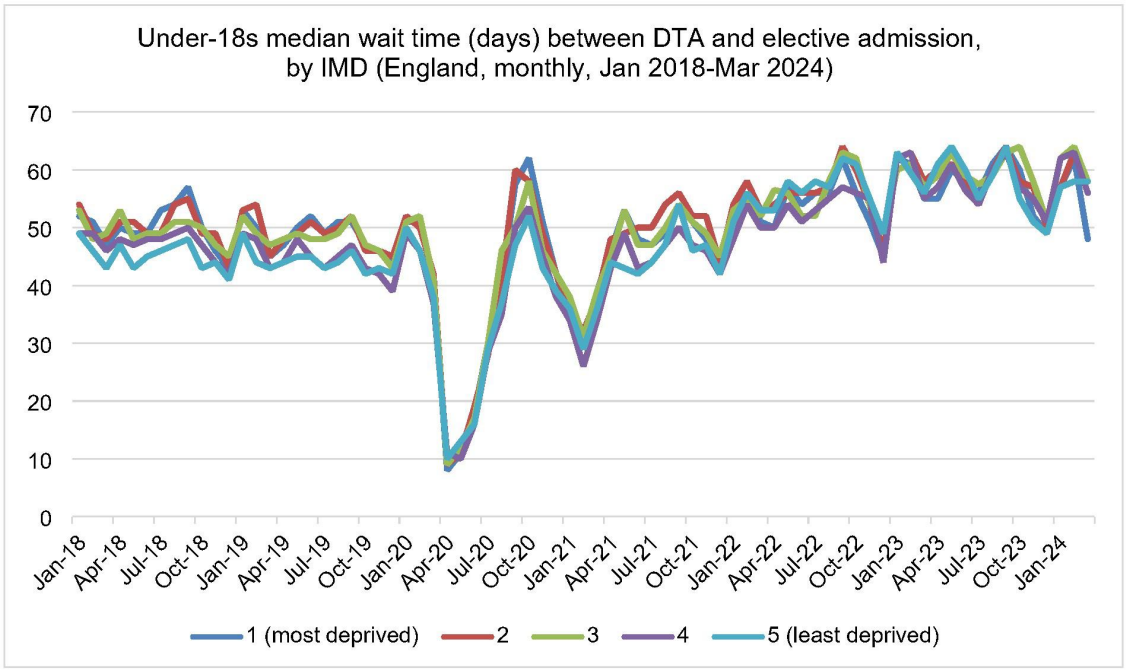


337. The proportion of incomplete RTT pathways still within the 18-week wait target, for under-18s, declined from 68% in September 2021 to 54% in October 2023. It increased to 59% in March 2025. Adult data reflected the same trends.



338. HES data indicates white children waited on average longer for an elective admission following a DTA, compared to children from other backgrounds, throughout the period 2018-2024. There do not appear to be consistent or sustained wait time discrepancies between children living in poorer and more affluent areas:


Under-18s median wait time (days) between a decision-to-admit and admission, by ethnicity (England, monthly, Jan 2018-Mar 2024)
80
70
60
50
40
30
20
10
0
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
Asian
Black
Mixed
Other
White


Under-18s median wait time (days) between DTA and elective admission, by IMD (England, monthly, Jan 2018-Mar 2024)
70
60
50
40
30
20
10
0
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
1 (most deprived)
2
3
4
5 (least deprived)

SECTION F – CANCER SERVICES

Background

339. Cancer in children is rare. In England in 2019 , there were 1,528 cancer diagnoses in children under 15, and 1,745 diagnoses in teenagers and young adults aged 15-24.

340. For the most part, children and adults are affected by different cancer types. More common cancers in adults are very rarely seen in children (e.g. breast cancer, prostate cancer, lung cancer, and bowel cancer) whereas certain cancers almost exclusively affect children: they occur in different parts of the body, are biologically different and they respond differently to treatment. Acute leukaemia (cancer of the blood) is the most common children's cancer, making up about a third of all diagnoses, followed by cancers of the brain and spinal cord. Other, rarer, cancers affecting children include retinoblastoma (eye cancer), Wilm's tumours (kidney cancer) and muscle or bone cancer.

341. Survival rates for children with cancer are much higher than for adults with cancer: more than 80% of children survive cancer for longer than five years following diagnosis. However, cancer remains the most common cause of childhood death outside of infancy. Amongst 15–24-year-olds, only accidents and suicide are responsible for more deaths. Treatment for children's cancer can be complex and intensive; it can have a significant long-term impact on a child and their family's quality of life.

Commissioning and delivery of children's cancer services in England

342. Children, teenagers, and young adults with cancer receive care primarily from a Principal Treatment Centre ("**PTC**") providing specialist care and holding overall responsibility for a child's cancer diagnosis, treatment and management. PTCs work in partnership with Paediatric Oncology Shared Care Units ("**POSCU**"), which provide supportive care and shared care closer to a child's home. Together, a PTC and its associated POSCUs are referred to as a Children's Cancer Network.

343. From 2013 until 2022, NHS England was responsible for commissioning specialist cancer services for children and young adults, including all care undertaken and overseen by PTCs, chemotherapy and radiotherapy, specialist cancer palliative care, and planning after care. Since 2022, commissioning of specialised cancer services has been increasingly delegated to ICBs.

344. NHS England began developing a new PTC service specification in 2017 and consulted formally in 2019 on a draft specification. The LTP committed to developing and implementing better 'networked care' for children with cancer, simplifying care pathways and transitions between services to improve children's access to specialist expertise with a view to improving outcomes.

345. In January 2020, an independent review recommended to the NHS England Board that all children's PTCs should be co-located with level 3 PICU services and other specialised children's services **[DB1/95][INQ000610879]**. Given the increasing complexity of new children's cancer treatments, young cancer patients were more likely to need PICU care. Around 50% of children receiving CAR T therapy (a type of immunotherapy) were likely to need access to PICU; those receiving bone marrow transplantation and other treatments carried a risk of needing PICU greater than 5%. A greater integration of services was likely to improve patient experience, to reduce the burden on staff, and increase efficiencies.

346. NHS England accepted these recommendations in full. NHS England published the final children's PTC and POSCU service specifications in November 2021, following a delay caused by the pandemic **[DB1/96][INQ000610902]** and **[DB1/97][INQ000610903]**. These specifications covered the cancer services provision for children ages 0-15 years, and sought to:

    a. improve integration between different children's cancer services (replacing current network groups with formal operational delivery networks);

    b. improve the experience of care;

    c. increase participation in clinical trials and tumour banking rates, to support research (in 2019, it was estimated only 40% of tumour tissue was stored); and

    d. improve the transition between children's and teenage and young adult ("**TYA**") services.

347. In May 2023, NHS England published service specifications for specialist TYA services, for young people aged 16 to 24 **[DB1/98][INQ000610909]** and **[DB1/99][INQ000610910]** and **[DB1/100][INQ000610911]**.

348. The Children's Cancer and Leukaemia Group ("**CCLG**") publishes supplementary clinical guidance, endorsed by NICE, for referring CYP with suspected cancer to local acute paediatricians.

349. In addition to PTCs and POSCUs, children with cancer also access other prescribed specialised services as part of their treatment, as determined by the PTC multi-disciplinary team ("**MDT**"). Such services include paediatric radiotherapy services, the proton beam service, BMT services, CAR T, retinoblastoma services and surgical services. National service standards are also in place for these services and specialist treatments.

Governance arrangements

350. The NHS Cancer Programme leads the delivery of the NHS LTP ambitions for cancer. The NHS Cancer Programme brings together:

a. overarching strategy for cancer across the NHS in England, including collaboration across arm's length bodies and the wider cancer community;

b. the delivery by NHS England of the ambitions and commitments for cancer in the NHS LTP; and

c. working with Regions and Cancer Alliances to support the delivery of cancer services across the NHS in England in line with the operational standards.

351. The National Cancer Board is chaired (and was chaired throughout the Specified Period) by the National Cancer Director, and brings together delivery partners from in and across NHS England and the cancer sector.

352. Cancer Alliances have, since 2017-18, led improvements at local level. There are 21 Cancer Alliances across England, working to transform cancer pathways and improve the quality of cancer services locally, including children's services. They bring together local senior clinical and managerial leaders representing the whole cancer patient pathway across a specific geography. NHS England provides Cancer Alliances with funding, support and guidance to transform the diagnosis, treatment and care for cancer patients in their local area.

Waiting Times Standards

353. Waiting times standards for cancer diagnosis and treatment apply to all cancer types patients, including CYP.

354. The Handbook to the NHS Constitution for England sets out the following government standards:

a. A maximum 28-day wait to be informed of a diagnostic test outcome, following an urgent referral for suspected cancer, or referral from a cancer screening programme (the 'Faster Diagnosis Standard' ("**FDS**")). The FDS should be met in 75% of cases and has been operational since April 2021. The FDS replaced the 'two week wait' standard ("**TWW**") standard in October 2023.

b. A maximum one month (31-day) wait for first cancer treatment, following a decision to treat. This standard should be met in 96% of cases.

c. A maximum 2-month (62-day) wait for first cancer treatment, following receipt of an urgent GP (or other referrer) referral for urgent suspected cancer, or urgent screening referral, or consultant upgrade. The standard should be met in 85% of cases.

355. Until October 2023, it was expected patients should not wait longer than two weeks for a first outpatient appointment with a cancer specialist, following receipt of an urgent referral for suspected cancer (the 'two week wait' standard ("**TWW**")). The standard should have been met in 93% of cases. Where a diagnosis of children's cancer is strongly suspected, GPs are generally encouraged to refer children immediately via telephone to an acute paediatrician, haematologist, or oncologist.

356. In many cases, GPs will refer children with suspected cancer to hospital very urgently (within 48 hours), via emergency departments. The most prevalent children's cancers, including leukaemia and brain cancer, require more urgent assessment than is required by some waiting time standards. Compared to adults, a relatively small number of suspected children's cancer cases are referred via the two-week wait route. Accordingly, the TWW and FDS standards are potentially less relevant for children.

357. Performance data is captured by the Cancer Waiting Times ("**CWT**") Data Collection. The CWT data collection was overseen by NHS Digital until 2023; the collection has been overseen by NHS England since 2023, when it merged with NHS Digital.

Steps taken by NHS England during the Specified Period

358. Any cessation of cancer services is an absolute last resort. Cancer services are always prioritised when NHS services experience periods of disruption, and this was equally true during the pandemic. During the Specified Period, NHS England's approach to CYP cancer generally reflected its broader approach to cancer for all

patients.

359. During the early pandemic stages, the aim was to support clinicians to reach decisions on how to balance the risk for cancer patients between having investigations, starting or continuing with treatment, and potentially increasing their risk of exposure to Covid-19, as well as prioritising cancer patients for treatment in the context of severe capacity constraints. NHS England provided advice to Cancer Alliances and local systems on the importance of maintaining cancer services wherever possible, and on what practical steps to take to organise services and pathways to help maintain service delivery. During the later pandemic stages, as part of wider recovery efforts, the emphasis shifted away from issuing urgent guidance towards setting priorities and performance targets through the normal annual planning cycles.

360. The Phase 1 Letter stated that cancer treatment should "*continue unaffected*".

361. On the same day, NHS England published the first iteration of a "*Clinical guide for the management of cancer patients during the coronavirus pandemic*" **[DB1/101][INQ000262193]**. This recognised that, whilst elective (planned) components of some cancer pathways might be impacted by the pandemic, cancer services would need to continue, and providers should seek out the best local solutions to continue the proper management of these services.

362. The guide included information on how to prioritise services in the event of disruption, setting out how to prioritise surgical patients and the general approach to take on prioritising patients on systemic anti-cancer treatment. The guidance did not set out prescriptive rules so much as principles to support clinicians when taking decisions, acknowledging that decisions would need to be made on a case-by-case basis.

363. This guidance was followed by a note to Cancer Alliances on 19 March 2020 **[DB1/102][INQ000470408]** which modified existing cancer waiting times with immediate effect and allowed telephone appointments with an appropriate specialist clinician to amount to an acceptable first appointment. This flexibility allowed for the service to adjust to allow for infection control measures whilst ensuring that patients still had access to appropriate specialist advice. However, the note confirmed that there was to be no adjustment to the inability to downgrade referrals without the consent of the referring clinician.

364. On the same day, NHS England set out the next steps of the Covid-19 response for

general practice, stating "*People who are concerned about any symptoms related to suspected cancer should still contact their GP and GPs should make sure they continue to refer those for suspected cancer for diagnostic tests as normal*" **[DB1/66][INQ000087325]**.

365. On 23 March 2020, NHS England published the second iteration of the clinical guidance issued on 17 March **[DB1/103][INQ000470416]**. The amendments made to the guidance made changes to the descriptions of vulnerable patients and the guidance on prioritisation of patients.

366. On 30 March 2020, a letter was sent to Trusts by the National Cancer Director, the NCD for Cancer and the National Medical Director to set out NHS England's advice on maintaining cancer treatment during the Covid-19 response **[DB1/104][INQ000000214]**.

367. The letter noted that NHS England had secured the use of almost all independent hospitals across England and recommended the use of "local cancer hubs", which would include provisions to consolidate all cancer surgery within the area on a "clean" Covid-19-free site. The recommendation was that a central triage point was also established to prioritise patients for surgery based on clinical needs and the level of risk, and referred to the guidance already issued to assist with prioritisation.

368. On 3 April 2020, NHS England published a SOP for managing proton beam therapy (**"PBT"**) referrals during the Covid-19 response. PBT is a specialised form of radiotherapy used to treat certain cancers, including highly complex brain cancers **[DB1/105][INQ000610884]**. In 2020, the sole NHS PBT centre in England was The Christie NHS Foundation Trust, whose PBT capacity was already limited notwithstanding additional Covid-19 pressures. A second centre in University College London Hospital opened in December 2021.

369. Many children need to be anaesthetised daily to receive PBT treatment, but the pandemic had put extra pressure on anaesthetists and ventilator equipment. Moreover, reduced PBT capacity was likely to impact significantly on conventional radiotherapy services, especially children's and TYA radiotherapy. The SOP set out principles to ensure the patients who were able to gain the greatest clinical benefit from PBT were still able to access it, that ensure PBT capacity was used in the most clinically effective way, and that approaches between PBT and conventional radiotherapy services were aligned.

370. Throughout the remainder of the Specified Period, NHS England provided guidance to health systems and providers to support the continuation and recovery of cancer services. Given CYP cancer services were delivered via PTCs and POSCUs, and given that specialist paediatric providers were relatively unaffected by the pandemic, delivery of CYP cancer services was generally well-maintained throughout the pandemic.

371. On 6 April 2020, the National Cancer Director, the NCD for Cancer and the NHS Cancer Programme Director sent further correspondence to Cancer Alliance leadership teams regarding the maintenance of cancer treatment during the pandemic **[DB1/106][INQ000470636]**. This advice referred to, and built upon, the letter of 30 March 2020 and set out the nationally led activities taking place to support the reprioritisation of services. The letter also confirmed strands of funding available and confirmed that additional activities to support the Covid-19 response should be recorded to be reimbursed.

372. Following this letter, the National Cancer Director and the NCD for Cancer wrote once again to Cancer Alliances on 8 June 2020 noting the requirements set out in the Phase 2 Letter and providing further guidance and support in this respect **[DB1/107][INQ000192818]**.

373. The letter noted the drop in the number of urgent referrals experienced during the pandemic due to a reduction in the number of patients contacting their GPs during this time was now starting to recover. By this time, NHS England had begun a communications campaign, "*Help Us, Help You*", encouraging people experiencing potential signs of cancer to seek help from their GP. The letter requested the Cancer Alliances' help in promoting this message.

374. The National Cancer Director wrote once again to Cancer Alliance Chairs on 3 August 2020 to follow up on the Phase 3 Letter and emphasised the priority given to restoring the full operation of all cancer services **[DB1/108][INQ000470641]**.

375. On 30 November 2020, a further letter was sent by the National Cancer Director and the NCD for Cancer to all Trusts to support the delivery of Phase 3 plans for cancer **[DB1/109][INQ000470508]**. Again, the emphasis was on the maintaining and recovering cancer services. The letter confirmed cancer services remained a priority for the NHS and to support the delivery of Phase 3 plans, NHS England was making available additional funding over and above the annual Cancer Alliance funding, including £4 million to lock in innovations developed during the pandemic.

376. NHS England published a "*Cancer Services Recovery Plan*" on 14 December 2020 **[DB1/110][INQ000399106]**, the aims of which were to:

a. restore demand to at least pre-pandemic levels;

b. reduce the number of people waiting longer than they should; and

c. ensure sufficient capacity to manage future demand.

377. On 15 January 2021, NHS England's COO, the National Cancer Director and the NCD for Cancer wrote to the regional teams in response to a sharp rise in Covid-19 cases, and asked them to stress test the local systems to ensure that the elements that helped sustain cancer services at the level seen in the first wave were in place, as well as taking a number of additional steps **[DB1/111][INQ000470520]**. The aim was to ensure that the elements which helped sustain cancer services at the level seen during Wave 1 were in place and additional steps taken in preparation for the second wave.

378. On 25 March 2021, systemwide planning guidance for 2021/22 was published by NHS England. This included a specific aim to restore full operation of all cancer services as one of the priorities for the year ahead **[DB1/112][INQ000060475]**. The guidance stated that Cancer Alliances were being asked to draw up a single delivery plan on behalf of their ICSs for the period of April 2021 to September 2021.

379. Following this, in April 2021, NHS England produced supporting information for Cancer Alliances in a planning pack for 2021/22 **[DB1/113][INQ000470634]**. The pack was produced to provide support and information to assist Alliances in drawing up delivery plans on behalf of the ICSs, asking them to set out the specific actions they would take to deliver the required success metrics set out within the pack. Cancer Alliances were specifically required to support children's and TYA ODNs to develop and implement the new service specifications for CYP, including improving access to clinical trials, which for TYA patients should be 50% by 2025. The pack also set out the timelines for the delivery plans, which were due to be finalised in mid to late May 2021 and refreshed where required in the second half of 2021. It also confirmed the funding available and the delivery principles in detail.

380. On 8 February 2022, NHS England published its "*Delivery plan for tackling the COVID-19 backlog of elective care*", setting out targets to ensure at least 75% of urgent cancer referrals received a diagnosis within 28 days by March 2024, and to

return the 62-day backlog to pre-pandemic levels by March 2023 **[DB1/86][INQ000087534]**. It committed to increasing investment in the "*Help Us, Help You*" campaign, to raise public awareness of cancer symptoms and risks.

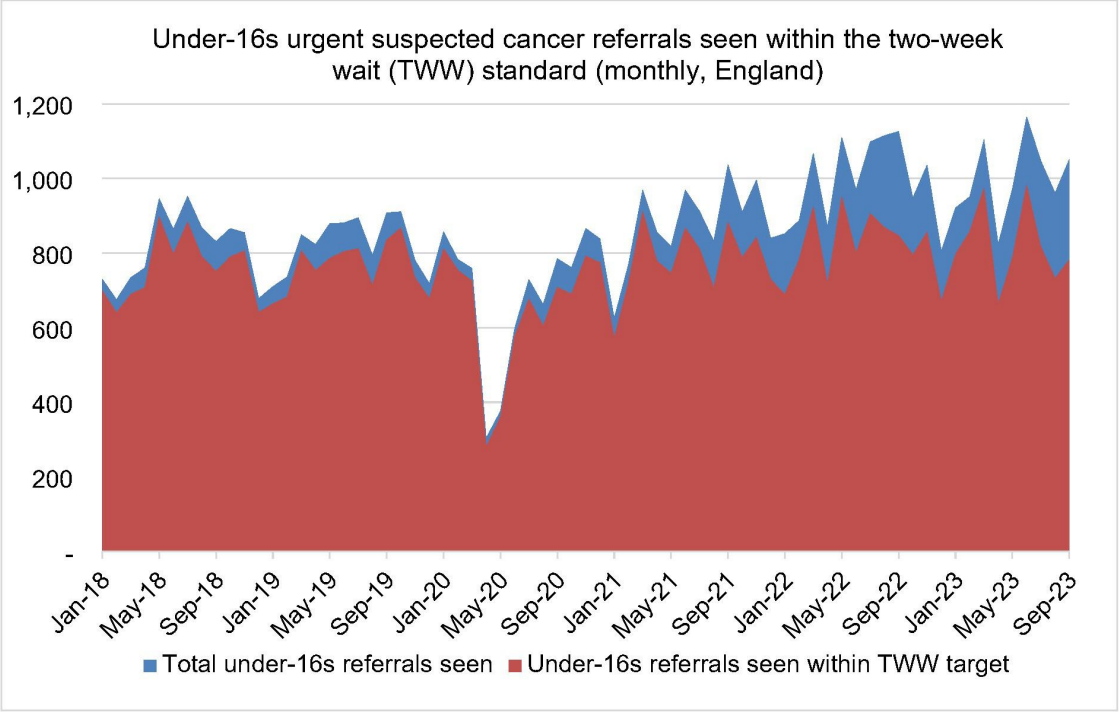
381. On 22 February 2022, NHS England published the 2022/2023 priorities and operational planning guidance **[DB1/87][INQ000113282]**. NHS England asked systems, as a priority, to complete any outstanding work on the post-pandemic cancer recovery objectives set out in the previous guidance, to return the number of people waiting for longer than 62 days to pre-pandemic levels, and to meet the increased level of referrals and treatment required to reduce the shortfall in the number of first treatments.

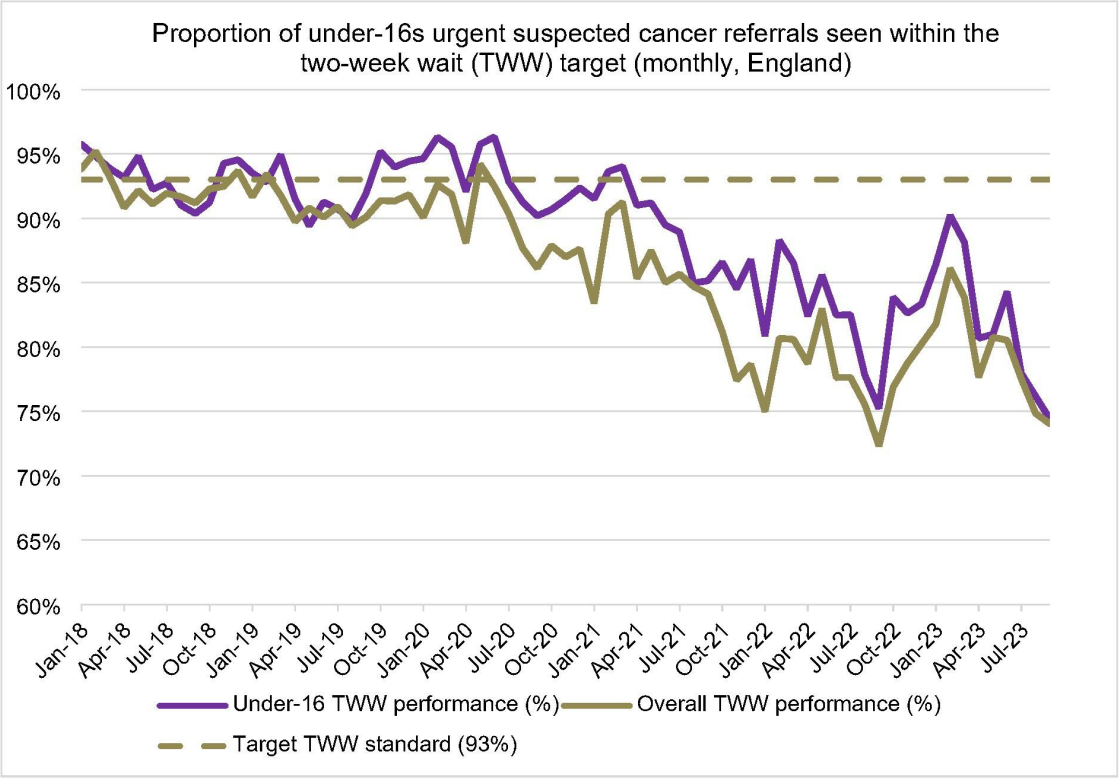
382. Again, systems were asked to work with Cancer Alliances to develop and implement a plan for the services going forwards. NHS England accompanied this guidance with a planning pack for Cancer Alliances with supporting information, which was published in January 2022, slightly prior to the system-wide guidance **[DB1/114][INQ000470635]**. This once again set out timelines for actions that needed to be taken to prepare a delivery plan and confirmation of funding available. It also set out the delivery principles that were expected to be delivered in a plan for care going forwards, including supporting the establishment of the new children and TYA Operational Delivery Networks.

Data on CYPs' cancer diagnoses, treatments, referrals and waiting times

Waiting Times

383. The graphs below show numbers of children under 16 receiving a first outpatient appointment with a cancer specialist, following receipt of an urgent referral for suspected cancer. The second graph shows the proportion of these children who were seen within the 'two week wait' (TWW) standard:

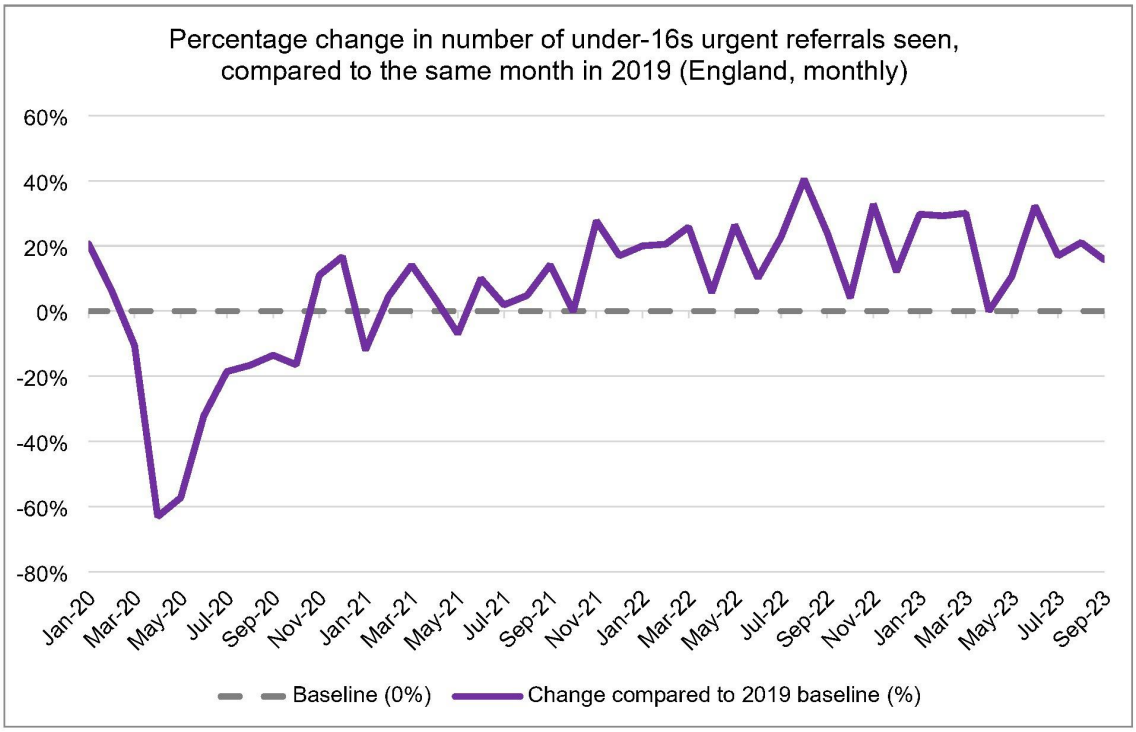




384. The first graph above shows a sharp drop in first appointments for urgent referrals in the months immediately following the start of the pandemic. This may have been due to children or their parents or carers becoming less willing to contact GPs, who would

have accordingly made fewer urgent referrals. The proportion of under-16 urgent referrals seen within the TWW target subsequently declined during the remainder of the Specified Period, consistent with all cancer referrals generally.

385. However, the number of appointments recovered to pre-pandemic levels by around November 2020. NHS England ran a targeted '*Help Us, Help You*' communications campaign in October 2020, encouraging people with symptoms of suspected cancer, to contact their GP. This may have contributed to encouraging more people to come forward. The graph below illustrates more clearly how, from June 2021 until September 2023, the monthly number of urgent referrals seen was consistently higher than in the same month in 2019:

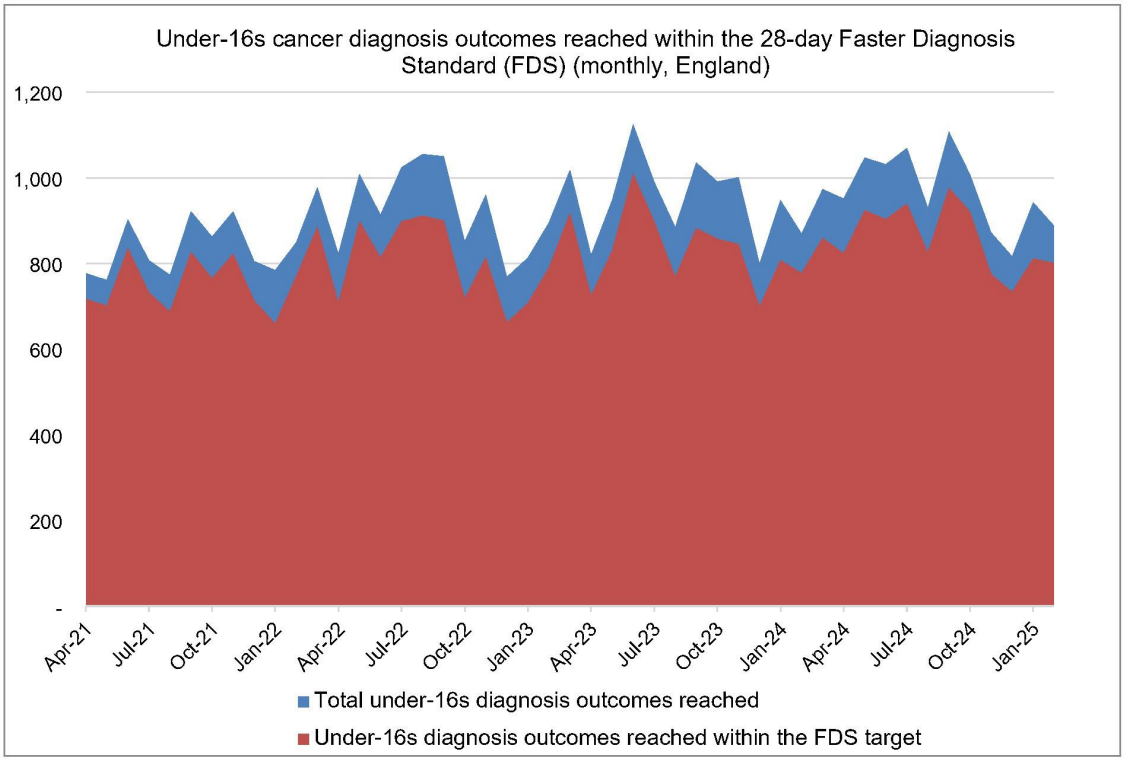


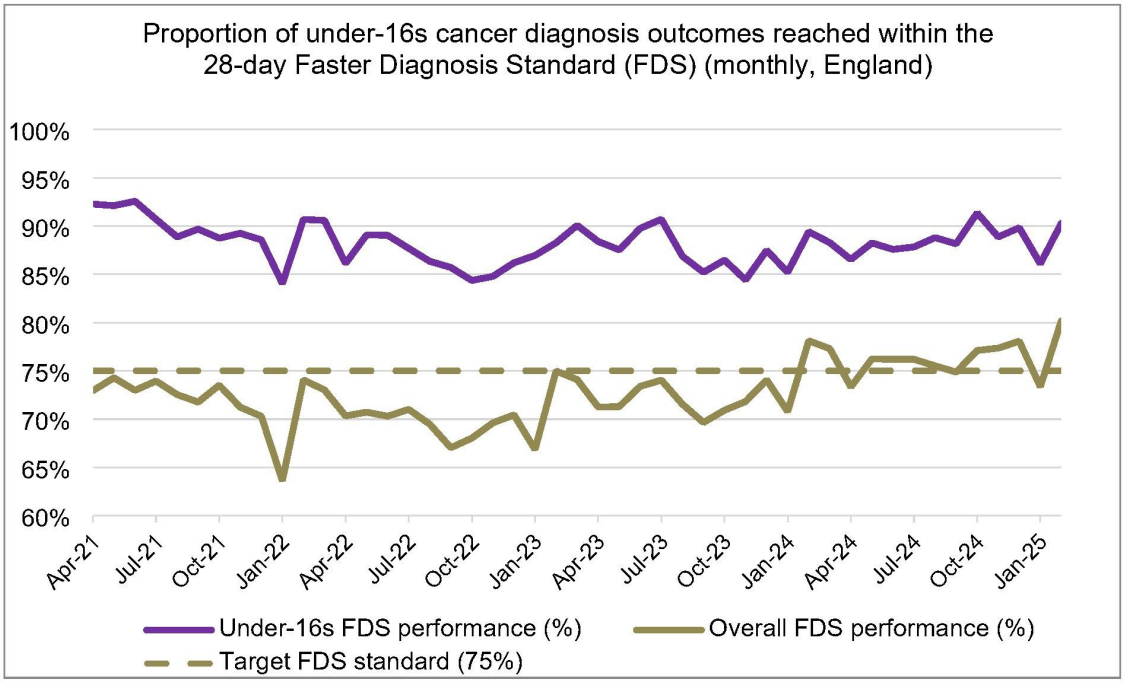
386. The graphs below show the monthly numbers of patients under 16 who received either a cancer diagnosis, or who had cancer ruled out, following an urgent referral for suspected cancer.

387. The second graph shows the proportion of patients who received the diagnosis test outcome within the 28-day FDS standard. FDS data has been collected from April 2021.

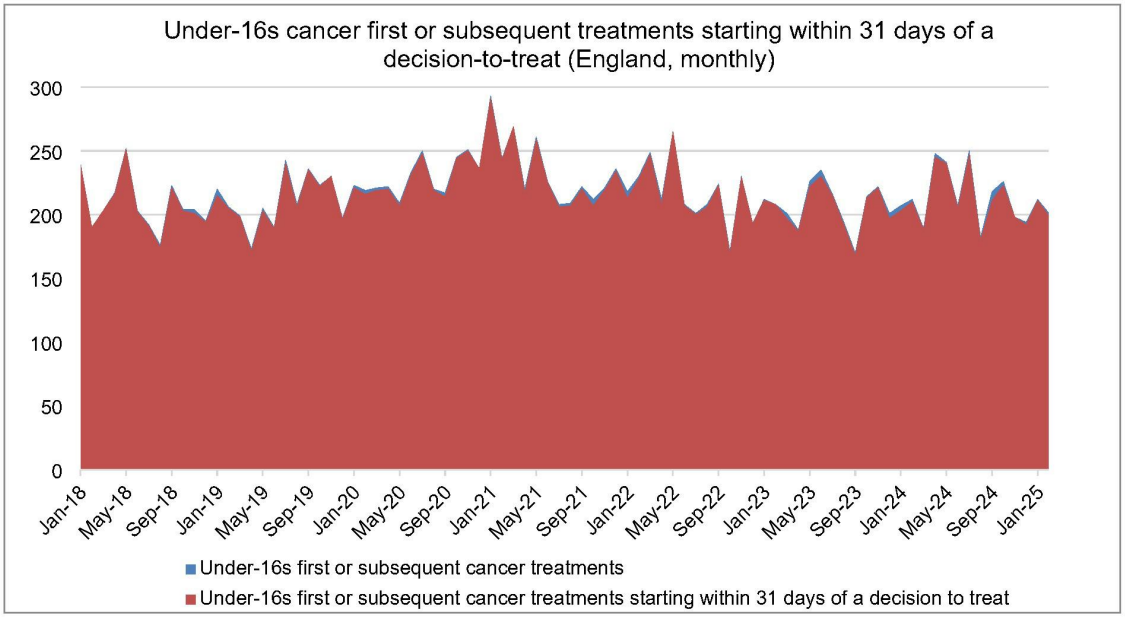
388. These graphs indicate the proportion of under-16s receiving a test outcome within the 28-day standard has been consistently over 84% (greater than the FDS standard of

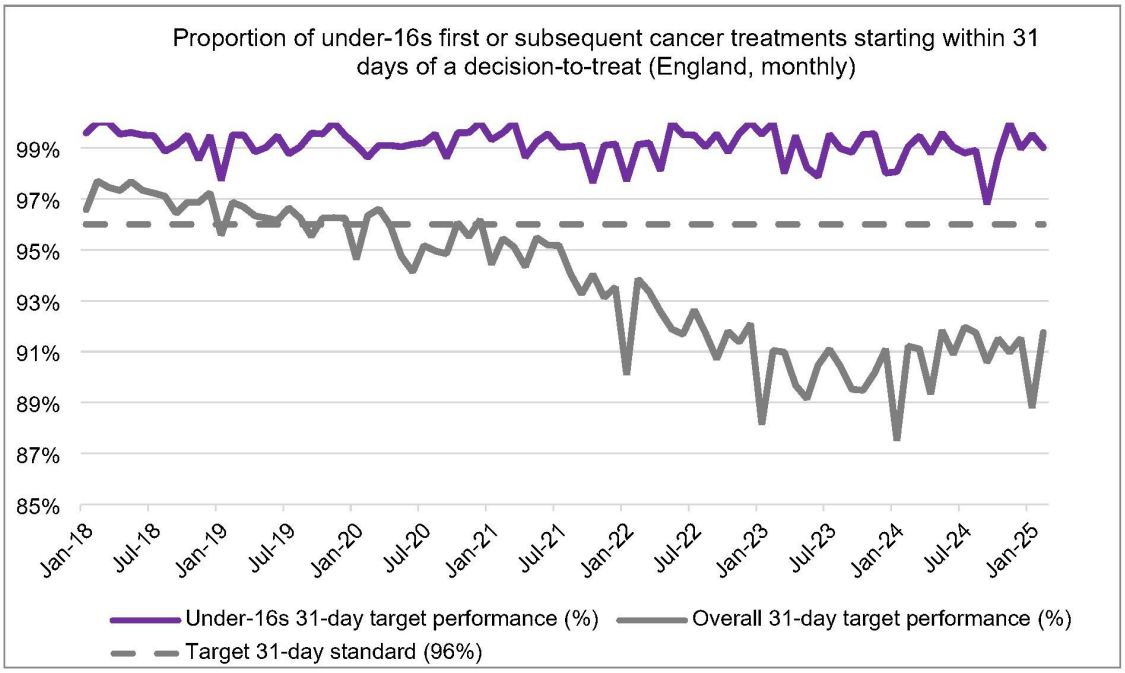
75%), and consistently higher than for all cancer referrals overall.



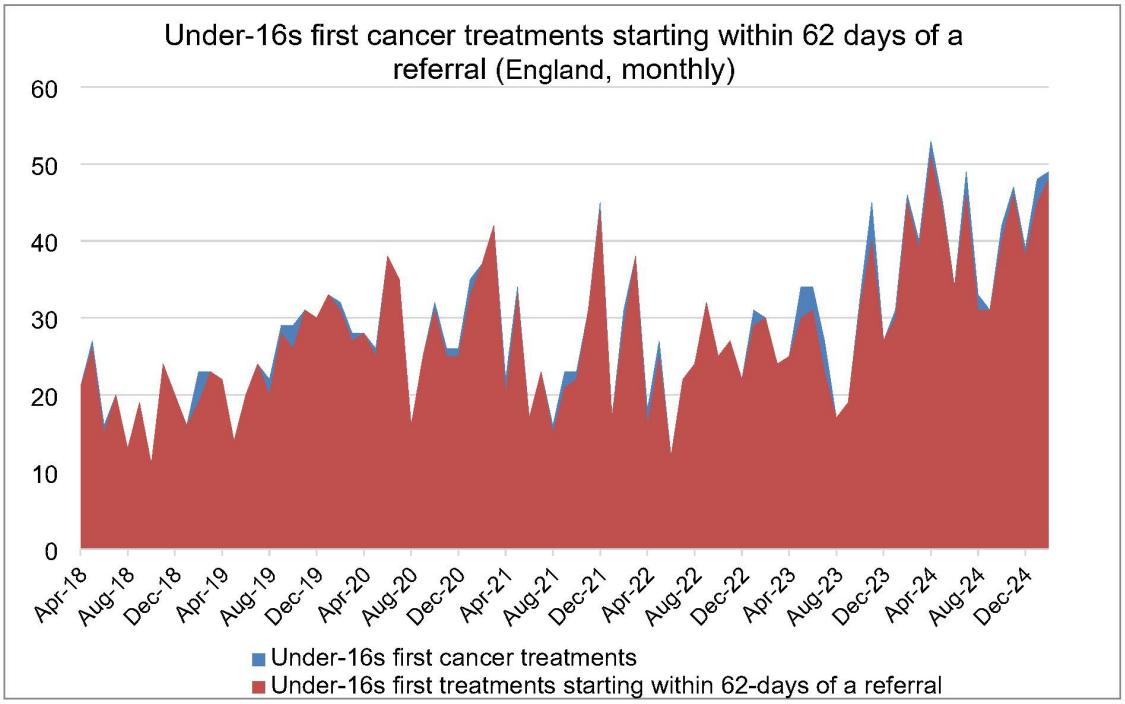


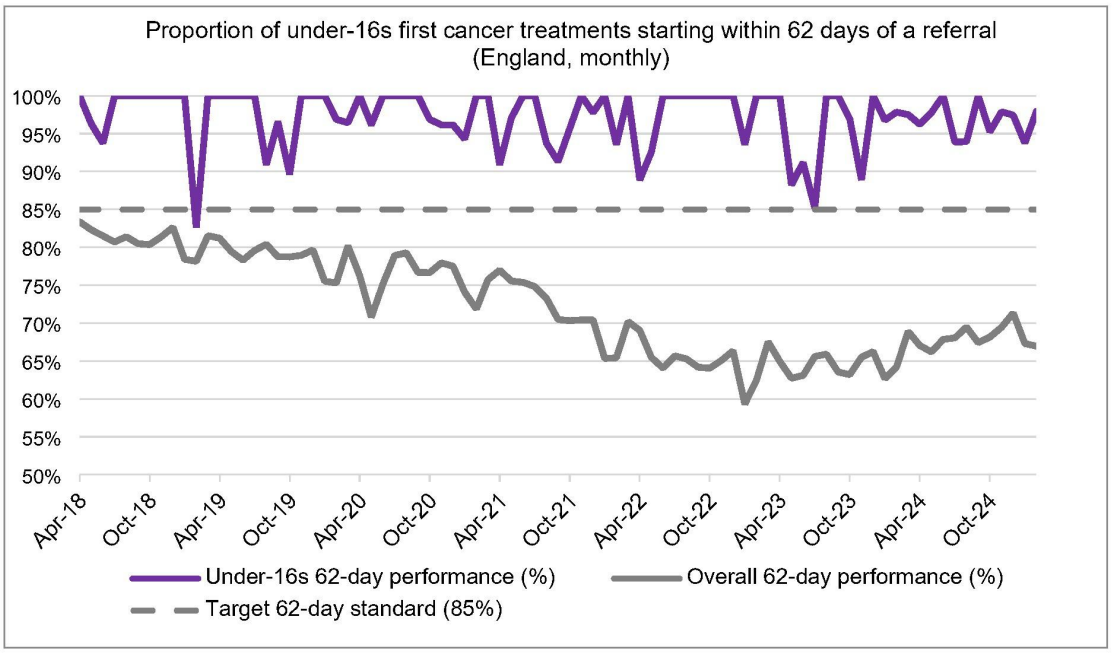
389. The graphs below show the number and proportion of children under 16 receiving a first or subsequent cancer treatment within 31 days of a decision to treat. The proportion of children treated with the 31-day wait target has remained stable at over 96% since 2018, including during the Specified Period, and consistently higher than the operational standard of 95%:





390. The graphs below show the number and proportion of children under 16 receiving a first cancer treatment within 62 days of a referral. The proportion of children treated within the 62-day wait target remained higher than the 85% target throughout the Specified Period:





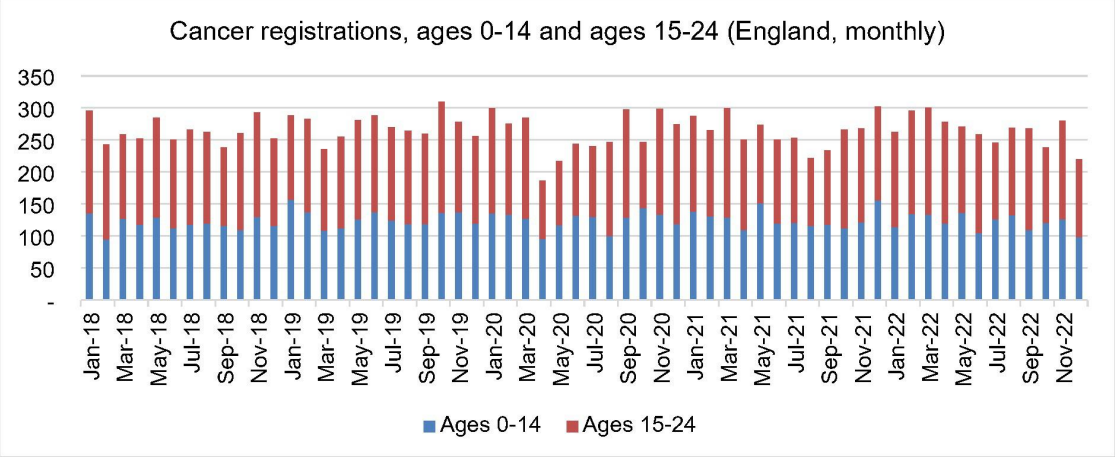
391. NHS England does not routinely publish 31-day and 62-day performance data for children's cancer: monthly numbers of children's cancer diagnoses are relatively very small. Moreover, children and adults tend to be affected by different cancer types requiring different treatments, so it is difficult to draw meaningful comparisons between adult's and children's cancer wait time performance.

Children's Cancer Diagnoses

392. NHS England captures national statistics on cancer registrations, as part of the National Disease Registration Service ("**NDRS**"). Cancer registration statistics distinguish between cancers diagnosed in children aged 0-14 and TYA aged 15-24.

393. The graph below shows the monthly number of confirmed cancer registrations amongst children aged 0-14 and TYA aged 15-24, between 2018 and 2022. It shows a decline from 285 registrations in March 2020 to 187 in April, following the onset of the pandemic. This may be due to children or their parents or carers becoming less willing to contact GPs.

394. Registrations had recovered by September 2020. The two graphs below suggest that, overall annual registrations were not significantly impacted during the Specified Period, despite the short-term decline.



395. Registrations had recovered by September 2020. The table below suggest that, overall, annual registrations were not so significantly impacted during the Specified Period, despite the decline in early 2020. Total registrations declined from 3,273 in 2019 to 3,116 in 2020, before recovering to 3,178 in 2021 and to 3,191 in 2022. For ages 0-14, males consistently comprised most registrations.

Cancer registrations, ages 0-14 and ages 15-24, by gender							
Year	**Ages 0-14**			**Ages 15-24**			**Total (ages 0-24)**
	Female	**Male**	**Total**	**Female**	**Male**	**Total**	
2018	626	791	1417	874	872	1746	3163
2019	667	861	1528	887	858	1745	3273
2020	658	830	1488	805	823	1628	3116
2021	671	844	1515	806	857	1663	3178
2022	615	836	1451	898	842	1740	3191

396. The table below illustrates that blood cancers made up between 46-49% of all cancers diagnosed in children aged 0-14 between 2018 and 2022; brain cancers made up between 28-32% of cases. In teenagers and young people aged 15-24, blood and brain cancers made up a smaller proportion of cancers.

Cancer registrations by type (as a % of cancers, by age group)						
Year	**Ages 0-14**			**Ages 15-24**		
	Blood (%)	**Brain (%)**	**Other (%)**	**Blood (%)**	**Brain (%)**	**Other (%)**
2018	47.07%	30.28%	22.65%	38.09%	17.53%	44.39%
2019	46.99%	31.28%	21.73%	36.50%	18.22%	45.27%

2020	46.44%	30.24%	23.32%	38.57%	16.40%	45.02%
2021	48.05%	28.45%	23.50%	39.57%	16.18%	44.26%
2022	46.86%	30.60%	22.54%	40.23%	16.49%	43.28%

397. The table below shows cancer registrations for 0-24 year olds by ethnicity. White patients comprised most young cancer patients from 2018 to 2022, followed by Asian patients. The proportion of young patients diagnosed with cancer who were white increased from 70% in 2019 to 74% in 2020 (the first year of the pandemic), before declining to 70% in 2021 and to 66% in 2022.

Ethnic group	**Age at diagnosis: 0 to 24 years - counts**					**Age at diagnosis: 0 to 24 years - %**				
	Year of diagnosis					**Year of diagnosis**				
	2018	**2019**	**2020**	**2021**	**2022**	**2018**	**2019**	**2020**	**2021**	**2022**
White	2363	2297	2302	2216	2093	75%	70%	74%	70%	66%
Asian	298	345	326	327	329	9%	11%	10%	10%	10%
Black	99	136	132	149	134	3%	4%	4%	5%	4%
Mixed	98	103	105	124	118	3%	3%	3%	4%	4%
Other	118	115	147	143	157	4%	4%	5%	4%	5%
Unknown	187	277	104	219	360	6%	8%	3%	7%	11%
Total	**3163**	**3273**	**3116**	**3178**	**3191**	**100%**	**100%**	**100%**	**100%**	**100%**

398. The table below shows cancer registrations for 0-24 year-olds by index of multiple deprivation (**"IMD"**). The proportion of young people diagnosed with cancer, living in the most deprived areas (quintile 1), declined from 24% in 2019 to 21% in 2020 – before increasing to 23% in 2021 and 2022. Conversely, the proportion of young people living in the most affluent areas increased from 17% in 2019 to 20% in 2020 (before declining again). This may suggest that, during the pandemic, young people in wealthier areas (and their parents) were relatively less deterred from seeking advice and treatment for cancer symptoms.

Deprivation quintile (1 - most deprived; 5 – least deprived)	**Age at diagnosis: 0 to 24 years - counts**					**Age at diagnosis: 0 to 24 years - %**				
	Year of diagnosis					**Year of diagnosis**				
	2018	**2019**	**2020**	**2021**	**2022**	**2018**	**2019**	**2020**	**2021**	**2022**
1	740	787	668	728	735	23%	24%	21%	23%	23%
2	671	707	645	685	686	21%	22%	21%	22%	21%
3	602	610	576	616	622	19%	19%	18%	19%	19%
4	566	598	601	576	596	18%	18%	19%	18%	19%
5	584	571	626	573	552	18%	17%	20%	18%	17%
Total	**3163**	**3273**	**3116**	**3178**	**3191**	**100%**	**100%**	**100%**	**100%**	**100%**

SECTION G - COMMUNITY SERVICES

Background

399. 'Community health services' (**"CHS"**) typically refer to care delivered in people's homes, or in local settings such as community hospitals, intermediate care facilities, educational settings, or hospices. The scope of CHS is not universally defined. However, community services for children typically refer (but are not limited) to:

a. Developmental services, i.e.:

i. Occupational therapy;

ii. Physiotherapy;

iii. Speech and language support;

iv. Community Paediatrics and child development centres;

v. Audiology;

vi. Wheelchair services;

b. Universal services, i.e.:

i. Health visiting;

ii. School nurses;

iii. Child/school-age immunisations;

iv. Newborn and child screening;

v. Child Health Information Service;

c. Specialist children's services, i.e.:

i. Safeguarding;

ii. Special Education Needs and Disabilities;

iii. Support for looked after children;

iv. Support for management of long term conditions ("LTC), including diabetes and epilepsy;

v. Support for children on long term ventilation;

vi. Community dentistry;

d. Children's palliative and end-of-life care; and

e. Hospital admissions avoidance support.

400. CHS providers include all types of Trusts, local authorities, for-profit and not-for profit providers (including community interest companies). Around a third of CHS providers are social enterprises. Patients with complex needs often receive care from multiple different CHS providers who coordinate with primary care providers, to provide preventative and proactive care. CHS play a crucial role in supporting some of the vulnerable children (including children with Special Educational Needs/looked after children) and identifying safeguarding concerns.

401. CHS are funded by a range of sources, including by NHS England, local NHS commissioners, and by the public health grant (funding provided to local authorities by DHSC). During the Specified Period, school nursing and health visitors were funded by local authorities. Some services are funded jointly by the NHS and local authorities. A table outlining CHS commissioning responsibilities during the Specified Period is exhibited at **[DB1/14][INQ000421234]**.

Steps taken by NHS England during the Specified Period

402. The Phase 1 Letter required all community health providers to support NHS acute providers to discharge as many patients as possible from hospital beds, in anticipation of an influx of Covid-19 patients. In line with advice for all sectors in the NHS, NHS England subsequently developed proposals for community providers to de-prioritise non-urgent activity, to support the release of as much capacity as possible to support the Covid-19 response **[DB1/116][INQ000269920]**. Relevant policy leads and clinical leaders in NHS England were engaged and the approach was tested with NHS provider leaders. PHE advised on the proposals, specifically in relation to health visiting. NIRB discussed and approved the prioritisation guidance on 17 March 2020, and it was published on 19 March 2020. Given the wide range of organisations funding and involved in CYP services (NHS, Local Authorities and the

education sector), it was not possible at this stage in the pandemic to fully engage with all stakeholders at this point.

403. While ICBs commission most adult community health services, local authorities commission community health services for CYP (up to 19 years old) including health visiting.

404. Under section 252A(6) of the 2006 Act, NHS England may take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by the ICBs and relevant service providers. Relevant service providers means any body or person providing services in pursuance of arrangements made under the NHS Act 2006, and includes ICBs, Trusts and local authorities.

405. NIRB discussed and approved the prioritisation guidance on 17 March 2020 and it was published on 19 March 2020 ("**Community Prioritisation Guidance**"). Although there was need to publish the Community Prioritisation Guidance at pace, some stakeholders were consulted on its content – including the Director of Nursing at PHE, and the COO/CEO's of 8 providers of community health services. However, due to the wide range of organisations funding and involved in CYP services (NHS providers, local authorities and the education sector etc), the ability to consult widely on the Community Prioritisation Guidance and to consider its longer-term impact on CYP was limited.

406. The Community Prioritisation Guidance advised community providers on prioritising non-urgent activity, to release as much capacity as possible to support the Covid-19 response. Some CYP services were impacted by this prioritisation:

a. three services were stopped completely (the National Child Measurement programme, audiology and the Friends and Family Test);

b. several services continued (including safeguarding, sexual assault services and emotional health and wellbeing /mental health support); and

c. the remainder of community services were partially paused, with many of these subject to prioritisation based on individual needs, clinical judgment and population needs.

407. On 2 April 2020, the CHS prioritisation advice was updated so that audiology provision should be made for essential or routine care (including diagnostic tests following newborn screening), but routine assessments could be delayed. The

updated advice also suggested immunisations for school-aged children should restart when schools re-opened.

408. NHS England published a CHS SOP on 15 April 2020 to support implementation of the CHS prioritisation guidance. The SOP advised CHS to prioritise support for patients identified as being at the highest risk from Covid-19 and who were shielding, and to triage and deliver care remotely where possible and appropriate.

409. The SOP acknowledged CYP, especially those who were most vulnerable, might experience additional pressures and stresses during the pandemic. CHS were expected to continue to offer universal and targeted support – including providing advice and guidance to allay children's anxieties and to signpost them to appropriate services, keeping in contact with children for whom there were safeguarding concerns, and planning support for children with long-term conditions.

410. NHS England was cognisant of the impact of the pandemic on CYP. This was especially the case as it meant some of the most vulnerable children and families (children with Special Educational Needs/looked after children) who may not have received some care services in the same manner as before the Specified Period. Support for CYP with additional needs at home (including advanced nursing interventions) were prioritised and provided with support such as PPE and other equipment in the same way as the adult population.

411. The Phase 2 Letter, published 29 April 2020, outlined that essential community health services must continue to be provided, and that other services should be phased back in wherever there was available capacity. Home visits were to be prioritised where there were child safeguarding concerns.

412. On 28 May 2020, the CNO sent the nursing phase 2 response letter to regional Chief Nurses. This communication outlined that she had been working with PHE colleagues (and Local Government and the Association of Directors of Public Health) to advise the following services that they should return to their commissioned service model **[DB1/31][INQ000421174]**:

a. Health visiting and school nursing teams commissioned by local authorities;

b. Looked after children's teams managed by CCGs;

c. SEND teams; and

d. Community children's nurses for complexly ill children.

413. On 3 June 2020, NHS England sent a system letter ("*Restoration of Community Services for Children and Young People*") setting out the framework to partially or fully restore each service for CYP, superseding the March and April prioritisation letters **[DB1/14][INQ000421234]**. The restoration guidance was updated on 10 June 2020, and on 31 July 2020, after the DfE advised that schools would re-open in full from the autumn term 2020.

414. The Institute of Health Visiting subsequently contacted the CNO and the Chief Nurse for Public Health to inform them that some organisations were planning to once again redeploy health visitors to manage increasing Covid-19 cases. To protect these services, the Chief Nurse for Public Health and the CNO issued a joint letter with the Local Government Association on 7 October 2020 making it clear that health visitors and school nurses should not be redeployed other than in exceptional individual circumstances, such as having critical care experience **[DB1/32][INQ000347184]**.

415. NHS England's Chief Allied Health Professions Officer subsequently advised on 9 December 2020 that no Allied Health Professional[13] who support CYP or their families – and specifically those children with SEND – should be redeployed to other services, and that those professionals should prioritise provision of children's services and services to vulnerable families **[DB1/163]** **[INQ000615432]**.

416. NHS England issued a further CHS national prioritisation framework on 11 January 2022, in response to increased service pressures caused by the Covid-19 Omicron wave, and the urgent need to deliver Covid-19 booster vaccinations. The framework was intended to support urgent local decision-making about the redeployment of community health staff. The National child measurement programme and Friends and Family Test were paused in full. CYP audiology and vision screening were able to be paused with exceptions. All other CYP CHS were expected to continue, or to continue with prioritised waiting lists. All services were expected to resume in full from 1 March 2022.

417. Were a future pandemic to arise, there is now a more rigorous and complete data collection of NHS services supporting CYP as well as better-established national leadership and oversight of these services, both within NHS England and the DHSC (including the Office for Health Improvement and Disparities). Development of any

[13] There are fourteen allied health professions, which include occupational therapists, paramedics, physiotherapists, speech and language therapists etc.

future guidance on the prioritisation of CYP community services should, in this context, be better tailored to the needs of local populations.

Monitoring restoration of CYP community services

The Restoration SitRep

418. In October 2020, NHS England established a Situation Report (**"Restoration SitRep"**) to understand the extent to which key community services, partially stopped after publication of the March 2019 prioritisation guidance, had been restored. This new data was intended to assist NHS England's understanding of providers' resilience as the second Covid-19 wave approached, and to identify issues in specific service areas or local regions. The new data set also enabled national assessment of performance and productivity, something that was not possible before the pandemic which made it difficult to identify challenges at local level.

419. Initially, the Restoration SitRep covered the following CYP services:

a. Audiology;

b. Vision screening;

c. New-born hearing screening;

d. Community paediatric service;

e. Therapy interventions (physiotherapy, speech and language, occupational therapy, dietetics, orthotics);

f. Looked after children teams;

g. Child Health Information Service;

h. Community nursing services (planned care and rapid response teams);

i. Nursing and Therapy teams support for long term conditions; and

j. Wheelchair, orthotic, prosthetics and equipment.

420. For each service line, providers were asked the following questions monthly:

a. Had the service been restored to its pre-COVID-19 form?

b. If the service had not been restored, or only partially restored, what were the reasons?

c. If the service had been fully or partially restored, what was the summary status of activity?

d. If the service had been fully or partially restored, was it experiencing a backlog?

e. How long did they estimate it would take to clear the backlog?

f. If the service had been fully or partially restored, had the method of delivering clinical interventions changed from face to face to remote?

g. If yes to f above, compared against a baseline of pre-Covid-19 levels, how much of this changed?

421. In March 2021, the following CYP service lines were added to the Restoration SitRep, and the questions were revised to reduce data collection burdens:

a. Safeguarding services;

b. Rapid Response Services;

c. Antenatal, new-born and children screening and immunisation services; and

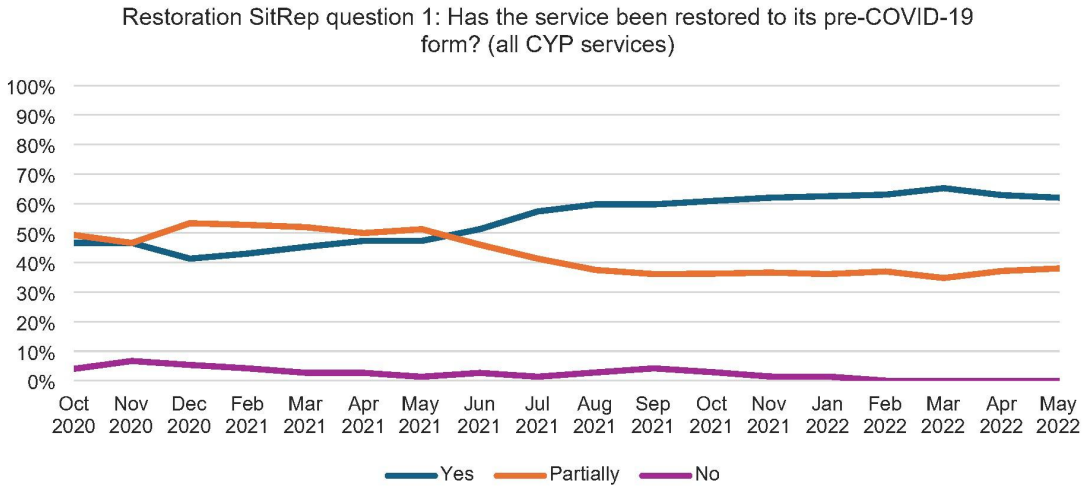
d. Emotional health and wellbeing/mental health support.

422. From August 2021, data on each of the five CYP therapy service lines were disaggregated. Providers were also asked about their waiting list sizes, and median wait times.

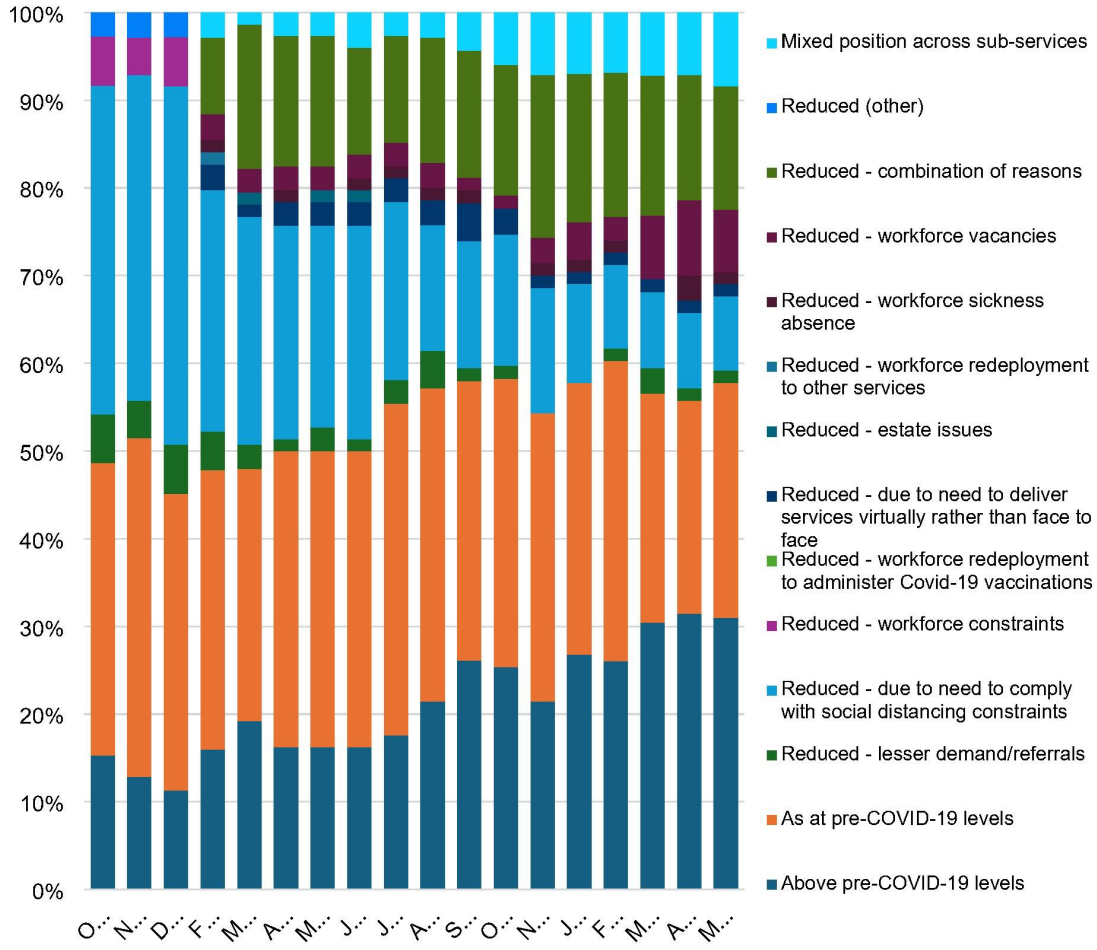
423. 142 CHS providers were included in the Restoration SitRep, from a range of NHS and independent providers and Community Interest Companies ("**CIC**"). It was estimated there were over 1,488 NHS-funded CHS providers, so the Restoration SitRep data represented a cross-section of the total CHS sector, including providers of different size. It was intended that all large CHS providers, from each region, were included in the SitRep. The number of providers submitting data varied month-to-month, which may have accounted for some data variation.

Restoration SitRep Data, October 2020 to May 2022

424. Restoration SitRep data suggests 62% of CYP service lines had been restored to pre-COVID-19 levels in October 2020. This declined to 54% in December 2020, during the second Covid-19 wave, but steadily increased thereafter, to 79% to May 2022.



425. The biggest reason for CYP service lines not being fully restored was the need to comply with social distancing measures. This remained the case from October 2020 until January 2022, after which point a 'combination of reasons' was the biggest factor.



426. By May 2022, off all CYP service lines included in the Restoration SitRep, speech and language services had the largest proportion of providers reporting a demand backlog (82%). This was followed by community paediatric services (79%).

Ranked list of services reporting existence of a backlog (May 2022)		
Services	**Reporting existence of a backlog (%)**	**# Providers reporting existence of a backlog by service**
(CYP) Therapy interventions: speech and language	**82%**	*64*
(CYP) Community paediatric service	**79%**	*56*
(CYP) Therapy interventions: occupational therapy	**72%**	*58*
(CYP) Audiology	**60%**	*29*
(CYP) Therapy interventions: physiotherapy	**59%**	*48*
(CYP) Therapy interventions: dietetics	**55%**	*26*
(CYP) Wheelchair, orthotics, prosthetics and equipment	**50%**	*17*
(CYP) Emotional health and wellbeing, mental health support	**46%**	*11*
(CYP) Vision screening	**44%**	*11*
(CYP) Screening and immunisation services	**33%**	*8*
(CYP) Therapy interventions: orthotics	**32%**	*6*
(CYP) Looked after children teams	**29%**	*20*
(CYP) Nursing and Therapy teams support for long term conditions	**19%**	*7*
(CYP) Antenatal, new-born and children screening and immunisation services	**14%**	*3*
(CYP) Community nursing services (planned care and rapid response teams)	**12%**	*7*
(CYP) New-born hearing screening	**10%**	*3*
(CYP) Safeguarding	**5%**	*2*
(CYP) Child health information service	**4%**	*1*
(CYP) Rapid Response Services	**0%**	*0*

427. Providers reported community paediatric services and speech and language services as having significantly the largest waiting list sizes, by May 2022 (75,559 and 74,389 respectively, followed by 26,815 in audiology).

Ranked list of services by reported waiting list size		
Services	**Waiting list size**	**# Providers reporting waiting list size by service**
(CYP) Community paediatric service	**75,559**	*71*
(CYP) Therapy interventions: speech and language	**74,389**	*81*
(CYP) Audiology	**26,815**	*50*
(CYP) Therapy interventions: occupational therapy	**21,150**	*81*
(CYP) Therapy interventions: physiotherapy	**20,930**	*82*

(CYP) Emotional health and wellbeing, mental health support	**14,417**	*25*
(CYP) Vision screening	**14,276**	*25*
(CYP) Therapy interventions: dietetics	**8,934**	*47*
(CYP) Nursing and Therapy teams support for long term conditions	**5,459**	*36*
(CYP) Screening and immunisation services	**5,229**	*25*
(CYP) Looked after children teams	**4,997**	*70*
(CYP) Antenatal, new-born and children screening and immunisation services	**4,097**	*24*
(CYP) Community nursing services (planned care and rapid response teams)	**2,262**	*59*
(CYP) Wheelchair, orthotics, prosthetics and equipment	**1,907**	*34*
(CYP) Therapy interventions: orthotics	**557**	*19*
(CYP) Safeguarding	**551**	*39*
(CYP) New-born hearing screening	**515**	*29*
(CYP) Rapid Response Services	**0**	*9*
(CYP) Child health information service	**0**	*24*

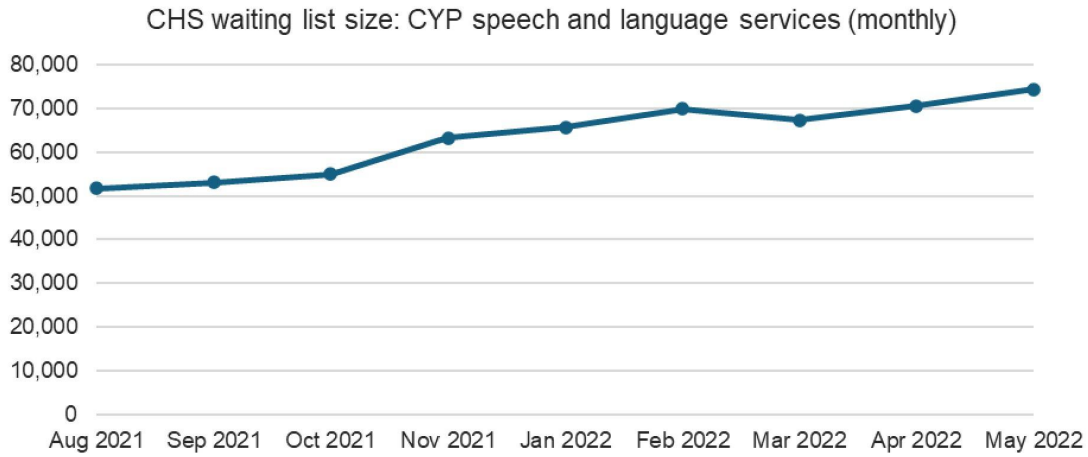
428. 73% of providers reported the waiting list for CYP speech and language services were worse in May 2022, compared to the same period in 2019. This was followed by community paediatric services, with 66%.

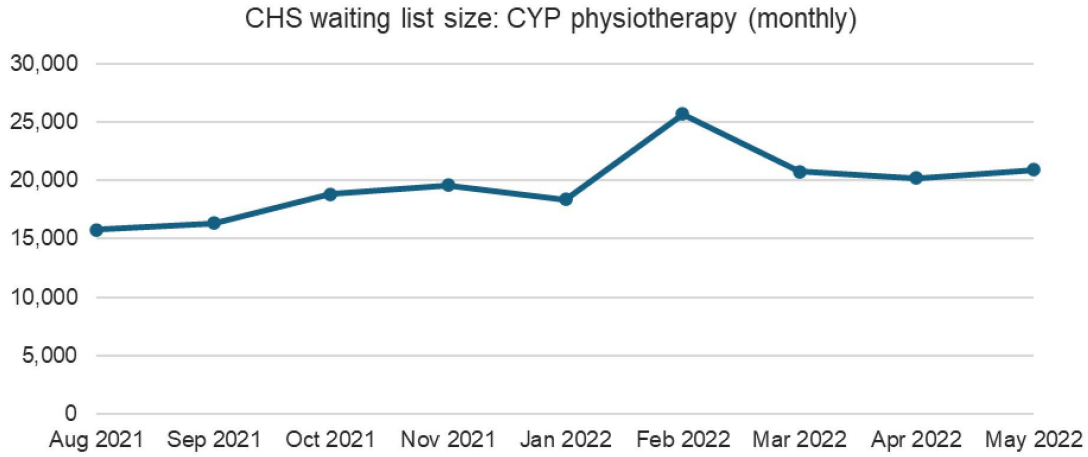
Ranked list of services reporting growth in waiting list compared to the same period in 2019 (pre-COVID)

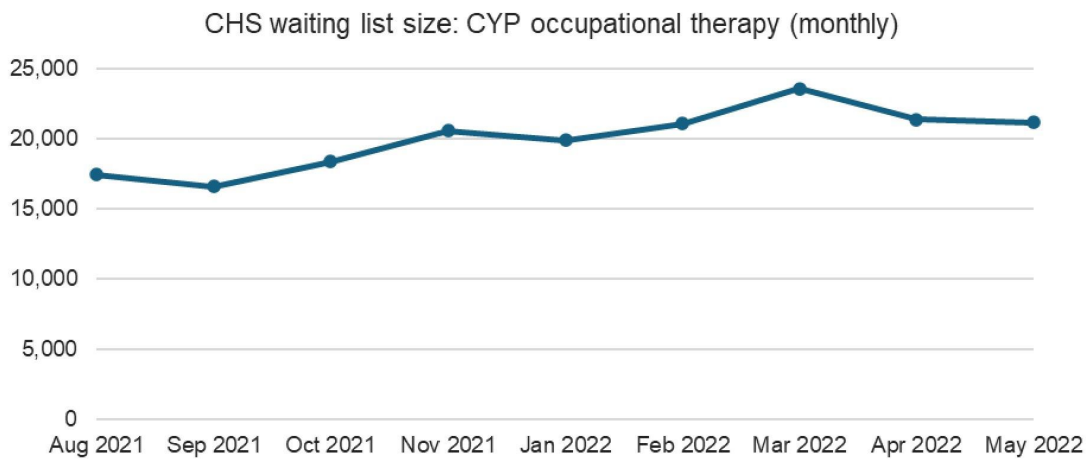
Services	Organisations reporting growth in waiting list (%)	# Providers reporting growth in waiting list by service
(CYP) Therapy interventions: speech and language	**73%**	*59*
(CYP) Community paediatric service	**66%**	*47*
(CYP) Emotional health and wellbeing, mental health support	**56%**	*14*
(CYP) Therapy interventions: occupational therapy	**54%**	*44*
(CYP) Therapy interventions: dietetics	**53%**	*25*
(CYP) Therapy interventions: physiotherapy	**51%**	*42*
(CYP) Audiology	**51%**	*25*
(CYP) Wheelchair, orthotics, prosthetics and equipment	**41%**	*14*
(CYP) Screening and immunisation services	**32%**	*8*
(CYP) Looked after children teams	**27%**	*19*
(CYP) Vision screening	**24%**	*6*
(CYP) Community nursing services (planned care and rapid response teams)	**22%**	*13*
(CYP) Therapy interventions: orthotics	**21%**	*4*
(CYP) Nursing and Therapy teams support for long term conditions	**19%**	*7*
(CYP) Antenatal, new-born and children screening and immunisation services	**17%**	*4*

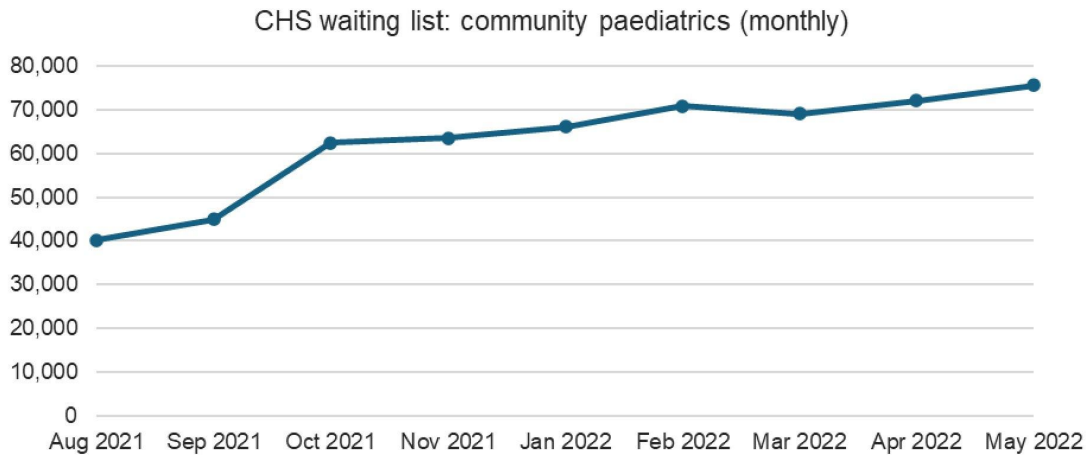
(CYP) Safeguarding	**10%**	*4*
(CYP) Child health information service	**4%**	*1*
(CYP) New-born hearing screening	**3%**	*1*
(CYP) Rapid Response Services	**0%**	*0*

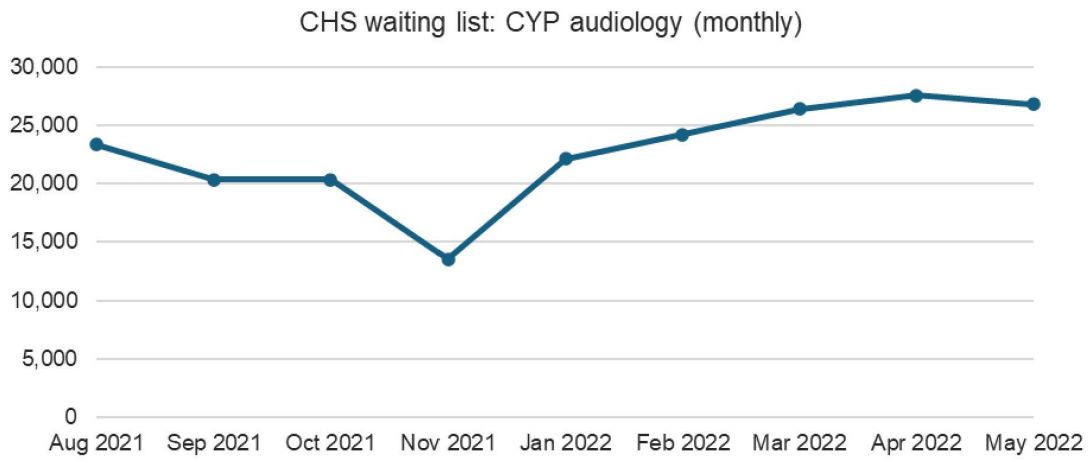
429. The graphs below show how reported waiting list sizes increased from August 2021 until May 2022, during the Specified Period, for CYP speech and language services, CYP physiotherapy, community paediatrics, and CYP audiology. Note these figures include only waits from the 142 providers submitting CHS SitRep data, so will not represent the total national waiting list size:






CHS waiting list size: CYP occupational therapy (monthly)
25,000
20,000
15,000
10,000
5,000
0
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Jan 2022
Feb 2022
Mar 2022
Apr 2022
May 2022


CHS waiting list: community paediatrics (monthly)
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Jan 2022
Feb 2022
Mar 2022
Apr 2022
May 2022


CHS waiting list: CYP audiology (monthly)
30,000
25,000
20,000
15,000
10,000
5,000
0
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Jan 2022
Feb 2022
Mar 2022
Apr 2022
May 2022

The CHS SitRep

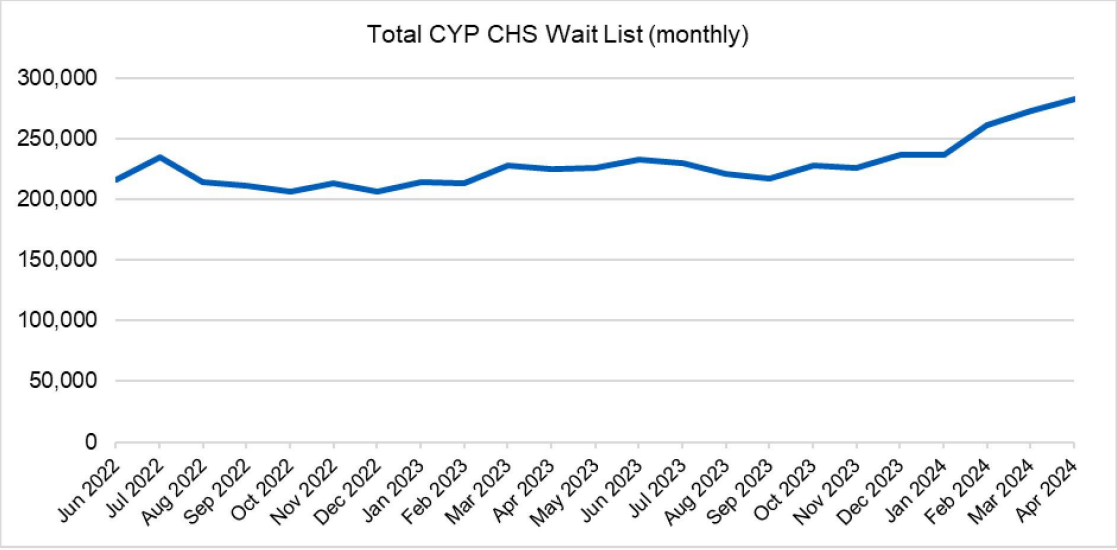
430. The Restoration SitRep became a business-as-usual collection (the **"CHS SitRep"**) in June 2022. The questions were adjusted to focus in more detail on waiting list and wait times, and less on service restoration.

431. The CHS SitRep collected information about waiting times for patients currently on CHS wait lists, as well as the median and mean wait times. Providers were asked to identify the key reasons for not being able to reduce waiting list sizes. The CHS SitRep covered the same CYP service lines as the Restoration SitRep but excluded emotional health and wellbeing and mental health support.

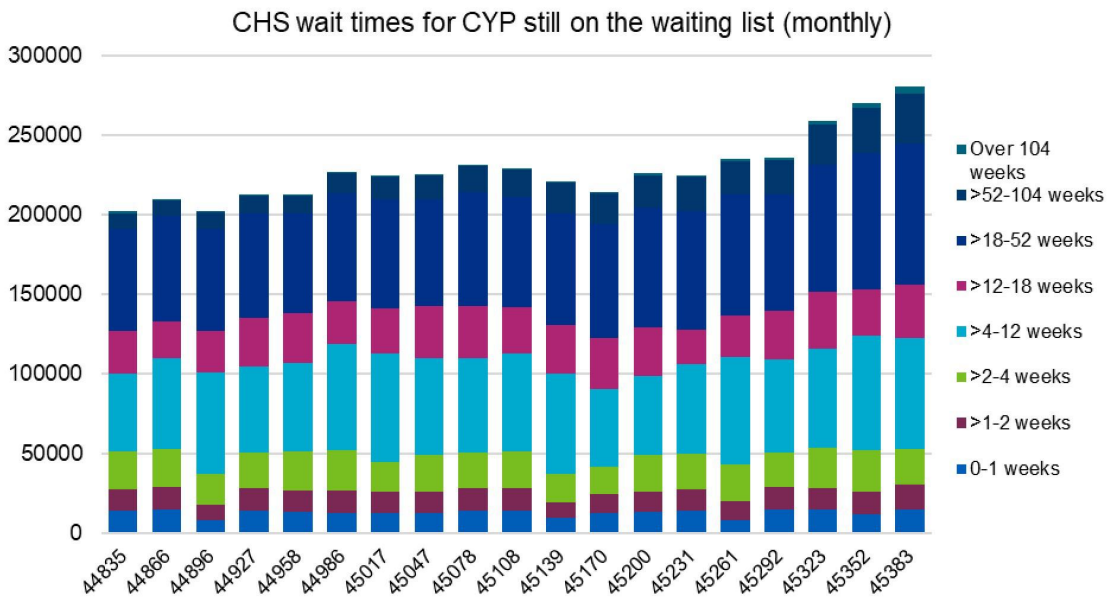
432. In February 2024, twelve new providers were added to the SitRep Data collection, which may have accounted for the significant increases in the waiting list observed from this point onwards.

CHS SitRep Data, June 2022 to April 2024

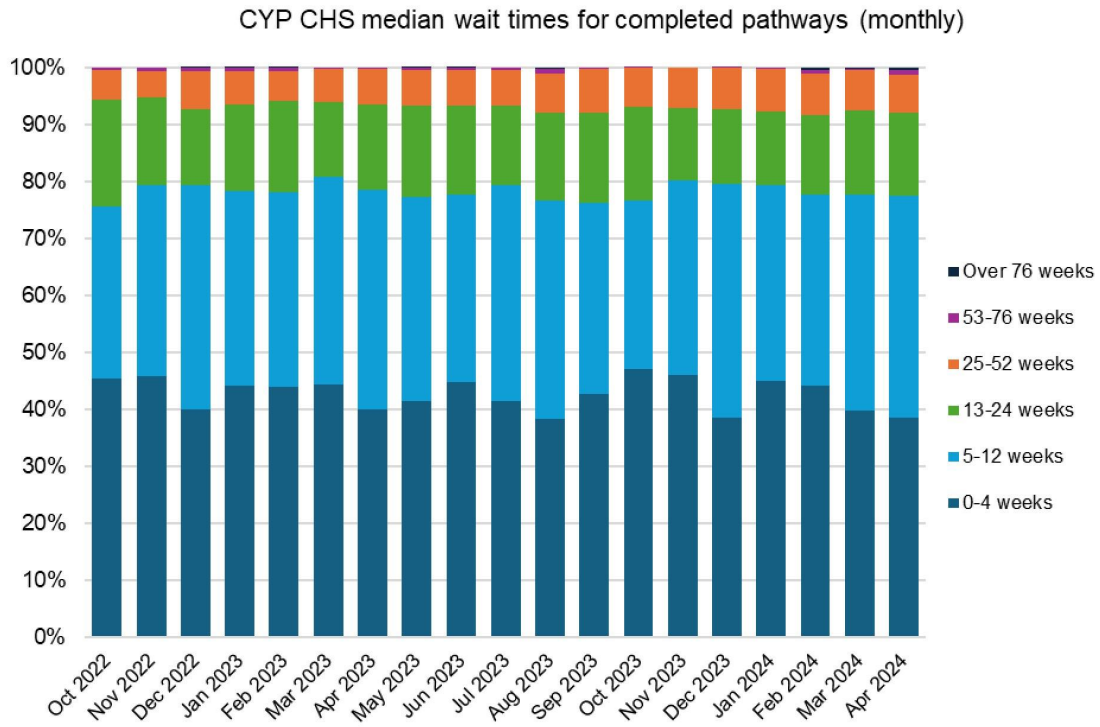
433. The total wait list size, across all CHS CYP services, was 215,653 in June 2022. This remained stable until winter 2023/24, before increasing to 282, 244 by April 2024.



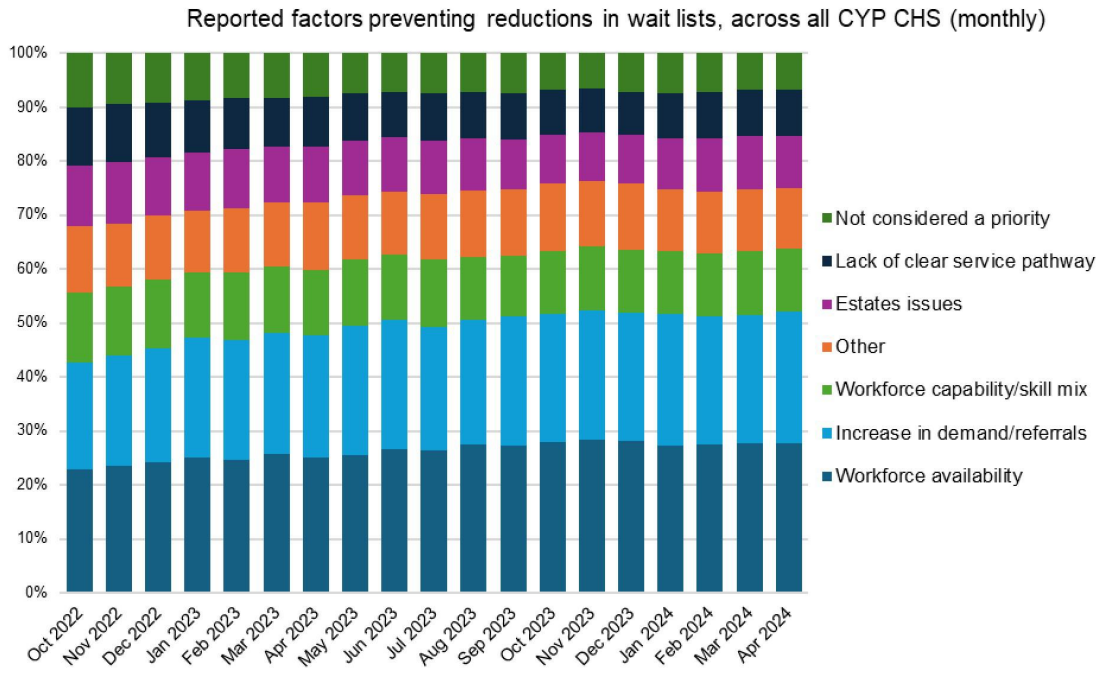
434. Of children currently on CHS waiting lists, the largest proportion had been waiting between 18 and 52 weeks. In April 2024, 88,249 CYP had waited between 18 and 52 weeks, 32,090 had waited between 52 weeks and 104 weeks, and 3,832 had waited over 104 weeks.



435. Each CHS SitRep provider reported median wait times, for completed pathways, for each CYP service line. The median wait time was within 12 weeks in over 75% of reports, for each month between October 2022 and April 2024. The proportion of reported median wait times within 24 weeks varied from 92% to 95%, in the same period.



436. Providers consistently reported workforce availability, and an increase in demand and referrals, as the biggest obstacles to reducing waiting lists.



437. In April 2024, community paediatric services had the largest waiting list of all CYP CHS, with 27% of children on the waiting list having waited over 52 weeks. Speech and language services had the second largest waiting list, with 7.9% of children having waited over 52 weeks. Note: a child may be on more than one waiting list.

Ranked list of CYP community services by reported waiting list size (April 2024)		
Services	Waiting list size	# Providers reporting waiting list size by service
(CYP) Community paediatric service	124,242	*81*
(CYP) Therapy interventions: speech and language	76,160	*89*
(CYP) Audiology	21,813	*47*
(CYP) Therapy interventions: occupational therapy	19,890	*90*
(CYP) Therapy interventions: physiotherapy	17,288	*89*
(CYP) Therapy interventions: dietetics	8,930	*49*
(CYP) Nursing and Therapy teams support for long term conditions	3,885	*22*
(CYP) Vision screening	2,454	*12*
(CYP) Looked after children teams	2,193	*42*
(CYP) Wheelchair, orthotics, prosthetics and equipment	1,864	*32*
(CYP) Community nursing services (planned care and rapid response teams)	1,818	*43*
(CYP) Antenatal, new-born and children screening and immunisation services	724	*18*
(CYP) New-born hearing screening	642	*19*
(CYP) Therapy interventions: orthotics	318	*15*
(CYP) Safeguarding	12	*22*
(CYP) Rapid Response Services	11	*4*
(CYP) Child health information service	0	*12*

CYP community services ranked by proportion (%) waiting 52 to 104 weeks, and over 104 weeks (April 2024)		
Services	Waiting 52-104 weeks (%)	Waiting list over 104 weeks (%)
(CYP) Community paediatric service	19.3%	2.4%
(CYP) Therapy interventions: speech and language	7.1%	0.8%
(CYP) Therapy interventions: dietetics	6.9%	0.1%
(CYP) Therapy interventions: occupational therapy	6.4%	0.8%
(CYP) Looked after children teams	2.6%	0.0%
(CYP) Audiology	2.6%	0.2%
(CYP) Wheelchair, orthotics, prosthetics and equipment	2.4%	0.1%

(CYP) Community nursing services (planned care and rapid response teams)	**1.4%**	**1.2%**
(CYP) Nursing and Therapy teams support for long term conditions	**0.7%**	**0.0%**
(CYP) Therapy interventions: physiotherapy	**0.7%**	**0.1%**
(CYP) Vision screening	**0.0%**	**0.0%**
(CYP) Therapy interventions: orthotics	**0.0%**	**0.0%**
(CYP) Safeguarding	**0.0%**	**0.0%**
(CYP) Rapid Response Services	**0.0%**	**0.0%**
(CYP) New-born hearing screening	**0.0%**	**0.0%**
(CYP) Antenatal, new-born and children screening and immunisation services	**0.0%**	**0.0%**

Section 7A Services

438. The SSHSC has delegated Section 7A Services to NHS England on an annual basis by way of "Section 7A agreements". The aim of these arrangements are ultimately to secure population health by preventing disease through, for example, vaccination, and screening to detect and, in some cases, prevent serious diseases. Many of the Section 7A Services are carried out in primary care and community settings.

Immunisation

439. Vaccination programmes fall within the SSHSC's public health function and are one of the responsibilities routinely delegated to NHS England.

440. Other organisations in the health sector have a role in ensuring vaccines are available and administered to the UK public. For context and to understand the day-to-day interactions, dependencies and challenges for any vaccine roll out, these further organisations are summarised below:

    a. UKHSA is responsible for (amongst other things) the development and publication of all the key clinical guidance used by vaccinators to deliver vaccination programmes. UKHSA maintain an online manual known as the "Green Book" which is updated to reflect the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK. It contains a number of "chapters" covering the appropriate principles, practices and procedures pertaining to these points. UKHSA also operates key national strategic warehousing for vaccines.

    b. The MHRA is an executive agency, sponsored by the DHSC. The MHRA regulates medicines, medical devices and blood components for transfusion in the UK. It licences (approves) new medicines including vaccines (also known

as market authorisation). It also has an ongoing role in monitoring the effectiveness and safety of all medicines once they are licensed and being used in clinical practice; this is known as pharmacovigilance.

c. The JCVI is an independent expert advisory committee set up to advise ministers and UK health departments on immunisations. Since 1 April 2009, Regulation 2 of the Health Protection (Vaccination) Regulations 2009 place a duty on the SSHSC to ensure, so far as is reasonably practicable, that the recommendations of JCVI (that have not been withdrawn by the JCVI) are implemented, where those recommendations:

   i. refer to new provision for vaccination under a national vaccination programme;

   ii. are made by JCVI (and not a sub-committee of the JCVI);

   iii. are in response to a question referred to the JCVI by the SSHSC;

   iv. are based on an assessment which demonstrates cost-effectiveness; and

   v. do not relate to vaccination in respect of travel or occupational health.

d. The Commission on Human Medicines is an independent advisory non-departmental public body sponsored by the DHSC. Its role is to advise ministers on the safety, efficacy and quality of medicinal products. This includes critically assessing data before advising on the safety, quality and effectiveness of any potential vaccine.

441. Vaccines are not mandated for CYP in England, and a parent may refuse consent to any or all vaccines for a child. Children under the age of 16 may be able to provide consent to a vaccine, but competence to give consent is assessed by the healthcare professional on a case by case basis. Young people over the age of 16 do not need parental consent provided they have capacity. Consent is required for vaccines given within schools.

442. Vaccines may be provided in GP surgeries, in community or school clinics, or in hospitals.

443. Immunisation services commissioned by NHS England for CYP during the Specified Period were:

a. Babies under 1 year old:

i. 6-in-1 vaccine, covering diphtheria, hepatitis B, Hib (Haemophilus influenzae type b), polio, tetanus, and whooping cough;

ii. Rotavirus vaccine; and

iii. MenB vaccine, which covers bacterial infections caused by meningococcal group B bacteria.

b. Children aged 1 year:

i. Hib/MenC vaccine, which helps prevent Haemophilus influenzae type b (Hib) and the type of meningitis caused by group C bacteria;

ii. Measles, Mumps and Rubella (MMR) vaccine ;

iii. Pneumococcal vaccine (PCV); and

iv. MenB vaccine.

c. Children between the ages of 2 to 15 years

i. MMR vaccine, for children aged 3 years and 4 months;

ii. 4-in-1 pre-school booster vaccine, for children aged 3 years and 4 months covering diphtheria, polio, tetanus, and whooping cough;

iii. Children's flu vaccine, for children between 2 and 15 years old, but it may also be offered to children aged 6 months to 17 years old with certain long term health conditions;

iv. HPV vaccine, to protect against human papillomavirus, for children aged 12 to 13 years old (it is also available to all girls under 25 and boys born after 1 September 2006)

v. 3-in-1 teenager booster, covering tetanus, diphtheria and polio for children aged 13 or 14; and

vi. MenACWY vaccine for children aged 13 or 14 (but can be given up to the age of 25) to protect against 4 types of bacteria linked to meningitis.

444. In addition to routine vaccinations, there are additional vaccinations for at-risk babies and children, as well as the Covid-19 vaccine.

Impact of Covid-19

445. On 13 March 2020, NHS England's weekly Leaders' Bulletin confirmed that:

"No changes should be made to how our national screening and immunisation services are delivered at this critical time. We are working with Public Health England and the Department of Health and Social Care to keep this under constant review, and prepare contingency plans, as the COVID-19 situation develops." **[DB1/115][INQ000610908]**

446. However, the situation was rapidly changing leading to the Phase 1 Letter to free-up as much capacity to deal with the pandemic, followed by the prioritisation of community services letter on 19 March 2020 **[DB1/116][INQ000269920]**,[14] which confirmed that in relation to the Section 7A Services:

a. newborn and other childhood immunisations were to continue;[15] but

b. services for school aged children delivered in schools would be paused until schools re-opened.

447. On 3 June 2020, NHS England issued guidance on the restoration of CHS for CYP. This confirmed that school-aged immunisation services would be commenced in with local commissioning arrangements, ensuring the delivery of Covid-19 safe services.

448. On 29 June 2020, guidance was issued regarding maintaining immunisation programmes during the pandemic, which was supported by the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health **[DB1/117][INQ000610892]**. It confirmed, amongst other things that:

[14] Schools closed from 20 March 2020.
[15] They would however be impacted by other restrictions such as the number of people allowed in a practice at any one time.

a. routine immunisation programmes in general practice should be maintained and anyone who had had their appointment cancelled as part of the Covid-19 response should be invited for vaccination as soon as possible;

b. the position regarding what PPE should be worn when administering vaccines; and

c. FAQs for the public around attending for routine immunisations.

449. A further impact on children, because of the response, was the anticipated surge in RSV (see further discussion above). The JCVI recommended the use of palivizumab prophylaxis to protect a particular cohort of at-risk infants, in whom RSV infection is likely to cause serious illness or death. Therefore, it was part of the UK-wide immunisation schedule as per guidance issued by JCVI in 2010, which recommended use in premature infants with conditions affecting the lungs and/or heart, and children with impaired immune systems.

450. As a result of the pandemic NHS England and the devolved nations agreed an interim clinical commissioning position for passive immunisation with palivizumab against RSV in at-risk pre-term infants, which was published on 20 October 2020 **[DB1/118][INQ000610896] [DB1/119][INQ000610897]**. This statement proposed that the assessment criteria for determining eligibility for palivizumab was widened to include a larger population of at-risk infants, to decrease hospitalisation and intensive care admission rates.

451. A summary of the impact of the pandemic on immunisations is set out in the Section 7A agreement reports, which note:

a. ultimately, because of the pandemic, coverage for nearly all childhood vaccinations, measured at either 1, 2 or 5 years of age, fell between 2019/20 and 2022/23. The exception was the PCV primary measured at 12 months, which changed from a 2 dose to a 1 dose course in 2021/22. All vaccination coverage levels were below the 95% optimal threshold;

b. coverage for primary vaccinations evaluated at 12 months of age remained above the efficiency standard of 90% in MenB and the DTaP/IPV/Hib/HepB course, but coverage of rotavirus fell to 89.9%;

c. for vaccinations evaluated at two years of age, coverage of the first dose of MMR was 89.2%, falling below the 90% efficiency standard for the first time

since 2010/11. Coverage for the HibMenC, PCV and MenB boosters was also below 90% during 2021/22;

d. immunisations in schools were impacted by lockdown measures and school closures across England. Providers continued to catch up adolescents from the 2019/2020 cohort who missed their immunisations (HPV1 and 2, MenACWY, Tetanus, Diphtheria and Polio completing dose & MMR) alongside the routine programmes for the 2020/21 cohort;

e. whilst lockdown and testing measures in school impacted provider recovery, they continued to catch up with all adolescent immunisations from the 2019/20 and 2020/21 cohorts alongside vaccinating the 2021/22 cohorts, timing operational delivery alongside the seasonal flu vaccination and Covid-19 vaccination programme requirements; and

f. the 2020/21 annual winter flu vaccination programme was the most successful in history, with 61.7% of school-age children in England receiving a vaccine. In 2021/22, the proportion was 53.8, declined to 51.9 in 2022/23.

Screening

452. The aim of screening programmes is to find out if an individual may have an increased risk of a particular health issue occurring to offer information to allow the patient to make informed decisions about their health and/or further diagnostics (for a positive screen) and treatment.

453. All screening programmes are optional, and for each programme a target population will be invited based on those most likely to benefit from the screening.

454. The population screening programmes provided during the Specified Period relevant to children were:

a. NHS newborn blood spot screening programme: this is usually done when the baby is around 5 days old. The test is usually done at home by a community midwife or health visitor but may be done while in hospital or at another planned appointment.

b. NHS newborn hearing screening programme: the test is done in the first 4 to 5 weeks, but it can be done at up to 3 months of age. The test may be before

the baby is discharged if the birth was in a hospital, otherwise it is done by a healthcare professional, healthcare assistant or health visitor.

c. NHS newborn and infant physical examination screening programme: usually carried out in hospital before the baby is discharged, otherwise it is undertaken at hospital or community clinic, GP surgery, children's centre or at home. A second examination is offered when the baby is 6 to 8 weeks old and undertaken at a GP surgery.

d. NHS diabetic eye screening programme: for diabetics from the age of 12 every 1 or 2 years (if the previous test found no changes).

455. The NHS newborn screening programmes were largely unaffected by the pandemic **[DB1/120][INQ000610889]**, and the NCD for CYP met regularly with the NHSNSP team to gain assurance on this. However, the newborn hearing screening programme experienced a backlog of audiological assessments as a result of lockdowns. A toolkit was developed in April 2020 to help identify babies whose screen or audiology assessment has been delayed **[DB1/121][INQ000610883]**. Ultimately:

a. coverage in the newborn blood spot and newborn and infant physical examination screening programmes remained above the acceptable threshold; however, coverage for newborn hearing screening fell to 97.5% in 2020/21, before recovering to 98.7% in 2021/22.

b. in 2022/23, coverage across newborn blood spot, newborn hearing, and newborn and infant physical examination screening programmes fell slightly from the 2021/22 position but remained above efficiency standards.

Child health information services

456. Child health information services ("**CHIS**") are patient administration systems providing clinical records for individual children, and supporting a variety of child health and related activities (including immunisation and screening). CHIS are operated at a local level, by multiple types of healthcare provider. During the Specified Period, CHIS providers continued to deliver 'business as usual' with minimal disruption during the pandemic. The digital child health programme's national events management service ("**NEMS**"), led by NHS Digital, which can share newborn screening and childhood immunisation data between clinical settings went live during the Specified Period, and covered 60- 80% of the 0-5 population by October 2021.

457. Several regions started re-procurement processes for their CHIS provision. As more services (including the GP IT suppliers) adopt the system changes required to interoperate with the NEMS, more information can be shared across clinical settings, ensuring greater oversight, safeguarding and support for screening and opportunistic delivery of childhood immunisations.

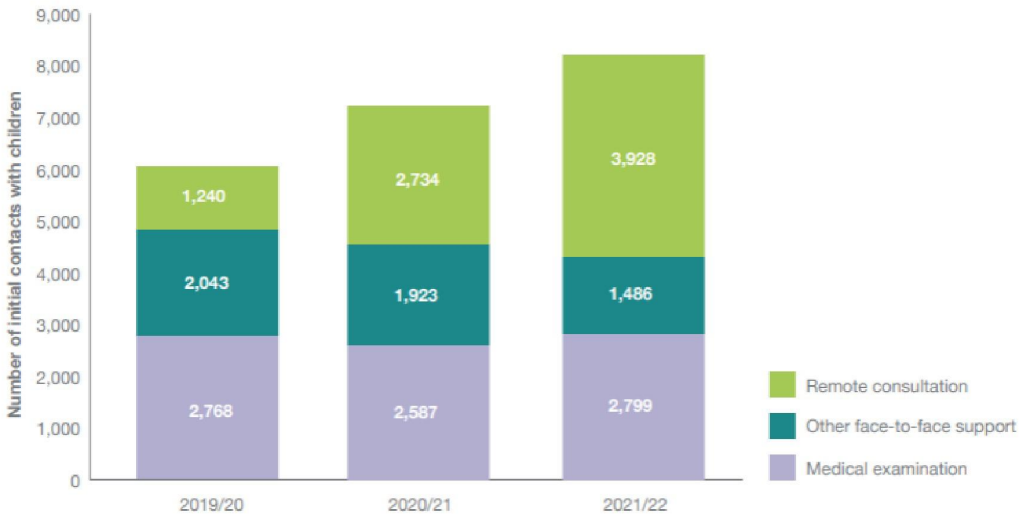
Sexual Assault Referral Centres

458. SARC services continued to operate throughout the pandemic with access to all key Section 7A health interventions maintained. A national SARC awareness raising campaign helped to raise the profile of services and promote accessibility, although CYP were not specifically targeted.

459. NHS England collects performance data through the Sexual Assault Referral Centre Indicators of Performance. This is collected from the 47 referral centres in England, and includes information about the age, gender and ethnicity of children.

460. Numbers of children accessing SARC increased throughout the Specified Period:

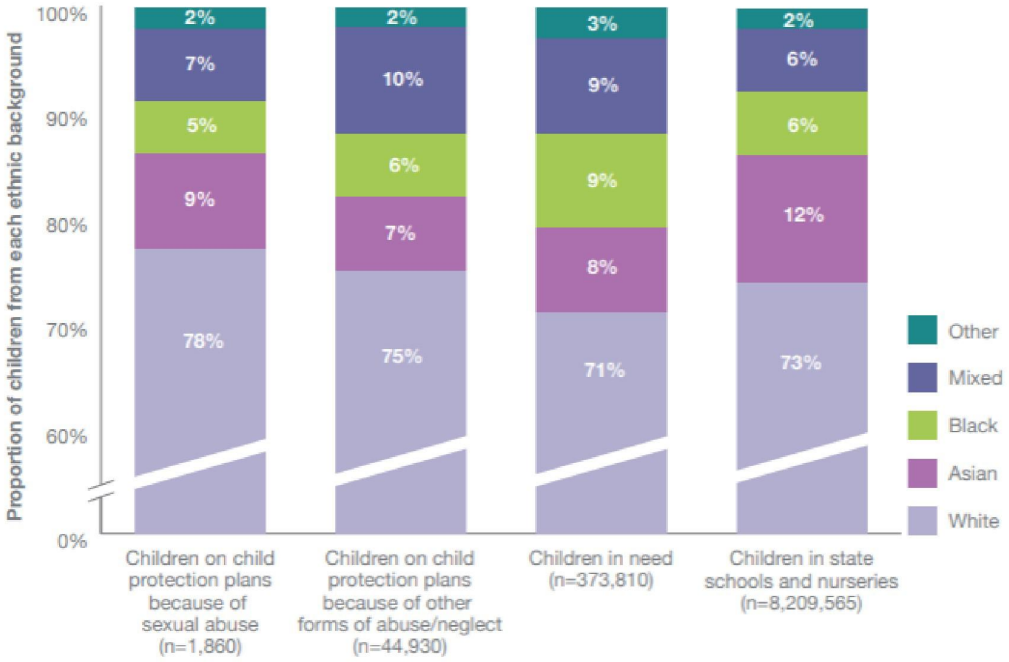
Figure 21. SARCs' initial contacts with under-18s, 2019/20–2021/22, England



Source: NHS England (2022a, 2022b, 2020b).

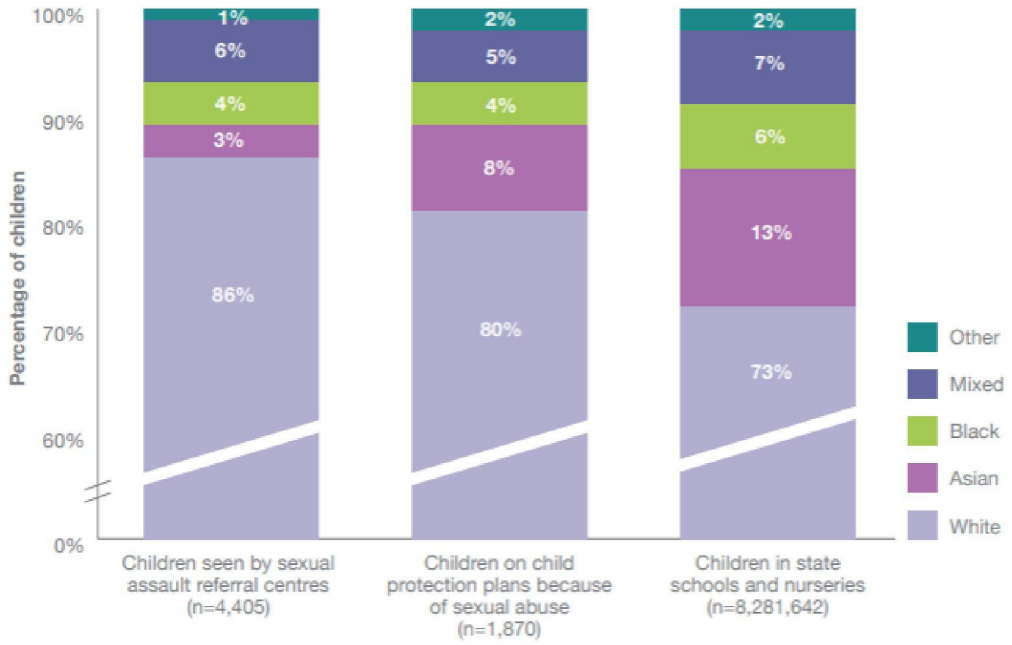
461. The majority of children making initial contact were white:

Figure 6. Children on child protection plans and children in need at 31 March 2021, by ethnicity, England



Sources: Department for Education (2021a: Tables A4 and A5, year ending 31 March 2021); Department for Education (2021b: 'Pupil characteristics - Ethnicity and Language' table – figures as at 31 January 2021). Chart excludes a small number of children whose ethnicity was not recorded.

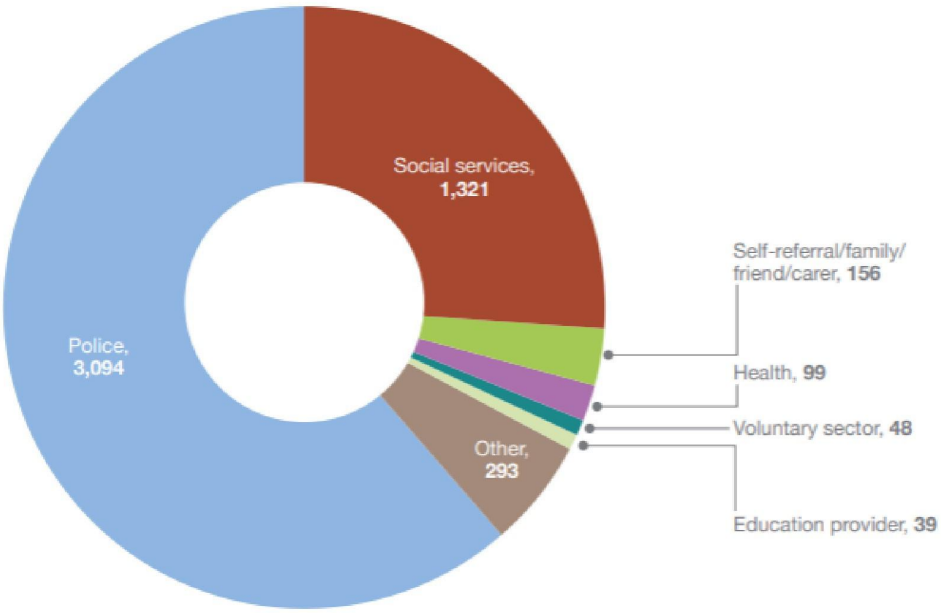
Figure 24. Under-18s making initial contact with SARCs, by ethnic background, 2021/22, England



Sources: NHS England (2022a); Department for Education (2022a: Table A5, year ending 31 March 2022); Department for Education (2022b: 'Pupil characteristics – ethnicity and language'). Excludes children whose ethnicity was not stated.

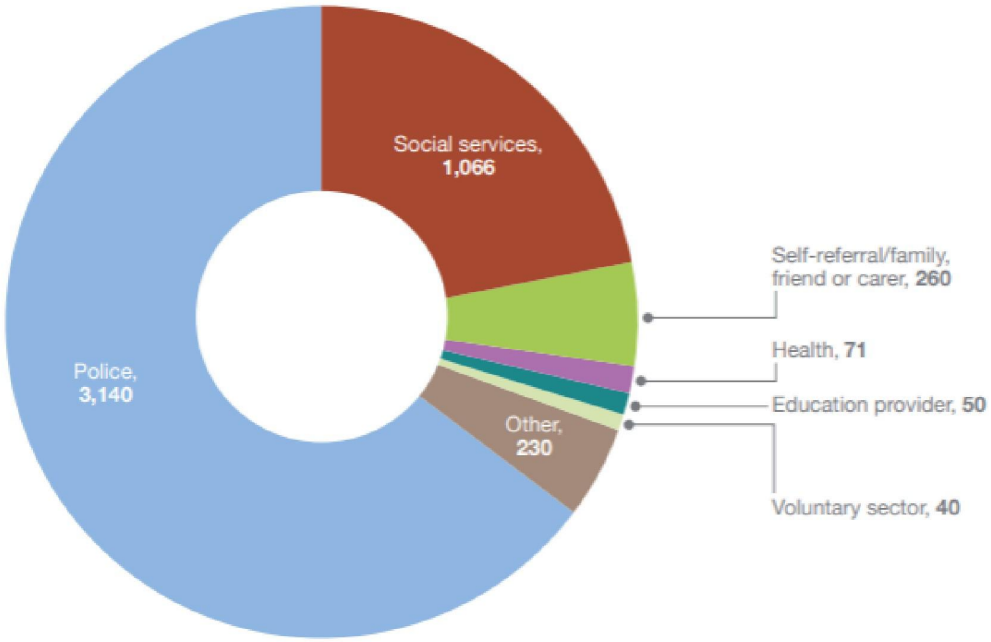
462. The primary source of referrals was via the police, followed by social services during the Specified Period:

Figure 23. Sources of referrals of under-18s to SARCs, 2020/21, England



Source: NHS England (2022). 'Health' includes Accident & Emergency departments, GPs, and genitourinary medicine/contraception and sexual health clinics.

Figure 25. Sources of referrals of under-18s to SARCs, 2021/22, England



Source: NHS England (2022a). 'Health' includes Accident & Emergency departments, GPs, and genitourinary medicine/contraception and sexual health clinics. Excludes cases where this information was not provided.

Learning Disability support, neurodevelopmental services and autism services

463. This section of the statement focusses on the impact of the pandemic on learning disability support, neurodevelopmental services, autism services and neurodivergence assessments for CYP. CYP with a learning disability, neurodivergence, autism and SEND needs are cared for across community, primary and secondary care settings, and other sections of this statement (such as primary care and mental health) also discuss the impact of the pandemic for this cohort of CYP in relation to those services.

464. During the Specified Period, and as set out above, CCGs were responsible for commissioning a range of children's services covering both physical and mental health. This included a range of community services and commissioner duties set out in Part 3 of the Children and Families Act 2014 (Children and young people in England with special educational needs or disabilities) and the SEND Code of Practice (2015). To support CYP with SEND, including looked after children or

leaving care, local authorities and CCGs were required commission services jointly (this is now an ICB duty).

465. As part of the pandemic response, a range of CYP services were partially paused or stopped in accordance with the Phase 1 Letter. All community services (save for the national child measurement programme, audiology and the friends and family test, which were stopped) were partially paused, with many of the services subject to prioritisation based on needs (e.g. looked after children team) or clinical judgement (e.g. community paediatric services).

466. At the start of Wave 1, there was concern amongst clinicians that Covid-19 would have a disproportionate impact on people with a learning disability or people with autism. Statistics from 2018/2019 suggested that 41% of people with a learning disability who died, had died as a result of a respiratory condition. People with a learning disability may have co-morbidities, in particular higher prevalence of asthma, diabetes, and of being obese or underweight; all these factors made people with a learning disability more vulnerable to Covid-19.

467. Recognising that potential impact early, NHS England published guidance on 24 March 2020 "*Clinical guide for front line staff to support the management of patients with a learning disability, autism or both during the coronavirus pandemic – relevant to all clinical specialties*" **[DB1/122][INQ000610882]**. It applied to both adult and paediatric services alike, and advised clinicians on how best to support and treat Covid-19 patients with a learning disability and / or autism.

468. Following the pause in some mental health, learning disability and autism community services for CYP after the Phase 1 Letter, the Phase 2 Letter on 29 April 2020 advised the system to:

    a. Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sectors and 111 services.

    b. Annual health checks for people with a learning disability should continue to be completed.

    c. Care (Education) and Treatment Reviews should continue, using online/digital approaches.

469. By 22 May 2020, there was increasing concern (from data surveillance of PHE and the NCMD sources) about the impact of lockdown on CYP mental health, particularly

for those with autism, ADHD or a learning disability. NHS England, the CMO, DHSC, PHE and DfE worked together on next steps.

470. On 28 May 2020, the CNO sent the nursing phase 2 response letter to regional Chief Nurses. This communication outlined that she had been working with PHE colleagues (and Local Government and the Association of Directors of Public Health) to advise these services to return to their commissioned service model **[DB1/31][INQ000421174]**.

471. On 29 May 2020, the NIRB resolved to approve the publication of guidance on restoring community health services for CYP. In particular, it discussed that supplementary guidance would be developed on the restoration of mental health, learning disability and autism services. The need to coordinate publication of this with the broader guidance on restoring CYP services was emphasised.

472. On 3 June 2020, NHS England sent a system letter ("*Restoration of Community Services for Children and Young People*") setting out the framework to partially or fully restore each service for CYP, superseding the March prioritisation letter **[DB1/14][INQ000421234]**. This included guidance to the system to prioritise essential services, including (as relevant to this section of the statement):

a. Learning disabilities annual health check;

b. Risk assess CYP 0-25 years with SEND with an Education Health and Care Plan;

c. SEND community services for CYP 0-25 with an EHCP;

d. Reasonable endeavours to prioritise the following for CYP with SEND:

i. Therapies speech and language therapy / occupational therapy / physio;

ii. Community paediatrics;

iii. Community children's nursing;

iv. Special school nursing; and

e. Children's community learning disability teams / crisis services.

<u>Care (Education) and Treatment Reviews</u>

473. Care (Education) and Treatment Reviews ("**C(E)TRs**") are part of NHS England's commitment to transforming services for CYP with a learning disability and/or autism. C(E)TRs are for people who have been admitted to a mental health setting or for people who are at risk of admission. They are undertaken by the commissioners to ensure that CYP are only admitted to hospital when absolutely necessary and for the minimum amount of time possible.

474. A C(E)TR is carried out by an independent panel of people, including an expert by experience, which will either be an autistic person, a person with a learning disability or a family carer with lived experience of services. The panel also includes a clinical expert who is qualified to work in healthcare and the commissioner.

475. To avoid unnecessary admission, there was a commitment throughout the pandemic to continue C(E)TRs, and a willingness to adapt how they are carried out (including by using technology). On 27 March 2020, NHS England's National Learning Disability Director wrote to the system advising that it must maintain the intention, purpose and ethos of the C(E)TR whilst undertaking these in an adjusted way during the pandemic. The system was encouraged to share instances of good practice with colleagues and NHS England.

476. The Phase 2 Letter advised the system to continue conducting C(E)TRs using online / digital approaches. Feedback collected in the winter of 2020 showed that the use of virtual technology had been a positive experience for CYP who would not have been comfortable attending large meetings about their care in person. Learning from virtual C(E)TRs has been carried forward beyond the end of restrictions.

Autism assessments

477. There was a decrease in the number of referrals made for a suspected autism assessment at the beginning of the pandemic. Although referrals dropped in the early stages of the pandemic, referrals recovered quickly in 2020 (with many being conducted online).

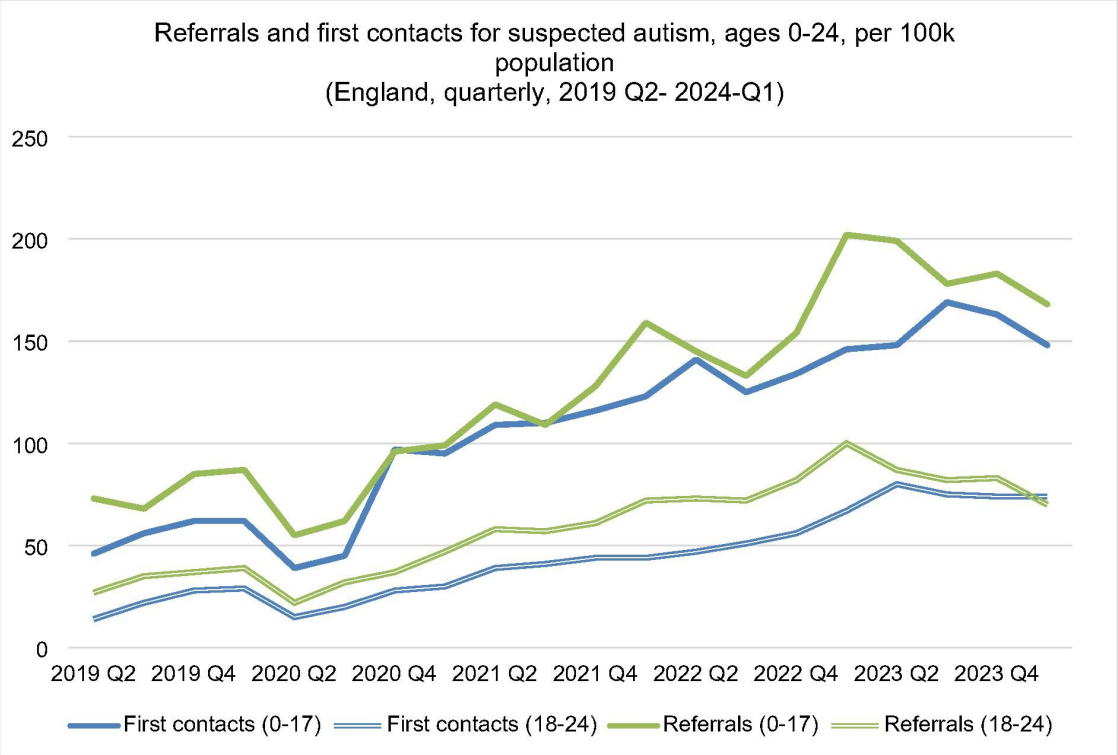
478. The Autism Waiting Time Statistics provides data on:

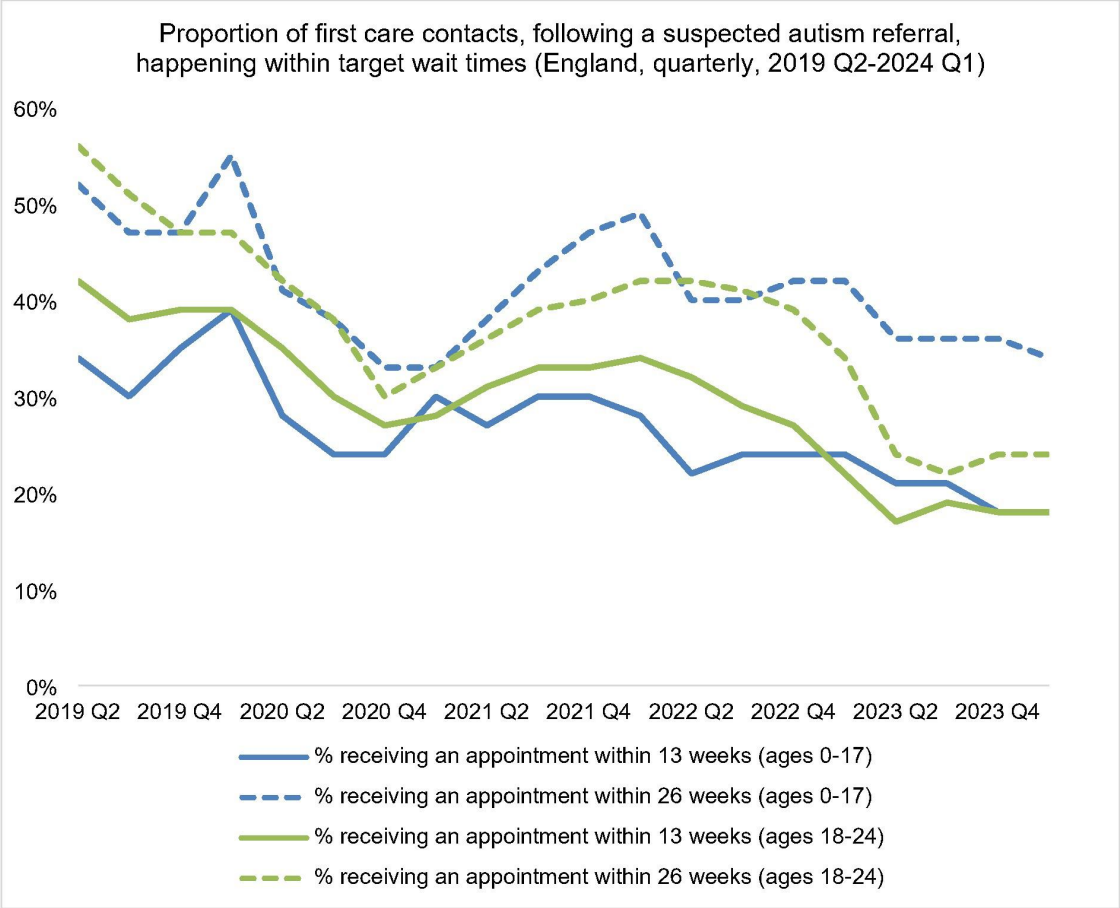
a. NHS referrals for suspected autism;

b. first NHS care contacts for suspected autism; and

c. NHS waiting lists and wait times for care contacts, following a suspected autism referral.

479. The Autism Waiting Time Statics are ‘experimental’, and are still undergoing evaluation and testing. The data collection began in April 2019.





Referrals for other neurodevelopmental conditions

480. The Mental Health Services Data Set ("**MHSDS**") captures data on referrals where the primary reason is "neurodevelopment conditions, excluding autism".

481. It is believed most of these referrals will identify people who have been referred for a Attention Deficit Hyperactivity Disorder ("**ADHD**") assessment. However, they will also cover referrals including dyslexia, dyspraxia and Tourette's syndrome.

482. The MHSDS only captures referrals made to NHS specialist secondary mental health providers, who submit data to the MHSDS. It excludes other NHS community providers, as well as independent providers, who do not submit MHSDS data. Consequently, MHSDS data represents an undercount of referrals/treatments for neurodevelopmental conditions.

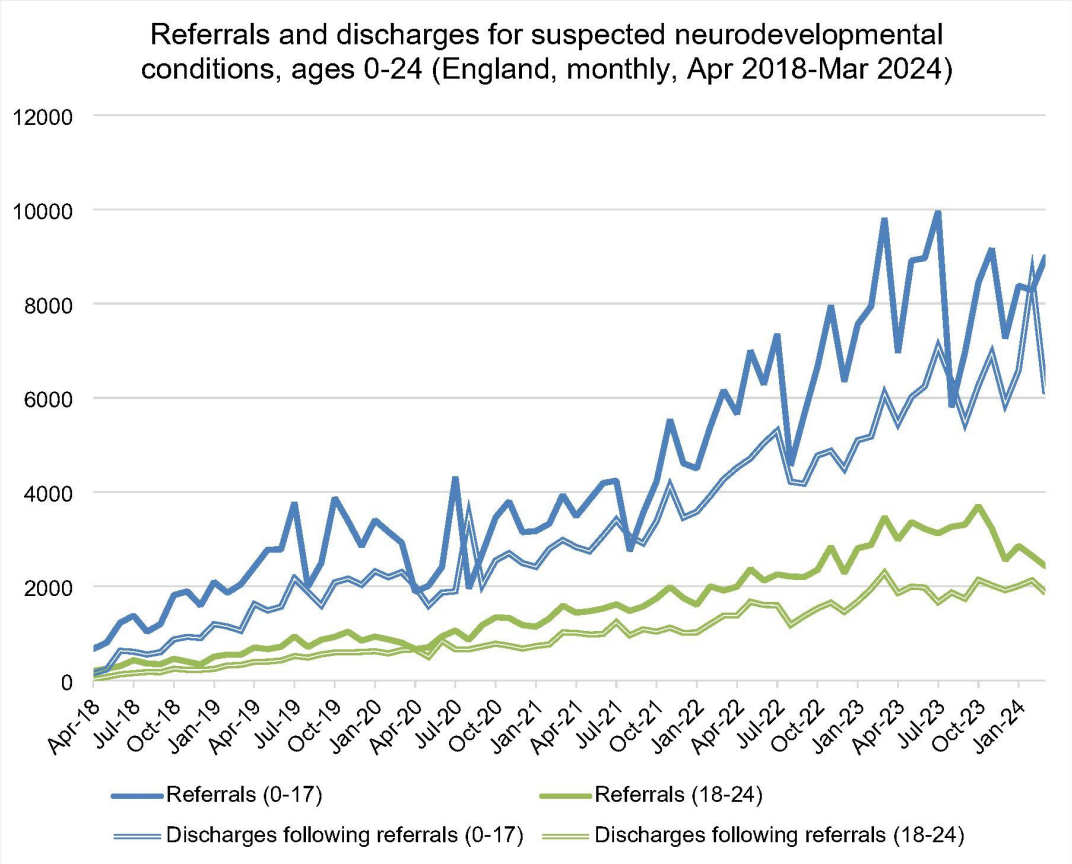
483. The MHSDS captures data on:

a. Number of referrals for suspected neurodevelopmental conditions;

b. Discharges of patients back to primary care, following assessment and diagnosis; and

c. Waiting list sizes (i.e. open referrals which have not yet been discharged).

484. There are currently very high numbers of patients not being discharged from specialist services, following a diagnosis of ADHD or other neurodevelopmental conditions. This is due to their ongoing care, including medication reviews, still being managed by the provider who offered the initial diagnosis – and issues with the patient not being accepted back to a primary care setting. Consequently, the waiting lists include many patients who have already received an assessment and diagnosis, but who have not yet been discharged back to primary care.



Mental Health, Learning Disability and Autism Covid-19 Response Cell

485. The Mental Health, Learning Disability and Autism Covid-19 Response Cell ("**MHLDA Cell**") was set up to provide coordination, information and expert advice on Mental Health, Learning Disability and Autism (including specialised commissioning) as well as support other cells given the pervasive, cross-cutting nature of the MHLDA Cell. It

reported to the NIRB on a regular basis, and was led by the National Mental Health Director.

486. The MHLDA Cell worked across adult and paediatric MHLDA and introduced measures such as a two page hospital passport grab guide supporting hospital admissions to be used in conjunction with clinical guidance about supporting people with a learning disability or autism. This was developed by NHS England in conjunction with Learning Disability England, Dimensions, National Autistic Society, Mencap, the Challenging Behaviour Foundation, Oxford Family Carers Network and NDTi.

Safeguarding

487. During the Specified Period, Section 11 of the Children Act 2004 required various bodies, including NHS England and CCGs to make arrangements to ensure that:

a. their functions are discharged having regard to the need to safeguard and promote the welfare of children; and

b. any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.

488. These requirements are summarised in the Working Together to Safeguard Children 2018 Guidance (as applicable during the Specified Period).

489. Local arrangements are also required under Section 16E of the Children Act 2004, and local authorities, the police and ICBs (CCGs prior to 1 July 2022) establish Multi Agency Safeguarding Arrangements for their local child population, together with other relevant agencies as they deem appropriate. The partners are required to work together to safeguard children and promote the welfare of all children in their area, and to monitor and ensure the effectiveness of those arrangements. They are equally accountable for the arrangements put in place.

490. NHS England had a statutory requirement to oversee assurance of CCGs in their commissioning role. This involved formal assurance reviews carried out quarterly, in line with the published framework and technical guidance.

491. NHS England's safeguarding role is discharged through the CNO, who is the Executive Director for safeguarding and has several forums through which assurance and oversight is sought. The National Safeguarding Steering Group coordinates

these forums. NHS England's Safeguarding team, led by NHS England's National Head of Safeguarding, would provide weekly SitReps to the CNO during the Specified Period.

492. There is a distinction between providers' responsibilities to provide safe and high-quality care, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned. During the Specified Period, CCGs were responsible for the safeguarding element of services that they commission. As commissioners of local health services, CCGs were required to assure themselves that organisations from which they commission have effective safeguarding arrangements in place.

493. Contracts for clinical services commissioned by NHS England or CCGs leading up to, and during the Specified Period, contained safeguarding requirements. These requirements continue to exist where NHS England and ICBs commission clinical services.

494. In 2013, NHS England first published the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework ("**Safeguarding Framework**") **[DB1/123][INQ000610876]**. This was updated just before the pandemic in 2019, and set out the safeguarding roles and responsibilities of those involved with NHS funded care (providers and commissioners) with respect to safeguarding.

495. The commissioning of public health services for children is undertaken by local authorities. This includes school nursing services and health visiting and family nurse partnerships services. These health services have an integral role in safeguarding CYP.

496. NHS England's key duties in respect of safeguarding children during the Specified Period were to:

a. provide leadership support to safeguarding children, children in care and adult professionals – including working with HEE on education and training of both the general and the specialist workforce;

b. ensure the implementation of effective safeguarding assurance arrangements and peer review processes across the health system, from which assurance is provided to the Board via the National Safeguarding Steering Group;

c. provide specialist safeguarding advice to the NHS;

d. encourage a culture that supports staff in raising concerns regarding safeguarding issues;

e. ensure that robust processes are in place to learn lessons from cases where someone has died or are seriously harmed, and abuse or neglect is suspected; and

f. ensure that NHS England teams are appropriate engaged in the local multi-agency partnerships to raise concerns about the engagement and leadership of the local NHS.

Direct Commissioning

497. As discussed elsewhere in this statement, NHS England directly commissions some healthcare services (including health care services in justice, specialised services and highly specialised services, health services for armed forces etc). NHS England ensures that safeguarding duties are met in relation to the services that it directly commissions.

498. Safeguarding will be particularly important for the healthcare services which NHS England directly commissions for CYP in the detained estate. There is a strong focus on support for young people transitioning into adult services in this regard. Joint commissioning procedures and partnership working standards seek to safeguard CYP suffering from mental health disorders from sudden, unplanned withdrawal of CYPMH provision or refusals / delays by adult mental health provision to take up the mental health responsibility for young people, especially care leavers.

499. Transitional planning is important for young people transferring out of the CYP secure estate ("**CYPSE**") to adult offender institutions, to ensure that their health and development, mental health and care outcomes are equivalent to young people in the wider community.

Information Sharing

500. The Safeguarding Framework sets out the requirements of information sharing specific to safeguarding CYP as follows:

a. **Children** – information must be shared to protect children, or to prevent or detect a crime. In addition, there are some specific statutory provisions that

will require information sharing, for example relating to the operation of local safeguarding children's partnerships and relating to the statutory vetting and barring process for staff.

b. **Information sharing specific to young people** – a child may be safeguarded and protected under the Children Act 1989 until their 18th birthday. Medical consent, medical capacity and consent to sexual activity are lawful from the age of 16. A Gillick Competency Assessment may be used to determine a child's capacity to consent to medical treatment or intervention before the age of 16. Child protection procedures should always be instigated when child exploitation is suspected, even if the child or young person is deemed competent.

501. The Child Protection Information System ("**CP-IS**") contains data on all looked after children, or children subject to section 47 protection plans[16]. The CP-IS was not initially accessible to health visitors.

502. In July 2020, a risk was identified in respect of looked after children who would be placed great distances away from their homes, with some having been moved a number of times during lockdown for various reasons. Without access to the CP-IS, it became increasingly difficult for health visitors to track such looked after children, which could result in looked after children falling in-between the gaps of service provision.

503. To mitigate the risk, a data dissemination request was made by NHS England's National Head of Safeguarding, which allowed the CP-IS collections to be shared with school nurses and health visitors. This provided school nurses and health visitors with a reliable source of information on who vulnerable children are in circumstances where the capacity of local agencies were reduced, and where face-to-face contact with statutory services were reduced. It was, and remains, the only national register of social care status for children in England, and the only system to provide information when a child is out of area.

504. A data provision notice was issued on 29 April 2020, requiring organisations within the scope of the notice to provide the requested data under s259 of the Health and Social Care Act 2012.

[16] This is a child protection plan made under section 47 of the Children Act 1989 if there are concerns about a child's safety.

505. SitReps from this data collection was shared with the CNO on a weekly basis as part of the executive portfolio for safeguarding.

Non-accidental Injury

506. NHS England records a count of attendance at A&E departments of hospitals in England showing "injury intent" for CYP aged 0-17. Non-accidental injury for the purpose of this section is the total of the attendances recorded as "alleged victim of physical assault by lone assailant" or "alleged victim of physical assault by multiple assailants". The table below shows the attendance to A&E owing to non-accidental injuries during the Specified Period, and for 2019 as a comparator:

	2019	**2020**	**2021**	**2022**
Q1 January – March	Not available	1,162	645	1,679
Q2 April - June	948	318	1,371	2,020
Q3 July – September	984	820	1,178	1,553
Q4 October - December	1,142	882	1,268	1,686

507. On 22 September 2020, the Minister of State for Mental Health, Suicide Prevention and Patient Safety, the Minister for Prevention, Public Health and Primary Care and the Minister for Safeguarding sent a joint letter to local safeguarding partnerships, expressing particular concern about the cohort of families who had new babies during the pandemic, and risk to those infants. The letter reiterated the importance of health visitors as the first line of defence for vulnerable infants.

508. NHS England's Safeguarding team introduced the ICON pathway through the National Maternity Safeguarding Network, encouraging systems to adopt the ICON Cope toolkit. ICON (which stands for "*infant crying is normal, comforting methods can help, it's ok to walk away, never ever shake a baby*") is a programme which seeks to prevent abusive head-trauma by supporting parents.

509. The Emergency Care Data Set ("**ECDS**") includes the ability to record "concern", as well as when a child is considered to be "at risk" of abuse or where abuse is "suspected" to inform the safeguarding data, in addition to a formal diagnosis of "non-accidental injury". These data are not routinely shared with any team or body for review or action. NHS England's ECDS team considers this to be a missed opportunity.

Child Protection Referrals

510. Although the CP-IS holds data on interim care orders, full care orders, voluntary care orders and child protection plans, it does not hold data on the number of child protection referrals made (although child protection plans are often preceded / necessitated by a child protection referral).

511. This data is controlled by each individual local authority in England.

Impact of the pandemic on child safeguarding

512. Fundamentally, the obligations to safeguard children did not change during the pandemic. However, professionals who would normally be able to identify and refer child protection concerns were not able to see children and families as regularly or in the same manner as before the pandemic.

513. Early in the pandemic, NHS England's Safeguarding team (led by the National Head of Safeguarding) liaised with Designated Nurses for Looked After Children, setting out that Initial and Review Health Assessments for looked after children should carry on according to the statutory duties to do so, but that these should be carried out virtually / hybrid where possible.[17]This was reiterated in the Community Prioritisation guidance.

514. In the first month of the Community Prioritisation guidance, NHS England received feedback that some local authorities had agreed not to carry out Review Health Assessments, as a number of the Designated Nurses for Looked After Children had been redeployed to support pandemic response. NHS England advised Regional

[17] Initial Health Assessments (IHAs) must be carried out by a registered medical practitioner, arranged by the local authority with responsibility over the looked after child. The IHA should be carried out before the first statutory review of a child's care which must take place within 20 working days from when the child started to be looked after. A review health assessment (RHA) is carried out by a registered nurse or midwife, as part of the local authority's duty that every child it looks after has an up-to-date individual health plan.

Safeguarding Leads to contact provider Chief Nurses to seek assurance on compliance with the Safeguarding Children Assessment and Analysis framework.

515. NHS England's Safeguarding team regularly updated an Equality Impact Assessment throughout the Specified Period. Assessing the impact of first 6 weeks of the pandemic, the team noted that to avoid adverse impact on CYP, work was undertaken to address how to get key messaging out to CYP, and to ensure that the voice of CYP is heard. To achieve this, the team engaged Youth Expert Advisors and NHS Youth Forum regarding the voice of Young People.

516. To mitigate the impact of reduced face-to-face interaction on opportunity to identify at-risk children, NHS England's Safeguarding team encouraged the system to make "every contact count". This included:

a. introducing safeguarding protocols regarding domestic abuse and child safeguarding at swabbing centres, NHS Test and Trace services and Covid-19 Vaccination Services;

b. Encourage system leaders to question (1) what would you do if Covid-19 wasn't here, and (2) who do you need to connect with to make good practice happen. This was supported by a mutual aid working group for national network chairs and national network meetings to create peer support and shared learning at pace;

c. Encourage those coming into contact with children and vulnerable families to be professionally curious, and trigger unique patients to test for "pressure-cooker homes" by asking:

i. "How are things at home?;

ii. Is everything really okay at home?;

iii. Do you feel safe at home; and

iv. Do you know that (various services and trusted peer groups) are contactable?";

SECTION H – CYP MENTAL HEALTH

Children and Young People's Mental Health Services

517. Demand for CYPMH services was increasing prior to the pandemic. The prevalence of mental health problems amongst young people increased further during the pandemic, possibly due in part to secondary factors such as the impact on parents and families and national measures put in place to limit the spread of the virus (including lockdowns and school closures).

518. A number of initiatives have been put in place over the last decade supported by additional investment (including service reconfigurations and workforce expansion), so the additional demand that arose during the pandemic came at a time that service provision was fortuitously already expanding. It was acknowledged in 2019 that closing the treatment gap was expected to take a decade, there therefore remains insufficient capacity to address unmet need and it may take longer than originally planned to close the treatment gap given that additional demand.

519. CYPMHS delivery adapted during the Specified Period, to respond to increased service demand as well as activity constraints (such as IPC restrictions and the need to free up bed capacity for Covid-19 patients). Examples include acceleration of roll out of telephone support for people of all ages in mental health crisis and, for community services, a switch to greater online delivery.

520. This section focuses on NHS England's role in relation to community and in-patient CYPMHS during the Specified Period. The section considers:

    a. commissioning of CYPMHS in England, and NHS England's pre-pandemic objectives;

    b. guidance published by NHS England relating to CYPMHS during the Specified Period;

    c. changes in demand for, and referrals to, CYPMHS during the Specified Period;

    d. changes to CYPMHS delivery during the Specified Period, including increased use of remote consultations and the establishment of single-point-of-access phone lines to provide urgent mental health support;

    e. how access and waiting times for community and in-patient CYPMHS

changed during the Specified Period; and

f. availability of funding for CYPMHS in England.

521. 99% of CYP who receive CYPMHS do so in a community setting including schools and colleges, rather than on an in-patient basis. In-patient services are provided to those CYP who are most unwell; accommodating and treating CYP in this setting during a pandemic raised specific issues concerning admission and discharge, staffing and IPC.

522. A range of data are also presented in this section, concerning both CYPMHS overall and information specific to in-patient settings. The following is a summary of themes emerging from these data:

a. following the immediate onset of the pandemic, referrals made to community CYPMHS decreased briefly but subsequently increased to significantly above pre-pandemic levels;

b. the number of first contacts with community CYPMHS, following a referral, declined from February 2020 to August 2020, but subsequently increased to above pre-pandemic levels. Wait times for a first community contact increased after the start of the pandemic, but subsequently recovered to pre-pandemic levels and remained stable; the proportion of referrals accepted for assessment, or added to the CYPMHS caseload, remained stable after the pandemic began, despite the increase in referrals;

c. the greatest increase in access to CYPMH services, after the start of the pandemic, was amongst female patients. Children from Asian or Black ethnic backgrounds, and children living in the most deprived areas, have been consistently less likely to access CYPMH services since before the pandemic;

d. there was a sharp increase in the number of CYPMHS in-patients discharged from hospital at the start of the pandemic. For the remainder of the Specified Period, in-patient CYPMHS admissions declined to below pre-pandemic levels; this may have reflected an implicit increase in the threshold for admission to match reduced bed capacity secondary to constraints on the availability of staff, through implementation of IPC measures as well as pre-existing vacancy levels;

e. the average length-of-stay and wait times for in-patient CYPMHS admission increased. This may have reflected an increase in illness acuity and

complexity, and/or a lack of available provision from community and local authority providers, leading to delayed discharges;

f. the number of commissioned CYPMHS beds declined slightly during the Specified Period; the number of temporarily closed beds increased. Bed occupancy appears to also have increased. Some providers reported closing in-patient wards due to the pandemic, or re-categorising some wards for patients with Covid-19; and

g. referrals to eating disorder services increased rapidly following the onset of the Covid-19, until a peak in the first quarter of 2021/22. Treatment activity also increased but did not keep pace with the increase in referrals. Accordingly, the number of young people seen within target wait times declined during the Specified Period.

Introduction

523. The mental health needs of CYP and the services in place to meet those needs are wide-ranging and varied. In the same way as there is limited common ground between the wide range of conditions that fall within "physical health", there is limited scope to generalise about mental health problems.

524. Mental health disorders are collectively the leading cause of child disability **[DB1/124][INQ000485260]**. Mental health and neurodevelopmental problems experienced by children seen by CYPMH services include but are not limited to: depression, anxiety disorders, post-traumatic stress disorder, obsessive-compulsive disorder, eating disorders, psychosis, attention deficit hyperactivity disorder, autism spectrum disorder and self-harm.

525. The mental health of CYP is influenced by multiple personal, social and environmental factors. After traumatic events, most children show transient symptoms; for example, they may become tearful, anxious or withdrawn. They may struggle to sleep, complain about headaches or stomach aches or become irritable as they struggle to cope with their emotions. These are normal psychological responses to trauma that usually subside within a few weeks or months in most children. However, sometimes they can persist and impair the child or young person's functioning.

526. A large group of young people may appear to be unaffected following major incidents, but some of these have mental health difficulties that appear later; some have

enduring problems for years. The different patterns are associated with many individual factors as well as secondary stressors such as the economic impact on their family or stressors that arise from the trauma and its effects on family e.g. divorce, domestic violence etc.

527. Most varieties of adverse experiences in childhood increase or intensify following natural and man-made disasters. Relative poverty or being a young carer may impact with loss of routine, sleep, or loss of support networks. Children with caring responsibilities may need to look after siblings not in school; lose contact with local services, have difficulty with home learning and have unremitting caring responsibilities.

528. NHS research suggests that in 2017, prior to COVID-19, there was already a substantial burden of mental health problems among CYP with 1 in 9 experiencing such problems. There was an approximately 50% increase in the prevalence of mental health conditions amongst 5-16 year olds, across all sex and ethnic groups from 2017 to 2020 **[DB1/125][INQ000485270]**.

529. The prevalence of probable mental health disorders amongst young people increased significantly again during and after the pandemic, with government figures published in 2020 suggesting that 1 in 6 CYP were then experiencing a mental health problem **[DB1/125][INQ000485270]**. Vulnerable young people, especially those with SEND, and young people living in areas of high deprivation, were disproportionately impacted. Among young people (17 to 22 year olds), one in five (20%) were identified with a probable mental disorder in 2020. About one in four (27.2%) young women were identified with a probable mental disorder compared with one in eight (13.3%) young men. Comparison with 2017 is not possible due to the different age groups covered in the surveys.

530. More than a quarter of young people and young adults reported disrupted sleep during the pandemic and one in ten young people and young adults reported they often or always felt lonely. 54% of 11-16 year olds with probable mental health problems said lockdown had made their lives worse **[DB1/126][INQ000250275]**.

531. A range of surveys in England during COVID-19 found that children commonly worried that family members might die from the virus, or that their own education and the future might be impacted **[DB1/127][INQ000485269]**. Most young people also reported increased loneliness, which increased with age. Young people linked this loneliness to feeling anxious and to experiencing lower life satisfaction

[DB1/128][INQ000270155]. CYP who were lonely were also much more likely to meet the clinical threshold for depression (5.8-40 times) and more likely report to feel anxious (1.63-5.49 times). In England, a national survey during COVID found the proportion of children with a probable mental disorder increased to 30.2% (from 23.2% in 2017) for children whose parent showed psychological distress, compared with 9.3% (from 8.5% in 2017) of children whose parent showed no distress, a risk increased between 2.7 to 3.2 times. However, these associations are complex and cannot explain causality.

532. Published literature (**[DB1/129][INQ000485271]**) suggests that individuals with eating disorders have experienced deteriorating symptoms and an increase in hospital admissions as a result of the pandemic. Data from England has also found a rise in eating problems in CYP. For children aged 11 to 16 years, the rate of possible eating problems rose from 6.7% in 2017 to 13.0% in 2021 and in young people aged 17 to 19 years, the prevalence of possible eating problems rose from 44.6% in 2017 to 58.2% in 2021. Rates then remained stable over subsequent waves. Reasons may include decreased access to a range of services, changes to routine and loss of structure, the negative influence of the media and social media, and social isolation.

Overview of CYPMHS commissioning arrangements and objectives

533. Tackling the mental health of young people requires multiple services to collaborate, including children's social care, acute hospitals and paediatric services, education, police and other emergency services, the voluntary, community and social enterprise sector; ensuring a needs-based, person-centred model of care.

534. There has historically been wide variation in CYPMHS in-patient services across the country, both in terms of access and the range of services offered. It has long been recognised that these services require reform. Significant progress has been made over the last ten years. In its published Annual Report for 2014/15, NHS England stated:

"Too many children and young people with mental health problems are being treated in hospitals and units far from home. In July 2014, a review of children and adolescent mental health services (Tier 4) revealed there were limited options for treatment, resulting in increased pressure on in-patient services and a small number of young people having to travel long distances to find a place. NHS England took immediate action to increase the provision of specialist beds, overhaul the management of cases and, in consultation with patients and their families, improve

access and discharge arrangements. Work is continuing to ensure the right type of services are available in the right place for these vulnerable young patients."

535. A later bed planning review undertaken by NHS England specialised commissioning team in 2017 identified a need for improved national distribution of the in-patient beds as well as a phased approach to more effective integrated treatment pathways. The phases were:-

a. Stabilisation by increasing in-patient capacity where there is unmet need;

b. Transition to reducing bed numbers by removing surplus in-patient supply; and

c. Transformation to a predominantly community-based model.

536. NHS England commissioned a Mental Health Task Force to review provision of both in-patient and community services. It reported in February 2016 in the Five Year Forward View for Mental Health ("**FYFVMH**") **[DB1/130][INQ000485248]** and made recommendations directed to a range of bodies with responsibility for aspects of health care planning and delivery. In relation to NHS England and in-patient services for CYP, those recommendations included:

a. ensuring that no acute hospital is without all-age mental health liaison services in emergency departments and in-patient wards; and

b. trialling new models of acute care for those aged 16-25 so as more effectively bridge the transition into adulthood.

537. In particular, it was recognised prior to the pandemic that CYPMHS in-patient services faced a number of challenges. These included bed closures, children being admitted to services a long distance from their home, and a disproportionately high number of CYP with learning difficulties or autism being admitted to in-patient services.

538. By the time NHS England published the NHS LTP **[DB1/65][INQ000113233]** in January 2019, it had been working on the recommendations of the FYFVMH for a number of years and was able to report in relation to community CYPMHS that:

"We are delivering on our commitments to expand mental health services for children and young people. The Five Year Forward View for Mental Health set out plans for improving mental health services so 70,000 more children and young people will

access treatment each year by 2020/21. Access is rising in line with our plans and, in 2017/18, around 30.5% of children and young people then estimated to have a mental health condition were able to benefit from treatment and support, up from an estimated 25% two years earlier."

539. Importantly, the NHS LTP committed to increases in funding of mental health services at a rate which exceeded increases in the funding of NHS services generally, and to increases in the funding of CYPMHS which exceeded the increase applicable to mental health services generally. The commitment applied for five years, covering the whole of the Specified Period.

540. Nationally NHS England exceeded the FYFVMH access commitment: in 2020/21, approximately 39.6% of CYP with a diagnosable MH condition were treated in NHS-commissioned community services, exceeding the 35% target (based on 2004 prevalence estimates which applied to the FYFVMH target). However, variation at regional and local levels existed, and continues to exist. NHS England regional teams work with underperforming areas with the aim of achieving greater uniformity across the country. Data also show the pandemic has been associated with a sustained increase in demand for CYPMHS. This has impacted on access to services, including waiting times, and has prompted changes to how services are delivered. This is discussed further below.

541. In early 2020 NHS England remained committed to investment in increasing numbers of in-patient beds. However, in the past it was too common for an admission into an in-patient unit to be driven by a lack of appropriate community services rather than assessment that it was the best treatment option. NHS England's efforts therefore became increasingly focussed on securing improvements to community services in such a way as to decrease reliance on in-patient services where CYP could appropriately be better cared for out of an in-patient setting; in the case of many CYP, in-patient care was not the optimal response to the presenting need. According to 2019 data, the average cost of an in-patient admission would support almost 100 young people within the community for one year.

542. As set out in paragraph 32 above, during the pandemic Provider Collaboratives started engaging in supporting the pandemic response through a variety of clinical and commissioning forums.

543. Provider Collaboratives are collections of providers of commissioned services to the NHS. They feature a Lead NHS Trust, which acts as the commissioned provider, a

number of other Trusts and, potentially, further providers, such VCSE sector organisations or other independent providers who collaborate with the Lead under partnership arrangements. The intention is that working at scale in this way enables providers to come together to improve quality of care by standardising clinical practice to tackle variations in access and outcomes across different sites, to increase sustainability through better use of a limited workforce, and to consolidate corporate services for greater efficiency. Collaboratives also focus on reducing the use of out of area placements for young people, as these can delay their recovery. The successful functioning of Provider Collaboratives is seen as an important contribution to improving services including CYPMHS. The Lead Provider's role involves understanding their local population and empowering local clinicians and Experts by Experience to design improved pathways of care. The Lead Provider will sub-contract to other providers, manage contracts, assure the quality of services and lead the necessary reporting regionally and nationally to NHS England.

544. NHS mental health services for young people can be broadly categorised as either:

a. "In-patient" services providing care for young people who need admission to a hospital bed; these services are commissioned directly by NHS England through its Specialised Commissioning function; or

b. "Community" services providing care for young people in outpatient or other community settings; these services which are commissioned locally by ICBs.

545. These categorisations replace the more traditional nomenclature of CYPMHS 'Tiers'; it is thought the simpler terminology helps focus on the needs of the young person themselves and the whole care pathway, rather than on rigid, specification-driven categories. The categories of 'in-patient' and 'community' CYPMHS can, however, be said to cover the more detailed sub-categories set out below:

a. In-patient CYPMHS services (traditionally referred to as 'tier 4'):

i. Eating Disorder in-patient service;

ii. General Children's services;

iii. General Adolescent services;

iv. Learning disabilities and autism in-patient services;

v. Psychiatric Intensive Care Units;

vi. Low Secure services; and

vii. Medium Secure services.

b. 'Community' CYPMHS services (traditionally referred to as tiers 1-3):

i. Tier 3: "specialist" community multidisciplinary CYPMHS teams (including community mental health clinics and child psychiatry outpatient services);

ii. Tier 2: "targeted" services, including youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third-sector providers; and

iii. Tier 1: "universal" services such as early years services and primary care (e.g. teachers).

546. Some services in Tiers 1 and 2 will be commissioned by or in partnership with the NHS, but also by other bodies, notably local authorities.

547. NHS England also commissions the National Deaf Child and Adolescent Mental Health Services, which provides a highly specialised mental health service to deaf CYP, and hearing children of deaf adults (in both community and in-patient settings).

548. NHS England is not a provider of mental health services to individuals. It has a statutory role to arrange a number of mental health services and also supports the commissioning of other mental health services by local organisations as part of its overall leadership role in the NHS, as described further below.

549. As set out earlier in this statement, CYPMHS, taken as a whole, are commissioned by a number of different commissioning bodies, depending on the nature of the service. Responsibilities are set out in the 2006 Act and in relevant regulations made by the SSHSC under that Act, namely the Standing Rules.

550. The above legislation allocates the commissioning of mental health services either to NHS England or to local commissioners. The latter were CCGs until 30th June 2022 and ICBs thereafter. For the majority of the Specified Period CCGs were the local commissioners and for ease of reference we refer to CCGs throughout this section.

551. Under the 2006 Act, CCGs were given responsibilities relating to the commissioning of mental health services as set out in paragraph 39 above.

552. Again, services which NHS England is required to commission are excluded from that power to avoid duplication of responsibilities.

553. As set out at paragraph 26 above, NHS England is required to arrange for the provision of services for rare and very rare conditions, including

a. medium secure in-patient services;

b. child and adolescent mental health in-patient services; and

c. mental health services for deaf children and adolescents.

554. The content of the services commissioned directly by NHS England is set out in its published service specifications **[DB1/129][INQ000485271] [DB1/02][INQ000485247] [DB1/03][INQ000485249] [DB1/04][INQ000485250] [DB1/05][INQ000485251] [DB1/06][INQ000485252]**.

555. NHS England's Specialised Commissioning team exercises these commissioning functions centrally and in each of NHS England's seven regions. Its work involves the assurance of the clinical governance, safety, and effectiveness of the providers' services – whether services are delivered by NHS Trusts or the independent sector. In rare cases, it also includes monitoring the care of individual patients, where issues have been escalated to NHS England. This might involve attending reviews and achieving assurance that a person is getting good care and the right treatment, and progressing towards appropriate discharge from in-patient care. Case managers are responsible for oversight of the pathway of an individual and contribute to the monitoring of quality, safety and compliance of specialised services. Much of that oversight is now undertaken by the 18 CYPMH Provider Collaboratives, with NHS England obtaining assurance that collaboratives are fulfilling this role.

556. CYPMHS often overlap with other services, such as the CYPSE. In this regard, NHS England directly commissions:

a. **Community Forensic Child and Young People Mental Health Services** deliver mental health consultation, advice, assessment and limited intervention for high-risk young people with complex needs living within the catchment who meet the following criteria:

i. Under 18 years' old at the time of the referral (no lower age threshold for access to the service although most referrals will be for 10-18 year olds).

ii. Presenting with serious conduct and emotional issues, neuropsychological difficulties or serious mental health problems and/or neurodevelopmental conditions (including learning disability or autism) with/without learning difficulties, where there are legitimate concerns about the existence of such conditions.

iii. Usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This includes young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.

b. **Low secure services** accommodate young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people may belong to one of two groups: those with "forensic" presentations involving significant risk of harm to others and those with "complex non-forensic " presentations, principally associated with behaviour that challenges self-harm and vulnerability.

c. **Medium secure services** accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk harm to others including those who have committee grave crimes.

d. **Psychiatric Intensive Care Units** manage short-term behavioural disturbance which cannot be contained within CYPMHS general adolescent services. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security.

557. NHS England's role in relation to CYPMHS extends, however, beyond directly commissioned in-patient services. NHS England's Mental Health team additionally supports the commissioning of community services, via CCGs (now ICBs), providing guidance, support and direction as appropriate.

558. Each of NHS England's regions has an appointed Mental Health Lead, with supporting staff, who shares relevant information with the central NHS England team. The central Mental Health Team contains a Project Management Office which co-ordinates engagement between the regions and the centre. During the pandemic this work included the setting of meetings, creation of dashboards and the flow of information/data.

Initial Pandemic Response: Changes in ways of working

559. It was recognised at the start of the pandemic at both national and local levels in the NHS that measures introduced to respond to the risk of infection, as well as widespread anxieties prompted by the pandemic, would require mental health services to respond rapidly to an increase in demand, and to adapt to new ways of working.

560. This section describes the steps that were taken at speed during the earliest stages of the pandemic to respond to this challenge and supplement business as usual arrangements. These steps allowed NHS England to establish timely flows of information to and from providers. Providers would detail the impact of the pandemic on their services and NHS England would issue guidance and offer support as appropriate based on a national view of the evolving situation.

561. In March 2020, NHS England established a cell for Mental Health, Learning Disability and Autism, for the purposes of supporting pandemic response. It reported to NIRB on matters including identification of risks, risk score and mitigations. It did not supplant the Mental Health, Learning Disability and Autism, and Specialised Commissioning teams but worked alongside them and included staff drawn from those teams.

562. From March 2020, the Mental Health Team and the MHLDA Cell issued guidance, bulletins and updates to the health system and held webinars with providers. A list of NHS England's guidance publications, relevant to CYPMHS is annexed at **[DB1/131][INQ000485273].** Concerns in Wave 1 of the pandemic included the impact of the disease on care provided in in-patient settings, likely increases in demand for CYPMHS as a result of Covid-19 and the measures taken to limit its spread, and the wish to maintain and continue as far as possible the good progress made to that point in the implementation of FYFVMH and LTP commitments.

563. Examples of guidance issued and letters written below illustrate the main features of NHS England's early responses to the impact of the pandemic on mental health services as they affected CYPMHS:

a. On 17 March 2020, the Phase 1 Letter required providers to make operational arrangements for IPC in in-patient services and assess the likely physical health needs of patients. Providers were asked to consider opportunities for safe discharge of current in-patients to support patient flow and ensure capacity for new referrals to in-patient care. Assessments were required to balance the risks to individuals associated with COVID-19 and continuing to care for their mental health needs.

b. On 20 March 2020, the initial version of guidance on managing capacity and demand required the creation and maintenance of dynamic risk registers, to determine those at most risk physically and mentally and coordinating care accordingly.

c. On 25th March 2020, the MHLDA Cell published guidance to the system including the following principles to inform a system-wide response:

i. all mental health Trusts should review advice lines to ensure that 24/7 advice was available to people of all ages through a single point of access. These may need to be shared across Trusts and may require additional funding. Those lines were already developing as part of the implementation of FYFVMH recommendation;

ii. people with mental health needs, a learning disability or autism should receive the same degree of protection and support with managing COVID-19 as other members of the population. This might mean providing additional support, including making reasonable adjustments;

iii. in preparing for and responding to Covid-19, staff within mental health/learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions would need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision-making, providers might choose to draw on an existing patient panel or an ethics committee to advise on decisions;

iv. when considering plans, providers should consider not only patients' vulnerability to physical infection, but also vulnerability stemming from mental health needs, a learning disability or autism too. People could be at risk of mortality through suicide, injury through self-harm and of self-neglect, and therefore any changes to services needed to have patient safety as the paramount concern;

v. partnership working was crucial, and responses would need to be co-produced where possible. To both maximise the use of community assets and to draw on the insight and expertise of partners, response plans would need to be developed alongside patients, families, carers, and VCSE sector organisations as well as neighbouring mental health/learning disability and autism providers;

vi. providers would need to maximise delivery through digital technologies to ensure continuity of care where patients are asked to self-isolate and in response to reduced staff numbers or mobility. Digital technology could also be used to support continuity of social contact for patients, families and carers; and

vii. providers should bear in mind the longer-term impact of the pandemic and associated impacts on the mental health needs of the population, and accordingly should seek to minimise changes that would impact on the capacity and capability of the system to respond to these needs in the longer term.

d. On the same day, NHS England published guidance on managing demand and capacity in MHLDA settings. The guidance:

i. provided information and guidance for providers and their clinical and non-clinical teams who were planning for how best to manage their capacity across in-patient and community services, and supported contingency planning, already underway, for a range of resource-constrained scenarios;

ii. provided guidance and considerations for specialised services as well as CCG commissioned services; and

iii. included information on maximising capacity, including via discharge planning where safe and creating additional in-patient capacity, and cohorting physically vulnerable patients. The cohorting of patients in an in-patient setting contributed to meeting the challenges of IPC in circumstances where discharge was not an appropriate option.

e. On 3 April 2020, NHS England's National Director for Mental Health wrote to NHS England regions, CCG and Sustainability and Transformation Partnership Mental Health Leads, and Mental Health Trust CEOs to the effect that:

i. all mental health Trusts should expedite the ambition to have a 24/7 single point of access for urgent mental health support that was available to the public. The NHS Long Term Plan Implementation Plan had originally outlined that this ambition was to be delivered by March 2021, but it should now be delivered within the following week to ensure the lines are established before the anticipated COVID-19 peak;

ii. CYP and their parents/carers should also have access to the lines, either through an all-age access point or a dedicated CYP access point; and

iii. as part of this, Trusts should ensure all efforts were being made to divert people away from A&E where possible and into mental health provision **[DB1/132][INQ000610885]**.

f. On 8 April 2020 NHS England published guidance on workforce in MHLDA services. It:

i. covered mental health, learning disabilities and autism, and specialised commissioning services. It provided information for systems, providers, NHS commissioned services and staff;

ii. was created to support local contingency planning under way for different resource-constrained scenarios; the guidance covered ways of working, which included PPE, staff safety and wellbeing and remote working. The PPE component adapted PPE information into MHLDA-specific scenarios, such as spitting and naso-gastric feeding;

iii. covered releasing time to care and training and continuing professional development; and

iv. noted that further work would be undertaken to review whether it would be appropriate to relax safer staffing requirements to ensure greater availability from the core workforce.

g. On 30 April 2020, NHS England published the first version of guidance for "*supporting patients of all ages who are unwell with coronavirus (COVID-19) in mental health, learning disability, autism, dementia and specialist inpatient facilities*". This was updated on 18 May 2020 and a second version was released on 24 January 2022. An accompanying document provided legal guidance on compliance with mental health legislation and considerations for the management of people who did not want to isolate. Providers were asked to assess individuals for pre-existing conditions which could make them high risk if they contracted COVID-19 as well as their general physical health. Providers were also asked to encourage all clinical staff to take training opportunities so that they could provide some level of physical healthcare for service users who were unwell. There was also guidance on the transfer of individuals who were unwell to an acute medical setting if their physical health needs escalated **[DB1/41][INQ000610890]**.

h. Further guidance was published in December 2020 relating to "*Learning disability and autism, dementia and mental health – patient, carer and family engagement and communication during the Covid-19 pandemic"* **[DB1/164][INQ000470650]**.

564. In addition to issuing guidance, the cell also established regular communication channels with stakeholders including Mental Health Trust CEOs and Voluntary, Community and Faith Sector partners to promote effective two-way communication between NHS England and other organisations involved in supporting patients.

565. NHS England also supported DfE and PHE on campaigns supporting CYP mental wellbeing more broadly, including "Wellbeing for Education" with DfE, and the CYP expansion of PHE's "Every Mind Matters campaign".

Changes in patterns of demand and access to CYPMHS

566. Changes in the patterns of demand and access to CYPMHS generally during the pandemic are set out and discussed in the data section below. A few introductory points are made here.

567. There are a number of confounding factors which complicate analysis of the impact on the demand for, and access to, CYPMHS during the pandemic. Referrals to CYPMHS were already increasing prior to 2020, so it is difficult to identify the extent to which subsequent increases in demand (during the Specified Period) was attributable solely to the pandemic. There had also been investment before the pandemic in additional capacity within CYPMHS as part of initiatives described elsewhere in this section. That capacity was intended to address unmet need, so any observed increase in access to services may in part be attributable to planned increases in service capacity, rather than just to increased demand.

568. In addition, where increased demand has been driven by Covid-19, the NHS is continuing to try to identify whether these increases are short to medium-term surges, or whether they will persist in the longer term. The answer is likely to vary from service to service. For example, England, in common with a number of other European countries, appears to be experiencing a significant increase in demand for CYP eating disorder services.

569. There were common issues impacting access to a range of services. The restrictions on day-to-day life including lockdowns disrupted CYP's education and social networks. Contacts which CYP have within these networks, including professionals such as teachers and social workers, play an important role in identifying a young person's potential need for support and facilitating access to services.

570. Ahead of the second wave of infection, the MHLDA Cell considered critical risks for Wave 2 as it related to CYPMHS. The following mitigations were recommended:

a. work with providers to ensure appropriate guidance and advice to reduce / prevent infection (whether Covid-19 or Flu), assess demand, free up beds where possible and create additional capacity, including short term crisis alternatives to inpatient care, maintain access to community services both face-to-face and remote;

b. providers encouraged to maximise return to face-to-face contact where safe to do so to provide greater levels of support than are possible using remote means;

c. discussing Covid-19 Cost pressures for beds with strategic finance, and ensuring discharge guidance and funding secured for mental health patients; and

d. continued work with NHS and third sector partners on the need to support families and carers **[DB1/133][INQ000610924]**.

Monitoring inequality of access

571. An Equality Impact Assessment was carried out during the Specified Period, to assess the inequalities of access to mental healthcare faced by different groups of CYP, particularly LGBTQ+ CYP, and black and minority ethnic individuals. Both groups reported poor levels of satisfaction with community mental health services compared to heterosexual and white British counterparts.

572. Proposed action to promote equality of access included:

a. working with the Patient and Race Equality Framework Steering Group to identify the enablers and barriers to race and ethnic equality in mental health service access, experience and outcomes for CYP to inform the development of the organisational competency framework for local organisations;

b. working in partnership with Young Minds to delivery engagement sessions with CYP, parents and carers to learn from their experiences and understand which organisational competencies are most important from their perspective;

c. Diversity, Culture and Social Inclusion training for Education Mental Health practitioners and Child Wellbeing Practitioners;

d. working with the national LGBT Health team to develop a Commissioner Support Programme module on LGBTQ+ children's mental health and wellbeing; and

e. local commissioners and providers to ensure that all staff receive mandatory LGBTQ+ awareness and inclusion training.

Availability & Sources of CYPMHS Data

573. The NHS in England has longstanding arrangements for collecting data about CYPMHS. These existing arrangements are described below, along with supplementary arrangements for data capture which were put in place in response to the pandemic.

574. One significant issue in relation to CYPMHS intelligence has been inconsistency in data quality and poor data flow to national datasets. This both reflects, and has been

a driver of, unwarranted variation in the way in which services are delivered. There has been a significant national improvement in recording of data since 2020, with the number of providers submitting information to key national datasets trebling between 2020 and 2022. Bespoke data collections have also enabled NHS England to monitor performance against key objectives (for example, the CYP Eating Disorder Waiting Times data below).

575. In addition to data about numbers of patients within different care settings (community or in-patient) and with particular diagnoses, there are a number of datasets focused on activity within particular pathways, such as those recording timescales for the assessment and treatment of eating disorders. Where there is more detailed data about a particular pathway, or performance against specific access targets, it is important not to give these undue prominence when assessing the overall picture of unmet need or pressure on services.

The Mental Health Services Data Set

576. The MHSDS for England is a collection of data obtained from the health records of individual children, young people and adults who are in contact with mental health services.

577. From the beginning of the Specified Period until 1 February 2023 the MHSDS was operated by NHS Digital. The MHSDS has since been operated by NHS England as part of NHS England's assumption of NHS Digital's data functions generally.

578. MHSDS contains patient level data which is collated to provide robust, comprehensive, nationally consistent and comparable person-based information about patients in contact with mental health services. It encompasses mental health services commissioned by both CCGs and NHS England. Information derived from the MHSDS is published, with safeguards in place to ensure patient identifiable information is not disclosed.

579. There have been a series of releases of the MHSDS. Within the Specified Period, the applicable releases were:

a. Version 3.0, released on 28 September 2017 and implemented over the following months;

b. Version 4.1, released on 9 October 2019 and implemented over the following months; and

c. Version 5.0, released on 8 April 2021 and implemented over the following months.

580. Each release of the MHSDS includes Technical Output Specifications, which define the data items to be submitted by providers. These are wide-ranging and a large proportion of them remain constant across the various releases. They cover key clinical and social information including:

a. Referral information;

b. Accommodation Status;

c. Diagnosis; and

d. Care plan details.

581. MHSDS data items are predominantly measures of processes, rather than outcomes.

The NHS Benchmarking Network

582. NHS England participates in the NHS Benchmarking Network ("**NHSBN**"), a community of health and social care providers and commissioners from all four UK countries, hosted by East London NHS Foundation Trust ("**ELFT**").

583. The Network's Children and Young People's project has been running annually since 2012. The project benchmarks data submitted by NHS providers of CYPMHS, who are also members of the NHS Benchmarking Network.

584. The project's aim is to provide insight into how a providers' services compare to their peers, enabling providers to identify areas for service improvement and consequently improving the outcomes for people in their care.

585. Although NHS England is not itself a provider, in its roles as commissioner and leader of the NHS nationally, the programme's reports and analysis have provided valuable insights.

586. The NHSBN collects data on both community and in-patient CYPMHS, routinely measuring metrics including:

a. Service user demographics; ethnicity and gender;

b. Caseload by service benchmarked per population;

c. Contacts by service benchmarked per population;

d. Waiting Times;

e. Number of admissions by bed type and benchmarked where appropriate;

f. Admissions under the Mental Health Act;

g. Lengths of stay by bed type;

h. Patient Safety Indicators on violence and restraint;

i. Use of Outcome measures; and

j. Workforce and finance metrics.

587. Whilst the following sections present NHSBN data (alongside MHSDS data) NHS England cannot attest to the completeness or reliability of NHSBN data. It should be noted that not all CYPMHS providers in England submit data routinely to the NHSB.

Covid-19 Situation Reports ("SitReps")

588. On 1 May 2020, NHS England directed all providers of NHS-commissioned in-patient mental health, learning disability and autism services to submit daily situation reports (Sitreps) to enable NHS England national and regional teams to oversee service demand and capacity in real-time during the pandemic. NHS England collected the SitReps from 5 May 2020 until 26 May 2021.

589. The SitRep submission template required providers to submit information on:

a. Numbers of in-patients isolating because they were defined as being 'clinically extremely vulnerable' to Covid-19;

b. Numbers of in-patients isolating because they were experiencing Covid-19 symptoms;

c. Numbers of patients who had tested positive for Covid-19;

d. Numbers of confirmed or symptomatic patients with a diagnosis of a learning disability or autism;

e. Whether services expected to meet 'safer staffing' requirements over the next 72 hours;

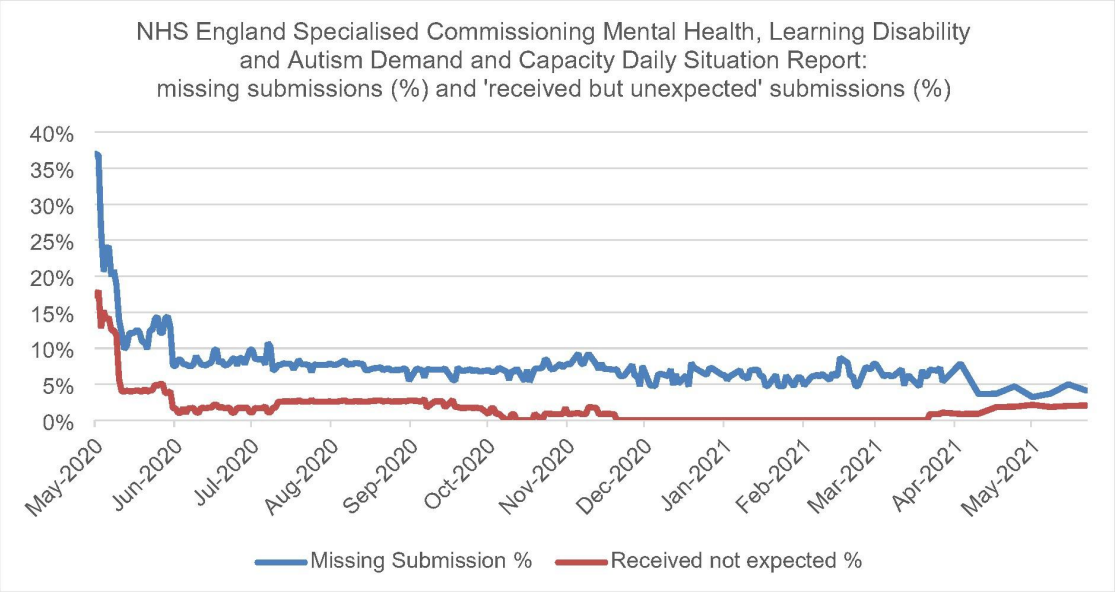
f. Number of wards closed completely for reasons related to Covid-19;

g. Whether any wards had been designated wholly for patients with Covid-19;

h. Total numbers of beds commissioned; and

i. Numbers of beds currently able to accept admissions (even if presently occupied).

590. CYPMH in-patient services data was collected from 143 individual units, from across 39 NHS Trusts and 11 independent providers. SitRep data completion rates are shown below. The graph also shows the proportion of SitRep returns from providers or units who NHS England had not previously identified as providing specialist in-patient services; in most cases, these data submissions were believed to have been sent in error:



Capacity Planning and Monitoring System ("CPMS")

591. The Capacity Planning and Monitoring System ("**CPMS**") is an online system delivered by North of England Care System Support ("**NECS**"), to which healthcare providers declare the status of their CYPMHS beds. NHS England uses the CPMS to monitor the total number of commissioned beds in England in real time. It was intended that this data collection should enable faster allocation of young people to appropriate beds.

592. During the Specified Period, healthcare providers submitted information to a different 'CAMHS Bed Availability System', but this data was all subsequently migrated to the CPMS. During the pandemic, the data on commissioned beds, available beds, occupied beds and temporarily closed beds were shared weekly with NHS England leadership teams and Provider Collaboratives.

Emergency Care Data Set ("ECDS")

593. The ECDS collects information about attendances at hospital emergency departments in England, and on the reasons why people attend.

594. Providers began submitted A&E activity data to the ECDS in 2019. It was not until 2020/21 that all A&E departments submitted ECDS data, so data from before April 2020 may be incomplete.

E-Referral System Dataset ("eRSDS")

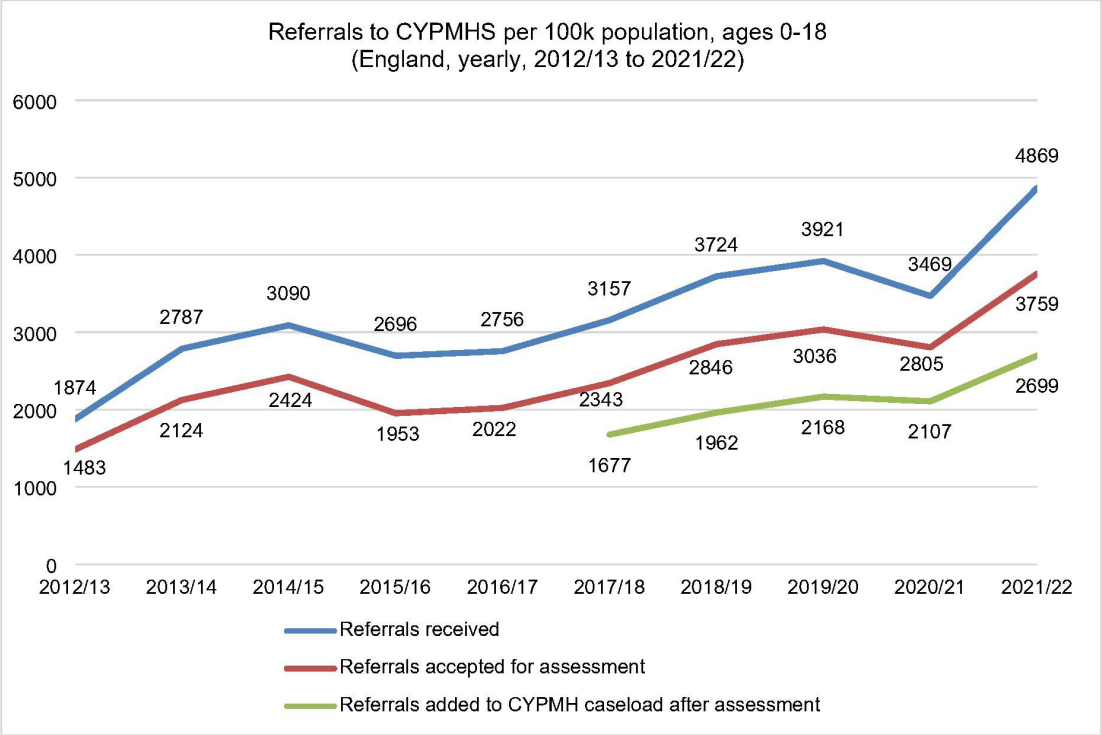
595. The NHS e-Referral System Dataset ("**eRSDS**") provides summary data on GP referrals to consultant-led services, including to CYPMHS.

596. All GPs in England use the NHS e-Referrals Service ("**e-RS**") to refer patients to secondary care providers. The eRDS does not include patients whose referral, booking, or attempted booking has occurred outside of e-RS.

597. Most GP referrals to CYPMHS are categorised as either 'routine' or 'urgent'.

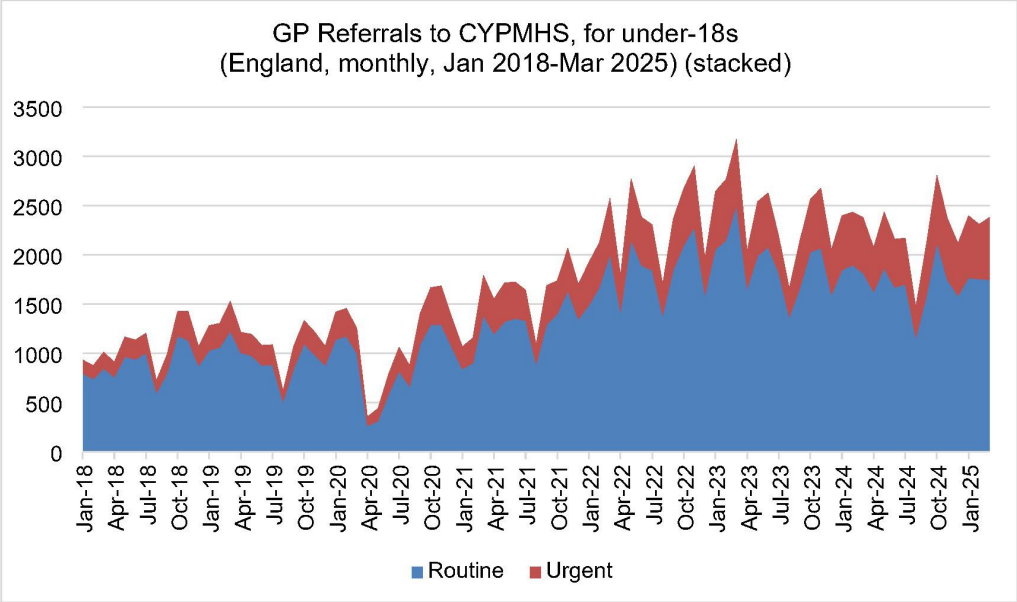
Community CYPMH Services: Referrals and Demand

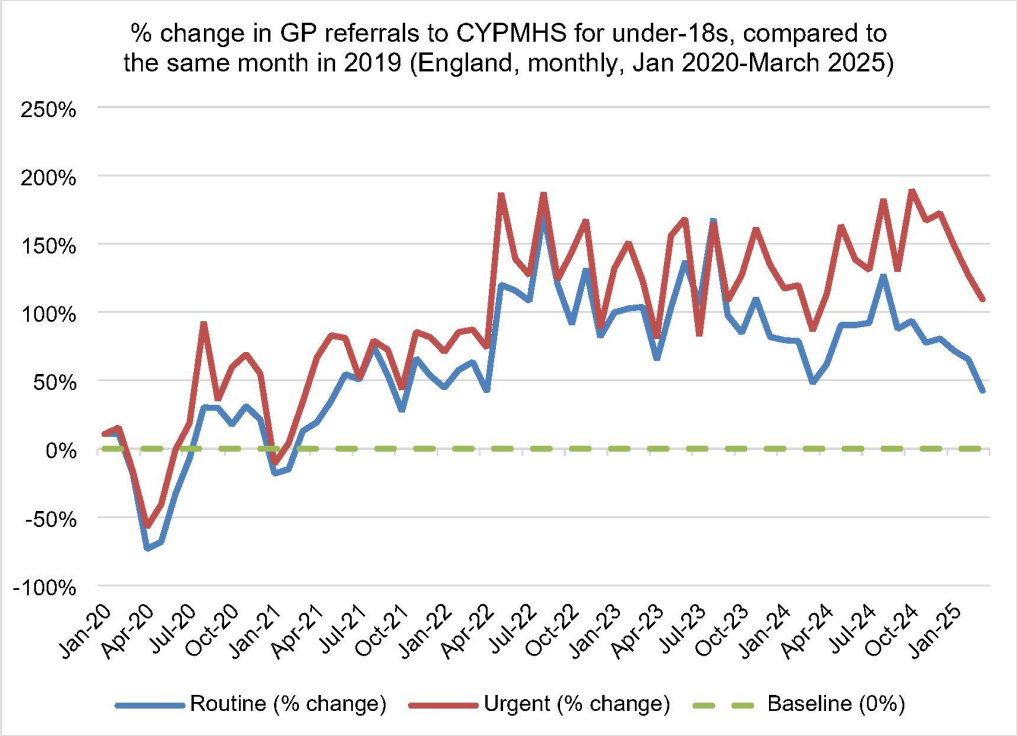
598. Prior to and during the Specified Period, NHS Benchmarking data was used to monitor demand for, and referrals to, community CYPMH services. Annual NHSB data illustrates how CYPMHS referrals were increasing prior to the onset of the C-19 pandemic, from 1,874 per 100k population in 2012/13, to 3,921 in 2019/20. The overall referral rate decreased in 2020/21, following the onset of the pandemic, but subsequently increased to above pre-pandemic rates in 2021/22 (to 4,869).



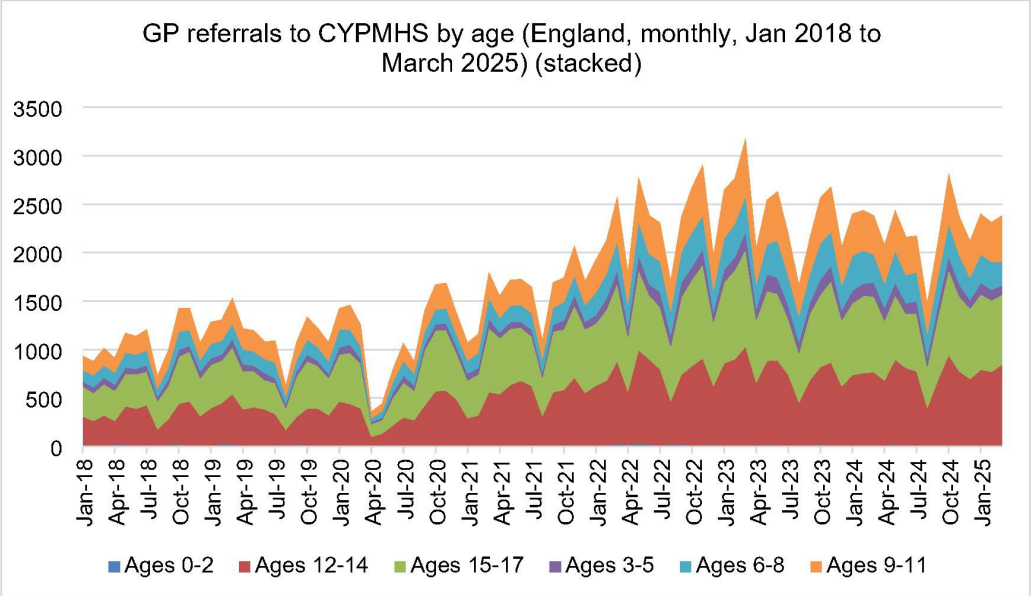
599. The data above suggests numbers of referrals accepted for assessment, and added to the CYPMHS caseload, generally increased in line with the increase in referrals. The proportion of referrals added to the CYPMHS caseload increased from 70% in 2019/20 to 75% in 2020/21 (following the onset of the pandemic), before falling to 72% in 2021/22 – still above levels seen in 2017/18 to 2019/20. The proportion of referrals assessed increase from 79% to 81%, from 2012/20 to 2020/21, before declining to 77% in 2021/22 (again, above 2017/18 to 2021/22 levels).

600. eRSDS data records referrals made by GPs to CYPMHS for under-18s. The graph below illustrates how referrals decreased suddenly following the immediate onset of the pandemic from 1,459 in February 2020 to 357 in April 2020 (a drop of over 75%). This decline was likely due to a decrease in people seeking GP advice. Referrals subsequently increased to above pre-pandemic levels by October 2020 and continued to increase until 2023 (reaching a peak of 3,176 referrals per month). This data does not include CYPMHS referrals from other sources, such as the justice system, social services, and schools, though the majority of CYPMHS patients are referred via their GP.



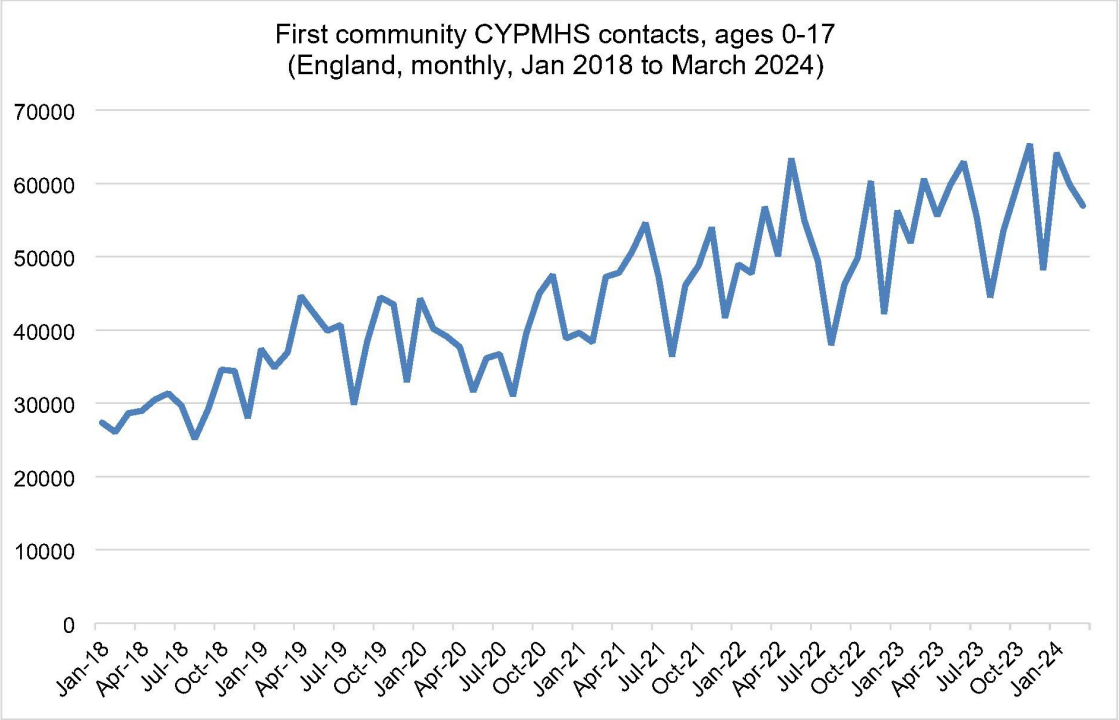


601. Most GP referrals to CYPMHS are for older children and teenagers (ages 12-14 and ages 15-17):

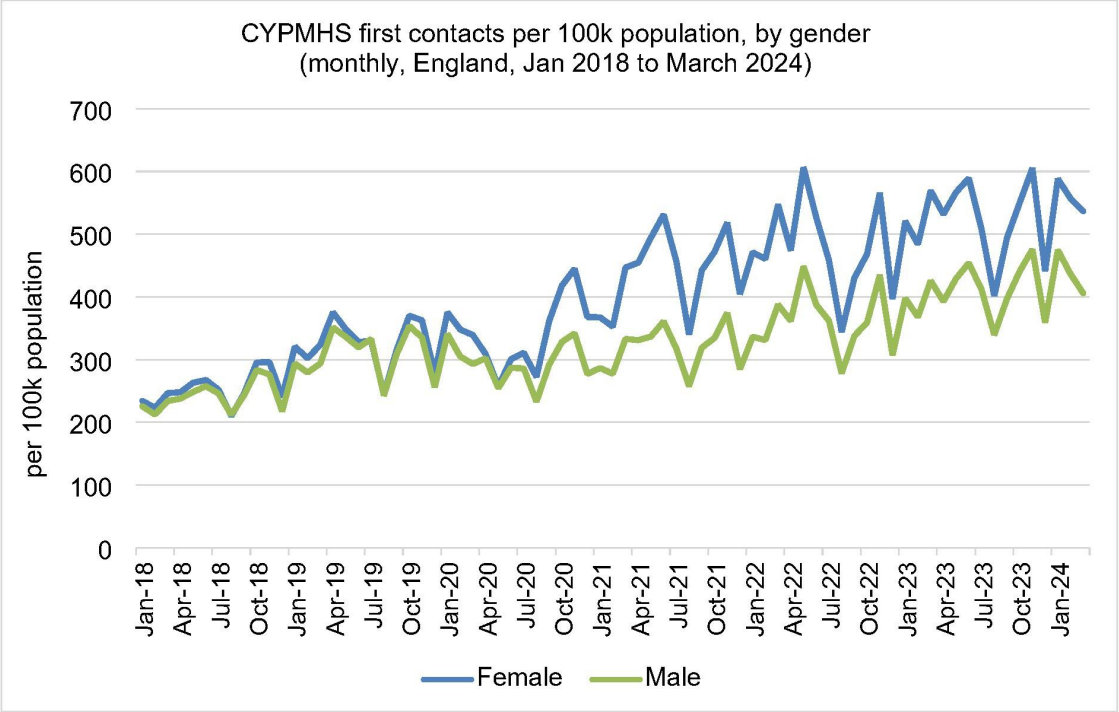


Community CYPMH Services: Access

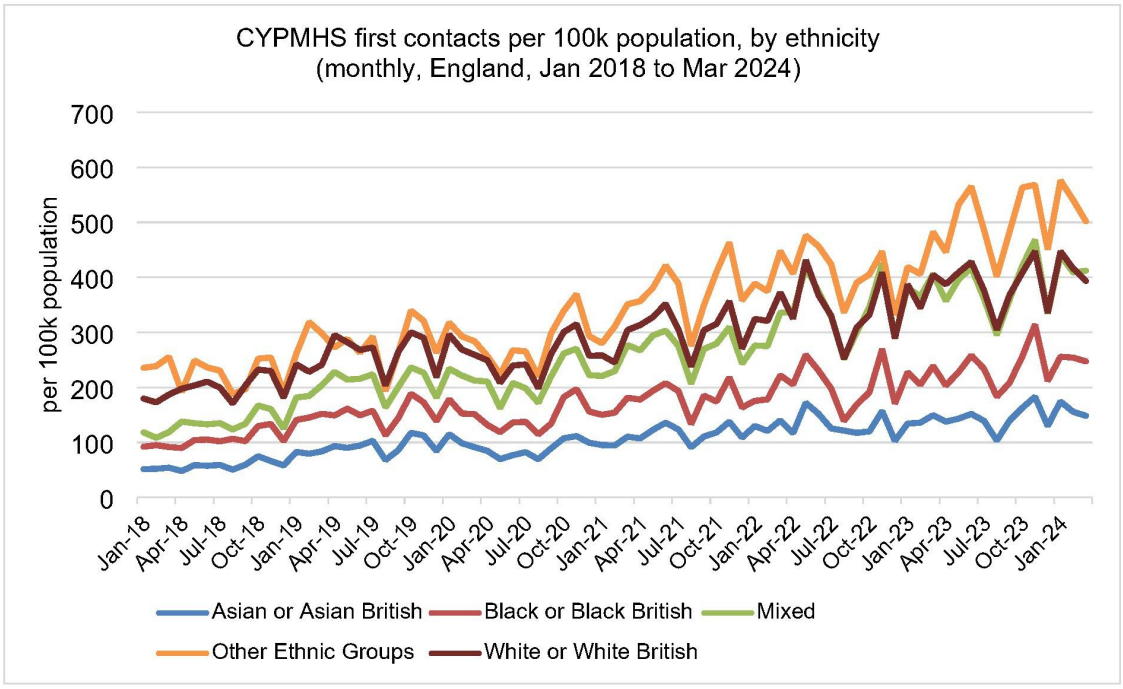
602. MHSDS data shows the monthly number of first contacts with community CYPMHS, following a referral, was already increasing before the Covid-19 pandemic (rising from 27,364 in Jan 2018 to 40,179 in Feb 2020). There was a decline in first contacts following the onset of the pandemic, but access had recovered by autumn 2020 and continued to increase throughout the Specified Period (to a peak of 63,387 first contacts in May 2022). Note that a single patient could potentially have multiple referrals or first contacts within the same month.



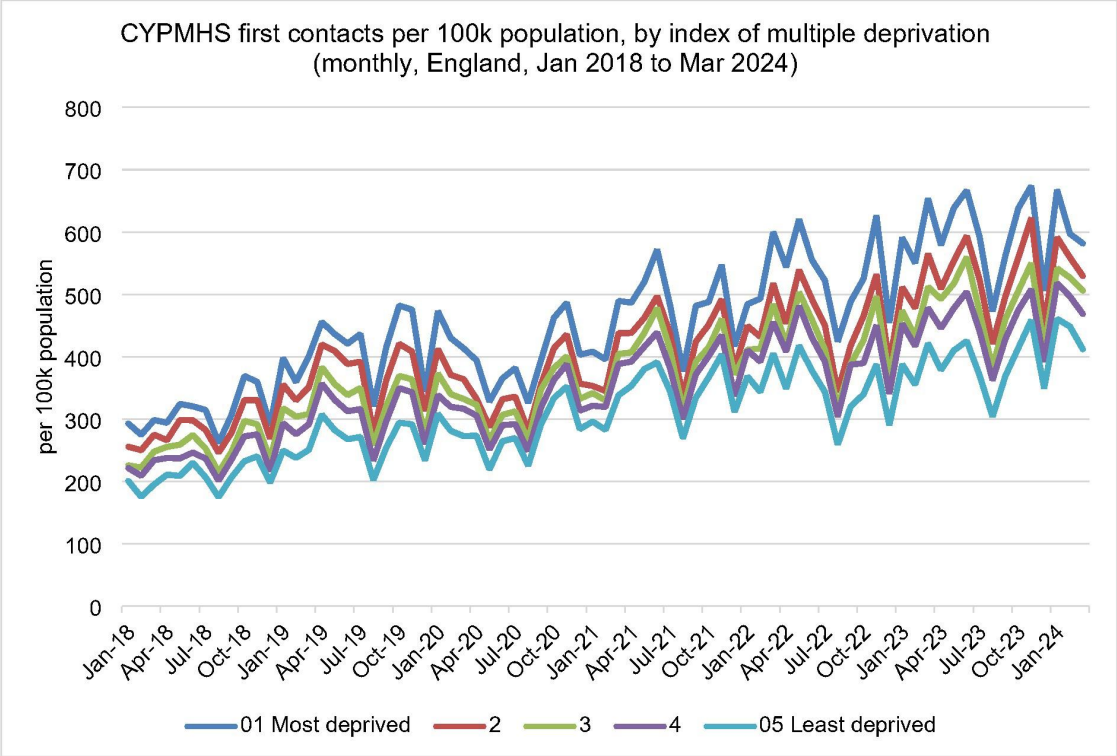
603. Rates of CYPMHS access for male and female patients were broadly the same prior to the pandemic, but there was a disproportionately greater increase in access by female patients from autumn 2020 and throughout the Specified Period. Numbers of non-binary patients, and patients with indeterminate or other genders are too small to include in this data:



604. CYPMHS access is consistently lower amongst patients from Black and Astian backgrounds, and higher amongst patients from White, mixed, or 'other' backgrounds. Population estimates for ethnicity are derived from 2021 census data:

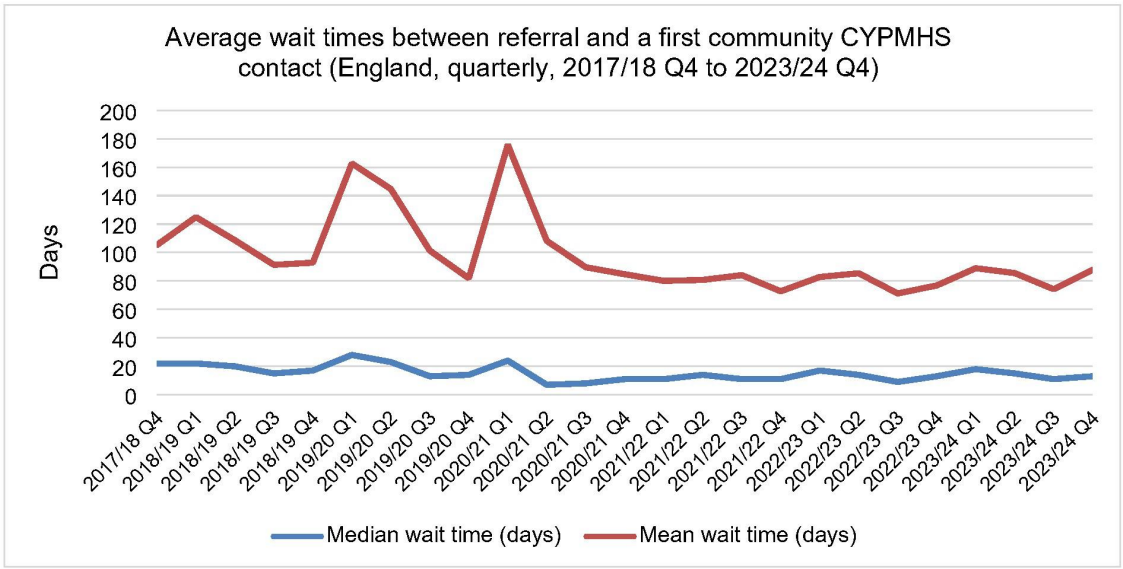


605. CYPMHS access is consistently higher amongst children living in the most deprived postcodes, and lower amongst those from more affluent areas:



Community CYPMH Services: Waiting Times

606. Following the onset of the pandemic, in April to June 2020, mean wait times for a first CYPMHS contact increased from 81 days to 175 days. Mean wait times subsequently declined to under 90 days, and remained stable throughout the Specified Period, despite the increase in referrals. Median wait times are typically much lower, as they are not skewed by outliers:



CYP Eating Disorder Services: Access, Referrals and Waits

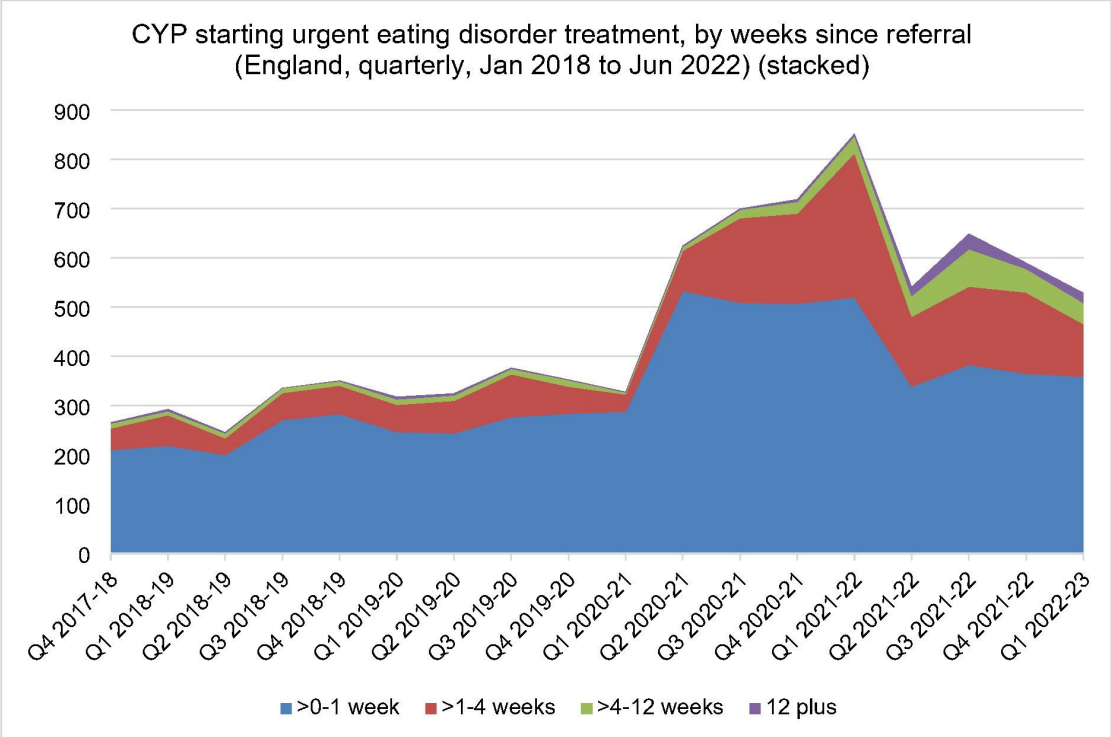
607. In 2015, NHS England introduced waiting time standards for CYP referred for assessments or treatments for eating disorders. Any young person (up to the age of 19) should receive NICE-approved eating disorder treatment within one week, for urgent cases, and within four weeks for every other case. Eating disorder treatment can take place in either community or in-patient settings.

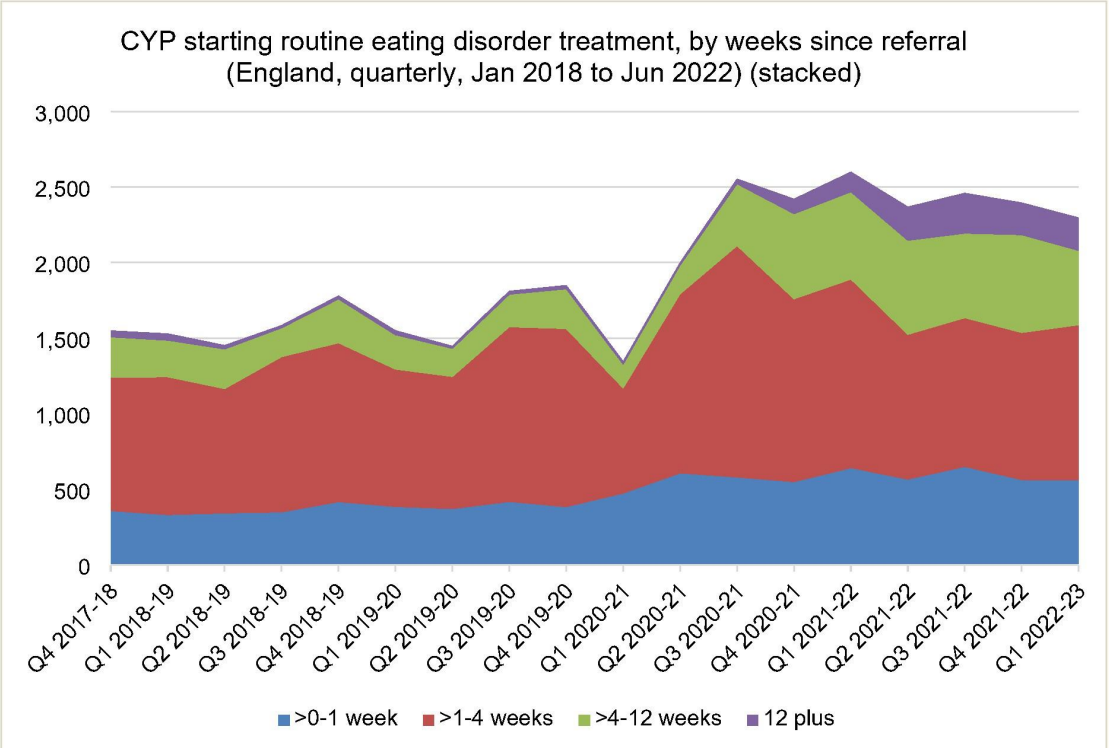
608. Guidance was first published in 2015 to help commissioners and providers meet standards and requirements for Community Eating Disorder ("**CED**") services. This guidance was then extended in 2019 to support the implementation of NICE recommendations on improved integration with in-patient settings (paediatric/medical wards and in-patient CYPMH units), with helpful resources on best practice **[DB1/134][INQ000485275]**.

609. The recommended approach to treating an eating disorder is NICE-recommended care in the community with a CED services. This should be supported by intensive day care or brief in-patient management for when there is a need to address acute complications. Some CED services can offer intensive community, home treatment or day care provision but there may be some instances where admission is required to either an acute ward for physical health treatment or CYPMH in-patient unit. In these instances, the CED service should provide oversight, support and consultation throughout the pathway, including during episodes of in-patient or intensive day care.

610. A bespoke 'Children and Young People with Eating Disorders Collection' captured data on CYP Eating Disorder wait times in England, from 2016/17 until 2022/23. Data from July 2022 until March 2023 should be analysed with caution, as we understand that a cyber incident experienced by some providers impacted the data collection informing this data set. The data collection was subsequently retired. Performance against the eating disorder standards has since been captured using the MHSDS since April 2023.

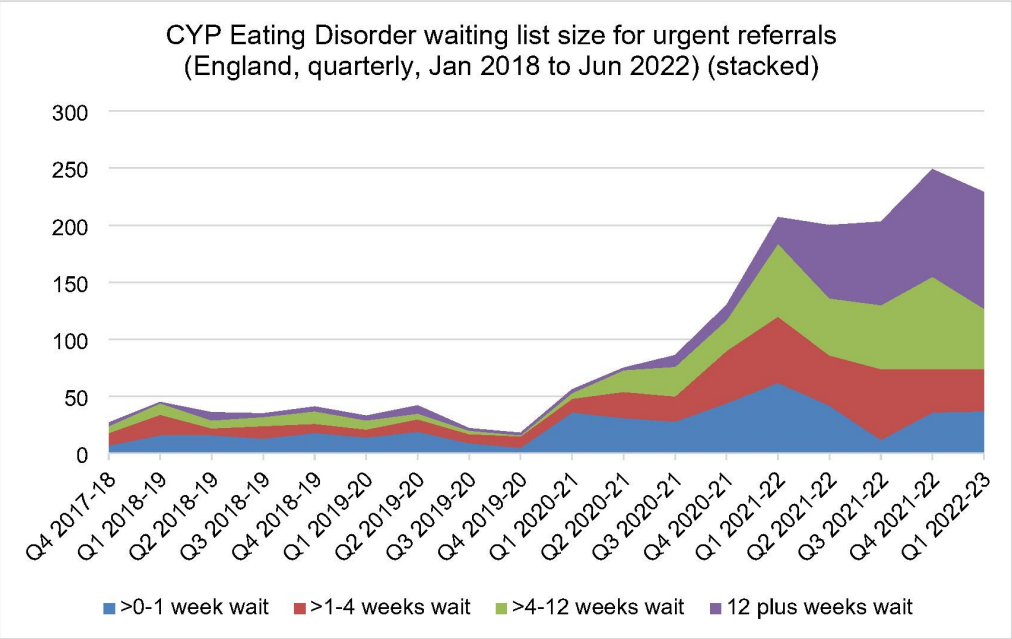
611. Graphs below show the significant increase in first assessments or treatments for CYP eating disorders, following urgent or routine referrals, following the onset of the pandemic in early 2021. Urgent first treatments increased by over 140%, from 353 in Q4 2019-20 to a peak of 852 in Q1 2021-22. Routine treatments increased by over 40%, from 1,850 to 2,600 in the same period.

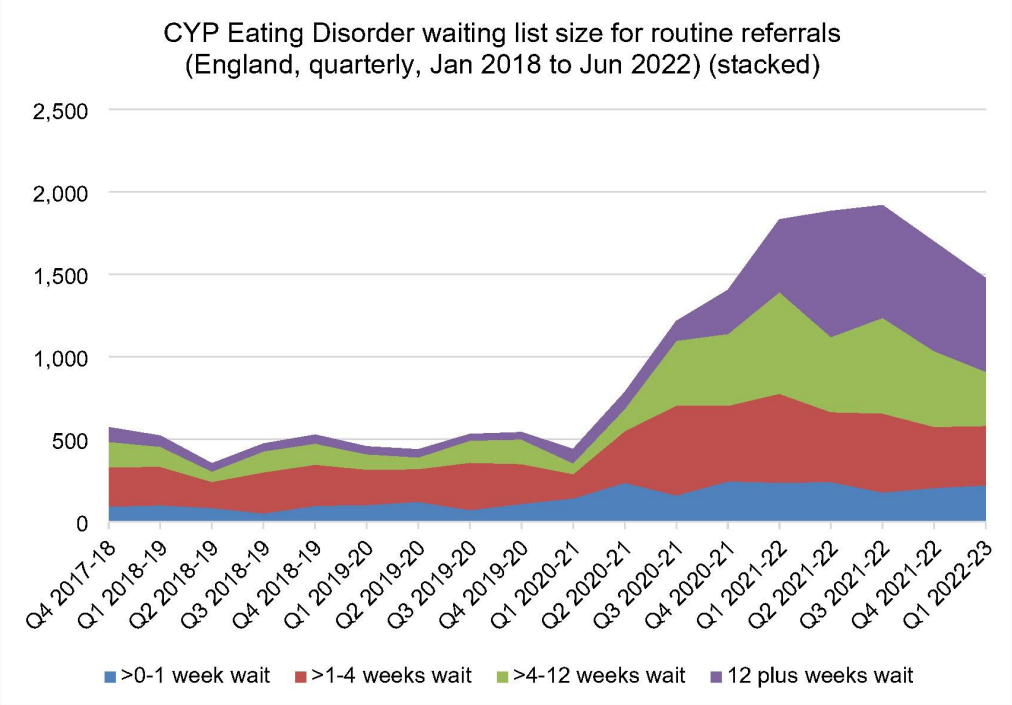




612. There was a corresponding increase in the size of the CYP eating disorder waiting lists. The urgent waiting list increased from 18 in Q4 2019-20 to a peak of 249 in Q4 2021-22. The routine waiting list increased from 543 in Q4 2019-20 to a peak of 1,918

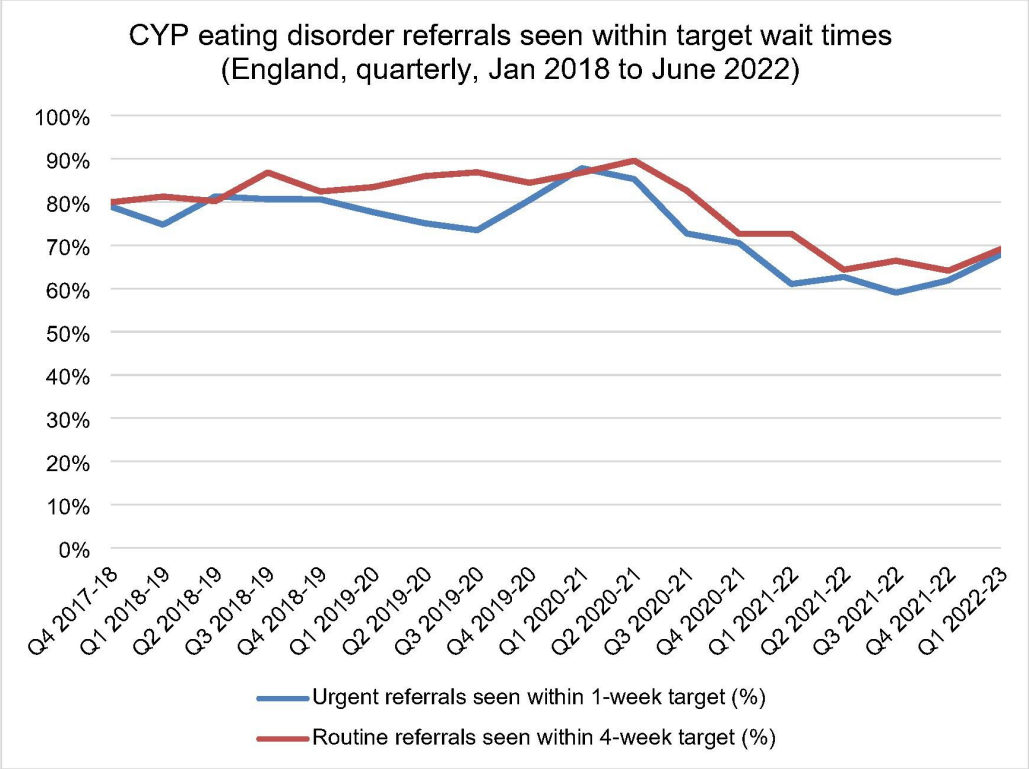
in Q3 2021-22.





613. Whilst the number of treatments and assessments for CYP eating disorders increased during the pandemic, this did not fully match the increase in referrals, so waiting times increased. The proportion of CYP seen within target wait times declined following the onset of the pandemic. In Q4 2019-2020, around 81% of urgent referrals were seen within the one-week target, declining to 59% in Q3 2021-22. 87% of

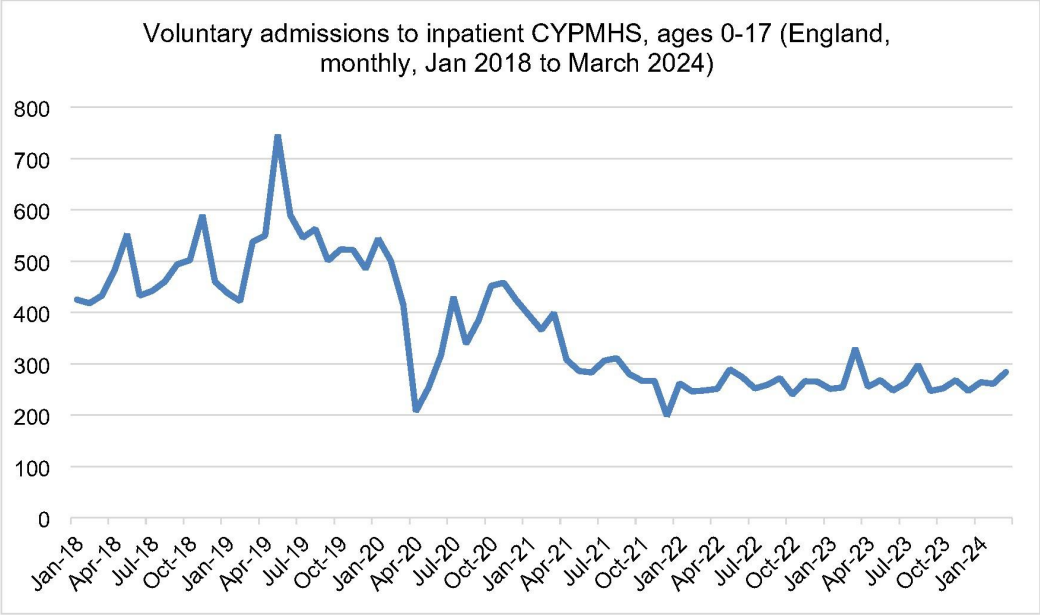
routine referrals were seen within 4 weeks in Q4 2019-2020, declining to 64% in late 2021. However, pressures on services declined slightly towards the end of the Specified Period, which led to improved wait time performance (but not to pre-pandemic levels).



CYPMH In-patient Services: Voluntary Admissions

614. MHSDS data shows the monthly number of voluntary referrals to CYPMHS inpatient services leading to an admission (for young people aged 0-17). Typically, the MHSDS cannot be relied on to make inferences about the total number of referrals, or the extent to which referrals were accepted.

615. Moreover, the decision to admit a young person to in-patient care is based on a complex clinical assessment, which accounts for multiple variables, including the individual's needs and preferences as well as the resources available to support them. Accordingly, it would be difficult to summarise the reasons 'why' patients were not admitted, in any aggregate data set.

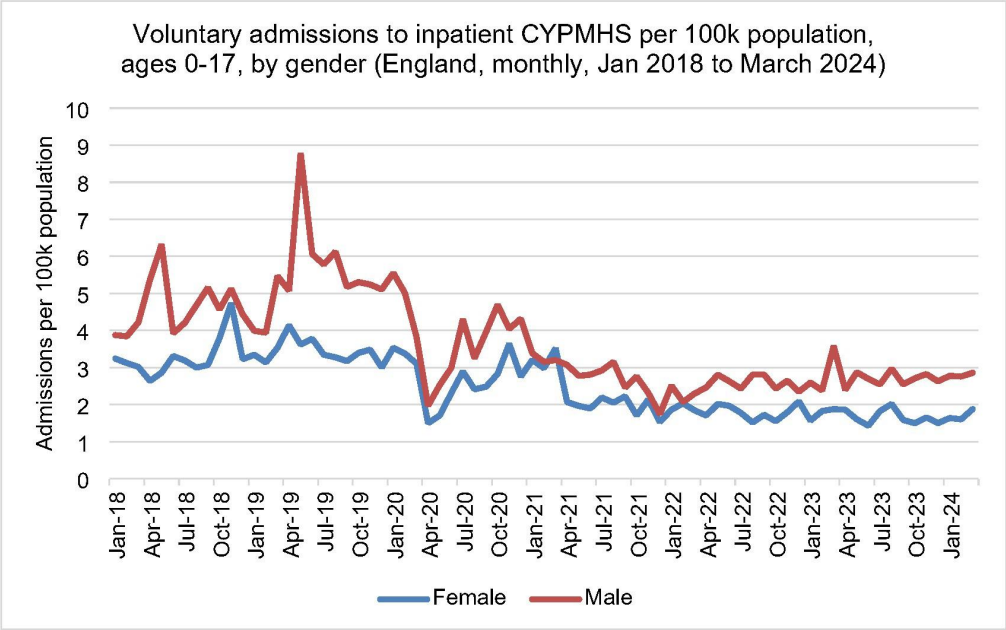


616. Monthly voluntary in-patient admissions declined steeply following the onset of the pandemic, from 544 in January 2020 to 207 in April 2020 (a decline of 62%). Admissions recovered slightly over the course of 2020 (to a peak of 458 in November 2020), but subsequently declined and stabilised to under 300 admissions per month.

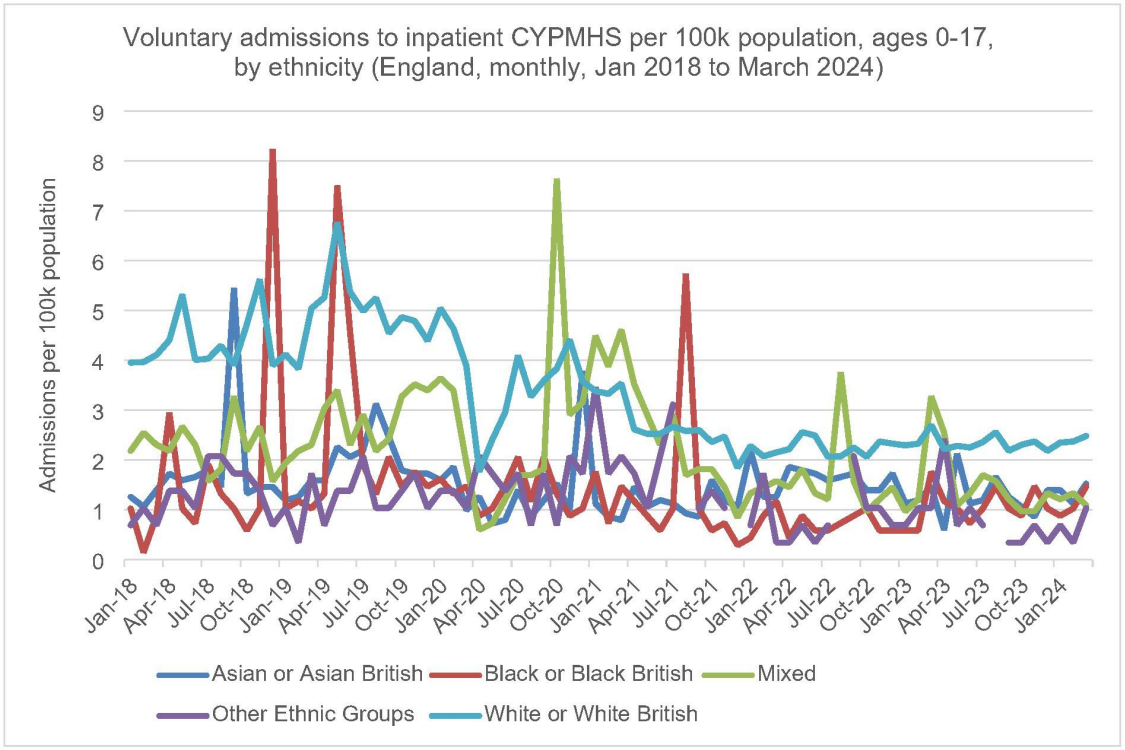
617. It may be that thresholds for in-patient admission were raised implicitly during the pandemic, either because of reduced workforce capacity (high vacancy rates and staff sickness) or more limited bed capacity due to IPC measures, or an increased reluctance to admit young people to units far away from home (given the increased restrictions on visiting and leave arrangements).

618. The increase in admissions in August and September 2020 coincided with an increase in presentations of autistic young people presenting with greater acuity than had previously been the case **[DB1/134][INQ000485275]**.

619. Male patients are consistently more likely to be admitted voluntarily to in-patient CYPMHS than female patients:



620. Voluntary in-patient CYPMHS admissions are generally higher amongst white and mixed-race patients, compared to patients from other ethnic groups. Admissions are also generally lower amongst young people from the most affluent backgrounds. However, it is difficult to draw strong inferences about race and deprivation, given the relatively small number of in-patient CYPMH admissions.


Voluntary admissions to inpatient CYPMHS per 100k population, ages 0-17, by ethnicity (England, monthly, Jan 2018 to March 2024)
Admissions per 100k population
0
1
2
3
4
5
6
7
8
9
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
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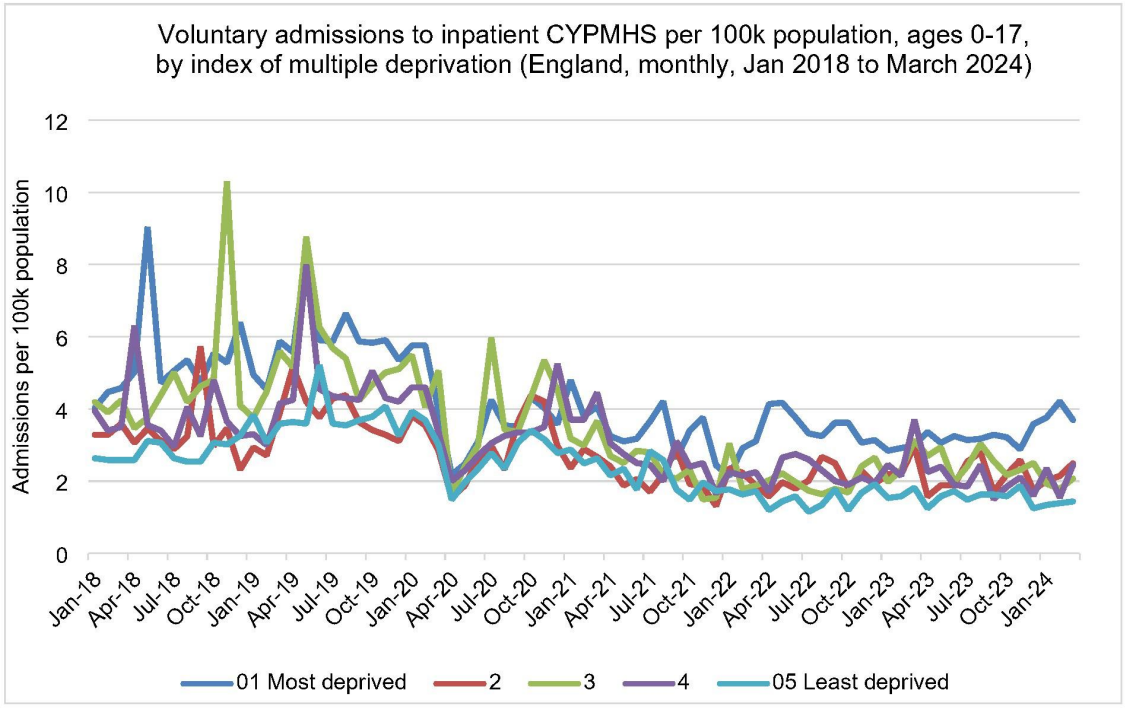
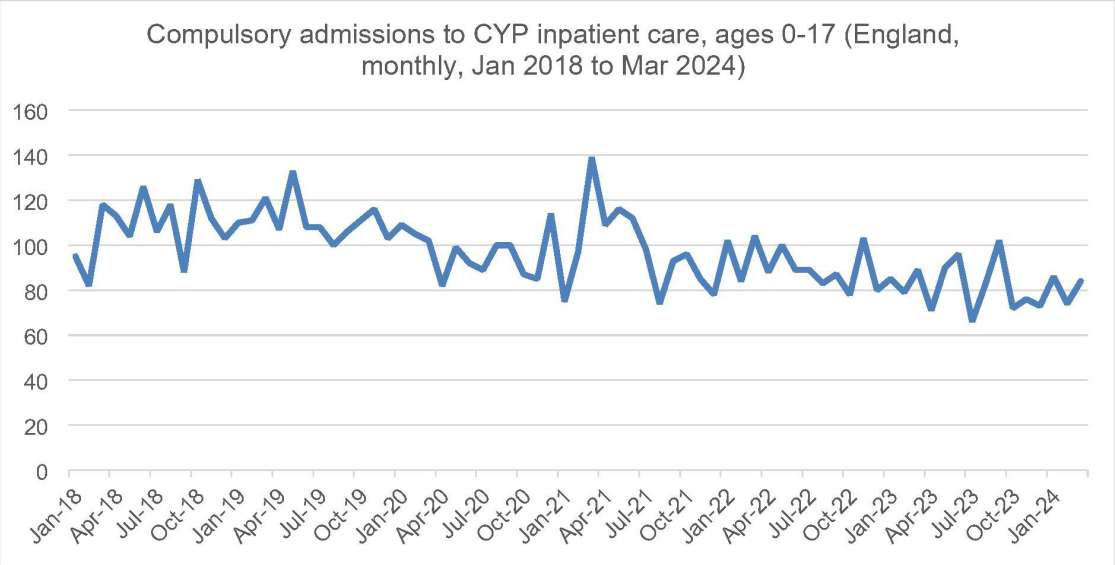
Jul-23
Oct-23
Jan-24
Asian or Asian British
Black or Black British
Mixed
Other Ethnic Groups
White or White British


Voluntary admissions to inpatient CYPMHS per 100k population, ages 0-17, by index of multiple deprivation (England, monthly, Jan 2018 to March 2024)
Admissions per 100k population
0
2
4
6
8
10
12
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24
01 Most deprived
2
3
4
05 Least deprived

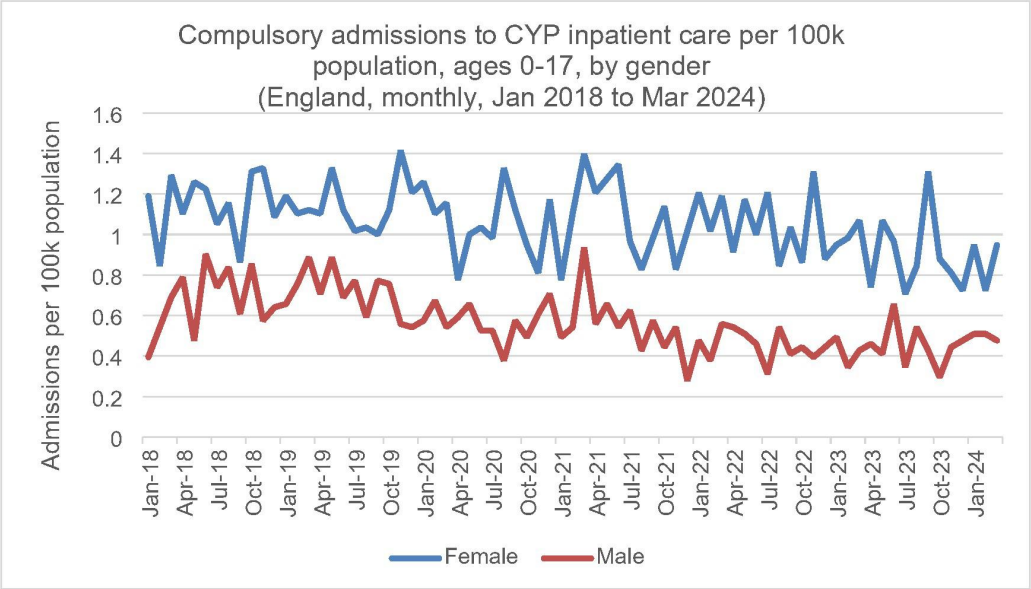
CYPMH In-patient Services: Compulsory Admissions

621. The MHSDS captures the number of young people admitted compulsorily to in-patient care, under provisions of the Mental Health Act 1983:



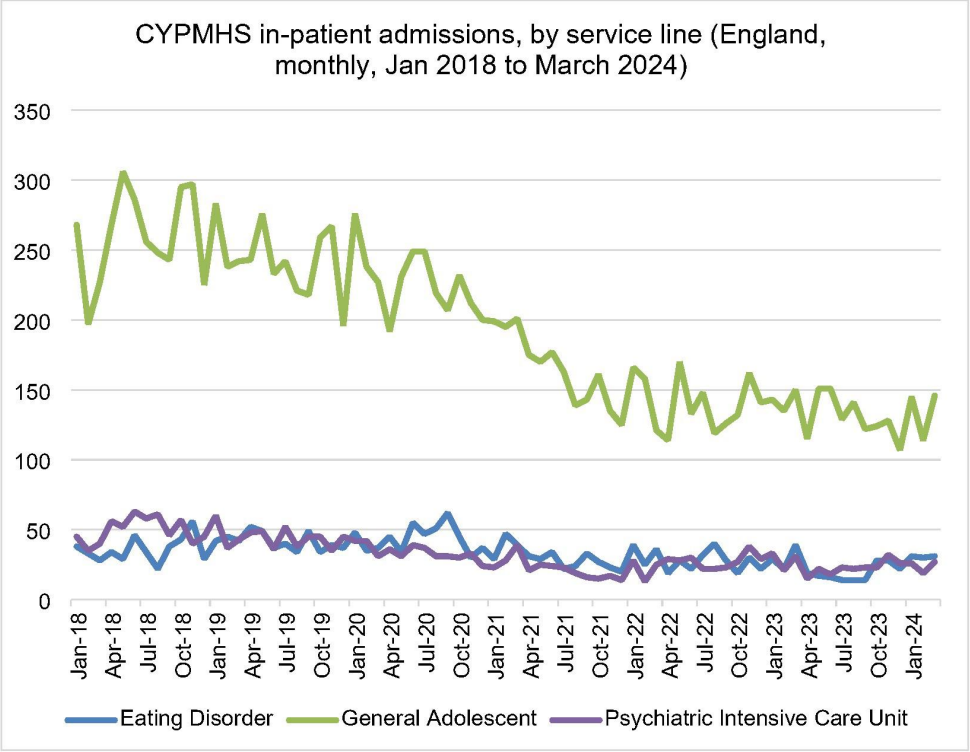
622. Compulsory admissions are relatively uncommon (ranging from 66 to 139 per month, in the period from January 2018 to March 2024). It is accordingly difficult to draw inferences about the extent to which any observed fluctuations, from during the Specified Period, were significant. The MHSDS does not record instances of young people being detained compulsorily in general paediatric wards, though these may have occurred.

623. Female patients are consistently more likely to be admitted compulsorily under the Mental Health Act 1983:



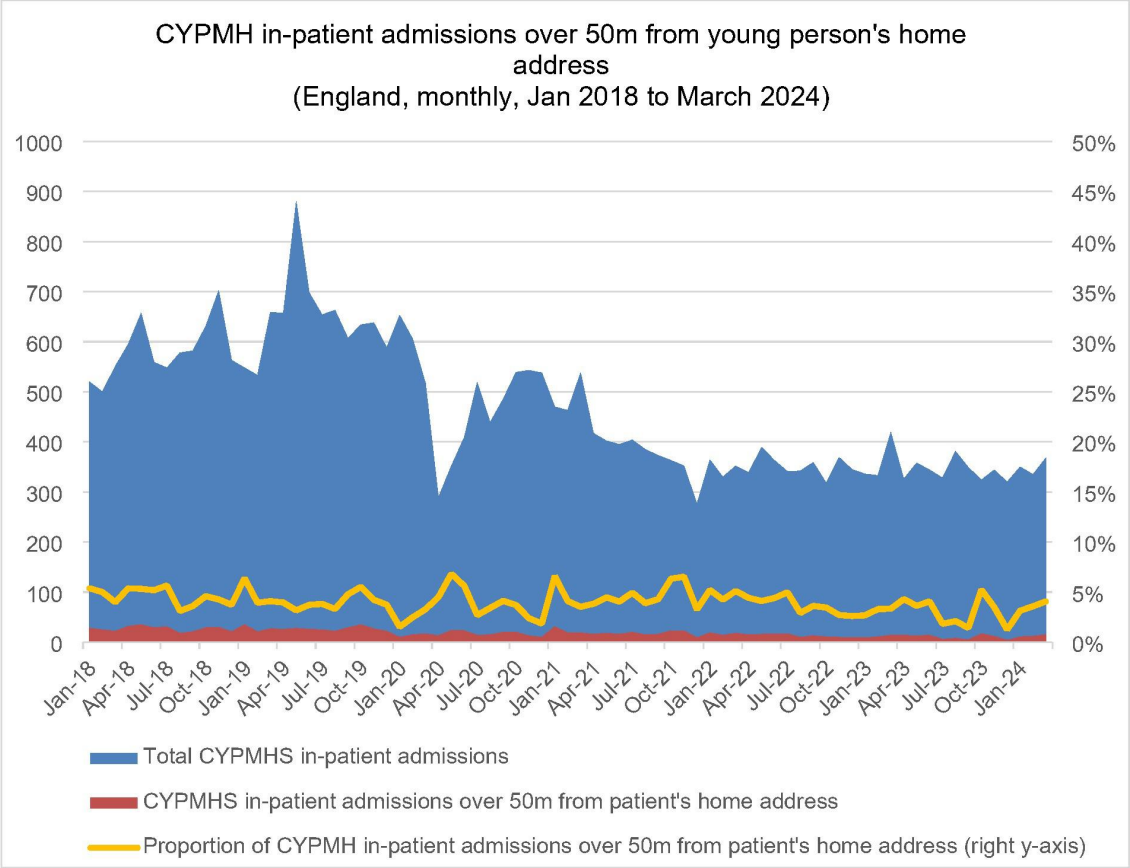
CYPMH In-patient Services: Admissions by Service Line

624. Admissions to general adolescent units form the majority of CYPMHS inpatient admissions, followed by eating disorder and psychiatric intensive care units. as shown in the graph below. These data do not include admissions to learning disability units, children's services, low-secure and medium-secure units, or units for deaf children, because of the small number of admissions to these services. These data also exclude a small number of data entries where NHS England does not recognise the unit as providing the relevant service.



CYPMH In-patient Services: Out-of-Area Placements

625. Young people admitted to in-patient CYPMHS should be treated close to home, so they can continue accessing their usual support networks. Provider collaboratives work to reduce the number of OAPs, where a young person is admitted to an in-patient unit outside of their usual local service network. NHS England collected data on the number of inappropriate CYP OAPs from July 2023. Prior to this, the MHSDS captured data on the distance between a young person's recorded home address and their in-patient unit. The graph below shows the proportion of admissions where the in-patient unit was over 70km (approximately 50 miles) from the patient's home address, from January 2018 to March 2024:



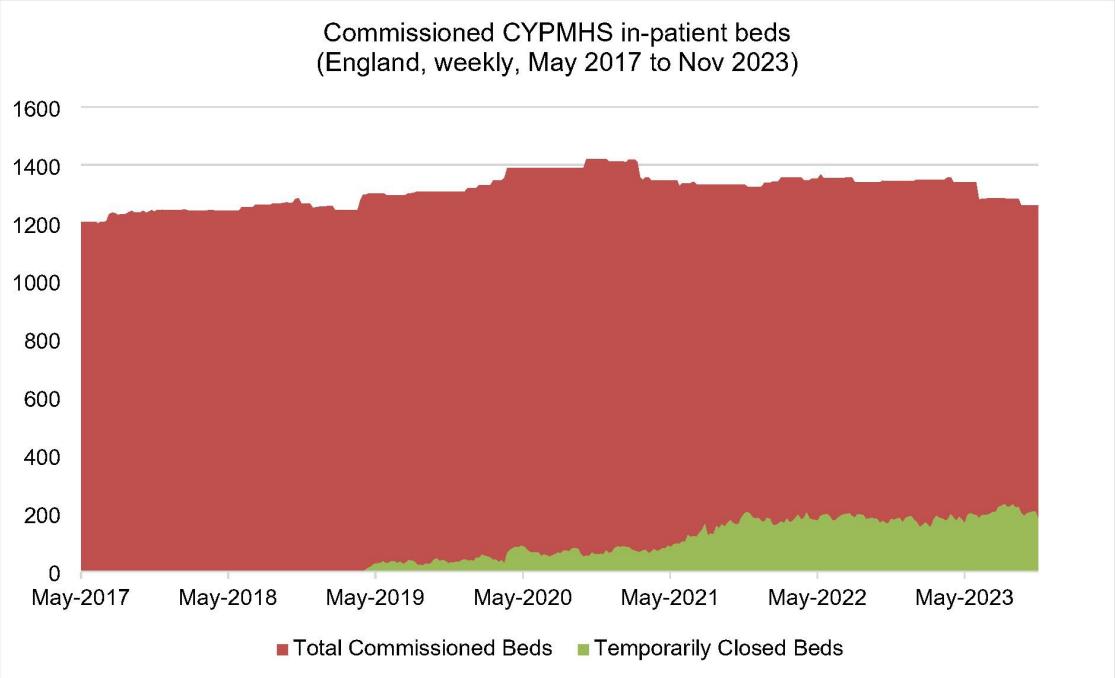
626. The graph above suggests that, prior to, during, and after the Specified Period, the proportion of in-patient CYPMHS admissions over 50 miles from a young person's home address did not fluctuate significantly, and remained consistently below 7% of all admissions.

CYPMH In-patient Services: Bed Availability & Occupancy

627. In 2016, NHS England undertook a review of in-patient CYPMHS beds. The review identified the need for an additional 115 additional beds; a costed bed expansion programme planned to achieve this by 2019. The programme was successful in opening a number of new units across the country, but as new services opened a significant number of CYP beds were closed permanently due to quality, safety and staffing issues **[DB1/135][INQ000485264].** Around 38% of CYPMH in-patient provision is in the independent sector, and 62% is in the NHS. There has been significant volatility within the CYP independent sector market, specifically.

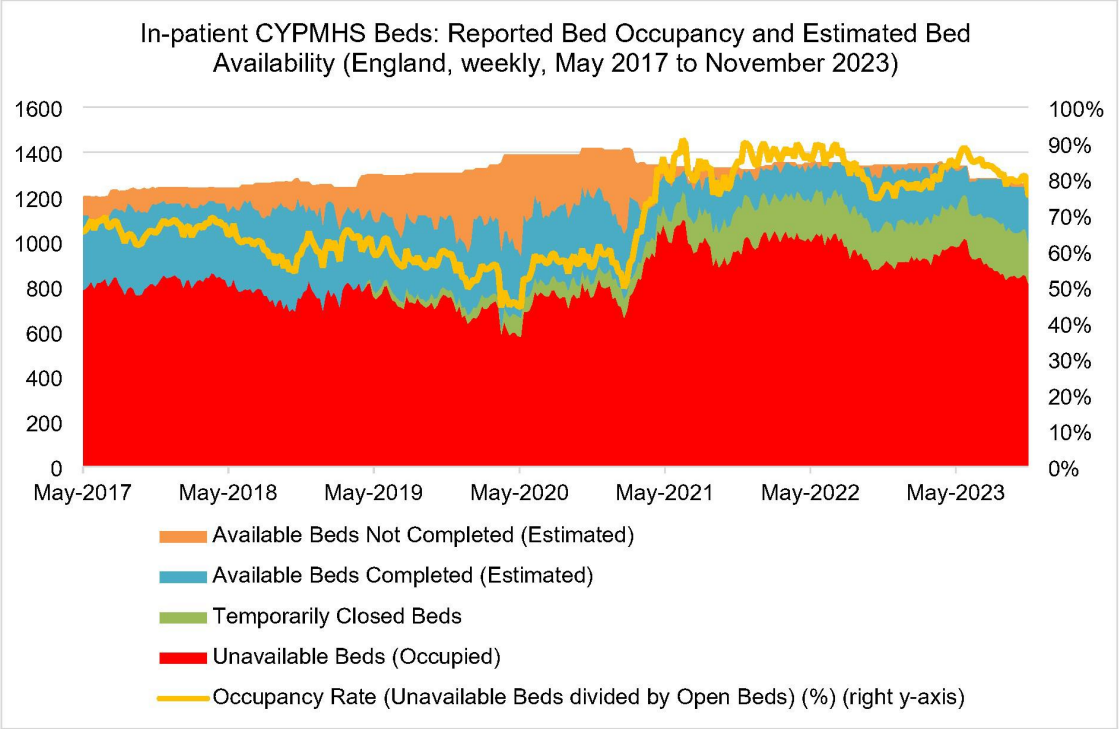
628. The CPMS captures data on the number of CYPMHS beds commissioned by NHS England. The graph below shows the total weekly number of commissioned beds,

from May 2017 until November 2023, including the number of commissioned beds that are temporarily closed. Note that figures prior to April 2020 are known to undercount the actual number of commissioned beds:



629. The graph indicates there were 1,389 NHS-commissioned CYPMHS beds from the end of March 2020 until October 2020. This increased to a peak of 1,419 in October 2020. From December 2020 until the end of the Specified Period, the number of beds declined (to 1,260 by the end of November 2023) and the number of temporarily closed beds increased (from 64 in the last week of March 2020 to 182 by the end of November 2023).

630. The graph below shows the availability and occupancy of NHS-commissioned CYPMHS beds, from May 2017 until November 2023. Note that, where a provider did not update their bed availability, the reported status of a bed defaulted to "available" (i.e. there was no patient in the bed, and it was available for admission). Of these beds, NHS England estimated the number which were genuinely available (labelled below as "available Beds Completed (Estimated)") and where the provider had simply not updated the system ("Available Beds Not Completed (Estimated)").



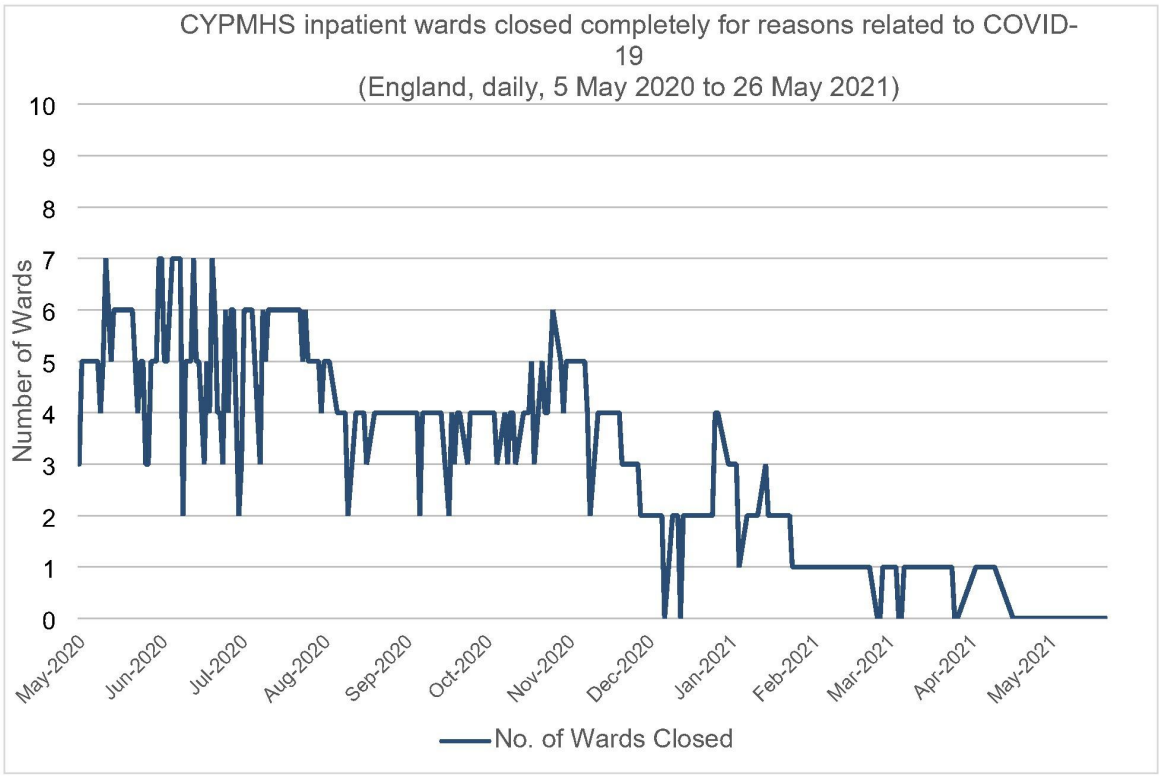
631. Following the immediate onset of the pandemic, in March-May 2020, occupancy fell below 40%. Occupancy rates increased thereafter, especially from early 2021. In June 2021, reported occupancy reached 90% - and it remained at over 80% until the end of the Specified Period, declining to 76% by November 2023. Note however, that data from April 2021 is believed to be more reliable. The apparent increase in occupancy rates may be attributable (at least to some extent) to improved data completion rates, rather than actual increases in bed occupancy. Likewise, in the period prior to early 2021, actual occupancy is likely to have been higher than reported.

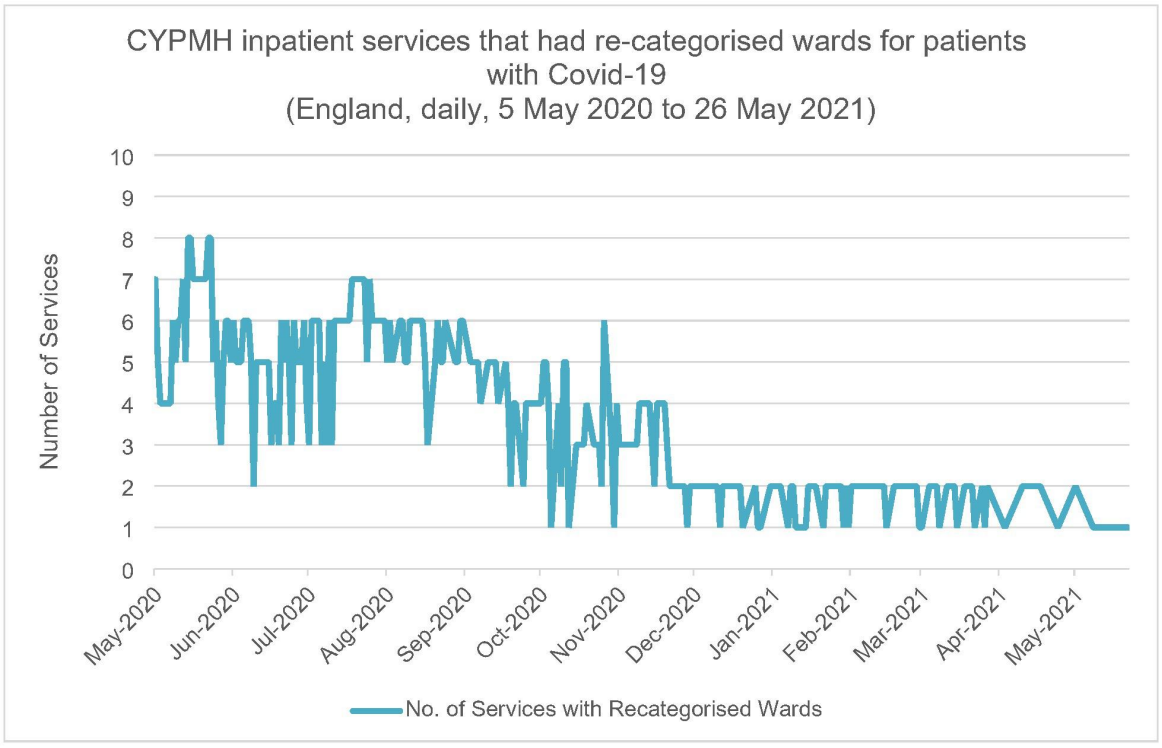
632. Not all unoccupied beds would have been available to patients. Some beds were closed due to staffing shortages in part due to infection control measures or vacancies, to help maintain social distancing, or because wards needed maintenance.

CYPMH In-patient Services: Impact of IPC Measures

633. Data from the NHS England 'Mental Health, Learning Disability and Autism Demand and Capacity' SitRep illustrates the extent to which services needed to be reconfigured, from May 2020 to May 2021, to protect young people and staff from the risk of Covid-19 transmission. SitRep data is collected on a rapid turn-around basis

for the purposes of managing services in 'real-time', so is subject to minimal validation – and is not intended for publication. The graphs below should therefore be treated with some caution.



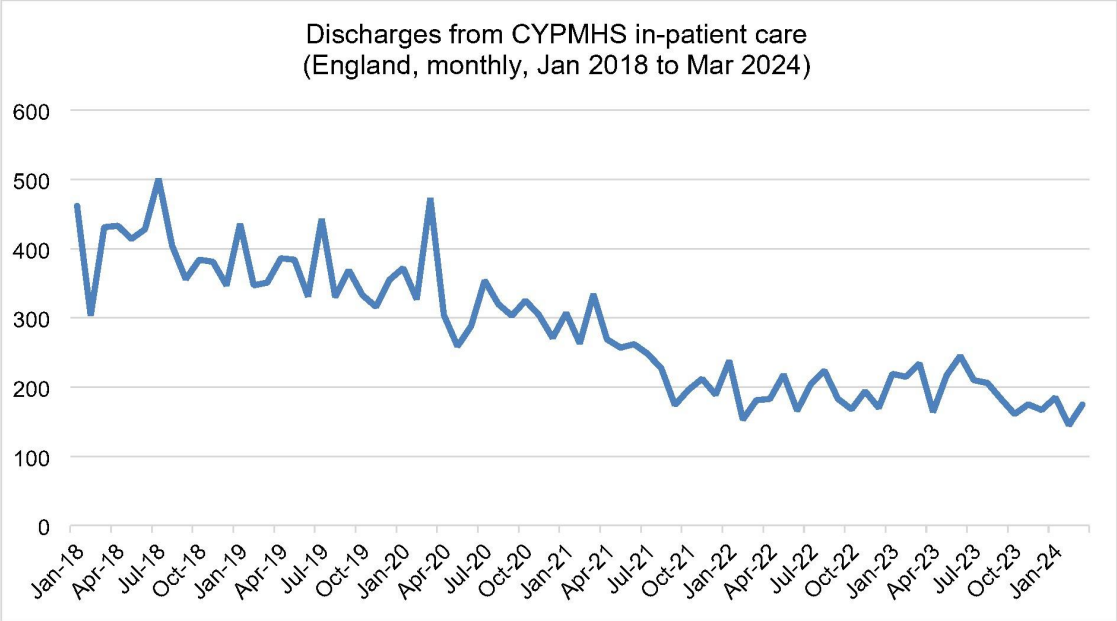


634. The graphs suggest that, during the summer of 2020, as the first Covid-19 wave subsided, between 2 and 7 CYPMHS in-patient wards were closed on any given day. Similarly, between 2 to 8 CYPMHS in-patient services reported having re-categorised at least one whole ward to care for young people with Covid-19. From August 2020 onwards, the numbers of reported ward closures, or wards being re-purposed, declined. The number of closed wards increased slightly in January 2021, during Wave 2.

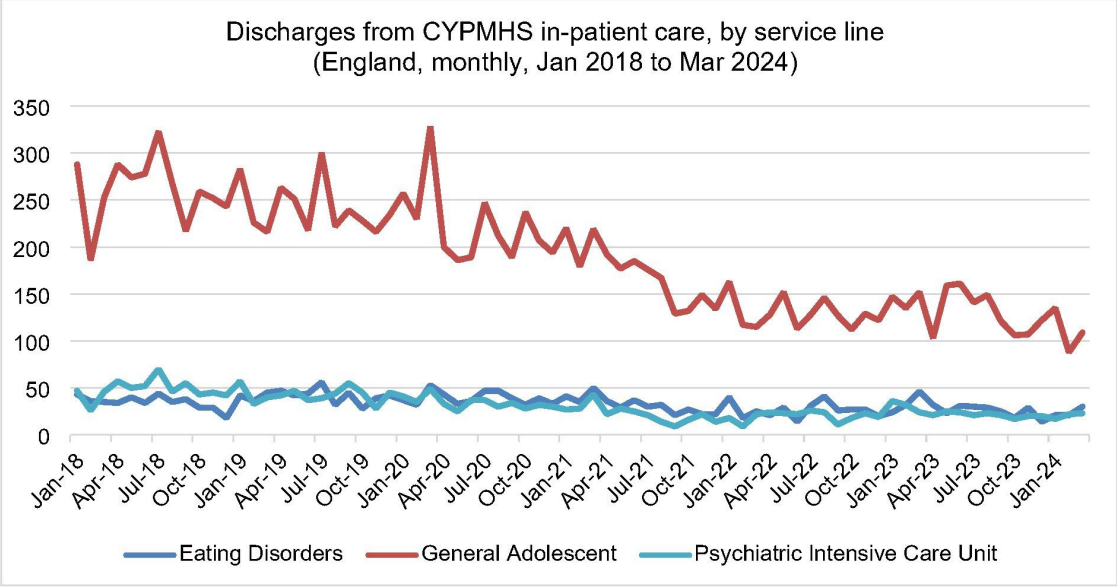
CYPMH In-patient Services: Waiting Times, Length of Stay, and Discharges

635. In England, there are no waiting time standards relating specifically to CYPMH in-patient care. Admissions to in-patient care have in the past sometimes been driven by a lack of appropriate community services, rather than a belief that in-patient care was the best treatment option for an individual. Accordingly, NHS England's efforts have focused increasingly on improving access to community services in such a way that decreases unnecessary reliance on in-patient services.

636. Data on CYPMHS in-patient discharges and length-of-stay ("**LoS**") is captured by the MHSDS. The graph below illustrates the sudden increase in discharges, following the immediate onset of the pandemic (rising from 327 in February 2020 to 472 in March 2020), and following NHS England's guidance to healthcare providers to discharge patients wherever possible, to free up bed capacity and to reduce the Covid-19 transmission risk. Thereafter, monthly numbers of discharges gradually declined to below pre-pandemic levels throughout the Specified Period, as admissions and bed occupancy also fell.

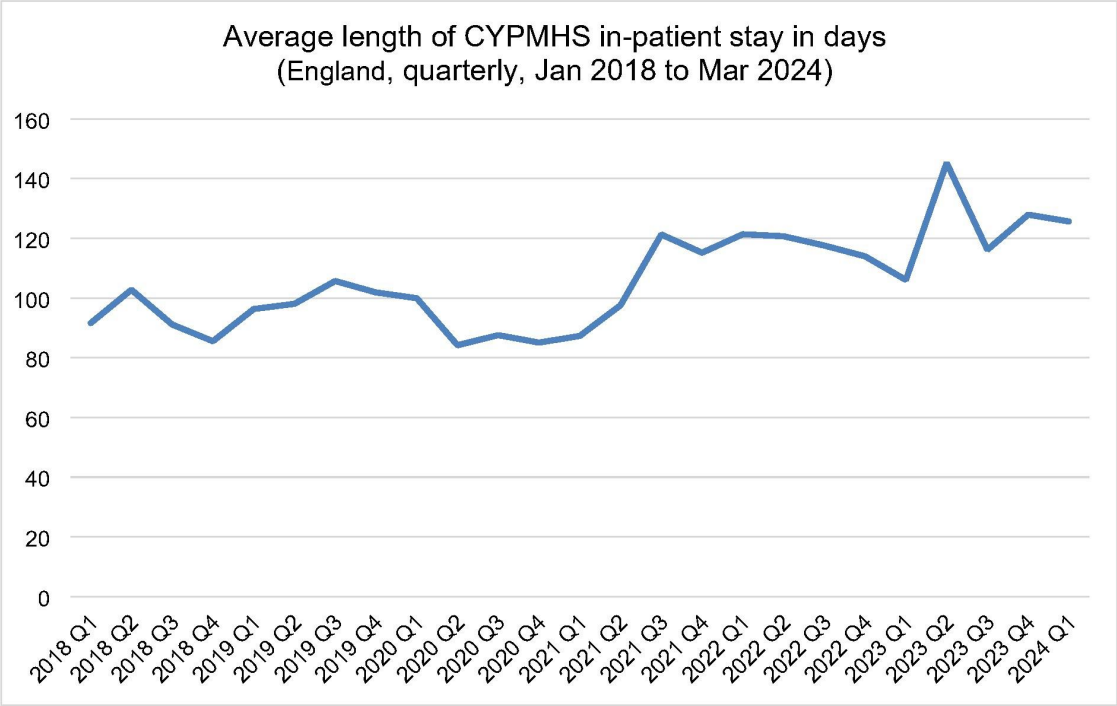


637. Overall changes in numbers of discharges are driven largely by general adolescent units, which comprise most in-patient CYPMHS admissions, as illustrated in the graph below. These data do not include admissions to learning disability units, children's services, low-secure and medium-secure units, or units for deaf children, because of the small number of admissions to these services.



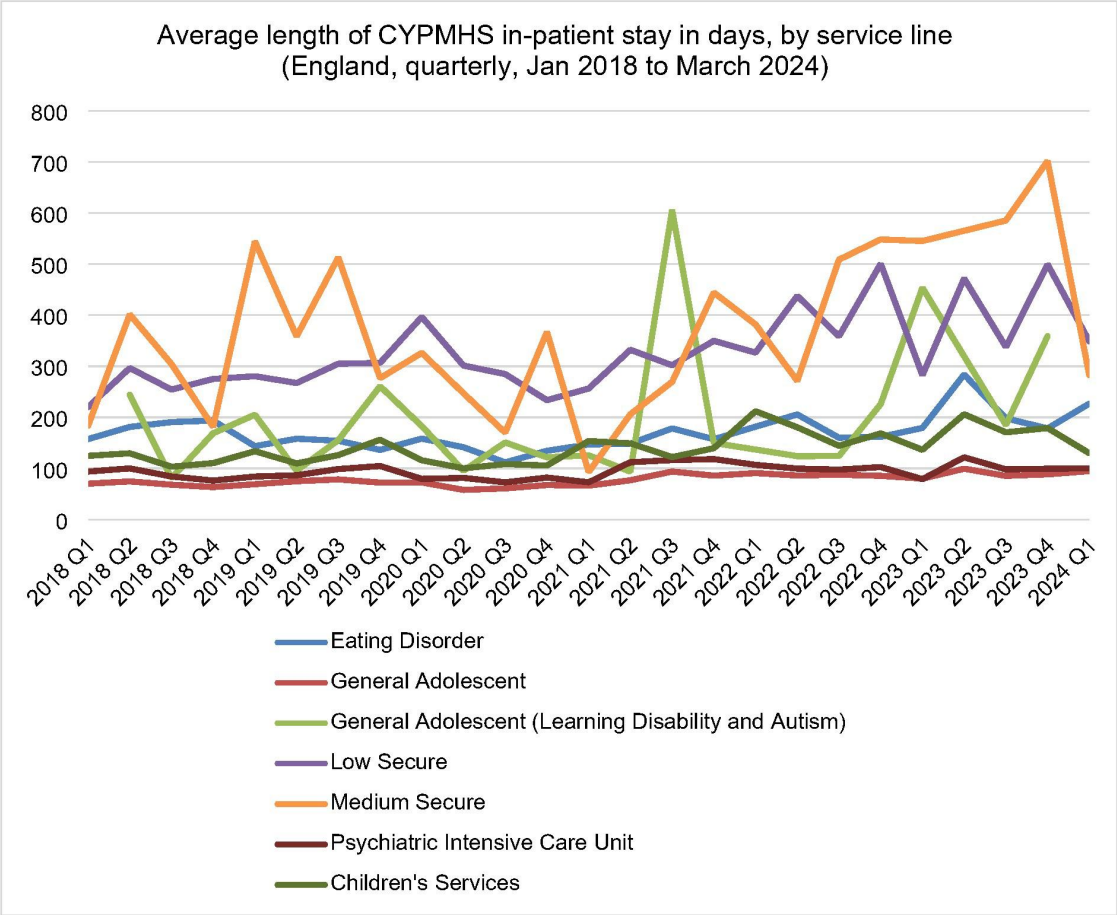
638. The mean LoS declined following the onset of the pandemic (from 100 days in Q1 2020 to 84 days in Q2), as more young people were discharged from in-patient services. LoS began increasing to above pre-pandemic levels from mid-2021 and remained higher until 2024. It may be that increased illness acuity and complexity

amongst patients, as well a lack of provision from community services and local authorities, has led to increased length of stay and discharge delays.



639. Note LoS varies significantly between different types of in-patient units: stays in low-secure and medium-secure units, and units for children with learning disabilities and autism, are typically much longer than in General Adolescent or psychiatric intensive care units. Overall mean LoS may be skewed by outliers, especially in the secure

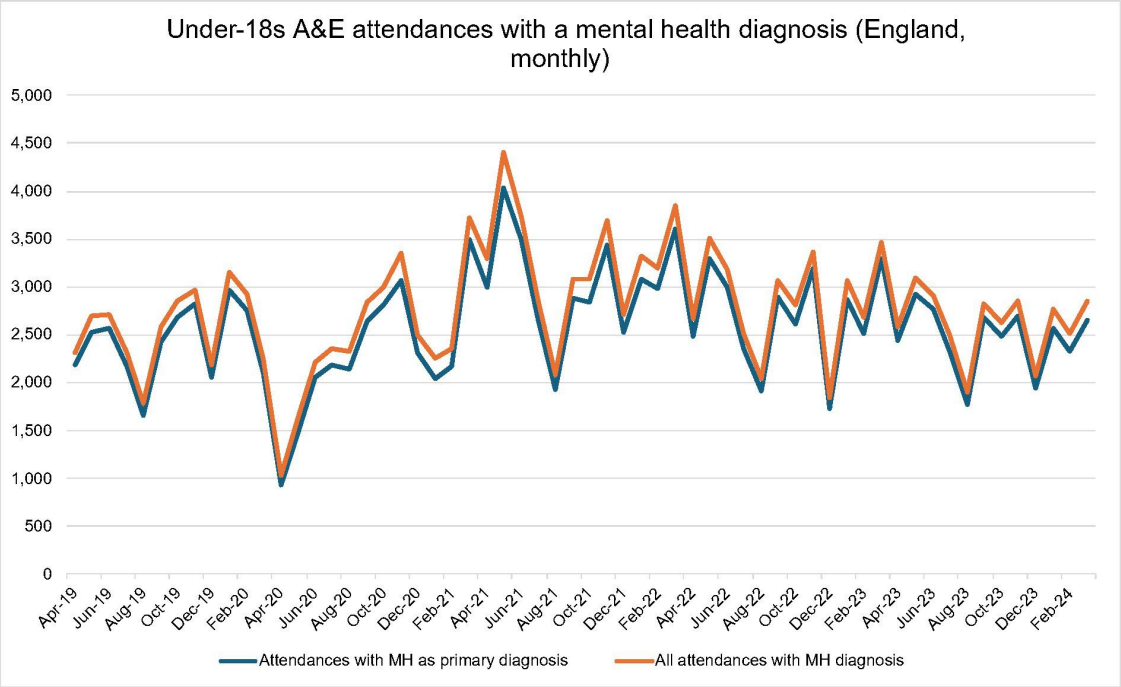
estate:

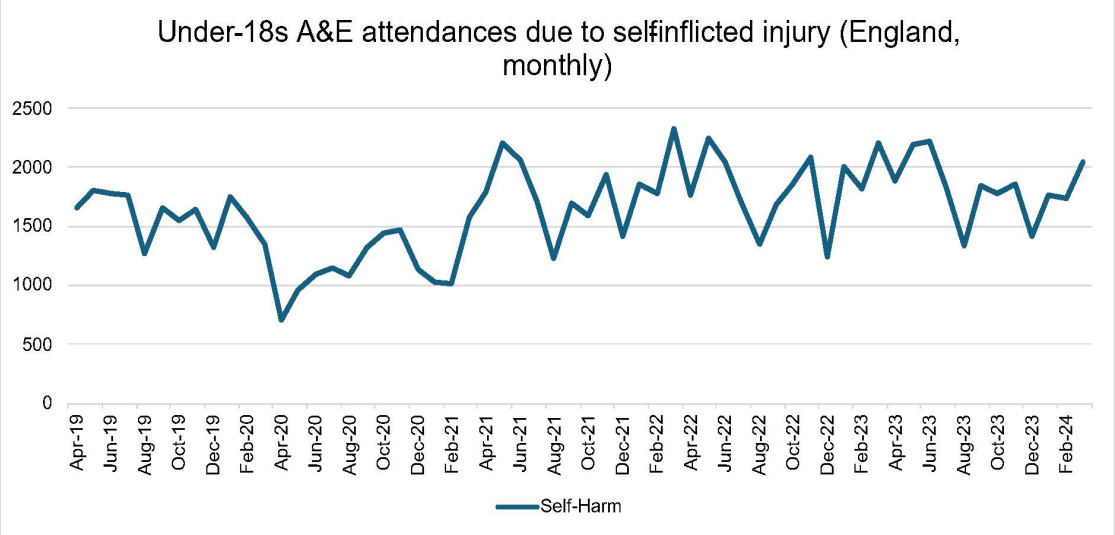


CYPMH presentation to UEC and general paediatric services

640. CYP experiencing an acute mental health crisis, or a physical health need arising from mental health problems (e.g. self-harm or eating disorders), may present to hospital emergency departments.

641. ECDS data shows the number of children who attended A&E departments, where the relevant diagnosis was related to mental health. Mental health problems can be assigned as a secondary diagnosis in ECDS, for example where a patient attends A&E for a physical injury arising from a mental health issue (self-harm for example).





642. In response to concerns around the number and acuity of CYP, both in mental health crisis and with physical health needs relating to mental health in acute settings, NHS England's NSA for CYP Transformation and the then NSA for CYP Mental Health co-led on a project on supporting improving integration between physical and mental health.

643. The project also worked with NHS regional teams, systems, Royal Colleges and professional bodies to ensure that the paediatric workforce:

a. is supported when caring for CYP presenting to hospital – emergency departments and paediatric wards – with acute physical and mental health needs, such as eating disorders or crisis presentations;

b. understand where to get additional support should the need it; and

c. working within a wider multi-disciplinary team and within a wider systems in providing support and care for CYP with acute mental health needs.

644. In February 2022, the NSA for CYPMH (as then was) contributed to the Royal College of Psychiatrists ("**RPsych**") Children and Adolescent Faculty's winter institute with a paper titled "*Supporting Children and Young People with mental health needs within acute and paediatric settings*".

645. It highlighted in particular the increase between 2016-2021 of admissions (an average of 495 admissions per month) of those with a primary diagnosis of a mental or behavioural disorder. This figure increased by 20% from 438 per month in 2016/2017, to 523 per month in 2019/2020. About 70% of admissions were following an emergency presentation, this increased to 80% in 2020/2021.

646. The GIRFT Report on CYPMH in 2022 called for the important role of acute hospitals in CYP mental health care to be clearly identified through commissioned arrangements, with A&E and paediatric staff given training to better understand and treat CYPMH needs.

Suicide

647. Suicide among CYP under 18 years is rare. Only around 2% of all suicides in the UK occur in CYP and only 4% of all deaths in CYP result from suicide, although rates are much greater in older adolescents. However, each death is, understandably, deeply distressing and an unimaginable loss for the young person's family and friends.

648. Reasons for suicide are complex and rarely ever caused by a single risk factor.

649. On 9 July 2020 NCMD published a briefing, which signalled there was a concerning signal that child suicide deaths may have increased during the first 56 days of lockdown; however, risk remained low and numbers were too small to reach definitive conclusions **[DB1/136][INQ000485253]**. NHS England highlighted the potential risk to CYPMHS providers, and reinforced public messaging that services were available to provide support to CYP and their families who needed it - via its key stakeholders, the

NHS England website, and blog posts. NHS England also continued to monitor NCMD data closely. Rates of deaths by suicide in CYP are now the same as pre-pandemic levels **[DB1/137][INQ000485272]**.

Changes in arrangements for service delivery – Community and In-patient

650. Across the CYPMHS sector, significant changes were made at pace to introduce videoconferencing and digital assessments, to help minimise the risk of Covid-19 transmission.

651. All-age open access 24/7 urgent mental health lines were established across the country. Using these lines children, young people, families and carers could get access to advice and support which could include early intervention techniques and, if necessary, triage via face-to-face assessments.

652. Bolstering crisis response services represented an acceleration of commitments set out in the NHS LTP. More generally, the NHS LTP and related programmes provided a solid foundation for delivery of CYPMHS during the pandemic.

653. CYPMHS providers and commissioners rapidly adapted to remote working in response to Covid-19, including frequent use of video consultations and digitally enabled therapy models. Levels of activity reflect strong adoption of digital consultations with approximately 20% of all contacts delivered through this medium in June 2020. 68% of all CYP contacts were delivered through alternatives to face-to-face contacts by February 2021 (compared to 54% of contacts in adult and older people MH services).

654. Although digital support is a valuable means of accessing some services, it should be seen as augmenting rather than replacing in-person support. Remote appointments do not work for everybody and there are particular issues in relation to their use with CYP. Remote assessments are not as effective as face-to-face assessments for assessing safeguarding risks, for example where the home environment or interaction between family members requires assessment, or where the young person's privacy within the family home is not assured. Some young people lack access to technology, or cannot afford it, or simply do not feel safe opening up online. Therefore, while face to face activity reduced significantly during the earliest stages of the pandemic, services were expected to move at pace to offer a blended model which offers choice to meet needs and that is clinically appropriate.

655. NHS England undertook an EHIA for video consultations in secondary care to capture potential impacts and identify options to mitigate them **[DB1/138][INQ000470539]**. This was followed by an EHIA specifically focused on CYPMH completed in March 2021 **[DB1/139][INQ000485259]**.

656. A guidance document published by NHS England to assist with the adoption of remote consultations across the NHS recommended that a clinical risk assessment should take place in all cases, with remote consultations only taking place where there was a low risk of impact to patient safety and outcome.

657. In addition to their use in direct patient care, video consultations have also been deployed to support meetings under the Care Plan Approach for CYPMHS and discharge meetings. The benefits of videoconferencing in adolescent in-patient units are potentially greater than in other in-patient units given the very large number of agencies that usually attend - for example, school, social care, CYPMHS, families, Youth Offending Services , drug and alcohol services, and youth workers. The ability to hold these meetings without attendance in person has led to better engagement by community teams and other agencies and promoted more rapid discharge. The same has been true of multiagency reviews in community CYPMHS: attendance and engagement improved, because remote meetings were more convenient and did not require travel.

658. In in-patient settings, a number of measures were introduced requiring a balance to be struck between preventing the spread of infection and maintaining an environment where individuals received the care and support needed - for example reducing home leave arrangements but increasing family contact through digital means **[DB1/140][INQ000610922]**. Another measure was cohorting. This involved allocating staff to a group of service users, thereby forming a cohort, and minimising contact between that cohort and others within the same location. Measures were taken to maintain social distancing between service users and staff, but there were circumstances in which this would be impossible or inappropriate.

659. Routine quality surveillance, undertaken by NHS England case managers and service specialists, also reduced significantly following the onset of the pandemic, to minimise the risk of Covid-19 infection. Face-to-face site visits were undertaken only where a risk was identified; NHS England teams interacted with providers remotely where possible.

Funding

660. There have been a number of funding initiatives over the last decade to improve access to and capacity and quality of CYPMHS.

661. In 2015 NHS England and the Department of Health published the "Future in Mind" report, setting out proposals for change to CYPMHS. This included proposals to increase funding and recruitment to the sector, but also to focus on early intervention including in schools and colleges.

662. The government then established a Mental Health Taskforce in 2016. Its remit included both CYPMHS and adult services. The Taskforce published its 'Five Year Forward View for Mental Health' in 2016. The Five Year Forward View included approximately 50 recommendations for the government and its partners to drive transformation through the system to achieve greater parity between physical and mental health. These drew on proposals from "Future in Mind". The Five Year Forward View for Mental Health was adopted by government in full, with NHS England as the leading delivery body. The government committed to investing an additional £1 billion in mental health services to provide increased access and better quality care to approximately 1m people by 2020/21.

663. When the pandemic began, the national programme was already taking a whole care pathway approach to mental health. This involved the creation of Local CYPMH Transformation plans in every CCG which included children, young people and families participation, with plans set out across health, social services, youth justice, the Voluntary and Community Sector. These plans set out how the new investment built on exiting systems to improve access to CYP's mental health community services, crisis services, dedicated evidence based CYP eating disorders community teams, for CYP with complex needs within the justice system, improving data capture and use of outcome monitoring in clinical settings, training commissioners across health and social care and for clinical services in best evidenced based care across a number of therapeutic modalities.

664. Local CYPMH Transformation partnerships were therefore in a good position to begin implementing the recommendations of "Transforming Children and Young People's Mental Health Provision: a Green Paper" **[DB1/165][INQ000624805]**. The Green Paper, which was jointly produced by DfE and DHSC expanded on Future in Mind by focusing on early prevention and intervention, including through the roll out of Mental Health Support Teams across schools and colleges. Prior to the pandemic the

programme was on track to deliver the planned improvements in access to community services, including to CYP community eating disorders services.

665. Essential regional leadership and coordination of the CYPMH Transformation initiative was provided by the programme investing in Clinical, Children's Services and Programme management in each region, enabling the sharing of good practice locally and nationally as initiatives developed in the regions were cascaded to other areas for example the work of the South East Region on suicide. Regional leads came together routinely with the national team and this infrastructure provided further local leadership and support to the CYPMH system during the pandemic.

666. The NHS LTP included additional funding for transformation of the mental health system. The overall commitment was to invest an additional £2.3 billion of ringfenced funding in mental health services to increase access and quality of care for approximately an additional 2 million people by 2023/24. Of this, £904 million was reserved for CYPMHS.

667. In July 2019, NHS England published the Mental Health Implementation Plan (2019/20 – 2023/24), which set out funding profiles over the five year period, transformation activities required of the system and indicative workforce profiles. The ringfenced funding was tracked using the Mental Health Investment Standard and transformation funding processes.

668. At the start of COVID-19, the Mental Health Team was nearing the 'end date' of the FYFVMH (due to end in March 2020) while delivering the new commitments in the NHS LTP. The majority of the commitments in these plans relate to system transformation (i.e. establishing new community mental health frameworks and services, increasing access to talking therapies (formerly known as Increasing Access to Psychological Therapies). NHS England created any relevant policy, flowed transformation and baseline funding, and assured delivery throughout the system. The majority of the deliverables were within the remit of the Mental Health Team, but there are also intersections with NHS England Health and Justice, Improvement Directorate and Specialised Commissioning teams.

669. The Mental Health Investment Standard is a requirement for each CCG to increase their planned spending on defined mental health services by a greater proportion than their overall increase in budget allocation each year.

670. Categories of expenditure which would count towards the Standard are defined in national guidance. This aims to prevent expenditure that does not support the achievement of key priorities being counted towards the total spent by a CCG. The permitted categories have been refined over time. For example, expenditure directly related to managing the risk of Covid-19 infection such as PPE did not count towards achievement of the Standard. Compliance with the Standard has to be validated by CCG auditors.

671. Additional funding was made available in response to the pandemic. The Spending Review of December 2020, covering the period April 2021 to March 2022, allocated an additional £500 million to address waiting times for mental health services, give more people the mental health support they need and invest in the NHS workforce.

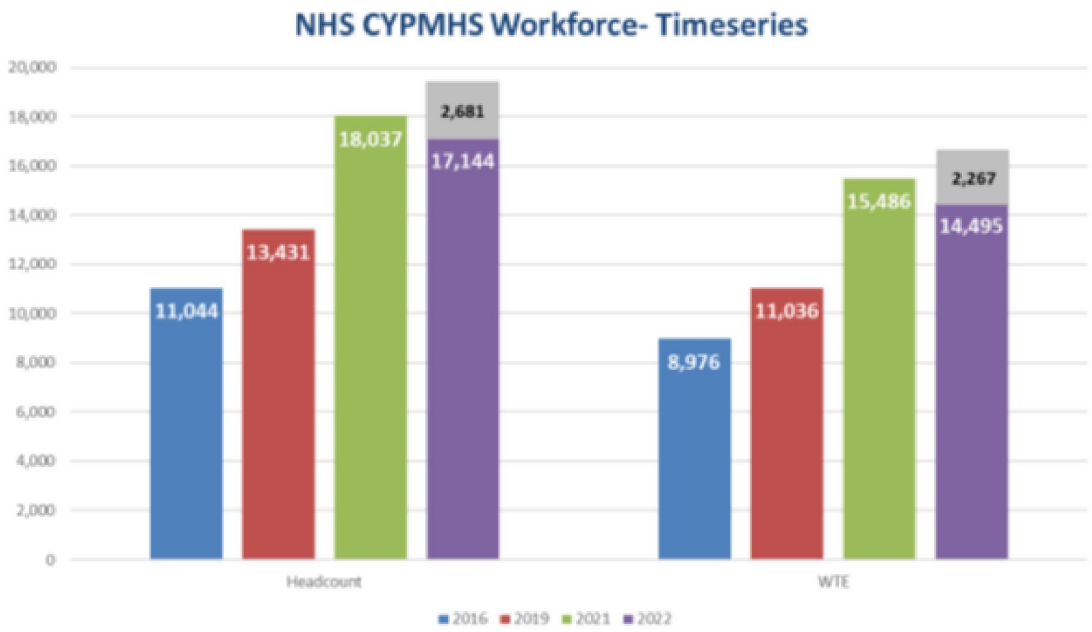
672. £79 million out of this £500 million amount was allocated specifically to CYPMHS. This funded measures such as improvements to access, crisis services, an expansion of capacity in eating disorders to meet demand and acceleration of aspects of the mental health Long Term Plan.

673. In addition, £10 million of capital funding over 2 years was repurposed from elsewhere in NHS England's specialised commissioning budget to support an expansion of in-patient CYPMH beds. A further £30 million from the specialised commissioning budget was allocated over 3 years to meet revenue costs of staffing and operating this expanded bed capacity.

Workforce

674. Expansion of the CYPMH workforce has been critical to meet the increased need for mental health support both prior to, during, and since the pandemic. In 2017, HEE published *Stepping Forward to 2021*: *the Mental Health Workforce Plan for England*. The plan focused on the health workforce changes required by 2021 to deliver the FYFVMH ambitions.

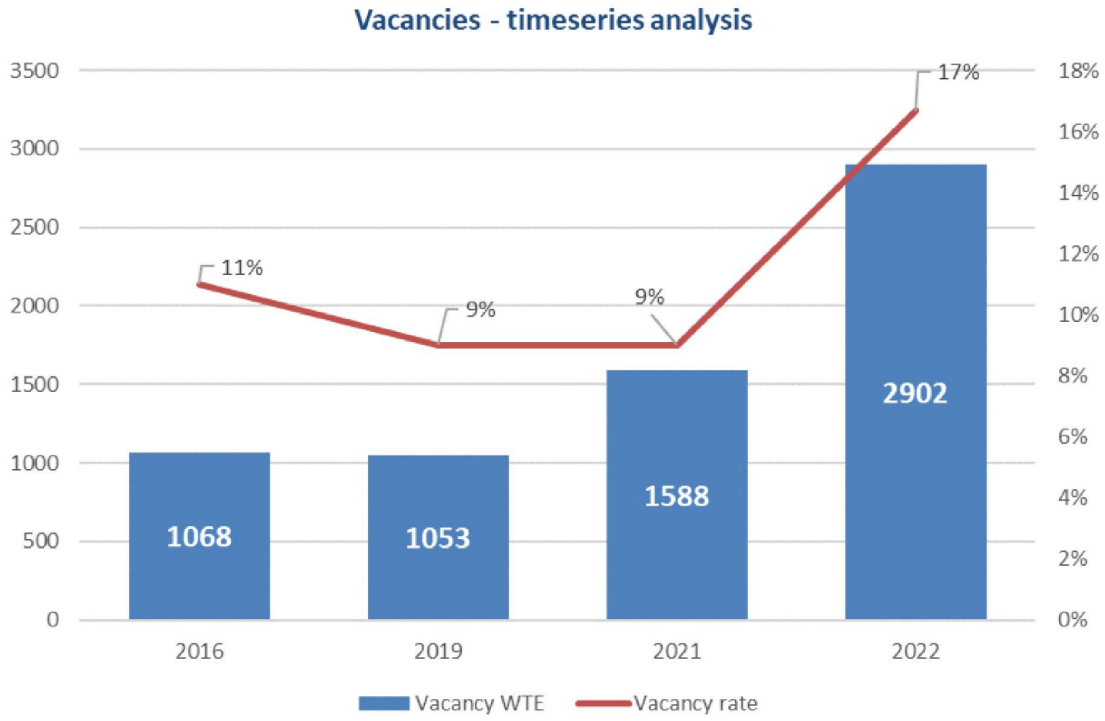
675. The NHSB has undertaken several national stocktakes of the CYPMHS workforce in England, on behalf of HEE (now merged with NHS England). Their 2022 census reported on the growth of the NHS CYPMHS workforce from 2016 to 2022, summarised in the graph below. NHS staff data for 2022 includes data extracted from 10 organisations who had not submitted data to the project (represented in grey). Note that this data excludes staff in independent sector providers:



676. NHS CYPMHS providers, covering both in-patient and community care, reported a 10% increase in headcount and an 8% increase in WTE staff in 2022, compared to 2021. This represented a slower rate of growth than reported between 2016 and 2019 (headcount 21%, WTE 23%) and between 2019 and 2021 (headcount 34%, WTE 40%), even accounting for the different lengths of time between each census.

677. The funded establishment (total WTE in post plus WTE vacancies) increased by 16% between 2021 and 2022, suggesting that the slow workforce growth was impacted by poor recruitment and turnover challenges.

678. The graph below shows changes in the reported number of vacancies, and the vacancy rates, across the NHS CYPMHS workforce:



679. The vacancy rate in 2021 was 9%, the same as in 2019, prior to the pandemic. However, 2,902 vacancies were reported in 2022 almost double the number reported in 2021 (1,642), so the vacancy rate rose 8 percentage points to 17%. Vacancy rates were highest amongst nurses (30% in 2022, 14% in 2021), followed by support workers (17% in 2022, 6% in 2021) and psychologists (15% in 2022, 10% in 2021).

680. Additional NHSB data suggests that, in FY 2021/22, the number of WTE staff for every 10 CYPMH in-patient beds (including staff in the NHS, IS providers, local authorities and youth offending teams) increased to 45, (compared to 43 in 2020/21). The vacancy rate was 25%, compared to 20% in community providers.

681. NHSB data also suggested there had been a decline in the number of in-patient CYPMHS staff remaining in post for longer than six years: This may have been influenced by the expansion of community CYPMH services and opportunities for career progression for staff. However, this may have impacted on clinical experience within these environments with greater changeover of staff.

Time in post	2016	2019	2021	2022
Under 1 year	29%	35%	29%	38%
1-5 Years	42%	43%	51%	43%
6-10 Years	13%	12%	9%	8%
11+ Years	17%	10%	11%	11%

682. NHS England, HEE and Higher Education Institutions mitigated training delays during the pandemic through a rapid shift to remote training delivery, including for in-patient staff (whole team training and additional modules to support patients with eating disorders and autism).

Reports and Reviews

The Getting It Right First Time (GIRFT) Report of April 2022

683. The GIRFT programme hosted by NHS England published a national specialty report on CYPMHS in April 2022. The report was based on findings from face-to-face 'deep-dive' visits to provider collaboratives across England starting in August 2020. The report relied primarily on data collected in 2018/19 (prior to the pandemic), so was not able to consider the longer-term impact of Covid-19. The report considered long term trends in services as well as impacts specifically related to Covid-19. Key recommendations from the GIRFT Report include:

a. Better access to intensive community support teams: Ensuring young people receive the right treatment close to home and making sure their family, social and educational networks do not break down. Intensive community support teams (ICSTs) help prevent patients from entering crisis in the first place, potentially avoiding admission to a psychiatric hospital. As part of a range of recommendations for establishing a seamless and effective crisis and community service, GIRFT recommended that all providers and commissioners invest in establishing ICSTs to offer early intervention and treatment to high-risk young people.

b. Ensuring acute hospitals are part of the crisis pathway: 78% of young patients access support via A&E or a paediatric ward in the six months before their admission to an adolescent psychiatric in-patient unit. The GIRFT report called for the important role of acute hospitals in CYP mental health care to be clearly identified through commissioned arrangements, with A&E and paediatric staff given training to better understand and treat CYPMH needs.

c. Reducing the use of restraining practices: The GIRFT review found that the use of seclusion, restraint and prone restraint in CYPMHS in-patient units was more than five times higher than in the adult equivalent, with significant variation between providers. However, the use of restraint for young people who had been victims of trauma has been shown to result in a longer recovery time. The GIRFT report offered practical examples of best practice for reducing the use of restraint and recommended that all providers had clear plans in place to reduce incidence of restraint, prone restraint and seclusion by 10% year on year. Data collection on restraint episodes should also be improved.

d. Reducing the length of time patients spend in a general adolescent unit: Around 4,500 CYP are admitted to CYPMH in-patient units each year, with an average cost of £77,000 per admission. Average LoS varies from 30 to 111 days, depending on the provider, but 39% of young people spend 60 days or more in a unit. The GIRFT report recommended that future investment should be focused on alternatives to admission. It called for providers, commissioners and the new NHS-led provider collaboratives to develop clear strategies to reduce 60-day+ LoS, including rapid access to therapeutic support on the in-patient unit and the ability to ensure a rapid discharge from hospital with support in a community setting.

Reflections

684. Pandemics impact on CYP and their families in many different ways. Their reactions and response can be influenced by the nature and extent of their exposure, personal characteristics, pre-existing vulnerabilities and strengths - particularly, family and social support.

685. The pandemic has had a significant impact on the mental health needs of CYP in England and subsequently increased demand for CYPMH services. The NHS in England was changing service models and expanding access to services ahead of the pandemic and continued to do so through the Specified Period and beyond. This underlines the importance of continuing in the programme of expansion and transformation as CYP needed, and will continue to need, support for their mental health across the spectrum of need – from prevention and support from universal services, to support in the community, from early targeted help in schools and colleges, to specialist NHS CYPMHS, and acute and in-patient care.

686. There were a number of challenges to the delivery of in-patient and community CYPMHS while trying to limit the spread of infection. Guidance and resources have now been developed that can be shared with stakeholders for any future event covering a range of practical and clinical considerations from infection control measures to how to adapt existing processes to ensure provision of accessible quality care.

687. The pandemic also highlighted that there were inherent risks with the model of specialised care for CYPMH which was based on a predominantly in-patient model delivered at a multi-ICB or regional level. Pandemics can have a significant impact on access to in-patient care through reduced bed capacity. Access to support networks is also limited by infection control measures. This was partly mitigated by the introduction of digital technology which widened the scope for contact opportunities. There was also recognition of the negative impact of blanket restrictions within units and the need to personalise care for individual CYP. Through the pandemic, providers did and have continued to deliver specialised services through alternatives to in-patient care such as day patient and intensive community outreach.

688. A new NHS England model for CYPMH specialised services will have a greater focus on localisation of service delivery and the need to offer services in the least restrictive settings, for example through day patient and intensive community models of care, especially for CYP with eating disorders.

689. It is recognised that this large scale transformation programme will take time and additional resources to achieve.

690. The pandemic saw the delivery of CYP cover for all-age crisis lines: Covid-19 encouraged the mental health sector to progress this change in weeks, when it was anticipated to take several years. Work continues to ensure 100% coverage of comprehensive CYP crisis services across the country, which is critical to reducing the reliance on specialised services, including in-patient care.

691. Increased choice in delivery of support, including digital support, saw a rapid transition during the pandemic, with colleagues adopting and embracing innovative practice, including delivering assessments and therapy via online delivery tools. This digital infrastructure has now been well established within CYPMH providers and is able to rapidly respond to future pandemics to sustain delivery of care for CYP, especially within a community setting. However, the pandemic has also highlighted the need to ensure digital advancements do not widen health inequalities through

digital poverty, and the importance of supporting staff training and considering patient choice, including where digital contacts may not be the most appropriate form for the child or young person.

SECTION I - LONG COVID

692. "Long COVID" (or "post Covid syndrome", as it sometimes known) is a condition which is highly likely to be a direct consequence of SARS-CoV-2. The existence of a significant cohort of patients with symptoms which did not resolve only became apparent after large numbers of individuals had been exposed to the virus and developed Covid-19, towards the end of the 'first wave' of the pandemic.

693. Whilst NHS England has learned a great deal about Covid-19 since the start of the pandemic – and new treatments are available – the long-term effects of the illness can be debilitating, even for young, fit people, or those who did not go to hospital when they had Covid-19 symptoms initially. In March 2022, the Office for National Statistics ("**ONS**") Survey found 1.7 million people living in private households (2.7% of the UK population) were experiencing self-reported Long COVID. Fatigue was reported as the most common symptom. As a proportion of the UK population, prevalence of self-reported Long COVID was greatest in people aged 35 to 49 years, females, people living in more deprived areas, those working in social care, teaching and education or health care, and those with another activity-limiting health condition or disability.

694. It is worth observing that scientific understanding of the long-term sequelae of Covid-19 is a developing area. It is still unclear whether there is one underlying mechanism of Long COVID, or whether it is a collection of different conditions, and it may be more appropriately addressed in a broader sense by expert evidence.

695. This chapter sets out information relating to the steps NHS England took in respect of:

a. recognition of Long Covid in CYP and provision of CYP Long Covid services;

b. ways in which symptoms and treatment of Long Covid in CYP are different to in adults;

c. mechanisms for gathering, analysing, and disseminating data on the way in which Covid-19 affected CYP in particular;

d. resource allocated to research and treatment of Long Covid; and

e. data on the number of children in England with Long Covid or other long-term sequelae.

f. Recognition of Long Covid in CYP and provision of Long Covid treatment services for CYP

696. As explained in more detail in Professor Powis' Fourth Witness Statement **[DB1/141][INQ000485652]**, NHS England's understanding of Long Covid evolved significantly over the course of 2020.

697. NHS England launched the first phase of the online portal "Your COVID Recovery" on 5 July 2020. This was a website containing information to support people suffering from the longer-term effects of Covid-19 **[DB1/141][INQ000485652].**

698. In October 2020, NHS England announced £10 million to establish Post COVID services. This money was aimed at providing service for both adult and CYP. By April 2021 90 Post COVID assessment services had been established.

699. Although the October 2020 plan did not explicitly emphasise the needs of CYP with Long Covid, paediatric services and CYP fatigue services were seeing CYP with Long Covid symptoms from June/July 2020 and regional planning for service evolution started in November 2020 (for example with a task and finish group in London) which was fed in to the work of the Long Covid National Taskforce from the outset.

700. By June 2021 NHS England committed to establish 15 hubs for CYP with Long Covid in the NHS England Long Covid plan for 2021 quarter three. These hubs built on existing paediatric services to extend reach and access to clinical expertise in this new clinical field.

701. CYP Long Covid hubs were established to provide access to specialist advice and guidance regarding assessment and treatment. General paediatricians managing CYP with symptoms of Long Covid were able to access specialist advice and support from the specialist hubs to enable patients and their families to access care and treatment locally wherever possible. Under this model, CYP would continue to have their care delivered as close to home as possible with access to specialist advice.

702. The overall approach was that NHS England would create a CYP steering group and thereby gain input from clinicians working with CYP with Long Covid to support understanding of the most appropriate and proportionate way to provide assessment and treatment for CYP with ongoing effects of COVID-19. The Long Covid CYP Steering Group met regularly from May 2021 onwards, and consisted of clinicians

with experience of Long Covid from across the regions, academics and members of the CYP Team.

Symptoms and treatment of Long Covid for CYP

703. Presentation of Long COVID in adults and CYP is largely the same with dominant symptoms being fatigue, breathlessness, cognitive effects, new allergy, pain and dysautonomia (a condition in which a part of the nervous system does not work properly). In children increased risk has been reported in neurodivergent individuals. Assessment of functional impact in CYP needs to include parents and carers and give consideration to the impact on education and how to best mitigate this.

704. As in adults, treatment requires a holistic MDT assessment and therapy-based interventions around physical and mental health taking a symptoms based approach. Some medicines are used to help manage specific symptoms but there is not currently a licensed treatment for the overarching condition.

705. The commissioning guidance for the CYP pathway clarifies the required elements of service provision and ways of working. In April 2024 commissioning and oversight of these services passed to ICBs which is associated with some challenge in the CYP pathway as services previously operated at a regional level and some reconfiguration has therefore been necessary.

Resources and funding for research into CYP long Covid

706. In mid-2021 the CYP Post COVID specialist services were to be funded through an allocation of £2.5m from the £70 million budget identified from post COVID services in 2021/22.

Data on number of CYP with Long Covid or long term sequelae

707. From 2021/2022 SNOMED codes were established for tracking diagnosis and treatment of Long Covid. As noted below, processes were established for reporting of data by CYP Long Covid hubs.

708. Data on the number of referrals for CYP Long Covid services were collected from March 2021 to June 2022. However, the results were not published because:

    a. The small numbers could lead to identification;

    b. Only 8 out of 14 CYP Long Covid hubs regularly submitted data; and

c. Due to poor data completion and poor data quality, the data were not considered a reliable indication of the true volume of CYP Long Covid activity.

709. The CYP with Long Covid (CLoCk) study shows 1 in 7 (14%) CYP testing positive for acute COVID-19 infection may have symptoms linked to the virus 15 weeks later.

SECTION J - Clinically Extremely Vulnerable Children

710. At the start of the pandemic, NHS England was asked by DHSC's primary care team to provide input on the emerging "isolate to protect" guidance and contribute to the definition of who would be considered at highest risk. This early work included proposals on operational models of support which could be provided to individuals at risk.

711. Over the following weeks, NHS England (including through its CRGs), DHSC, the Royal Colleges, DA's, NHS Digital, PHE, and the Care Quality Commission ("**CQC**") all contributed to a workstream to help develop the clinical criteria to identify clinically vulnerable groups.

712. On the 17 March 2020, NHS Digital was commissioned by DHSC and the CMO to create a shielded patient list.

713. On 18 March, the UK CMOs agreed the clinical criteria for clinically extremely vulnerable ("**CEV**") individuals who would be advised to shield, and on 20 March 2020 NHS Digital produced the first iteration of the shielded patient list ("**SPL**") (which comprised 867,789 patients). Those considered clinically extremely vulnerable included:

a. Solid organ transplant recipients

b. People with specific cancers

i. People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer

ii. People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment

iii. People having immunotherapy or other continuing antibody treatments for cancer

iv. People having other targeted cancer treatments which can effect the immune system, such as protein kinase inhibitors or PARP inhibitors

v. People who had had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

c. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease

d. People with rare diseases and inborn errors of metabolism that significantly increase risk of infection

e. Women who were pregnant with significant heart disease, congenital or acquired.

714. The clinical criteria for CEV individuals did not discriminate on the basis of age, and so applied to CYP falling within the above criteria. NHS England's involvement in the shielding programme focused primarily on people designated as CEV, who were advised to shield.

715. Of the 867,789 patients considered CEV in the first iteration of the SPL, 93,000 of whom were children or young people.

Shielded Patient List and QCovid™

716. There was no pre-existing national mechanism or organisation for identifying or supporting CYP who had been advised to shield.

717. As described above, NHS Digital was commissioned to develop the SPL on 17 March 2020. The SPL was developed and generated on a regular basis between 20 March 2020 to 29 September 2021.

718. NHS Digital took the established clinical criteria for identifying CEV patients, and developed a clinical methodology (i.e. a ruleset) to identify patients who met those criteria based on coded information in their health records. Over time, the SPL included patients registered for healthcare in England and identified nationally using both the clinical methodology (those falling within the CEV criteria) and those routinely identified as at high risk by their GP or hospital specialist. The data was shared with NHS England for the purpose of strategic commissioning, and with CCGs for the purpose of providing patients and GP practices with support.

719. Using data provided by NHS Digital from the SPL, DHSC commissioned Oxford University to develop an underlying risk calculator to underpin the digital infrastructure, based on a combination of specific characteristics (such as age, sex, ethnicity, medical conditions etc). This was known as QCovid™ and became the coronavirus risk prediction model which underpinned the NHS Digital provided risk

stratification service. This led to the development of the Covid-19 Population Risk Assessment Service tool, operated centrally by NHS Digital, which used the QCovid™ risk prediction model to identify additional people to be added to the SPL as a precautionary measure. The Covid-19 Population Risk Assessment tool was not authorised for use in CYP under 19 years' old.

720. There were operational challenges in ensuring the CEV status of CYP was kept up to date. The original CEV criteria captured a wide range of children's medical conditions, and around 93,000 CYP under the age of 18 were added to the SPL in the first instance.

721. However, in June 2020, the RCPCH published new CEV guidance for children, based on new evidence about the nature of risks posed by Covid-19 **[DB1/142][INQ000395362]**. The guidance advised that any decision to shield a CYP should balance the clinical and social impact of shielding, weighing the benefit of keeping CYP underlying co-morbidities safe whilst protecting the most socially vulnerable, due to family and social circumstances, who may risk additional harm from continued shielding.

722. Adopting that position, evidence suggested that not all those CYP who were initially classed as CEV should remain on the SPL. The underlying principles of the RCPCH's CEV guidance was:

a. CYP who are cared for just in primary care are very unlikely to be CEV

b. A small group of children who are CEV due to their pre-existing condition will need to follow public health advice on shielding,

c. A further larger group of children exists who due to their underlying condition may be CEV and the decision to follow public health advice on shielding would normally result from a discussion between the clinician, the child and their family.

723. Adopting the principles in the RCPCH guidelines, the updated CEV guidance issued by PHE on 8 July 2020 advised that all CYP on the SPL should continue to shield until 31 July 2020 **[DB1/143][INQ000348057]**. At which date, a clinical discussion with either the CYP's paediatric specialist or GP was required to consider whether the CYP needed to remain on the SPL. As a result, NHS England asked specialists and GPs to review the CEV status of their patients under the age of 18.

724. The number of children on the list fell more slowly than anticipated with around 58,000 children still on the list by 23 December 2020. This challenge is likely to have been caused by multiple factors, including:

a. Difficulties in defining the relative responsibilities of specialists and GPs, given both had a potential role in reviewing a child's CEV status;

b. The confidence of clinicians, especially GPs, to undertake reviews;

c. The time required to undertake reviews being longer than initially estimated, especially in the context of other pressures faced by clinicians during the pandemic; and

d. Delays or omissions in submitting removals to the SPL following clinical review, given this was a new and unfamiliar process.

725. NHS England provided additional advice to GPs and Trusts on how to remove children from the SPL in a letter of 2 November 2020 **[DB1/144][INQ000058815]** and **[DB1/145][INQ000409930]**. GPs were advised to immediately review any CYP remaining on the SPL and, where appropriate, remove them from the SPL. The letter stressed that "*given the detrimental impact to children's wellbeing of following unnecessary additional restrictions, it is important we complete this exercise as soon as possible".*

726. On 4 November, the Government wrote to the parents of children on the SPL, advising them to proactively contact whichever clinician usually cared for their child, if that clinician had not already been in contact to discuss their child's CEV status **[DB1/146][INQ000409931]**.

727. In August 2021, the RCPCH confirmed all children were no longer to be considered at high risk of complications from Covid-19, including those previously identified as CEV. The UK CMOs accepted a recommendation from the UK Clinical Review Plan to remove all remaining children from the SPL before schools re-opened in September 2021.

Covid-19 vaccination for CEV CYP

728. In January 2021, NHS England's NCD for CYP was commissioned by the deputy CMO to undertake an evidence review to understand which CYP are at risk from Covid-19. It used linked national routine administrative data on hospital admissions

(SUS data) and national Covid-19 testing data to analyse (using ICD-10 admission codes) to analyse which categories of CYP were most at risk from Covid-19.

729. The evidence review was presented to the JCVI to inform decision-making around vaccination of CYP aged 5-17 years' old.

SECTION K - Health and Justice

730. NHS England directly commissions the following healthcare services for CYP in the secure estate in England:

a. Services delegated pursuant to a Section 7A agreement: Public health services for CYP in secure and detained settings in England

b. Under the Standing Rules (Regulation 10): healthcare services for prisoners and other detainees, which includes CYP detained in secure children's homes, secure training centres, secure schools and young offenders institutions (under 18). This includes community services (including dental), secondary care, and rare and very rare services. It does not include inpatient CYPMH services.

Children and Young People Secure Estate

731. The CYPSE accommodates children between 10 – 17 years old. Those 18 and above are detained in the adult secure estate on criminal justice grounds. As a result, where CYP is mentioned in this section of the statement, it refers to those 10 – 17 years' old (to mirror NHS England's terminology and the Children Act 1989).

732. CYPSE is the collective term for four types of residential placements where 10 to 17 years olds remanded to custody can be placed by the HM Prison and Probation Service Youth Custody Service ("**YCS**"):

a. Secure Children's Homes (SCHs);

b. Secure Training Centres (STCs);

c. Young Offender Institutions (under 18) (YOIs); and

d. Secure Schools (SSs).

733. SCHs can also provide care and accommodation for children placed by local authorities under a secure accommodation order made under section 25 of the Children Act 1989. It is important to note that these children are not offenders.

734. These latter placements are achieved via the Secure Welfare Coordination Unit which is commissioned by the DfE. Some SCHs hold only children placed for welfare reasons under the Children Act 1989, and others take a mixture of these children and

those placed by the YCS.

735. There are 14 SCHs in England and Wales (though NHS England only commissions healthcare in the 13 SCHs in England) . DfE is responsible for SCH policy, they are commissioned by individual Local Authorities and one voluntary sector organisation, but each individual SCH is operationally managed by its Registered Manager (who is in turn regulated by Ofsted). As a result, at the start of the Specified Period, no organisation held collective operational responsibility for all 14 SCHs in England and Wales.

736. The CYPSE in England holds a small cohort of children. At the beginning of the Specified Period, there were c.625 CYP detained in the secure estate on youth justice grounds, and c.90 on welfare placements.

Governance

737. Wave 1 saw the establishment of a Health and Justice cell as part of NHS England's wider incident response, with cross-partner Outbreak Control Teams set up across regions to establish a national picture and control outbreaks.

738. During the Relevant Period, NHS England's Health and Justice Children Programme was headed by the National Children and Young People Quality Lead for Health and Justice ("**Quality Lead**"). The Quality Lead reported into NHS England's Director of Health & Justice, Armed Forces and SARCs.

739. The Health and Justice children's team was restructured during the pandemic to meet changing demands, undertaking work with an operational focus, increasing regular meetings allowed for faster turnarounds, and the provision of increased support.

740. A Covid-19 Dashboard was developed and stood up in conjunction with Youth Custody Service as an operational risk management tool, and this was updated daily. For various reasons, it was not possible to mirror a similar tool for the welfare sector.

741. NHS England joined a weekly Covid-19 Health & Justice Contact Group meeting with leads across government and agencies, including PHE, the Home Office, DHSC, DfE and the YCS.

742. The Health and Justice CYP team worked particularly closely with YCS for efficiency. This included frequent meetings, including each organisation attending each other's senior leadership meetings to enable joined up-working at pace. NHS England

provided awareness training with regards to the pandemic for the YCS.

Healthcare provision in the CYPSE

743. NHS England commissions health services to CYP in the secure estate. In practice, this means that NHS England's commissioned provider works alongside the provider of the secure setting to provide a health service to children held in that setting.

744. Healthcare services in the CYPSE are commissioned locally by regional health and justice commissioners. These commissioners procure service providers against core outcome-based service specifications which are benchmarked by the RCPCH Healthcare Standards for Children in Secure Settings, with an overarching specification supported by separate specifications for physical healthcare, mental health and neurodevelopmental conditions, substance misuse, and dental and oral health.

745. NHS England commissions to the principle of equivalence, meaning that children in the secure estate should receive the same standard of care as their peers would receive in the community. All children in the secure estate receive an assessment via the Comprehensive Health Assessment Tool (CHAT). This is an evidence based, validated health assessment tool for under 18s, which screens for physical health, substance misuse, mental health and neurodisability.

746. This includes all the same health services that might be provided to children in the wider community, for example primary care, dental and optical services, mental health and substance misuse services. It does not include emergency services, but CYP in the secure estate have access to these in the same way as other CYP (i.e. would be transferred to hospital if necessary).

747. It is important to note that healthcare provision in the CYPSE did not stop during the Relevant Period. The Health and Justice CYP Team worked hard to support detained settings to maintain a balance between keeping CYP safe and free from infection, and supporting CYP mental health. The latter was particularly important due to the high level of complexity of need among this group of CYP and the subsequent impact of isolation.

748. Given the nature of the detained estate, the vector for Covid-19 outbreaks in detained settings were often the staff in that setting. The Health and Justice CYP team supported detained settings, and healthcare workers in those settings, to access

PPE. Where there was an outbreak of Covid-19 in a detained setting, the Health and Justice CYP team would attend outbreak meetings, led by regional public health teams.

749. Understandably, families and carers of CYP detained in the secure estate during the Specified Period were anxious about their child's health and wellbeing. NHS England worked together with the YCS to issue joint communications to families and carers of those detained in the CYPSE. Communication was also developed for the CYP within the secure estate, as they were necessarily physically isolated from the wider community and their families/carers. Owing to the overrepresentation of neurodiverse children in the secure estate, specific communication was developed to support work with that cohort of children.

SECURE STAIRS

750. The Framework for Integrated Care (SECURE STAIRS) was a programme that existed before Covid-19, that allowed for a trauma informed, collaborative approach to assessment, intervention planning and care, including input from mental health staff, social care professionals, education professionals and the operational staff working on a day-to-day basis at the setting. It also sought to ensure that staff have the right skills and support to care for the CYP appropriately. Co-produced formulation (planning) for each child through the understanding of the child's background story ('My Story') sits at the centre of the Framework.

751. In response to the challenges within CYPSE during the pandemic an Enhanced Framework for Integrated Care (SECURE STAIRS) team was stood up to form a "blanket of support" around children in the secure estate. This was implemented in partnership between NHS England and YCS.

752. During the Specified Period, the purpose of the Enhanced SECURE STAIRS team was to progress, the various different areas of support provided to staff and CYP within the secure estate in response to Covid-19 and recovery. This included focussed guidance for staff on maintaining physical distance but staying socially and relationally connected. This included the following guidance to providers of secure settings to support the wellbeing of children in the secure estate:

a. Maximise opportunities for relational connection, whilst maintaining physical distance;

b. Promote physical health, including diet, exercise, sleep, personal and hand

hygiene, and continued access to medication;

c. Maximise access to fresh air where it is possible to safely maintain physical distance outside;

d. Maintain (or establish) a sense of structure or routine;

e. Ensuring there are meaningful activities available to protect well-being and preventing challenging behaviour;

f. Allocating or developing roles, allowing CYP to develop particular roles and responsibilities within their groups, as mentors, helpers, entertainers etc

g. Limit the amount of time spent watching / reading the news;

h. Promote openness, normalise anxiety and encourage CYP to access support if needed;

i. Ensure there is a clear crisis plan for CYP with particular difficulties or high levels of distress; and

j. Supporting staff to keep well and connected.

753. As part of the Enhanced SECURE STAIRS offering, NHS England and the YCS jointly published a Covid-19 guide on "psychological first aid for children and young people". This was published as a resource for staff and HCWs in the CYPSE to support CYP experiencing mental health challenges during the pandemic **[DB1/147][INQ000610891].** Additional resources were developed to support neurodiverse children, including resources explaining the Covid-19 vaccine.

Challenges

754. As described above, SCHs house a mix of children, those under welfare placements and those placed by the Youth Justice Board. Although the DfE held policy responsibility over the SCHs, it did not hold operational responsibility. NHS England convened a meeting with the DfE and the DHSC to mitigate this risk in the absence of any national operational structure.

755. NHS England agreed to lead on supporting the development of a Covid-19 operational policy in SCHs. In addition to that guidance development, there was a weekly call between NHS England, DfE, YCS and the SCH managers which was

stood up to support SCH Registered Managers during the Specified Period.

756. Another challenge, which sadly existed in the CYPSE before the pandemic and remains now, is that a number of the children detained have multiple vulnerabilities. Between 2014 – 2016, it was estimated that of the admissions entering youth custody from the community there were concerns relating to suicide or self-harm (31%), physical health (30%) mental health (33%) and learning disabilities or difficulties (32%) for around one third of admissions. During the same period, it was estimated that around one third of admissions to the secure estate from the community were care experienced children (33%).

757. As a result, striking an appropriate balance between protecting detained CYP and staff / healthcare workers in detained settings from Covid-19 infection, with maintaining mental health and wellbeing – was often challenging. Programmes such as the expanded SECURE STAIRS provision sought to support CYP, and offer resources to providers in supporting CYP within their settings in challenging circumstances.

Lessons Learned

758. The Enhanced SECURE STAIRS team was stood down after the pandemic, but NHS England have continued to work to sustain the implementation of SECURE STAIRS in the CYP secure estate in conjunction with partners. Providers have provided feedback that understanding a child or young person through the lens of "my story" allow for more holistic support and understanding.

759. The NHS Long Term Plan also committed to supporting the full-roll out of the health and justice digital patient record information system across secure settings for children. This will include the digital transfer of patient records before placement, in secure setting and on discharge.

760. It also committed to investing in additional support for the most vulnerable children in, or at risk of being in, contact with the youth justice system. This includes sustaining the implementation of SECURE STAIRS in the CYP secure estate and the roll out of 12 Framework for Integrated Care vanguards in the community, at present covering 19% of potential population coverage.

SECTION L – CONCLUSION

761. Throughout NHS England's statements to the UK Covid-19 Inquiry, across all Modules, it has set out its reflections and lessons learned in respect to the issues under discussion. We do not seek to duplicate all of those reflections here, especially where they relate to issues affecting people of all ages, but instead focus on those lessons learned falling explicitly within the scope of Module 8.

762. In the context of a national pandemic or emergency situation, the needs of CYP can easily be overlooked. The physiology of CYP is not the same as adults: they respond to diseases and healthcare interventions differently. They also have different emotional, educational, developmental and social needs. Any decisions taken to prepare for, respond to, or recover from pandemics must account for these differences. Pandemic responses should consider not only the potential direct impacts on children (e.g. the physical impact of contracting the disease), but also the indirect impact (e.g. the unintended consequences of actions taken to limit the spread of a virus). Such impacts, if left unmitigated during a child's formative years, can have a profound and long-lasting effect.

763. Since the end of the Specified Period, the profound long-term impact of the educational disruption and mental health consequences for children, arising from the pandemic, have been more widely acknowledged. Vulnerable children, and children from disadvantaged backgrounds, in particular, were impacted by school closures. Schools play a significant role in identifying safeguarding concerns and referring children to mental health, learning disability, and autism services; these referrals were disrupted during the pandemic.

764. This section incorporates NHS England's learning from the following reports, originally produced for internal purposes:

a. NHS England's Lessons Learned Report **[DB1/166][INQ000226890]**

b. NHS 111 Paediatric Clinical Assessment Service Interim Report **[DB1/167][INQ000610912]**

c. Report on Paediatric Respiratory Surge Response – Lessons Learnt **[DB1/168][INQ000624349]**

<u>Preparedness</u>

765. There were no national pandemic preparedness exercises, in which NHS England was involved in or aware of, that focussed on the specific needs of CYP. However, specialist and non-specialist children's providers, and non-specialist and specialist mental health providers would have tested their own preparedness for children and younger people through wider exercising (e.g. around pandemic influenza and other scenarios).

766. In responding to a number of major incidents prior to the pandemic (including the Manchester Arena terrorist attack, the 2017 London Bridge attack and WannaCry cyber-attack), NHS England EPRR infrastructure had been well practiced. Learning from these incidents have contributed towards preparedness for future major incidents.

767. We understand that the DHSC has commissioned a pandemic preparedness exercise in response to Recommendation 6 of the Inquiry's Module 1 Report, scheduled for late 2025. We understand that the impact on CYP will be considered as part of this exercise.

768. The availability of paediatric ventilators is limited. Due to Covid-19's impact on the majority of children being milder than in adults, availability was not constrained during the Specified Period. However, future pandemic preparations should include planning for conditions which may affect children more severely than adults (such as avian flu) which may require children to be cared for in adult critical care units.

769. The paediatric critical care workforce is considerably smaller than for adults, so the ability to surge PICU capacity would be limited should a future pandemic have a greater impact on children. Preparing for an instance where paediatric critical care capacity is exceeded would require the additional training of staff, and the procurement of ventilators suitable for babies and children. In future pandemics, additional support should be considered for redeployed staff who may be unfamiliar with the emotional pressures of working in paediatric critical care.

770. Preparation for future pandemics should also anticipate the rise of unseasonal outbreaks of other diseases which are often an inevitable consequence of social-distancing and other NPIs. During the pandemic, the almost complete absence of other respiratory infections meant that a cohort of children were immunologically immature. This led to subsequent unseasonal and large outbreaks of diseases in children such as RSV, and scarlet fever / invasive group A streptococcus, and non A-E hepatitis – all of which can have profound outcomes/consequences for CYP and their families, as well as placing significant strain on primary and secondary care.

Working with others

771. The pandemic strengthened the relationship between NHS England's CYP team and PHE/UKHSA and RCPCH. At the beginning of the Specified Period, there would be daily calls between NHS England's CYP Transformation Team, the NCDs / NSAs, PHE and RCPCH. Later on in the Specified Period, these meetings also included DHSC / DfE representatives.

772. These close working relationships facilitated a joint response to emerging trends. One example is the working group established by the NCD for CYP and RCPCH, working with the newly established ODNs for Children's Critical Care and Surgery to develop consensus statements for the diagnosis and treatment of children suspected of having PIMS-TS.

773. This close working relationship continues today and is strengthened by the President of the RCPCH having a position on NHS England's CYP Transformation Board.

774. Future pandemic responses should ensure that CYP interests are represented in formal response structures. Where possible, decisions affecting CYP should be informed by engagement with CYP and their families. In the event of a future national emergency, mechanisms should be in place whereby active consultation with CYP and their families continues.

Communications

775. There was a difficult balance to strike between enabling local responses to issues, as seen and experienced by those on the frontline, and the need to coordinate resources, communication and actions consistently across the whole country. NHS England is aware that at times different organisations felt that it did not get this balance right all the time or that responses to requests for guidance and information were not as quick as desired.

776. NHS England considered requests for advice and guidance from a range of stakeholders and balanced such requests against any competing considerations. NHS England had to take into account the existing guidance and communication load being placed on the system, so as not to overwhelm the system and colleagues working within it.

777. In some cases, NHS England contributed to guidance which was subsequently published by other stakeholders (e.g. RCPCH). Some stakeholders felt such guidance should have been published by, or publicly endorsed by, NHS England or other

governmental bodies, to encourage more consistent adherence to the guidance. NHS England further understands, through its NCD for CYP, that guidance which was not published by (for example) NHS England or NICE was likely not given the same weight of consideration by clinicians, compared to guidance published or endorsed by those bodies.

778. NHS England recognises the need for clarity and consensus on different bodies' roles in developing and publishing national guidance for healthcare providers, in the event of a future national emergency. NHS England would welcome the Inquiry's findings on this issue, accounting for the multitude of issues, organisations, and perspectives that were being managed during the Specified Period.

Shielded Patient List

779. Initial guidance issued by DHSC around shielding did not take age into account. 93,000 CYP considered clinically extremely vulnerable were added to the first iteration of the SPL. As understanding of the clinical presentation of Covid-19 in CYP developed over time, the CMO changed the shielding guidance so that clinicians could remove children from the shielding list.

780. There was an expectation on a child's GP or paediatric specialist to consider whether that child needed to remain on SPL. Clinical reviews had been deemed necessary given clinicians were best-placed to interpret the CEV criteria flexibly to accommodate the needs of individual CYP.

781. The number of children on the list fell more slowly than anticipated, with around 58,000 CYP still on the SPL by 23 December 2020. Many parents were also still worried about sending children to school, even if they had not been issued a shielding letter.

782. The requirement for clinicians to review patient lists to suggest additions or removals to the SPL was time-consuming, the division of responsibility between the child's GP and paediatric specialist was not always clear, and the considerable other pressures placed on clinicians during the pandemic also impacted their ability to review individual children's CEV status.

783. Were the shielding policy to be implemented in the future, and data systems were still not yet reliable enough to automate the adding and removing of children from a national list of CEV patients, national bodies would need to provide additional support and clarity to clinicians, with respect to their role in reviewing patients' CEV status.

Referrals and presentation to and pausing of services

784. In the first wave of the pandemic, concerns were picked up that parents were not bringing in children to urgent and primary care with non-Covid related issues in the numbers that were expected. Communications were rapidly put out to reassure parents that urgent care and primary care remained open to all and should be used appropriately if they had concerns about their children.

Urgent and Emergency Care

785. PCAS was stood up by NHS England's CYP Transformation Programme and IUC teams as part of NHS 111. The service directed eligible callers to a re-deployed paediatrician (often retired, shielding or returning) rather than to the core services for all ages.

786. The launch of PCAS during the pandemic clearly demonstrated the benefit (in respect of both outcomes for the child and appropriate use of health service resources) of having specialist, paediatric clinicians assessing children via PCAS (rather than the whole-population CAS). The results showed that calls handled by paediatricians were less likely to result in avoidable attendances to primary care / ambulance call outs than those handled by non-paediatric clinicians.

787. In January 2023, NHS England launched a blueprint for the expansion of NHS 111 to transform patient access. The blueprint included a permanent role for PCAS as part of the NHS 111 family of services. The permanent adoption of PCAS will support future pandemic responses, providing the infrastructure to ensure that CYP receive appropriate advice which is less likely to result in avoidable attendances.

Community Services

788. The first wave of the pandemic saw elective and community services for children reduced to divert resources and capacity to support services that were under significant pressure. This coincided with a reduction in the number of children presenting at hospitals and other health care settings.

789. Although there was need to publish the Community Prioritisation Guidance at pace, some stakeholders were consulted on its content – including the Director of Nursing at PHE, and the COO/CEOs of 8 providers of community health services. The Community Prioritisation Guidance was also approved by the NIRB. However, due to the wide range of organisations funding and involved in CYP services (NHS providers, local

authorities, education sector etc), the ability to consult widely on the Community Prioritisation Guidance, and to consider its longer-term impact on CYP, was limited.

790. The pausing of children's community services caused concern to parents, carers and guardians of children. Guidance was also issued to reprioritise children's community services. In Wave 1, health visitors (commissioned by local authorities) had fewer face-to-face interactions with new mothers, and some were redeployed to other services, and therefore, some potential safeguarding concerns were being missed.

791. A SOP published by NHS England on community health services on 15 April 2020 acknowledged that CYP, especially those who were most vulnerable, might experience additional pressures and stressed during the pandemic. Community health services were expected to continue to offer universal and targeted support – including providing advice and guidance to allay children's anxieties and to signpost them to appropriate services, keeping in contact with children for whom there were safeguarding concerns, and planning support for children with long-term conditions.

792. The restoration of community services for children was confirmed through NHS England's letter to the system dated 3 June 2020 **[DB1/169][INQ000421234]**.

793. To ensure that children's community services were resumed and protected, the then CNO, PHE's Chief Nurse and the Chairman of the LGA's Community Wellbeing Board wrote to all Directors of Nursing on 7 October 2020 advising that professionals supporting children and families (including health visitors, school nurses, designated safeguarding officers and nurses supporting children with SEN) should not be redeployed to other services.

794. Should community prioritisation guidance be needed in future pandemics, CYP stakeholders should be consulted where possible to mitigate the impact on CYP.

795. Since the onset of the pandemic:

a. NHS England and the DHSC have established clearer national leadership and oversight of community services; and

b. data collection from community services is also now more rigorous and complete, which should facilitate more rigorous policy development, tailored to meet the needs of local CYP populations.

Elective care

796. Delivery of elective care, including planned surgery for CYP was impacted significantly by the pandemic, as most non-urgent hospital care was suspended to free up hospital capacity for an anticipated surge in Covid-19 patients. The subsequent recovery of routine hospital care was constrained by multiple factors, including IPC restrictions and the redeployment of clinicians to support critical care.

797. As local health systems restored routine hospital care, the NHS England CYP Transformation Board continued to monitor children's elective services. By June 2022, backlogs in paediatric services did not appear to have been addressed at the same pace as adult services. This may have been in part because many strategies implemented to accelerate elective recovery were targeted at routine interventions more often provided to adult patients (including so-called “high-volume low complexity” procedures such as cataract surgery and joint replacements). Financial rewards offered to local systems and Trusts to increase overall volumes of elective care may have indirectly incentivised providers to focus on more routine, less specialised procedures, from which children were less likely to benefit.

798. NHS England subsequently published a "*Children and young people's elective recovery toolkit"* in May 2023, setting out actions that local regions, systems and providers should take to accelerate the recovery of children's elective services and to ensure parity between children's and adults' services.

799. Work to accelerate the recovery of elective care for CYP has continued since the pandemic, with the DHSC and NHS England publishing an elective care reform plan in January 2025, which encourages the establishment of CYP hub models, and requires providers to carry out a local quarterly review of CYP waiting list data.

800. The learning from this is that CYP data should be published and scrutinised alongside adult data, to encourage fair and equitable distribution of resources between age groups.

RSV

801. Few cases of RSV and other respiratory infections were reported in 2020 in the UK and other countries, a pattern associated with the use of measures to reduce social contact to prevent the spread of Covid-19. As a result, there was a larger group of young children who had never been exposed to RSV and had no immunity to this infection.

802. This increased the risk of a surge in RSV cases in 2021, greater than seen in a normal

winter.

803. The NHS in England anticipated this surge by putting in place additional sentinel surveillance of RSV cases in May 2021 to expand sample testing and provide an early warning system.

804. NHS England worked closely with colleagues in the devolved administrations to respond to the RSV surge, given the need to ensure sufficient paediatric critical care capacity across the Four Nations. The paediatric critical care ODNs reflect the need for cross-border working, with the North West and North Wales ODN covering paediatric critical care in north Wales, and the South West ODN delivers a paediatric critical care transport service in partnership with Cardiff PICU. Planning for, and response to, future pandemics, should also adopt a UK-wide approach – in part to ensure health care resources are distributed efficiently across the Four Nations, and focused on where the need is greatest.

805. A lessons learnt exercise took place on 23 February 2022 to capture learning from the response, which culminated in 19 recommendations to better deal with unseasonal surges in paediatric respiratory infections in future.

Data

806. Increased funding for the NCMD (funded by NHS England) facilitated 7-day data collection and early warning of emerging trends, which meant that NHS England had a near real-time sight on child death trends enabling a rapid response when trends were determined. This enabled clinicians to conclude at pace that direct mortality from Covid-19 infection in children was similar to the rates of direct mortality in children from influenza.

807. Targeted use of data also enabled rapid tracking and identification of emerging risks to children's health from outbreaks of diseases (including PIMS-TS and RSV). This supported the ability to respond rapidly, and such proactive approach should continue to be used in future.

808. One challenge faced by some providers of CYPMH was that not all records had been digitised. To support effective remote working in the future, it is essential that all CYPMH services have access to electronic patient records and electronic prescribing through a robust digital infrastructure.

809. From November 2020, in advance of the second pandemic wave, NHS England began

collecting daily data from paediatric critical care units, to identify and assess operational strain in real-time. This ongoing data collection remains a beneficial legacy of the pandemic.

810. Data on referral-to-treatment ("**RTT**") waiting lists and wait times was not disaggregated by age until late 2021. Consequently, disparities in the rate of elective recovery between adults and children were not well-recognised until towards the end of the Specified Period. The improved disaggregation of RTT data has since enabled closer monitoring of the extent to which elective recovery has been equitable.

811. In future pandemics, it is imperative that a single source of linked data between primary, community, secondary and critical care is available to coordinate national, regional and ICB level responses in all age groups including CYP. This should be linked to real-time immunisation and test data.

812. Moreover, a single unique identifier for each child, that could be used across health, social care, and education services, would enable more effective identification and monitoring of at-risk children.

Health and Justice

813. Due to estate constraints and HMPPS guidance, roll out of remote consultations did not happen as quickly in the detained estate as in other parts of the health services. Although this was later resolved, it remained difficult to carry out effective remote consultations in the detained estate.

814. Although the DfE held policy responsibility over the SCHs, it did not hold operational responsibility. Consequently, there was no one organisation with a natural remit to develop guidance for the SCHs (this remains the case today). In the absence of one organisation responsible for SCH guidance, NHS England worked with the DfE and DHSC to bridge the gap.

815. Learning from the pandemic has been incorporated into NHS England's Health and Justice Children Programme – National Partnership Agreement 2023-2025, which supports the further development of public health services in the CYP secure estate – including improving proactive detection, surveillance and management of infectious diseases and the joint capability to detect and respond to outbreaks and incidents.

CYP Mental Health

816. Demand for CYPMH services was increasing prior to the pandemic. The pandemic has had a significant impact on the mental health needs of CYP in England and subsequently increased demand for CYPMH services. The NHS in England was changing service models and expanding access to services ahead of the pandemic and continued to do so through the Specified Period and beyond.

817. There were a number of challenges to the delivery of in-patient and community CYPMH services while trying to limit the spread of infection. Guidance and resources have now been developed that can be shared with stakeholders for any future event covering a range of practical and clinical considerations from infection control measures to how to adapt existing processes to ensure provision of accessible quality care.

818. One example is that across the CYPMH sector, significant changes were made at pace to introduce video conferencing and digital assessment to help minimise the risk of Covid-19 transmission. This enabled new approaches to MDT meetings, which would enable clinicians to meet with multi-disciplinary professionals, the child / young person and their families/carers without having to travel vast distances. It was however recognised that remote consultations would not be appropriate for every interaction a child or young person would have with CYPMHS. This shift in delivery of support reiterated the need to ensure digital advancements do not widen health inequalities through digital poverty, and the importance of supporting staff training and considering patient choice, including where digital contacts may not be the most appropriate form for the child or young person.

819. The pandemic also highlighted that there were inherent risks with the model of specialised care for CYPMH which was based on a predominantly in-patient model delivered at a multi-ICB or regional level. Pandemics can have a significant impact on access to in-patient care through reduced bed capacity. Access to support networks is also limited by infection control measures. This was partly mitigated by the introduction of digital technology which widened the scope for contact opportunities. There was also recognition of the negative impact of blanket restrictions within units and the need to personalise care for individual CYP. Through the pandemic, providers did and have continued to deliver specialised services through alternatives to in-patient care such as day patient and intensive community outreach.

820. A new NHS England model for CYPMH specialised services will have a greater focus on localisation of service delivery and the need to offer services in the least restrictive settings, for example through day patient and intensive community models of care,

especially for CYP with eating disorders. As well as ensuring that these specialised services are in place for those that need them, work also continues to both prevent and intervene early in common mental health conditions, including the rollout of mental health support teams in schools and colleges across England and the development of neighbourhood multi-disciplinary teams embedded within primary care and community settings.

821. This underlines the importance of continuing in the programme of expansion and transformation as CYP needed, and will continue to need, support for their mental health across the spectrum of need – from prevention and support from universal services, to support in the community, from early targeted help in schools and colleges, to specialist NHS CYP Mental Health services, and acute and in-patient care.

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: **PD**

Dated: 1 August 2025

ANNEX A
Key Individuals, roles and functions

1. This Annex sets out a brief summary of:

   a. key individuals within NHS England with responsibility for CYP healthcare during the Specified Period; and

   b. NHS England functions focused specifically on CYP, carried out by teams from across NHS England during the Specified Period.

2. CYP healthcare during the Specified Period was necessarily affected by any decision which impacted on the whole of the NHS in England, or on the whole patient population. Key decision makers who attended the NHS England Board as Executive Directors during the Specified Period are listed in this Annex (reflecting information previously provided to the Inquiry by NHS England).

Key decision makers during the Specified Period

3. The Key Decision Makers for the Specified Period are set out below alongside a description of their role:

Key Decision Makers	Role(s)
Lord Simon Stevens	Former Chief Executive Officer (until 31 July 2021).
Amanda Pritchard	Former Chief Operating Officer (until 31 July 2021). Accountable Officer for Emergency Preparedness Resilience and Response (until 13 December 2021); Chair of NIRB Chief Executive Officer of NHS Improvement (until 31 July 2021) Chief Executive Officer NHS England (1 August 2021 – 31 March 2025)
Professor Sir Stephen Powis	National Medical Director of NHS England Interim Chief Executive Officer NHS Improvement from 1 August 2021 to 31 July 2022 (when NHS Improvement was abolished)
Dame Ruth May	CNO (throughout the Specified Period)
Julian Kelly	Chief Financial Officer (throughout the Specified Period)
Ian Dodge	National Director of Primary Care, Community Services and

	Strategy (throughout the Specified Period))

Chief Executive Officer

4. The Chief Executive Officer ("**CEO**") of NHS England leads the NHS's work nationally to improve health and ensure high quality care for all. The role is accountable to Parliament for the NHS annual funding. The CEO is jointly accountable to the Board of NHS England, the DHSC, and to Parliament.

Chief Operating Officer

5. The Chief Operation Officer ("**COO**") is responsible for operational delivery of the NHS in England including performance standards across all systems. This includes oversight of the ongoing NHS emergency response to Covid-19 and other EPRR incidents, ensuring that appropriate plans are in place to support the delivery and recovery of NHS services. They are also responsible for the Delivery of National programmes for **UEC**, cancer, mental health and learning disabilities.

Chief Financial Officer

6. The Chief Financial Officer ("**CFO**") is responsible for strategic financial management of NHS England's resources. They oversee the development and administration of financial policy levers and lead financial and corporate performance management.

7. Oversight of specialised commissioning, including specialised children's health services and healthcare for children in detained settings, sits within the NHS England finance directorate.

Chief Nursing Officer

8. The CNO for England is employed by NHS England to provide expert clinical and workforce advice to the Board and is formally the CNO providing advice to the Government and the DHSC. The role also provides professional leadership for all Nurses and Midwives in England (with the exception of public health nursing, which was not part of the CNO's portfolio during the Specified Period, though has since transferred).

9. The NHS England CYP Transformation programme is part of the CNO portfolio.

National Medical Director

10. The National Medical Director ("**NMD**") is the most senior doctor in the NHS in England and provides clinical governance across the health system.

National Director for Primary Care, Community Services and Strategy

11. Throughout the Specified Period, the National Director for Primary Care, Community

Services and Strategy was an Executive Director on the Board of NHS England with strategic responsibility for primary care and community services.

Clinical advisers

12. NCDs and NSA are senior practising clinicians who provide clinical leadership to NHS England. Several of these post-holders have specialist expertise in CYP's healthcare.

13. Key roles and post-holders from during the Specified Period are listed below.

Key Clinical Advisers	**Role(s)**
Professor Simon Kenny	NCD for Children and Young People since 2019
Professor Prathiba Chitsabesan	NCD for Children and Young People's Mental Health. Prathiba Chitsabesan joined NHS England as National Speciality Advisor for CYP Mental Health in 2017. The role was subsequently changed to NCD for Children and Young People's Mental Health in October 2022 and Prathiba Chitsabesan remains in that role.
Dr Matthew Clark	National Specialty Adviser for Children and Young People since 2019

National Clinical Director for Children and Young People

14. The National Clinical Director for Children and Young People ("**NCD for CYP**") is responsible for providing clinical leadership, advice and input into the NHS England CYP Transformation programme, and more broadly within NHS England, to drive forward the transformation of CYP services.

15. During the Specified Period, the NCD for CYP reported to the National Medical Director.

16. The NCD for CYP is also the Chair and Clinical Lead of the National Programme of Care ("**NPoC**") for Women and Children, which oversees the commissioning of specialised healthcare services.

17. The NCD for CYP is supported by a National Speciality Adviser for CYP.

National Clinical Director for Children and Young People's Mental Health

18. During the Specified Period, the portfolio of the National Clinical Director for Children and Young People's Mental Health ("**NCD for CYP MH**") was held by a National

Specialty Adviser for Children and Young People's Mental Health.

19. The NCD for CYP MH is responsible for providing clinical leadership, advice and input into the NHS England on issues relating to children's mental health, working with the NHS England Mental Health and Specialised Commissioning teams.

20. The NCD for CYP MH is chair of the Clinical Reference Group (CRG) for specialised secure and non-secure CYP mental health, learning disability, autism and eating disorders services.

Other Clinical Advisers

21. There is a considerable number of other clinical advisers with roles covering CYP, who are likely to be less relevant to the Inquiry's terms of reference, and so who are not listed in full here.

22. They include the NSA for CYP diabetes, the NSA for CYP cancer, the NCD for neonatology, the NSA for eating disorders (all ages), the NCD for learning disabilities and autism (all ages) and the NCD for health and justice (all ages).

23. In addition, Getting It Right First Time clinical leads provide advice and leadership to help identify unwarranted clinical variation within their specialty, at national, local, and provider level. They also provide advice on identifying and implementing best practice standards.

Key functions and decision-making structures

National Incident Response Board ("**NIRB**")

24. NIRB's role was to set the strategic direction for, and provide oversight of, NHS England's and NHS Improvement's pandemic response. It provided a forum via which National Directors, and the Strategic Incident Director, could steer the pandemic response.

25. NIRB was formally established as a committee in common of NHS England and NHS Improvement boards on 1 April 2020, but many of its members had been meeting collectively since 18 February 2020.

26. NHS England teams and Covid-19 response 'cells' briefed NIRB throughout the Specified Period on issues relevant to CYP healthcare.

27. NIRB was stood down on 31 July 2021 but was re-established on 22 December 2021 and continued until 25 May 2022.

CYP Transformation Team

28. The NHS England CYP Transformation team works to improve the health outcomes and wellbeing of CYP. It works with teams across NHS England to ensure the health needs of CYP are considered and met, as part of wider organisational policy and decision-making.

29. During the Specified Period, the CYP Transformation team held weekly meetings with the president and officers of the RCPCH, the NHS England CYP Mental Health Team, the NHS England CYP Learning Disability Team and the scientific adviser to the DfE and PHE.

CYP Mental Health Team

30. The NHS England CYP MH team sits within the broader Mental Health and Dementia ("**MHD**") programme. The MHD Programme Board is accountable for the delivery of NHS England's strategic objectives for mental health. The CYP MH team supports the commissioning of community CYP mental health services via CCGs, now ICBs, and provides monitoring, oversight, and assurance of programme delivery via regional teams.

31. The Head of Perinatal, Children and Young People Mental Health reported to the National Director for Mental Health during the Specified Period. A weekly Mental Health Leadership Group was the main decision-making forum for CYP Mental Health decisions.

CYP Learning Disability, Autism and SEND

32. The NHS England Learning Disability programme works to improve the quality of healthcare for, and to address health inequalities experienced by, patients with learning disabilities and autism.

33. The Head (now Deputy Director) of CYP Learning Disability, Autism and SEND reports to the National Director of Learning Disability & Autism, who is supported by an NCD for Learning Disabilities & Autism.

Mental Health, Learning Disability and Autism Covid-19 Cell

34. The MHLDA Cell was one of the cells reporting into NIRB during the Specified Period. The Cell Structure was created to support the Covid-19 response and were adapted over time to support the evolving nature of the incident.

35. The MHLDA Cell did not supplant the existing CYP Mental Health, Learning Disability teams, or relevant specialised commissioning functions, but worked alongside them

and included staff drawn from those teams.

Safeguarding

36. The NHS England Safeguarding team works to ensure the duty to safeguard children and adults is applied in all NHS settings. NHS England defines the roles and responsibilities of everyone working in the NHS, and its partner agencies, in relation to safeguarding via the Safeguarding accountability and assurance framework.

37. The NHS England Head of Safeguarding reports to a Deputy Chief Nursing Officer.

38. During the Specified Period, the NHS England Safeguarding team convened a fortnightly Covid-19 Safeguarding Partnership Group with external partners.

Specialised Commissioning

39. Specialised services support people with a range of rare and complex conditions. NHS England commissions specialised services directly, though these responsibilities have increasingly been delegated to ICBs. The specialised services commissioned by NHS England have been grouped into six NPoC.

40. The NPoC for Women and Children oversees commissioning of (for example) specialised surgery in children, paediatric neurosciences, paediatric and neonatal critical care, and specialised paediatric respiratory.

41. The Women and Children NPoC for Women has a Steering Group chaired by the NCD for CYP.

42. The Cancer NPoC also covers a range of specialist services for CYP with cancer. A CRG for CYP's cancer is chaired by an NSA for CYP cancer.

43. The Mental Health NPoC covers specialised mental health services for children, including secure and non-secure inpatient services. Its CRG is chaired by the NCD for CYP MH.

Health and Justice Children Programme

44. NHS England is responsible for commissioning a range of healthcare services for CYP in youth justice systems in England. Responsibility for commissioning these services is discharged at an NHS England Regional level, with assurance provided by a central Health and Justice Oversight Group.

45. The CYP Secure Estate ("**CYPSE**") includes Secure Children's Homes, Secure Training Centres and Young Offender Institutions. The Health and Justice Children Programme is responsible for commissioning healthcare services across the CYPSE.

46. During the Specified Period, the Health and Justice Children Programme was led by a Quality Lead (now Deputy Director, Health and Justice Children Programme).

ANNEX B
Overview of the NHS in England

The NHS in England

1. In accordance with the framework established by Parliament, the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly-funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care and community health.

2. Many bodies hold contracts with the NHS and are part of the publicly funded health service, such as GP practices, dentists, independent hospitals, community rehabilitation providers, but not all will be NHS bodies. For the most part, the term 'NHS' is used as an umbrella term to mean all those performing their services with NHS monies and contracts.

3. The Health and Social Care Act 2012 (the "**2012 Act**") re-organised the NHS, with many of the changes coming into effect on 1 April 2013. The 2012 Act amended the 2006 Act which remains the main piece of primary legislation governing the NHS. For completeness, and as the Inquiry will be aware, the Health and Care Act 2022 (the "**2022 Act**") changed structures to place system working on a statutory footing, abolishing CCGs[18] and replacing them with ICBs.

Department of Health and Social Care

4. DHSC is responsible for setting policies that deliver the Government's strategic health objectives; and in turn for making sure the legislative, financial, and administrative frameworks are in place to deliver those policies (including the NHS Mandate, which sets NHS England's financial allocation). DHSC oversees the health and social care system through its agencies and public bodies, holding them to account for the implementation of agreed plans and commitments.

5. There is also a national multi-agency safeguarding and child protection working group to assist the government with regard to the implementation an integrated multi-agency approach to safeguarding, child protection and family help.

[18] CCGs were membership bodies with specific membership requirements pursuant to the National Health Service (Clinical Commissioning Groups) Regulations 2012. Each CCG had a 'governing body' made up of GPs, clinicians and lay members. They were clinically led, including all GPs within their defined geographical footprint.

NHS England

6. NHS England is an Executive Non-Departmental Public Body ("**NDPB**") sponsored by the DHSC. It is referred to as an ALB as it is a public body established with a degree of autonomy from the SSHSC, and is party to a Framework Agreement with the DHSC (**[DB1/148][INQ000113155] [DB1/149][INQ000113154]**). It was established on 1 October 2012 and is operationally distinct from DHSC. Until 1 July 2022, when changed by the 2022 Act, NHS England's legal name was the 'National Health Service Commissioning Board'.

7. NHS England's primary responsibility is the co-ordination of the provision of health care services in England, certain commissioning and oversight of local commissioners and providers of those health care services.

8. Statutory ALBs (such as NHS England) do not set strategic national health and/or public health policy but have a key role in implementing and advising on it. The Government, via DHSC, will seek input from NHS England on how to improve existing policies or address new challenges. NHS England may engage other people and organisations across the healthcare sector, including service users before providing its advice. The Government is then responsible for selecting from the policy options and ensuring any policy selected is appropriately financed.

9. NHS England is responsible for determining how to operationalise those policies to ensure effective delivery and evaluating their impact. This is reported to Government, via DHSC, through the usual arrangements.[19]

10. One method NHS England uses to communicate priorities out to the sector is through publication of the NHS Priorities and Operational Planning Guidance which sets out the NHS' priorities, typically for the year ahead.[20]

11. Whilst many things changed operationally during the pandemic and NHS England took on many roles beyond its usual remit, the overall parameters of its role in central Government decision making and policy development remained broadly the same as before the pandemic.

12. NHS England did not take on exclusive responsibility for any Government policy and retained its role of providing expert and advisory input (which included providing skilled individuals in areas such as medicines and supply chain), information and

[19] See for example the NHS England 2020/21 End-of-year Mandate Assurance Report.
[20] See for example NHS England 2022/23 priorities and operational planning guidance.

modelling, all of which the Government used to inform its decision-making.

13. Both prior to and during the pandemic, NHS England officials at all levels of the organisation regularly met with policy-makers in Government, as part of NHS England's role, contributing to the development of Government policy. There were many channels, including bilateral and ad-hoc meetings, which complemented more formal structures.

14. NHS England officials attended Government meetings such as COBR when requested by Government to do so, and advisory groups such as Scientific Advisory Group for Emergencies (commonly known as "SAGE").

15. In reaching its decisions, the Government had to consider not just NHS England's input, but also that of many others, in and outside of the health sector.

16. NHS England:

    c. is governed by its Board which provides strategic leadership and accountability to Government, Parliament and the public; and

    d. operates by way of a national team and a number of regional teams. From 2019 there have been seven regional teams: East of England, London, Midlands, North East and Yorkshire, North West, South East and South West.

17. NHS England is not:

    e. a core political or governmental decision-making body;

    f. responsible for setting national health or public health policy; or

    g. a provider of patient services.

18. On 13 March 2025, the Prime Minister announced the integration of NHS England into DHSC. Further details were set out by the SSHSC in a statement to Parliament on the same day. Since 1 April 2025, a Transition Chief Executive Officer of NHS England has been heading the transformation team to implement these reforms.

19. NHS England can only be abolished by an Act of Parliament with provision made for the transfer of all its commissioning and regulatory functions (this cannot be achieved through regulations, see section 103(3) of the 2022 Act).

Public Health England

20. PHE was established as an Executive Agency to DHSC. Its core role was to fulfil the SSHSC's statutory functions (primarily set out in sections 2A and 2B of the 2006 Act) to protect the nation's health, address health inequalities and promote the health and wellbeing of the people of England.

21. Prior to its dissolution on 1 October 2021, and the replacement of its functions primarily by the UKHSA and the Office for Health Improvement and Disparities, PHE was the body responsible for providing specialist health protection, epidemiology and microbiology services across England and collaborating with the health protection agencies (providing similar specialised services) in the devolved administrations.

22. Like PHE, the UKHSA is an Executive Agency with close ministerial oversight while still permitting "*independence in the delivery of policy advice*". As set out in the Framework Document between DHSC and the UKHSA, the UKHSA "*will form an essential part of the UK's national security infrastructure, helping to protect the country from societal and economic shocks arising from pandemics and other external threats to health*", while bearing in mind that health is a devolved matter.

23. PHE/UKHSA is responsible for supporting the ongoing development of the public health workforce in local authorities. It helps to inform commissioning of early years services and the ongoing support and development of the children's public health nursing workforce. This includes school nursing, health visiting and family nurse partnerships. PHE/UKHSA has a named doctor and nurse for safeguarding, and liaised with NHS England to access local expertise and advice.

Regulators

24. Providers of healthcare services i.e., those that provide direct care to patients at an organisational and clinician level, are regulated by different regulators depending on their structure and the services being delivered. For the Specified Period this included:

    a. the CQC, the independent regulator for the quality and safety of care who oversees and inspects organisations that provide health and social care services **[DB1/150][INQ000269886]**;

    b. NHS Improvement (bringing together Monitor and the Trust Development Authority) which oversaw Trusts; and

c. for clinicians themselves, the relevant healthcare professional bodies, such as the GMC and the NMC.

Categories of health services

25. Taxpayer-funded health services are commonly grouped into four broad categories, denoting the typical way in which a patient can experience the health system from first point of contact. These services are intended to act as an integrated system:

a. Primary care includes: general medical practice (GP), community pharmacy, primary dental care and primary optometry services. Almost all primary care providers are independent businesses operating in accordance with contracts commissioned by NHS commissioners;

b. Secondary care includes: planned (elective) care that usually takes place in a hospital (including specialised dental and ophthalmology), UEC including 999 and NHS 111 services, urgent treatment centres, ambulance services, hospital emergency departments, and some mental health services. Secondary care is predominantly provided by public sector organisations such as Trusts but can also be provided by independent sector organisations under contract to the NHS;

c. Tertiary care includes: highly specialist care provided to patients who are referred from primary or secondary care services. Tertiary care includes neurosurgery, transplants, specialist stroke units and inpatient mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations also provide this under contract to the NHS. The exception to this is inpatient mental health which is provided predominately by independent sector organisations. Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

d. Community care includes: community nursing, community mental health services, health visiting, child health services and sexual health services. Community care is provided by a range of independent and public sector organisations. Commissioning of community care is a mixture of local authority and NHS commissioning.

Ambulance services

26. Ambulance Services were commissioned from 'ambulance trusts' by CCGs prior to the pandemic.[21] Each of the ten ambulance trusts[22] covers a wide geographical footprint and supports the ambulance needs of individuals present in their region. In addition, they provide support and assistance to neighbouring regions and cross border assistance with the devolved nations by way of mutual aid in accordance with agreed protocols.

27. Ambulance service staff did not, either before or during the pandemic, have the authority to make any decision as to whether a patient is admitted to hospital. That decision is made by hospital clinical teams after the patient has been conveyed to hospital by an ambulance or other means.

Patient interactions with the NHS

28. Most interactions with the NHS occur outside of acute hospitals, in primary care, community services and mental health services. These services support people with complex health and care needs to live in their own home for as long as possible without the need for hospital admission.

29. Different patients will have a different journey depending on their clinical requirements and where their journey begins. Depending on a patient's health condition, there are advisory guidelines, provided by NICE, for the diagnostic and treatment 'pathway' that providers and clinicians follow which can determine that journey.[23] Professional guidance may also supplement this.

30. For example, when feeling unwell a patient (or their parent or guardian) will probably first see a GP (primary care) or contact NHS 111[24] unless they present through UEC routes (e.g., by calling 999). Following first presentation, they then may be given advice, or referred to an urgent community service, a hospital A&E department or more specialist care, perhaps for investigations and diagnosis. In very specialist (tertiary care) or end of life situations (e.g., hospices), the patient will be referred to an appropriate provider.

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[21] They are now commissioned by Integrated Care Boards.
[22] Isle of Wight is a combined Trust and so acute and ambulance are all part of single trust.
[23] NICE is a national advisory body established by the 2012 Act as an executive NDPB sponsored by DHSC. NICE's role is to provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services. NICE supports the health and care system by describing what good quality care looks like in the NHS, public health and social care sectors and helps promote the integration of health and social care.
[24] NHS111 services provide prepared advice, referral to community pharmacy, GPs, urgent care facilities including A&E and 999 response as appropriate. This was supplemented by a front end 119 Covid-19 helpline.

31. Decisions about hospital admissions are exclusively made by the relevant hospital's clinical team. To avoid doubt, GPs do not make decisions regarding admission to hospitals, rather they make referrals.

Delivery of health services

32. As noted above, providers of the different groups of care range from public sector organisations e.g., NHS Trusts (established by orders of the SSHSC) and NHS Foundation Trusts (public benefit corporations),[25] to independent providers including charitable and other not-for-profit organisations (e.g., providers of children's hospice facilities), and independent contractors (e.g., GP practices).

33. Independent sector providers provide services to the NHS under contract. Since 2014 they have been required to hold an NHS provider licence unless they are exempt. The NHS provider licence is used to regulate providers of NHS services and was regulated by NHS Improvement during the Specified Period. It sets out the conditions that providers of healthcare services, for the purposes of the NHS in England, must meet to help ensure that the health sector works for the benefit of patients.

34. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS workforce'. To avoid doubt, the workforce of Trusts are not employed, or managed, by NHS England.

35. "Commissioning" is the continual process of planning, agreeing and monitoring that services are delivered. For example, where NHS England commissions a service, it develops and issues a service specification, which forms part of a contract between NHS England and the relevant provider. Under this contract, the provider agrees to deliver the service in accordance with the service specification, in return for payment by NHS England.

36. During the Specified Period, CCGs commissioned the majority of NHS services, including most hospital and ambulance services and NHS 111, whilst NHS England directly commissioned:

    a. primary care services; however, during the Specified Period NHS England had principally delegated this role to CCGs for GP services. NHS England, particularly through its regional teams, retained responsibility for

[25] Trusts can operate multiple hospital and community sites.

commissioning dental, optometry and community pharmacy services;

b. specialised services (often provided as part of tertiary care), which includes highly specialised services. These services, which are defined in statute, support patients with rare (and very rare) and complex conditions;

c. military and veteran health services;

d. health services that support children and adults throughout the youth justice and criminal justice systems in England; and

e. a limited number of public health services (working closely with PHE / UKHSA and DHSC) **[DB1/151][INQ000270071]**.

37. Providers are accountable to commissioners through their contracts for the services commissioned. To maintain services, the health service provider makes its own decisions on staffing, purchasing and stock levels, maintenance etc. During the Specified Period, NHS England was under legal duties to promote the autonomy of NHS organisations and reduce regulatory burdens.[26]

38. It is the responsibility of the provider to ensure that services are carried out in accordance with specifications, allocated budgets and taking into account appropriate clinical guidance.

39. The day-to-day management of patients is the responsibility of the relevant provider. For example, in hospitals clinicians use their professional judgement and appropriate clinical guidelines to determine the treatment that a patient should be offered and receive. This judgement includes the patient's suitability for treatment options (assuming those are NHS-funded and commissioned services/treatments) as well as whether or not a patient should be admitted.

40. The discharge of patients, as well as their admission and treatment, is a matter of clinical judgment of individual clinicians who are best placed to assess all relevant factors.

[26] See for example, section 13F of the 2006 Act

ANNEX C

Children's Healthcare Access during the Pandemic: Timeline

1. The timeline below is intended to be read alongside NHS England's Module 8 Statement. The purpose is to aid the reader understand the timeline of events as they occurred, during the Specified Period.

2. The timeline provides a summary of key events, actions, and decisions taken by NHS England, which impacted on children's healthcare access during the pandemic. These events have been described in NHS England's Module 8 Statement and are not exhaustive.

3. Some national events and key government decisions have been included for context.

2020

NHS Response

March

13th – NHSE clarifies screening and immunisation services should continue as normal

16th – hospital paediatric services advised to keep children out of the healthcare system, except for essential and urgent care, and to use telemedicine where appropriate.

17th - Phase 1 letter instructs the NHS to free-up capacity to cope with anticipated increase in Covid-19 patients. This includes postponing non-urgent elective operations, but emergency admissions, cancer treatment and other urgent care needed to continue.

19th – NHSE sets out how CYP community health services can be prioritised, to help release capacity to support the pandemic response; GPs are also advised how they can free up capacity.

25th – all routine and non-urgent dental care is temporarily stopped.

25th - mental health trusts are instructed to ensure 24/7 advice is available to people of all ages, through a single point of access.

26th – Paediatric critical care units advised they may need to prepare to admit adult patients, to support Covid-19 surge; community paediatric doctors advised they can be redeployed to support acute paediatric services if needed

April

2nd - CHS prioritisation advice is updated so that audiology provision should be made for essential or routine care, but routine assessments could be delayed.
9th – all 111 under-16s calls are retained within the 111 Core service and not transferred to the Covid Clinical Assessment Service
11th – with Royal Surgical College, NHS England publishes guidance on prioritising surgery
29th - Phase 2 letter encourages trusts to consider whether they have the capacity to resume some non-urgent elective care.

May

28th – Regional chief nurses are advised that health visiting/school nursing and other services should return to their commissioned service model.

June

3rd – Community services are instructed to partially or fully restore all CYP services, superseding the 19th March prioritisation letter

8th – dental practices begin reopening for face-to-face care

29th - Guidance confirms that routine immunisation programmes should be maintained

July

17th – RCPCH, with NHSE input, publishes national guidance for the recovery of children's elective surgery

31st - Phase 3 letter sent instructs trusts to recover the maximum possible elective activity between then and winter 2020/21.

October

7th - The Chief Nurse for Public Health and the CNO issued a joint letter with the LGA making it clear that health visitors and school nurses should not be redeployed other than in exceptional circumstances.

20th – Eligibility criteria for passive immunisation with palivizumab, for RSV is widened to include more at-risk children, to help decrease hospitalisations.

December

9th – Chief Allied Health Professions Officer advises no AHP who supports children, especially those with SEND, should be redeployed

January - March	April - June	July - September	October - December

UK Government response health -

March

16th - PM says "now is the time for everyone to stop non-essential contact and travel"
19th - PM says the UK can "turn tide of coronavirus" in 12 weeks
23rd - PM announces the first lockdown in the UK, ordering people to "stay at home"
25th - Coronavirus Act 2020 gets Royal Assent
26th - Lockdown measures legally come into force

April

16th - Lockdown extended for "at least" three weeks. Government sets out five tests that must be met before restrictions are eased

May

10th - PM announces a conditional plan for lifting lockdown, and says that people who cannot work from home should return to the workplace but avoid public transport

June

15th - Non-essential shops reopen in England
23rd - PM says UK's "national hibernation" coming to an end – announces relaxing of restrictions and 2m social distancing rule
29th – SSHSC announces that the UK's first local lockdown would be applied in Leicester and parts of Leicestershire

July

4th - UK's first local lockdown comes into force in Leicester and parts of Leicestershire. More restrictions are eased in England, including reopening of pubs, restaurants, hairdressers.

August

14th - Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play

September

14th - 'Rule of six' – indoor and outdoor social gatherings above six banned in England

October

14th - A new three-tier system of Covid-19 restrictions starts in England
31st - PM announces a second lockdown in England to prevent a "medical and moral disaster" for the NHS

November

5th - Second national lockdown comes into force in England

December

2nd - Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions

26th - More areas of England enter Tier 4 restrictions

School Closures: 20th March – 1st June (phased re-opening)

Covid-19 waves: Wave 1 (Wuhan Variant): February to May 2020 | Wave 2 (Alpha): September 2020 to January 2021

2021

NHS Response

March

25th - 2021/22 operational planning guidance instructs local health systems to plan to undertake highest possible level of elective activity in that financial year

June

4th - NHS England commits to establishing 15 specialist hubs for CYP with Long Covid.

August

3rd - PCAS went live and accepted referrals from all NHS 111 providers through a national clinical queue

September

3rd – NHSE publishes framework to support redeployment of nursing staff to support CYP in-patient care, in anticipation of RSV admissions.

20th – Update to 2021/22 operational planning guidance reiterates children and young people should continue to be treated according to clinical priority.

22nd – UEC Recovery 10-point action plan commits to increased CYP support, to prepare for anticipated RSV surge.

December

23rd – NHS England publishes guidance to support development of local adult and paediatric respiratory clinical assessment service hubs

January - March	April - June	July - September	October - December

UK Government response health -

January

5th - England enters third national lockdown

February

22nd - PM publishes a roadmap for lifting the lockdown

March

29th - Outdoor gatherings of either six people or two households will be allowed, including in private gardens. Outdoor sports facilities also reopen. 'Stay at home' order ends but people encouraged to stay local.

April

12th - Non-essential retail, hairdressers, public buildings e.g. libraries and museums - reopen. Outdoor venues, including pubs and restaurants, zoos and theme parks also open, as well as indoor leisure e.g. gyms -. Self-contained holiday accommodation opens. Wider social contact rules continue to apply in all settings

May

17th - Limit of 30 people allowed to mix outdoors. 'Rule of six' or two households allowed for indoor social gatherings. Indoor venues will reopen, including pubs, restaurants, cinemas. Up to 10,000 spectators can attend the very largest outdoor-seated venues like football stadiums.

July

19th - Most legal limits on social contact removed in England, and the final closed sectors of the economy reopened e.g. nightclubs.

School Closures

5th Jan – 8th March

Covid-19 waves

Wave 2 (Alpha): September 2020 to January 2021

Wave 2 subsiding (Delta): Feb 2021 to September 2021

Wave 3 (Omicron): Sep 2021 – Feb 2022

2022-2023

NHS Response

January

11th – NHSE publishes community services prioritisation framework in response to Omicron wave, in place until March 2022.

25th - NHS England publishes 2022/23 operational planning guidance instructing local health systems to plan to undertake highest possible level of elective activity in that financial year.

February

8th – 'Delivery plan for tackling the COVID-19 backlog of elective care' sets out targets to eliminate long elective and cancer waits

July

1st – Normal contracting arrangements for dental practices resume

October

22nd – NHSE publishes updated guidance on developing adult and paediatric acute respiratory infection hubs

January

30th - UEC plan for England commits to expanding paediatric clinical assessment services in 111

May

22nd – NHS England publishes CYP elective recovery toolkit for local health systems

2022	2023

UK Government response health -

School Closures

Covid-19 waves

Wave 3 (Omicron): Sep 2021 – Feb 2022