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Managing capacity and demand within inpatient and community mental health, learning disability and autism services for all ages

17 November 2020, Version 2

Updates from version 1 are highlighted in yellow.

Contents

Introduction

This guidance has been produced by the national NHS England and NHS Improvement mental health, learning disability and autism and specialised commissioning COVID-19 response cell. It provides information and guidance for providers and their clinical and non-clinical teams who are planning for how best to manage their capacity across inpatient and community services. It should support contingency planning, already underway, for a range of resource-constrained scenarios. It will be updated as required.

It provides guidance and considerations for specialised services as well as CCG-commissioned services.

Context for guidance

This guidance is one of a suite of resources that should be consulted in parallel.

This guidance is for regional NHS England and NHS Improvement colleagues, commissioners (CCG, specialised commissioning or health and justice), providers, social workers, local authorities, experts by experience, clinical experts, the criminal justice system, independent chairs for care and education and treatment reviews, and others who may be involved in pathways of care for all ages.

This guidance has been assessed to identify potential equality impacts of the COVID-19 pandemic on people with mental health needs, a learning disability, autism or both. People with mental health problems or a learning disability, autism or both who contract COVID-19 may require reasonable adjustments to access mainstream services. Further, the impact of the COVID-19 pandemic has the potential to affect mental health and wellbeing. Health services must continue to have due regard to their obligation to advance equality under the Equality Act 2010. This includes recognising and factoring-in the vulnerability of different cohorts with protected characteristics; and inequalities in access, experience and outcomes in health services. The advancing mental health equalities toolkit helps with identifying and addressing mental health inequalities in the round. Partnership working with the voluntary and community sectors (VCS) is also encouraged to facilitate wrap-

around support for vulnerable people, and to maximise engagement with underrepresented groups.

Considerations for all services

1. General principles

COVID-19 and the national measures introduced to reduce the spread of COVID-19 will inevitably have a significant impact on both demand for and capacity to deliver support for people of all ages with mental health needs, a learning disability, autism or both. The impact on people's mental health will endure beyond the pandemic and it is vital that mental health services are maintained to meet people's needs now (including for people who are not yet coming forward) and as we move into a post pandemic period.

These are some of the principles that should inform our response as a mental health/learning disability and autism system:

i. People of all ages with mental health needs, a learning disability, autism or both should receive the same degree of protection and support with managing COVID-19 as other members of the population. This may mean providing additional support, including making reasonable adjustments.

ii. In responding to COVID-19, staff in mental health/learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient, staff and public safety and risk. Decisions should ensure critical services are maintained during the pandemic including those services within the community which can impact significantly on both mental and physical health. Providers should ensure that they have in place a patient panel or an ethics committee to advise on decisions regarding the prioritisation of resources or changes to service delivery. This can be an existing group.

iii. When considering plans, providers should consider not just patients' vulnerability to the physical infection, but their vulnerability stemming from mental health needs, a learning disability, autism or a mixture of these.

People of all ages will be at risk of mortality through suicide, injury, self-harm and self-neglect, so changes to services need to have patient safety as the paramount concern, including issues related to safeguarding. Providers should also consider the access to support a patient may receive from informal and formal care and whether this is also impacted by the pandemic. I think we need to qualify what we mean by informal and formal care.

iv. Providers will wish to consider the cumulative impact on the mental and physical well-being of carers of the pandemic, especially family members caring for a person who has additional needs at a time of increased social isolation, reduced access to activities and in some cases where shielding has been advised for an individual, (carer or cared for).

v. Partnership working is crucial, and responses, including prioritisation decisions, will need to be co-produced wherever possible. To both maximise the use of community assets and to draw on the insight and expertise of partners, response plans will need to be developed alongside patients, including children and young people and their families, carers, VCS organisations as well as neighbouring mental health/learning disability and autism providers. This will include planning within an NHS-led provider collaborative, with social care partners (both commissioners and providers), the criminal justice system, commissioners, local authority children's services and education providers for children and young people (CYP).

vi. To respond to government guidelines on social distancing, providers will need to consider carefully their policies and procedure regarding family visits and the benefits to patients of all ages, facilitating face to face contacts where safe to do so and where this can be jointly agreed with patients. Digital alternatives should also be used to support continuity of social contact for patients, families and carers. Providers will need to consider their need to make reasonable adjustments in respect of visiting and be aware that a individual person centred decisions should be made for people with a learning disability and for people who are autistic. Visits from family members and loved ones may support recovery and discharge and be vital in enabling staff to understand people with communication difficulties or those whose behaviour challenges.

vii. Providers should consider taking a blended approach between face to face and remote delivery, when planning for service continuation; taking into consideration both patient choice and the clinical needs of patients to ensure that both COVID secure face-to-face and digital alternatives are available. Providers should ensure that there is adequate support for staff, patients and families to use digital alternatives when accessing and delivering care remotely. A person's ability to adapt to new approaches to service delivery should be considered as well as their ability to use technology appropriately. Where there are any safeguarding concerns a face to face visit is always recommended

viii. Providers must bear in mind the longer-term impact of the pandemic and associated impacts on the mental health needs of the population. Providers must minimise changes that impact on the capacity and capability of the system longer term and, where changes are made, keep these under regular review.

ix. It is essential that wellbeing of staff (both mental and physical) is maintained and considered when providers are adapting service provision in response to the COVID-19 outbreak. Providers should be signposting staff to relevant support.

2. Additional funding for the response to the COVID-19 outbreak

Simon Stevens and Amanda Pritchard wrote to the NHS on 17 March 2020 with a letter titled **IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19**, which set out detail on the financial regime under COVID-19 for the first 6 months of the year.

Phase 3 guidance to the system which set out the financial regime for October to March was published on the 15th September. For the rest of the financial year 2020/21, each system will receive an envelope of additional costs for COVID-19, based on the amount requested nationally in Q1 2020/21, split on a fair shares basis. The distribution of this is to be decided locally and should include additional costs incurred by MH Providers, the Phase 3 guidance specifically states-

"In distributing the overall funding envelope (including additional COVID funding), systems should ensure that they recognise the additional costs incurred by Mental Health providers in responding to COVID (including but not limited to packages of care to avoid delays in discharge of MH patients to support bed flow, expediting delivery of all age 24-hour crisis support including phone lines, implementing new models of A&E provision for MH patients and MH support to both staff and patients impacted by COVID) and reflect the priority given to MH in the Phase 3 letter."

3. Maximising capacity where needed across services for people with mental health needs, a learning disability, autism or both

- Guidance on *Implementing phase 3 of the NHS response to the COVID-19 pandemic* was issued on 7 August 2020, further to the high level letter distributed on 31 July 2020.

- In developing plans to follow this guidance and ensure services can rapidly maximise capacity where needed across mental health, learning disability and autism services, providers will need to continue to consider:

- **Ongoing risk stratification for all and review of the dynamic risk registers for those with a learning disability and autism** – to determine who is most at risk physically and mentally and how-to co-ordinate response and care accordingly.
- **Flexible approaches to deployment of workforce across different settings**, for example:
    - using mental health practitioners from other services to provide additional capacity in crisis teams if required
    - putting in place urgent duty rotas to cover staff absence or self-isolation, including for tasks that may require face-to-face contact
    - ensuing capacity in liaison psychiatry teams in acute trusts to support discharge and patient flow
    - working with VCS partners to create different workforce solutions
    - moving to remote working and using technology to provide remote access to professionals wherever possible and safe to do so

- providing mental health and dementia clinical input to care homes and supported housing where appropriate
- Utilising the expertise and skills of staff who are unable to attend work in person for example where they are self-isolating or shielding, to support the wider workforce effort.

- **Refresher training and upskilling staff on key aspects** e.g. physical healthcare to ensure:
  - appropriate physical health monitoring is undertaken; this could be supported by refresher training: e.g. on monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams – providers may wish to consider tools such as NEWS2 and RESTORE2 to support this endeavour and to help detect deterioration in people for whom they care either as in patients or in the community
  - a sufficient pool of staff is available to undertake mandatory blood testing: e.g. for patients on clozapine or lithium; this may include pharmacy staff undertaking phlebotomy training and refreshing knowledge, skills and practice in infection control.
- **Temporarily standing down activity that is not directly related to care provision, to free staff capacity and enable redeployment if needed**. These decisions need to be mindful of the impact on service delivery and the users of those services both in the short and longer term, and to be stepped back up as soon as possible, eg:
  - non-essential staff meetings
  - non-essential education and training – for further advice please see workforce guidance published on 8th April 2020.
  - audit activities
  - quality improvement initiatives
  - research and trials where safe to do so
  - before stopping activity, providers should risk assess the impact on patient and staff safety and wellbeing (e.g. could it lead to a deterioration in mental health and behaviours that challenge and could lead to admission?), business continuity and impact on other parts of the health and social care system

    - Activity such as notifications to the LeDeR programme should not be stopped at this time as this data will support our continued service improvement through the pandemic

- Where activity is stopped after due consideration of any reasonable adjustments and the legal requirement to reduce health inequalities, providers should record what is stopped and how changes should be communicated clearly to patients, families and carers in line with their assessed communication needs.

- Waiting times may be affected for routine and non-urgent care, including in mental health, learning disability and autism services; disruption and delay should be minimised where possible and patient and clinical safety prioritised.

- Providing a rapid response to the changing situation is vital; regional and local colleagues will need to report into and make use of daily situation reports (sitreps) to manage the fast-moving context and enable a rapid response to changes in demand and capacity.

It may be helpful for services to use the CREST appointment/bed modelling tool originally developed for use with CYP's mental health services.

The CREST tool enables an assessment of the level of resources required to properly manage a flow of patients through a service – whether in a clinic (outpatient) or bed-based (inpatient) setting. It is particularly appropriate where a queue for a service is time sensitive. The tool's inpatient module is designed to model numbers of beds required to meet demand. It combines:

- numbers of patients requiring beds
- average length of stay expected
- maximum waiting time for beds.

4. Service planning in inpatient settings

Discharge planning to free inpatient capacity

- Providers should continue to review all current inpatients to support safe discharge where feasible, to support patient flow and ensure there is capacity in the system for those that require inpatient care. A case-by-case assessment of

patients' needs, and risks will need to be done, in partnership with them and their family, carers, and onward care provider (including housing and community teams) where relevant.

- Discharge of long stay patients, particularly patients who are autistic or have a learning disability, should be progressed in line with their discharge plans and should not be negatively impacted by the effects of the pandemic

- Providers should also refer to hospital discharge service requirements for further considerations, including NHS trusts' statutory duty under the Homelessness Reduction Act (2017) to refer people who are homeless or at risk of homelessness to a local housing authority.
- Providers will need to continue to ensure that all patients being discharged from hospital safely and appropriately to a care home are first tested for COVID-19 in line with national guidance.
- Discharge plans need to reflect the risks in relation to COVID-19 for individuals. This should include ensuring no one symptomatic or asymptomatic, at risk of severe illness from COVID-19, is discharged without appropriate accommodation to support shielding or self-isolation where necessary. The regional lead for the homeless response should be contacted for advice if the individual fits into the shielding or advised self-isolation group, appropriate accommodation cannot be found, and they are likely to rough sleep if discharged. The national Homeless Response Team can be contacted at: england.covid-homeless@nhs.net.
- There should be no undue delays in agreeing funding for discharge packages. The NHS finance guidance for months 7-12 of 20/21 (issued on 15 September 2020) clarifies that mental health services should receive its share of additional costs relating to COVID-19.
- Discharge planning will require close partnership working with adult and children's social care to quickly agree who will fund and arrange the required packages of social support and care for people to be discharged. This may be supported by funding panels such as Section 117 panels meeting more frequently, regular commissioner/provider calls, temporary pooling of budgets or 'placement without prejudice' arrangements, working rapidly with housing and VCS partners, and bolstering capacity within intensive home treatment teams. Cross-system approaches such as multi-agency discharge events (MADE events) could be used.

- Providers should ensure that S17 leave is being used safely and appropriately to support transitions to the community and that any barriers to discharge are identified and notified to the care manager/ commissioner/ regional team as appropriate.
- People with a learning disability, autism or both who are inpatients within mental health, learning disability or autism specific services fall under the Learning Disability and Autism Transforming Care work that aims to reduce unnecessary admissions and lengthy stays, and increase the quality of inpatient provision. It is important that this activity is maintained, including commissioner visits, host commissioner responsibilities and C(E)TRs, as outlined in Section 7.

Assessing referrals for admission

- Alongside timely discharge, providers will need to review their processes for assessment of referrals for admission. Where possible all referrals should be assessed using a multi-agency care planning approach such as the care programme approach (CPA) or for those with autism or a learning disability (or both) the C(E)TR multi-agency framework before admission, with robust review of community alternatives, including those in the VCS. C(E)TRs and other multi-agency care planning meetings can take place remotely using digital technology if there are risk identified with face to face meetings, as outlined in Section 7 and should be supported by the referring community mental health team or the community learning disability team to also agree the purpose of admission, anticipated length of stay and the relative risks associated with the admission.
- Dynamic support processes including at risk of admission registers for people with a learning disability, autism or both should be in place in every locality and can be used to help identify those at risk of admission and who may need additional support on discharge and so plan the right support in the community.
- Providers should test all patients for COVID-19 on admission to ensure appropriate bed allocation and isolate people wherever possible prior to any test results being received.

Cohorting physically vulnerable patients

- Providers should consider whether it is possible to reconfigure the inpatient estate to create ‘cohorted’ wards to reduce the risk of contagion. This will need to be considered in line with the specialist nature of service provision and the

needs of each patient group and the requirement to make reasonable adjustments for people with a learning disability and those who are autistic.

- In line with guidance on supporting patients who are unwell with COVID-19 in mental health, learning disability, autism, dementia and specialist inpatient facilities, inpatient settings should 'cohort' patients, wherever possible, into:
  - those with confirmed or suspected COVID-19
  - those without confirmed COVID-19.
- All patients should be tested for COVID-19 on admission, including those who are asymptomatic. In addition to cohorting patients as outlined in previous paragraph, providers will therefore also need to isolate patients while they await their test result
- Patients identified as highly clinically vulnerable (those who previously met the govt requirements for shielding) should be prioritised for a single occupancy room
- Providers should continue to consider the vulnerabilities of every patient they are caring for when reconfiguring the inpatient estate to reduce the risk of contagion among specific vulnerable groups outlined in Staying alert and safe guidance:
  - particular consideration needs to be given to those with a learning disability and people with an SMI. The annual LeDeR report published in May 2019 evidenced that 41% of deaths of people with a learning disability resulted from respiratory conditions.
  - Recent learning from the deaths of people during the pandemic indicate that particular attention to the need for reasonable adjustment to be made for people with a learning disability to ensure that they are not inadvertently disadvantaged
  - Diagnostic overshadowing may prevent clinician teams form identifying deteriorating or presentation of symptoms at an early stage
  - Providers may wish to consider the opportunity to implement pulse oximetry in routine observations of physical health care of in patients, at the point of discharge and those under their care in the community
- Providers will also want to consider whether wards are able to provide flexibility in the management of acuity – e.g. by bringing high dependency unit capacity onto a ward if required so that vulnerable patients do not need to be transferred between wards.

- Providers may similarly want to consider whether usual restrictions on ward types can be relaxed: e.g. where ward type is based on age, sex or diagnostic group on a case-by-case basis. A record of decision-making and ethical considerations should be kept, including of the involvement of patients and service users. Service reconfigurations should be kept under regular review and the impact on reasonable adjustments considered.
- Providers will want to consider where enhanced mental health care may be needed to mitigate the impact of isolation when face to face visiting is not possible, including the use of digital technology to retain social connections.
- Refer to the guidance on supporting patients of all ages who are unwell with COVID-19 in mental health, learning disability, autism, dementia and specialist inpatient facilities, for more information on inpatient care.

Flexible use of the inpatient estate

- Social distancing on admission wards will need to be maintained. To follow the PHE guidance on social distancing, where possible providers with dormitory rooms should space beds two metres apart. If this is not possible within the ward set-up, this should be recognised in local risk assessments.
- To follow PHE guidance on self-isolation, patients with the virus will require single-room accommodation and access to their own bathroom. This will require a flexible approach to accommodation and reconfiguration of the estate, potentially across a group of providers, including the independent sector, in a provider collaborative or local geographical footprint.
- Providers should consider:
    - how additional, single-room accommodation for patients with COVID-19 could be provided in partnership with the independent sector (which may offer a higher proportion of single-room accommodation)
    - whether modifying any available capacity within the adult secure estate is possible, to accommodate voluntary patients.
- We expect providers to continue to:
    - analyse and map the current and potential inpatient estate
    - identify key gaps, risks and pressures

- develop several contingency plans to match likely scenarios, in partnership with other inpatient providers locally
- keep any service changes under regular review and continue to engage patients, families and carers on their experience.

Implications for out-of-area placements for adult acute mental health services specifically

- The ambition to eliminate out-of-area placements by March 2021 has not changed. However, it is understood that service capacity is likely to be affected by the COVID-19 pandemic and, in some cases, this may result in the need for out-of-area placements: for instance, through use of additional independent sector capacity.
- Efforts to care for all people locally should continue. However, the advice remains that patient safety is paramount and that when an acutely unwell person requires inpatient admission, it is safer to admit them to an out-of-area (including independent sector) bed until they can be cared for locally, than to turn the person away and not admit them at all. Providers should continue to operate the continuity principles as far as possible (see Annex B for the principles).
- Providers and commissioners should consider at this stage whether any beds previously scheduled for closure – e.g. as part of reconfiguration and repatriation through provider collaborative approaches – could be retained, or what opportunities there are to re-activate mothballed wards to ensure sufficient capacity is available to meet patient need on a temporary basis.

Visiting arrangements and reasonable adjustments.

- On 12 September 2020, Claire Murdoch and Ray James, National Directors of the Mental Health and Learning Disability and Autism Programmes in NHS England and NHS Improvement wrote to all providers with several clarifications about arrangements for visiting during the pandemic. This included emphasising the importance of making the reasonable adjustments needed to ensure people can remain in contact with their loved ones.
- This communication was to ensure that all providers are allowing families to visit their loved ones unless a risk assessment has been carried out for the

individuals which demonstrates that there are clear reasons specific to their individual circumstances as to why it would not be safe to do so.

- Providers MUST take all steps possible to enable safe regular visits and should contact their contract manager immediately if there are challenges to discuss this and come to an agreed plan as a matter of urgency.

5. Service planning for all ages within Community settings, including CMHT, IAPT and CYPMH services

Community considerations for all ages

- Patients of all ages with mental health needs and those with a learning disability, autism or both may require significant support to manage their mental and physical health during this time, and support to understand and implement guidance.
- During the first peak of the pandemic there was significant variation in delivery of contacts, particularly for people with SMI on CMHT caseloads, and variation in delivery of face-to-face care. Learning suggests that it is vital that community services, including face to face provision where possible, are maintained during the pandemic and any changes made to service configurations are regularly reviewed, with the aim to restore full-service provision as soon as possible.
- We know that providers have prepared to provide as much continuity of care as possible in any second peak of the virus or in local peaks. It is critical that services avoid partial or complete closures. Services should make every effort not to blanket discharge patients from community team caseloads. Many services have reorganised services to continue to deliver 'business as usual' and have maximised their efficiency as they lead and support staff to embrace digital and remote working.
- Where possible, choice and flexibility on method of contact should be offered to all patients, with the most vulnerable, those living alone and those who may find digital services difficult to access, prioritised for COVID secure face-to-face contact, and especially those who have a learning disability or who are autistic. Plans should be put in place with primary care and VCS partners if appropriate and with social care providers where required, to support:
  - safe discharge from inpatient services

- keeping those on community caseloads (including within specialist teams such as EIP) as well as possible by providing therapeutic and meaningful interventions to help prevent building up and creating avoidable demand for crisis services
- existing and anticipated new referrals from primary care, or people who have already been assessed and are awaiting a first appointment (the fulfilment of which has been affected by the pandemic)
- people who have been recently discharged from community caseloads and may need to re-access services in the short term

- For people with a learning disability or people who are autistic; to support the prevention of future admission where possible and where identified on a dynamic support register. This may require adjustment to individuals existing risk assessments.
- Continued co-production is vital to meeting patient needs across all services. Areas will need to engage patients, families and carers to ensure any service changes (e.g. the use of remote consultations) maintain delivery of meaningful care and a full range of treatment options. In the context of delivering care in new ways, capturing patient experience and outcomes is more important than ever to ensure equitable and meaningful care continues to be delivered, and to understand and mitigate risks of iatrogenic harm.
- The options below could be considered to release and create capacity for priority support services in the community:
  - the potential to temporarily pool services which are currently standalone, e.g.:
    - pooling resources across early intervention in psychosis (EIP) teams to increase CMHT capacity
      - pooling resources across intensive support-enhanced and community learning disability teams
      - where services are pooled it is important to ensure changes can be easily reversed once workforce capacity returns to usual levels. Services will also need to ensure that staff can continue to draw on specialist advice where needed, such as EIP and community eating disorders expertise to prevent relapse and further inpatient admissions. Where possible people with a learning disability and

people who are autistic should continue to be supported by individuals with whom they are familiar

  - releasing appropriately skilled staff from corporate functions to enhance clinical capacity
  - partnership working with the VCS to support NHS service delivery.
- Areas should avoid disputes about who has ultimate responsibility for delivery and payment of a patient's treatment: e.g. responsibility for a looked-after child.
- Primary care, community mental health and community learning disability teams will need to consider, in partnership with primary care services where appropriate, how to continue to deliver critical aspects of care: e.g. physical health monitoring, blood tests for patients on clozapine or lithium, and medical monitoring for people with eating disorders.
  - Where services are unable to deliver medication monitoring as recommended by local and national guidance, for example due to staffing shortages; risks need to highlighted using the trust risk log and steps agreed on how to mitigate these risks.
- For people with severe mental illness, their physical health should be protected by ensuring access to physical health checks and free flu vaccines for eligible cohorts
  - For physical health checks, service provision should be adapted to meet service user choice [this could include completing some elements of the check remotely where possible]
  - Services should explore partnerships with primary care and VCS sector to ensure holistic care pathways for mental and physical health care of people with SMI, and consider targeted local outreach to service users and carers
- Finally, community services should have an awareness of new any homelessness accommodation in their area and how they support access to this.

IAPT specific Considerations

- Where possible, and in line with national and regional government guidelines, IAPT services should offer face to face appointments for those for whom the clinical need is indicated and/or they would fail to receive appropriate

interventions remotely. Services should utilise their local risk assessment processes to enable use of Covid secure accommodation for patients requiring face to face appointments.

- More detail on approaches to communications and care planning are set out in a new IAPT guide for delivering treatment remotely during the coronavirus pandemic.

CYPMH Considerations

- Disruption to their education and access to other services has had a considerable impact, not just on children and young people themselves, but also on their families and carers. There was also an impact on referral pathways during the closure of schools and colleges earlier in the year. Children and young people's mental health services need to support partners such as social services, schools and FE colleges particularly as children and young people return to the classroom noting the increased pressures particularly that schools are under and the impact of COVID 19 on school staff.
- Options should be considered to release and create capacity for priority support services in the community, such as pooling resources across early intervention in psychosis (EIP) teams to increase CYPMHS team capacity.
- **CYPMH Services need to work closely with other agencies**
    - To ensure local referral pathways for CYPMH is communicated and supported by all key stakeholders including education, local authority, primary care, A and E etc.
    - Support local agencies in promoting messages about prevention, including validating and normalising feelings of stress and anxiety during the pandemic.
    - Clinicians must work closely with other agencies to share understanding of CYPMH needs and risks and agree a multi-agency care plan including the role of different agencies and escalation processes for concerns.
    - To ensure that reasonable adjustments are made to ensure autistic young people and those with a learning disability are able to access provision.
- **CYPMH Services need to increase contact with vulnerable groups of CYP.**

- These include CYP with serious mental illness such as eating disorders, looked after CYP, those with previous history of self-harm and where there are additional safeguarding concerns.
- A recent briefing based on the National Child Mortality Database, suggests CYP with neurodevelopmental disorders (including CYP with autism and ADHD) are at greater risk.
- Services and practitioners need to be aware of increased risks related to these groups and to proactively provide support.
    - For example, there may be limitations in remote risk assessments for certain groups of CYP including autistic children and young people. It may be difficult to fully assess safeguarding concerns or family difficulties and therefore consider if face to face assessment is required.

Partnership working with the VCS to deliver support in the community

- Partnership working with local community groups, the VCS and other providers will be critical to maintaining a viable support service for patients and their families in the community. Providers will want to identify local VCS organisations, the service offers they have to offer and what options there are for working together – either alongside the VCS to augment stretched NHS services, as direct replacements for NHS staff or in supporting individuals for whom usual services are no longer available, including carers whose mental wellbeing may be impacted by the pandemic in a range of ways.
- Commissioners should make additional resources available as required to enable new or enhanced contracting, supported as rapidly and flexibly as possible by procurement teams. Funding will be made available to STPs in support of this via the Mental Health Winter Funding 20/21, which is allocated via regional MH teams (see contact details .
- Providers and local commissioners should consider working with local authorities/local resilience forums to co-ordinate such support.
- Providers should consider services that a VCS partner may be well placed to provide; which would help to maintain safety in the community. This may include peer support, family/carer support, befriending, and telephone or social media outreach. In addition, they may work alongside crisis teams to provide telephone/ virtual and listening support.

Maximising use of digital technologies

- In planning how to deliver services, providers will need to use a blended model between remote and face to face provision. Decisions about whether or not face to face care is provided will be based on: a) clinical needs and risk levels of individual patients, b) patient choice, c) the type of activity being provided (eg assessment, therapeutic intervention, multi-agency care planning), and d) the availability of COVID secure clinical space, clinical governance guidelines and workforce considerations. All these factors should be considered in decision making when considering the use of digital and remote technology.
- Providers will need to maximise capacity through remote working and move care contacts to telephone or video consultations where safe and appropriate to do so. In order to do so, services need to ensure they have sufficient supply of mobile and other devices for clinical staff. Technology should also be used to support continued multi-agency working. Consideration may need to be given to whether patients have access to appropriate technology and, in some cases, whether restrictions on access to such equipment may need to be reviewed to facilitate remote contact.
- Providers will need to prioritise face-to-face contacts (in line with existing guidance on use of personal protective equipment (PPE) and social distancing) for those patients for whom remote or virtual contacts are not possible or viable, and for those deemed at higher risk, such as people with complex and severe mental health problems and co-existing needs who do not have access to technology and those living alone as well as some people who have a learning disability or who are autistic. Decisions regarding the type of contact offered should be risk assessed and considered in terms of reasonable adjustments, documented and regularly reviewed.
- Providers will also need to maximise the use of digital and virtual channels to manage the impact of self-isolation on staff and patients, including to support maintained social contact for inpatients where face-to-face visits are restricted in line with NHS visitor guidance.
- As far as possible, clinical teams should seek to discuss in advance with patients and families/carers the suitability of and their willingness to engage via different means of contact. Mechanisms should be set up to receive feedback from service users, families and carers on receiving care via digital channels.

- Providers need to ensure patient confidentiality can always be maintained when using remote channels.
- Providers need to consider whether there are any safeguarding considerations in respect of the use of remote and digital technology
- Where it has been appropriately risk assessed as suitable including in respect of safeguarding, services should consider providing digital devices to service users who do not already have one, to maintain contact if the service user or the provider is unable to arrange face-to-face contact, and information on using and troubleshooting digital platforms should be given to service users and carers.
- NHSX has published guidance to support the use of messaging and video conferencing. As well as tools such as Skype, WhatsApp and Facetime, there are products designed specifically for health and mental health. Providers should weigh up the benefits and risks when choosing which of these approaches to use and ensure that staff have sufficient training in their use. Specific tools designed for health and mental health such as Attend Anywhere are now available alongside other products and supported by local providers. Providers should use tools as needed based on local service requirements.
- The Information Commissioner's Office has published a statement and Q&As to complement a joint statement from the health regulators. Further questions can be directed to the NHSX IG Policy team.

24/7 mental health crisis lines / Single Points of Access

- NHS mental health providers must maintain or enhance their NHS crisis lines or single point of access (SPA) lines so they are available 24/7 and open to people of all ages, including those who self-refer. These lines must have the capacity to respond to urgent mental health needs, with access to patient records (where someone is already known to services) and should be reasonably adjusted to ensure they are accessible to people with a learning disability or who are autistic or both. Other reasonable adjustments may include language and cultural interpretation services that may be relevant to particular local demographics and the need to access British Sign Language interpreters. Many needs can be met on the phone or by video, but the SPA should also be able to facilitate access to further interventions in the urgent mental health pathway (including urgent face-

to-face assessment where needed), or access to routine primary, community or VCS services.

- The services **must** be freephone.
- As an urgent service, there should be no wrong door. Where people call a crisis line outside their home provider, they should be informed in a compassionate way, and be facilitated (ideally through a warm transfer) to access their home service. Neighbouring providers should seek to put in place arrangements to facilitate this.
- The SPAs / crisis lines should be part of local communications on winter and implementation of NHS 111 First. Anyone with urgent mental health needs can find their local crisis line number by visiting NHS.UK/urgentmentalhealth. People with urgent mental health needs should be encouraged to phone first rather than attending A&E where possible. However, it should be made clear that it may also be appropriate for people to attend A&E or call 999. Wording can be taken from the NHS.UK website.
- Mental health services should work with NHS 111 services to ensure that the 24/7 mental health crisis lines are profiled on the 111 Directory of Services, and NHS 111 services.
- Comms relating to NHS 111 First and mental health must also make clear that when people do attend A&E they should be treated compassionately and must not be turned away or made to feel like they are in the wrong place or wasting anyone's time. As a matter of patient safety, all mental health attendances to A&E should receive a referral to the liaison psychiatry services, or equivalent timely response (ideally within 1hr in line with national guidelines) from an expert mental health professional).
- Those operating SPAs will need to work closely with social care, housing and homelessness teams and VCS in providing a response. Some providers are already augmenting SPA lines with IAPT, CYPMH and VCS staff, to provide capacity for the potential additional demands for psychological/mental wellbeing support while freeing capacity for crisis care staff to provide urgent/acute response. The service may need additional funding and to continue timely recruitment. As well as redeploying staff from other teams, providers will wish to consider using clinical staff who are well but self-isolating to provide remote support.

- Providers must urgently review information on their websites to ensure it is clear and does not direct people to A&E, NHS 111, 999 or GPs for urgent mental healthcare unless this is appropriate (e.g. there is an immediate serious need or physical and mental health emergency). Where areas have planned and resourced dialling NHS 111 into their 24/7 mental health response (with access to specialist mental health staff), this will remain appropriate.

Considerations specific to services for people with a learning disability, autism or both

6. Identifying those likely to be affected and multi-agency planning for people with a learning disability, autism or both

- Individuals with a learning disability have higher rates of morbidity and mortality than the general population. 41% of people with a learning disability died due to respiratory conditions in 2019[1]. Recent data indicates that the high prevalence of diabetes, obesity and being underweight along with a range of other comorbidities, in people with a learning disability increases vulnerability to COVID-19 significantly.
- CCGs and local partnerships should have dynamic support processes and 'at risk of admission' registers that help to identify those children, young people and adults who are autistic or with learning disability or both who have specific support needs. It is essential that these are regularly reviewed and updated.
- It is vital that local areas review these processes and ensure they are including all individuals who are autistic or with learning disability or both who may be affected by COVID-19 using their clinical judgement to support consider whether specific individuals may be better to take additional precautions such as shielding to prevent infection as far as possible.
- It is particularly important that local areas identify children, young people and adults for whom they are responsible who may be placed outside their local area in a residential special school or college, social care children placement or adult placement. Whilst many children and young people have returned to school there remain a small group who have not or for whom a return to school will be

[1] Of those deaths notified to the LeDeR programme and reviewed in 2019 41% died from pneumonia or a respiratory condition

particularly difficult. Local areas should work together to ensure they fully understand the support needs of this group and are working with families to prevent crisis.

- Recent evidence also shows that in the Transforming Care group, autistic young people have been most likely to present in crisis with potential need for admission during the pandemic.
- It is vital that local areas fully understand their population and recognise the significant additional challenge placed on individuals, families and carers who may find a sudden and drastic change in organised support most hard and this is reviewed via the dynamic support and at risk of admission registers.
- Plans and support must be as robust as they can be, including use of tools such as positive behavioural support (PBS), social stories and the books beyond word resource available to support understanding of COVID-19 for those with a learning disability, autism or both. VSC partners may be able to offer additional support where funded to do so to help support mental and physical wellbeing of individuals and their carers.

7. Care (education) and treatment review

"We must maintain the intention, purpose and ethos of the care (education) and treatment review whilst undertaking these in an adjusted way during this period."

Dr Roger Banks, National Clinical Director, Learning Disability and Autism Programme

Continuation of C(E)TRs during this period

- Care (education) and treatment reviews (C(E)TRs) are an embedded and essential part of the pathway of care for people with a learning disability, autism or both in inpatient CCG-commissioned or NHS England and NHS Improvement (specialised commissioning) commissioned mental health or learning disability and autism provision.
- C(E)TRs have an important contribution to make in (i) ensuring people are not in settings or conditions that expose them to increased risk; (ii) facilitating

discharge; and (iii) regulating admission considering pressures on services and workforce.

- While recognising the COVID-19 guidance means we were required to adapt the way C(E)TRs were undertaken, we expect all local areas to continue to ensure that a process remains that fulfils this role.

Adapting where necessary during this period

- During the initial response to the pandemic, C(E)TRs moved to virtual meetings. Commissioners should now move towards a return to face to face C(E)TRs where it is safe and appropriate to do so, considering risk to all participants. Where it is not, there must be a continuation of virtual C(E)TRS.
- Commissioners remain responsible for ensuring a review of care, education and treatment happens and, in particular considers the risks to individuals subject to restrictive interventions. Risks to the individual because of the COVID-19 pandemic must also be considered to ensure they are being adequately addressed and minimised, including the physical health of the individual.

Community C(E)TRs

- See also Section 5 above for general guidance on service planning for community services.
- It is essential that a process remains for clear review and scrutiny before any proposed inpatient admission, not only considering alternatives to admission but defining clearly the managed risks, purpose, expected interventions, outcomes and timescales of admission.
- Commissioners should make use of technology to enable virtual C(E)TRs to take place with the input of usual participants (where it is not possible to revert back to face to face C(E)TRs) and explore all options available for provision of treatment and care in the community. The use of specific provider supported health and mental health technological solutions (such as Attend Anywhere) or Skype, WebEx, Microsoft Teams or other technology alternatives should be considered to enable the participation of members including the family.
- This may mean the process is to some extent abridged, but it remains an essential activity and care should be taken to ensure the essential elements of the C(E)TRs are addressed in the time available.

- In exceptional circumstances, the use of the local area emergency protocol or a joint CPA and C(E)TR could be considered.
- Efforts should be made to ensure that family members, experts by experience and clinical experts are enabled to join the meetings through technological means.

Inpatient C(E)TRs

- See also Section 4 for general guidance on service planning in relation to inpatient admissions.
- All commissioners should ensure there continues to be a process to review an individual's care, education and treatment during their inpatient stay.
- Learning through the Covid-19 period so far has told us that many people are concerned about missing quality issues where there are only virtual C(E)TRs, and with concerns about quality of carer across a number of providers critical information could be missed. Some patients and families have told us they find it harder to participate in a virtual meeting, although some people have preferred them. It is proposed that a person-centred approach , alongside considering when the person and their environment was last visited face to face (through CETR, Commissioner oversight visit, or other meeting) along with a risk based approach should be used with regards to whether any face to face contact can be part of a CETR (e.g. having one panel member attending the ward, with other participants using technology).
- Particular efforts should be made to ensure that technology is in place to support family members, experts by experience and clinical experts to join the meetings.

Interim measures for Children and Young People with autism, a learning disability or both who are at risk of admission or admitted to a mental health inpatient setting.

- Due to a potential surge in admissions and issues raised by local areas we are putting in place a number of interim measures specifically around Care, Education and Treatment Reviews for children and young people. They should be read in the context of the substantive policy and supplementary guidance

and are detailed below. We anticipate these measures will be introduced as an interim measure until 31st December 2020 and will be reviewed at that time.

1. **Rapid review Dynamic Support Registers (minimum standards) to:**
    a. Ensure a standard (referral) criteria for entry onto the Dynamic Support Register – for “at risk level” - and identify Children and Young People at risk of admission.
    b. Identify those Children and Young People who are likely to become at risk of admission without immediate intervention.
    c. Particular attention should be given in relation to autistic children and young people who make up the largest number of admissions – including admissions without a community CETR
    d. Ensure a two-way information flow between the DSR and C(E)TRs
    e. Admission without a community CETR should be exceptional and in line with the current CETR policy
    f. Local system communication should ensure compliance to a minimum of the agreed compliance standard.

2. **Ensure community CETR compliance to agreed standard**

    a. There will be draw down funding available on a locally agreed basis to support individual interventions that will potentially lead to an avoidance of admission.

3. **Post -Admission CETRS** – the following interim changes reflect the urgency of the situation
    a. Post-admission CETRs will be by exception where a valid Community CETR has not been possible
    b. Post-Admission CETRS will take place within 5 working days (1 week) not 10 (2 weeks) as previously stated [interim measure] (*)
    c. Post-Admission CETRS will be co-chaired by CCG and Specialised Commissioners
    d. There will be draw down funding available on a locally agreed basis to support individual interventions that will potentially lead to an avoidance of admission.

4. **Root Cause Analysis – there should be a Root Cause Analysis undertaken to understand the circumstances of any admission without a community CETR. This will:**
    a. Explore why a community CETR was not possible
    b. Determine whether the Child or Young Person had been identified on the Dynamic Support Register
    c. Inform system changes to ensure CETR compliance and better identification through DSRs

- A CETR Covid Addendum to the 2017 Policy is being published which covers areas such as managing sharing of patient notes and use of Microsoft teams in line with IG rules, tips for chairing virtual CETRs, and good practice examples. This has been produced based on learning gathered from people participating in Covid CETRs.

- Booklets in easy read and plain English are available to support patients in their virtual C(E)TRs.

Key lines of enquiry for community and inpatient C(E)TRs

- In late 2019 a new set of CETR Key Lines of Enquiry (KLOEs) were developed and piloted. The feedback from this along with two reports to be published (CQC thematic review of restrictive practice and the ICETR report from Baroness Sheila Hollins) will inform the further revision of the KLOEs which will be published as part of the refreshed C(E)TR policy in 2021.
    - In the interim, the existing published KLOEs should be followed, with the addition of a specific Covid question that considers **the individual's risk of COVID-19 and what is in place to support and protect them.**
    - **There should be exploration about the impact of additional restrictions bought about by Covid (e.g. limited visits from family or outings) and the potential distress that this may cause, leading to the possibility of increased restrictive interventions (e.g. increase in psychotropic medication).** An additional set of questions in relation to impact of Covid is being published as part of the CETR Policy Covid Addendum. The addendum also contains tips for chairing a virtual CETR and best practice examples.

Independently chaired C(E)TRs

- The same principles noted for C(E)TRs above apply for the independently chaired care (education) and treatment review process.

8. Annual Health Checks

- GPs and practices are expected to be proactive in providing annual health checks for people with a learning disability; this has been confirmed in the letter from Simon Stevens and Amanda Pritchard (29 April 2020) and in the primary care bulletin shared on 18 May 2020.
- During the covid-19 crisis, considerably fewer annual health checks have been undertaken and as a result, health inequalities have increased. This will be a key area of focus in restoring services.

9. Commissioner oversight visits (six to eight-week visits) for people with a learning disability, autism or both

Responsible Commissioner oversight visits during this period

- We expect commissioner oversight visits to continue for children, young people and adults with a learning disability who are in inpatient mental health setting.
- There should be a risk assessment with the provider setting to assess if face to face visits can be undertaken or whether restrictions mean this may need to be undertaken virtually. If this is the case specific consideration need to be given to ensure that commissioners directly speak to and see the individuals that they are responsible for.
- Face to face visits should be prioritised for those patients identified in services where quality concerns have been raised or the service has an inadequate or requiring improvement Care Quality Commission (CQC) rating.
- Effort should be made to ensure that family members, advocates or other people who the patient wants to be involved and know the patient best are enabled to join the meetings through technological means.
- The principle of commissioners assuring that the patients they are responsible for are safe and their wellbeing is safeguarded remains the same. Recent events highlight the importance of this responsibility.

Assurance planning where visits are adjusted

- All commissioners should develop a process that enables them to be assured of this using telephone and/or virtual methods of communication with the individuals they are responsible for. For this period, we would recommend more regular virtual contact with individuals.

10. Host commissioner model (learning disability and autism)

- Host commissioners should continue to maintain their responsibilities for keeping an oversight of concerns in relation to the provision in their areas.

- The COVID-19 outbreak creates additional pressures in the system and on the workforce, and social distancing and self-isolation mean that many of the individuals we are concerned with are potentially more vulnerable than usual, so the additional safeguards and assurance this model provides are essential.

Adjustments and assurance planning during this period

- Risk assessments should be undertaken to consider if it is safe and appropriate for commissioners to visit provider settings during this period. Restrictions may mean that virtual visits may need to be undertaken, but we do expect host commissioners to continue to oversee and accept any concerns raised with them and to follow the agreed process for raising these with the region and, if necessary, through the agreed safeguarding processes.

11. Safeguarding issues in inpatient settings

- Safeguarding individuals remains a priority, and if safeguarding concerns or issues are raised, we would expect them to be prioritised and managed in the same way as usual. We will not hesitate to make visits if necessary, in these circumstances, working closely with families and the Care Quality Commission (CQC). There are specific additional vulnerabilities and risks that individuals who are inpatients may experience during this unprecedented period. These may include increased use of restrictive practice, concerns being missed due to the pressure on the system, and increased use of unfamiliar and agency staff who may not be able to meet individual's needs.
- If there is a need to visit, those involved would follow the recommended process for ensuring this remains as safe as possible to prevent transmission.
- Safeguarding processes are continuing as before and you should use your usual reporting mechanisms including raising alerts for safeguarding issues that are a result of the pandemic.
- We encourage areas to consider the role of local ethics committees in decision-making on restrictive practice and how to strengthen access to advocates.

12. Learning disability mortality review (LeDeR)

- As articulated in the NHS Long Term Plan, NHS England and NHS Improvement remain committed to the LeDeR programme. CCGs are being

encouraged to continue to complete LeDeR reviews, especially where family members have already been engaged in the process.

- However, many of the people who carry out LeDeR reviews have a clinical background and may be called to support frontline colleagues. Therefore, there is recognition that, in the current COVD-19 situation, local systems may not be able to support the completion of LeDeR reviews.
- The phase 3 letter and implementation guidance confirmed a return to “business as usual for the LeDeR programme. All LeDeR eligible reviewed notified to the programme prior to 30 June 2020 must be completed by 2020.
- From January 2021 all reviews must be completed within 6 months (subject to other legal processes)
- CCGs are expected to publish a LeDeR annual report by September 2020 and to appoint a BAME lead for steering group by December 2020.
- Delivering action from local learning is crucial to prevent further premature mortality.
- Particular attention and support should be provided for those with a learning disability and respiratory condition and these individuals should be particularly encouraged to update the annual flu vaccination

13. Ensuring escalation of reduction in provision or service to local TCP / STP / ICS leads and regional teams

- As this work is considered an essential continued activity, the expectation is that you will follow this guidance and any difficulty in doing so should be escalated to transforming care partnership (TCP) areas /STP/ regional team.

Considerations specific to specialised services

Much of what is included in this guidance is applicable to specialised mental health, learning disability and autism services too. Across all specialised services (inpatient, specialised community and outreach) the following should be considered.

14. Demand and capacity

- It is important regionally and nationally that there is detailed understanding and oversight of the capacity across specialised services so that access to services for the acutely unwell can be managed.
- To facilitate this, it is important that the existing Children and Young People's inpatient and mother and baby unit bed availability systems continue and are accurately maintained.
- Specialised commissioned services will need to report into and make use of the daily sitrep. This information will also support regional specialised commissioning teams to work with providers in developing plans for managing demand and capacity, including surge management plans or patient cohorting, which may require consideration across a number of provider organisations on regional or national footprints.
- Closure of specialised commissioned inpatient services, or restricted access to specialised community or outreach services, purely on the grounds of precautionary measures and in the absence of other factors, is not supported. It is really important that all attempts should be made to ensure these services remain operational and open to admissions wherever possible.
- If providers are considering temporary closures or restricting admissions or activity for any reason, this should be planned and agreed jointly with the relevant regional specialised commissioning team at the earliest opportunity. This will help ensure any temporary closures can be proactively managed and available bed capacity regionally and nationally can be closely monitored and communicated to the wider system. Any temporary changes must be kept under

regular review, with the aim of restoring full-service provision at the earliest possible opportunity.

14. Access to services

- Robust access assessment arrangements are important to ensure the most acutely unwell patients receive the care they require in a timely way. Specialised services should consider alternative ways in which they can carry out assessments and any subsequent clinical discussions to inform decisions about admission, through digital consultations. Providers need to ensure they have access to appropriate technology to facilitate this.
- Where applicable, it is important to discharge as many patients as possible where it is safe and clinically appropriate to do so. Enhanced focus on delayed discharges at this time will support throughput.
    - Ringfencing local beds is not supported in specialised services ordinarily, but especially not at this time.
    - Provider Collaboratives, particularly those for CYPMHS, are shaping local services to facilitate the admission of local people to local units as part of a whole pathway approach but crude ring fencing of local beds is not supported in specialised services and especially not at this time."

15. Working together across the system

- NHS-led provider collaboratives, those about to go live and those in development, plus other networks and partnerships, should plan across relevant geographical footprints for these patients, acknowledging that these may be larger footprints than for generic mental health, learning disability and autism services.
- The independent sector is already a key provider of specialised services and partners across many of the local arrangements described. Where these partnerships can be further developed with greater joint working, this should happen as soon as possible to ensure best use of all available capacity.
- Where appropriate, specialised inpatient services should consider redeployment of specialist community staff who have the skills to work in these inpatient settings, and consider redeployment of other staff who may need a

bespoke/rapid induction package – considering training specific to service area, e.g. security and key training for secure services.

- Estate and capacity should be considered flexibly while taking into account the requirements of specific provision, e.g. mother and baby units, CYPMHS and adult secure services, including physical security requirements.
- Ordinarily for many of the specialised services specific stakeholders are involved in ensuring the pathways work effectively: e.g. criminal justice system, Ministry of Justice (MoJ), Her Majesty's Prison and Probation Service (HMPPS), local authorities, maternity services. At this time, these collaborative relationships are more important than ever to ensure demand is managed and capacity is maximised.

16. Cohorting patients in specialised services

- Cohorting patients in specialised services needs to consider the specialist nature of service provision and the needs of each patient group.
- A proportion of patients in specialised services are particularly physically vulnerable and should be considered in capacity planning: e.g. pregnant women, those with low body weight or underlying physical health conditions and the elderly.
- For example, adult secure services will need to draw up detailed plans and consider how best to cohort patients while maintaining security and safety of patients, staff and the public. This may involve identifying at the outset a specific ward where patients with confirmed illness may be isolated and another area for those suspected to have the illness, as well as easy and timely access to adequate PPE. Please refer to the corresponding PPE infection control guidance and workforce guidance for more information.
- Where admission to a mother and baby unit is required, the mother should be offered a joint admission with her baby. Providers and local teams should put in place means of facilitating joint admissions irrespective of the mother's and/or baby's COVID-19 status.

17. Specific specialised services

Adult secure – transfer and remissions from prisons and immigration removal centres

- During this time, individuals in prisons and immigration removal centres will continue to require transfer and remission to and from mental health inpatient services, including adult secure services, based on their mental health needs. This applies to all, regardless of diagnosis, so includes those requiring access to mental health, learning disability or autism secure services, and those remitted back to a custodial setting when their mental health has stabilised, and they are no longer detainable under the Mental Health Act.

Transfers and remissions to and from prisons/Immigration Removal Centre (IRCs) and mental health inpatient services

- During this time patients will continue to require transfer and remission across organisations based on their mental health needs.
- It is important that current service specifications and guidance are adhered to as far as possible, but it is recognised that there may be some inevitable delays that will need to be managed on an individual case by case basis.
- Robust and live communication across the mental health inpatient assessment services (secure and non-secure), prisons and IRCs is very important at this time.
- Guidance has now been developed with Her Majesty's Prison and Probation Service (HMPPS) and other relevant stakeholders to support the pathway to and from prison during this time.

Community forensic CAMHS

- Stakeholders will require advice and guidance regarding the risk assessment and management of young people who present with a risk of harming others, both for new and existing community forensic CAMHS cases. It is likely that community forensic CAMHS referrals and input will be more acute and crisis-focused in nature. Specific changing dynamics relevant to this work include:
    - The closure of schools for many young people. The current situation regarding school and in particular special schools, which provide structure and containment for many young people who present with risky behaviours,

is likely to vary nationally. Despite the policy that all young people with an education, health and care plan should be provided with ongoing education, we should expect that many more young people with mental health and risk needs will be out of school and in less containing home/community settings.

  - There will be consideration of how best to use the secure youth justice and secure welfare estate at this time. This may result in some young people who would otherwise be in secure settings being in the community, thus increasing need for specialist risk assessment and risk management input.
  - The CYP secure estate may also need to look at early release for some young people who will require continued support. The recent changes in court processes may mean fewer young people go into the secure estate – other than those who do so as a result of serious crime – and they may also require increased mental health support.
  - Secure adolescent psychiatric hospitals may need to consider which current inpatients can receive ongoing treatment in the community, ahead of their planned future care pathway plan: i.e. there is the possibility of early discharges for high-risk young people.

- The community forensic CAMHS model means we are in a good position to continue service provision using a non face-to-face approach, including via remote working: i.e. telephone and email. Teams should check their information technology needs in line with their trust's contingency planning.
- Individual providers will need to make their own arrangements for contingency planning and ensuring staff are available across the wider services they provide. Some community forensic CAMHS staff may therefore be pulled into more acute service provision, whether in mental health or physical health.
- Mental health providers should consider how they can continue to provide some ongoing community forensic CAMHS provision, albeit scaled down. A specific need is likely to arise from the changing dynamics outlined above, and support for community teams to facilitate early discharge for young people will need specific consideration. Any changes to community forensic CAMHS provision need to be jointly planned and agreed with commissioners, who will be aware of the specifics as they apply to community forensic CAMHS.
- Where community forensic CAMHS services are considering a reduced offer for any reason, it is important this is planned jointly with regional commissioners at the earliest opportunity so any reductions in service can be proactively

managed, monitored and communicated to the wider system. It is essential that the loss of any capacity in a region is considered by the regional incident management team in respect of contingency planning and business continuity. This joint planning and review with commissioners should include a review of contingency plans and assurance sought that all appropriate actions and alternatives have been fully explored.

CAMHS inpatient guidance (referrals and admissions)

- While there is great pressure on community CYPMH teams, the benefits of mobilising services to prevent A&E presentations where possible cannot be overestimated. Such A&E presentations by young people would potentially repeat and compound their experiences of rejection and invalidation, increase their risk (both of self-harm and infection) and – should they be admitted – risk COVID-19 contamination of inpatient units.
- It is important to remember that young people are more resilient to COVID-19. However, due to the nature of some of their mental health difficulties (eg those with a learning disability or eating disorder), additional physical health needs or nature of the treatment they are receiving (eg clozapine), infection may make them more vulnerable to developing additional physical health complications.
- Young people in inpatient services may have co-morbid neuro-developmental conditions that can make it difficult for them to adapt to the new restrictions/limitations on their routines.
- CYP may particularly struggle with restrictions on visits from family members and carers, and limitations on community and home leave in line with national visitor guidance. This may be particularly difficult for those with neuro-developmental disorders.
- All decisions should balance the principles of least restrictive, individually care planned and limiting risk of infection to the unit and family or carer.
- When considering referring a young person to an inpatient setting, decision-making should consider the impact of COVID-19 and new processes now been established in accordance with national guidance on visits which is primarily designed for acute services. This is likely to impact on engagement and treatment of the young person.
- Inpatient units are environments where several children/young people and staff live and work in a confined space; this increases the risk of transmission of

COVID-19. Visits to units have been reviewed and are being managed differently in line with national visitor guidance, to support social distancing and isolation, and to prevent contamination and infection. Contact with families and carers, should be promoted using virtual communication options. This should form part of the discussion with families and young people when considering admission.

- Where there is an outbreak of COVID-19 on the ward, a physically highly vulnerable cohort of young people in the unit or the family has been in isolation due to infection, then visits may not be possible.
- Due to social distancing and the closure of shops, cafes and restaurants in the community, leave is likely to be similarly affected. Services will need to work creatively to support leave to facilitate discharge. This might include extended leave with intensive virtual support and co-ordination with the community to ensure a safe and supported discharge plan.
- As outlined in Section 7, C(E)TRs should be held for young people with a learning disability, autism or both (with adaptations as necessary) to ensure all other alternatives to admission are considered in the first instance. It is likely that, as many schools have closed (including special schools and special residential schools and colleges) and normal routines are disrupted, CYP with neuro-developmental conditions may particularly struggle to adapt to and accommodate the new changes in and restrictions on their lives. As a result, they may present in crisis. It is important to consider all options of support and intervention in their home or current placement before considering an inpatient admission, as they are likely to struggle further in inpatient settings. Hospital admission should not be considered as an alternative to an appropriate respite placement or educational placement, and there needs to be robust multi-agency care planning with education and social care services to review all options.
- Community services should make efforts to assess, monitor and treat all young people in their place of residence, and consider innovative means of doing this. This includes supporting families and carers in considering:
    - how they might support or supervise their child or young person if they are presenting a risk to themselves
    - helping children and young people access various online apps and resources to support their mental health
    - ensuring they are not left on their own.

- Regular routines and activities can provide structure and distraction from negative ruminating thoughts. Services can provide regular reviews and support through telephone and video technology and, if indicated, virtually providing CYP with one-to-one therapy. Consideration should be given to how a young person's physical health can be safely monitored at home; an example is portable blood pressure monitoring.
- In some circumstances, where no adolescent beds are available for an admission, it may be felt that no option will mitigate harm. If so, a local ethics consideration process may be necessary to determine the ethically appropriate way forward (eg prioritising acute admission over discharge of an unwell young person, admission of an under-16 onto an adult ward, provision of best possible community care when an inpatient admission is preferable).

See Annex D for case examples of how to facilitate decision-making for admissions.

19. Who to contact if you have additional queries

We always recommend in the first instance that colleagues raise concerns with their regional lead.

NHS England and NHS Improvement regional contact details for learning disability and autism:

If you have any queries specifically for the national team, please direct them to england.improvinghealthquality@nhs.net and include **Learning disability and autism COVID-19 query** in the subject title.

NHS England and NHS improvement regional contact details for mental health:

Region	Contact details
NE & Yorkshire and North West	Fleur Carney (fleur.carney1@nhs.net)
Midlands	Giles Tinsley (giles.tinsley@nhs.net)
East of England	Helen Hardy (helen.hardy9@nhs.net)

	Emma Willey (emma.willey@nhs.net)
London	Emma Christie (emma.christie2@nhs.net)
South East	Oral Arrindell (oralarrindell@nhs.net)
South West	Vikki Cochran (Vikki.cochran@nhs.net)

If you have any queries specifically for the national team, please direct them to england.mhldaincidentresponse@nhs.net and include **Mental health COVID-19 query** in the subject title.

NHS England and NHS Improvement regional contact details for learning disability and autism:

NE & Yorkshire and North West	Claire Swithenbank (claire.swithenbank@nhs.net)	Alison Cannon (Alison.cannon1@nhs.net)
Midlands	Robert Ferris-Rogers (r.ferris-rogers@nhs.net)	Yasmin Surti (Yasmin.surti@nhs.net)
East of England	Sue Fox (susan.fox11@nhs.net)	Mark Hall (mark.hall8@nhs.net)
London	Heidi Peakman (h.peakman@nhs.net)	Shepherd Ncube (shepherd.ncube@nhs.net)
South East	Alison Leather (Alison.leather4@nhs.net)	Gavin Thistlethwaite (gavinthistlethwaite@nhs.net)
South West	Kevin Elliott (kevin.elliott@nhs.net)	Gavin Thistlethwaite (gavinthistlethwaite@nhs.net)

If you have any queries specifically for the national team, please direct them to england.improvinghealthquality@nhs.net and include **Learning disability and autism COVID-19 query** in the subject title.

NHS England and NHS Improvement regional contact details for specialised commissioning:

Region	Contact details
NE & Yorkshire and North West	Andrew Simpson andrew.simpson20@nhs.net Rita Thomas rita.thomas1@nhs.net
Midlands	Alison Kemp (alison.kemp1@nhs.net)
East of England	Denise Clarke (deniseclark1@nhs.net)
London	Ian Darbyshire ian.darbyshire1@nhs.net
South East	Vanessa Fowler (vanessa.fowler@nhs.net)
South West	Nikki Churchley (nikki.churchley@nhs.net) Barry Day (barry.day1@nhs.net)
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include **Specialised commissioning COVID-19 query** in the subject title.	

Annex A: Resources that have been developed to support clinical practice in mental health settings in light of COVID-19

- The Royal College of Psychiatrists has produced Guidance for psychiatrists and other professionals working in mental health settings (COVID-19).
- The Royal College of Nursing has produced COVID-19 guidance providing general principles to support the delivery of care.
- The British Psychological Society endorsed guidance for psychological professionals during the Covid-19 pandemic has also been published.

Annex B: Continuity principles for reporting out-of-area placements in mental health acute adult beds specifically

Principles of continuity
1. Clear shared pathway protocols between units/organisations – particularly around admission and discharge.
2. An expectation that a person's care co-ordinator: • visits as regularly as they would if the patient was in their most local unit • retains their critical role in supporting discharge/transition.
3. Robust information-sharing, including the ability to: • identify cross-system capacity • access full clinical records with appropriate information governance where necessary.
4. Support for people to retain regular contact with their families, carers and support networks: eg this might be achieved with optional use of technology, transport provision, etc.

Annex C: Case examples to support decision-making on admission to inpatient CYP mental health, learning disability and autism services

A young person who presents with low mood and ongoing suicidal ideation or self-harm

- Assess risk and review delivery of evidence-based interventions. Consider treatment of any mood disorder and psychological work around suicidal ideation and self-harm while young person is being kept safe in the community.

- Can the young person be supported at home by parents or carers who should always be available to supervise?

- Is the young person eating and drinking?

- The family or carers to be given clear advice on making the home safe and the young person to be reviewed remotely with regards to mood and treatment (to include medication and psychological intervention virtually).

- Escalation of risk to be regularly reviewed by the community team.

- Admission to an inpatient unit may result in increasingly risky behaviours in young people who present (and may have a long history of presenting) with emotional dysregulation, repeated self-harm and suicidality. They are likely to struggle with the current increased restrictions, including limited contact

with existing support systems, which may place them and others on the unit at increased risk.

A young person with first-episode psychosis presenting with serious risk towards self and others, and who is not consenting to any treatment and cannot be kept safe at home as presents risk to family members

- If the young person is refusing medication and may require intramuscular medication and close monitoring of their mental state and risk, careful consideration needs to be given to inpatient admission under the Mental Health Act.

- Admission should be as short as possible, and discussion supported discharge discussed with community teams.

A young person with an eating disorder – impacting on daily functioning – isolating at home, limited food intake but drinking

- Ideally, consideration of the therapeutic benefits of an inpatient unit would include a clear behavioural plan alongside psychological therapies. With current inpatient units unable to run optimum therapeutic programmes, etc, and offering interventions virtually, the risk of transferring the young person to an inpatient setting where they are likely to be managed in isolation needs to be weighed against continuing to engage with them remotely at home where they will get support from their family.

Autism and challenging behaviour: a young person with a known history of autism presenting with challenging behaviour due to the disruption in routine, increased isolation, absence of educational structure and difficulty adapting to a situation they do not understand. The challenging behaviour may escalate

- Checks should be undertaken to ensure that the individual is on the 'at risk of admission dynamic support register'. All efforts should be made in the community to support the young person at home, including supporting them with developing a routine, having appropriate sensory aides and a PBS plan that can be actioned in the community with social stories.

Visits to the unit

These can be facilitated off the ward, eg in a garden area or a big room off the unit. Consideration should be given to:

- whether the unit is safe with regards to COVID-19 infection
- whether the parent/carer is able to give a clear history of no contact with COVID-positive cases
- whether the young person and parent/carer are able to understand and follow social distancing rules.

Leave to facilitate discharge:

- Consideration should be given to whether, ideally, a period of home leave should be trialled for the young person, to facilitate discharge. If there are no safeguarding concerns, then an extended period of leave with intervention and support provided virtually can be considered. This could include remote group work, virtual psychology sessions and remote review. For young people with an eating meal plan, intensive support can continue to be provided on the telephone to both the young person and the family. Simultaneously the community team should be involved for a robust handover.