C19 National Foresight Group

National Foresight and Intelligence Briefing Paper: Commissioned by Shaun West, Chair of C19 National Foresight Group

Covid-19 Psycho-Social and Economic Trends 02/11/2020

Paper prepared by Dr Stacey Stewart, Adam Potter, Rich Pickford, Kelly Smith, edited and synthesised by Dr Rowena Hill

Nottingham Trent University

This briefing synthesizes data with systematic findings from across academic subjects. This evidence of empirical data and academic insight contributes to our existing knowledge on who is most likely to be experiencing adversity in our communities.

Contents

Context

A data review is undertaken by academics at Nottingham Trent University every week to inform the C19 National Foresight Group. Evidence related to Covid-19 psychological, social and economic trends are reviewed to inform, frame and prioritise discussions at national and local strategic decision-making level (LAs and LRFs). The C19 National Foresight Group synthesise data trends and academic findings across disciplines, with evidence of existing vulnerabilities and inequalities to start to build existing and emerging risk or adversity profiles of impacts from Covid-19.

Who is this for?

This is most useful for **national thought leaders, local strategic decision-makers, intel cells and those involved in populating the MAIC**.

Focussed theme this week: This week we are focussing on those cohorts within our community who have had the most restrictions on their liberty for the longest period of time.

Academic Synthesis

Gathered from systematic literature reviews, rapid reviews, webpages, academic articles, pre-prints, academic expertise.

N.B. This is not a literature review, but a review of the broad area (balanced with Covid-19 specific literature)

to see what topics lie within the area to inform future work. Predominantly based on systematic literature reviews and rapid reviews, this is to indicate the size of the literature review should we wish to commission one. Carried out by Adam Potter, Dr Stacey Stewart, and Rich Pickford, with revisions and edits by Dr Rowena Hill, NTU. Please contact us if you require a list of sources consulted to develop your own literature review. Our purpose is to provide an overview of the academic and research foresight on the developing areas of latent and emergent needs in the community.

What Groups Are Having Their Liberty Most Restricted by Covid-19?

Whilst completing this review, the academic group aimed to try and ascertain the size of each cohort. However this proved very challenging, as the usual practices of tracking the numbers within each of these cohorts has been suspended since the start of the first lockdown measures in Spring 2020. Consequently the academic team have used less reliable sources than government, or independently approved and quality assured figures to inform the general scale of the cohort sizes. Please only use these as an indicative estimate of the size of the cohorts throughout this document, unless stated otherwise – where the data source will be cited.

Summary:

- The restrictions on liberty for those in all types of care is significant, as typically these are multi-occupancy living, there is restricted visiting permitted, increased isolation through physical distancing between residents, and the isolation requirements on arrival.
- The impact on liberty is also being compounded by increasingly difficult healthcare provision, reduced activity (for example days or visits out, arranged activities within the setting), increased presence of conditions which challenge their ability to communicate or accommodate the changes (for example deafness, dementia).

Care Homes for Older Adults

Size of the Population

It is difficult to ascertain exact numbers of individuals living in care homes. The Kings Fund, based on NHS statistics, reported that:

"In 2018/19, 841,850 adults received publicly funded long-term social care, primarily in care/nursing homes or in their own homes. In addition, there were 223,605 episodes of short-term care provided."

A report by the Competitions and Markets Authority estimated in 2017 that there were around 410,000 residents living in 11,300 care homes.

Since these estimates, there is a significant number of residents who have lost their lives to Covid-19, so caution should be applied to interpreting the specific size of this cohort.

Reductions of Liberty

Visiting Restrictions:

Government guidelines on visiting arrangements in care home is stratified by local area Covid-19 alert level. For areas that are classed as High or Very High Risk, the guidance states that "visiting should be limited to exceptional circumstances only such as end of life."

For areas classed as Medium Risk, the guidelines state that care homes should "limit visitors to a single constant visitor wherever possible, with an absolute maximum of 2 constant visitors

per resident. This, for example, means the same family member visiting each time to limit the number of different individuals coming into contact."

Isolation Requirements:

The Department of Health and Social Care Adult Social Care: Our Covid-19 Winter Plan 2020 to 2021 report also states that care homes should only accept people discharged from hospital if they can isolate them for 14 days, regardless of Covid-19 test result, unless they have already undergone this period of isolation in another setting.

Restrictions Within Care Homes:

Policies within individual care homes may also further restrict residents. For example, the Scottish government recommend that residents should: be isolated within their rooms as much as is practical; reduce time in communal areas by 75%; be served meals in their rooms where possible and; avoid communal sitting areas. The Care Quality Commission's (CQC) 2019/2020 State of Care report states that "measures in place to try and prevent the spread of the virus within homes had a huge impact on people, with some residents confined to their rooms, social events cancelled, and shared areas in the home – such as dining rooms and lounges – closed due to physical distancing."

Deprivation of Liberty:

The CQC State of Care report also highlights that the Liberty Protections Safeguards, which were designed to better safeguard individual's liberties and intended to replace Deprivation of Liberty Safeguards (DoLS) from October 2020, will now not be implemented until April 2022 due to the pressures of the pandemic. The third CQC COVID-19 Insights Report reports that, although notifications of deprivation of liberty from adult social cares services dropped by 31% since the start of lockdown, poor understanding of DoLS has remained a fundamental issue. This together with the delays and uncertainty over the progress of LPS may mean there is an increasing risk of people being deprived of their liberty without the proper authorisation.

Healthcare:

The CQC State of Care report also expresses concerns that "advance care plans, sometimes including Do Not Attempt Cardiopulmonary Resuscitation orders, were being placed on groups of older people and disabled people without individual discussions taking place to make sure this was appropriate", and also that some older and disabled people living in care homes were not getting access to urgent hospital treatment, based on a value judgement rather than on clinical need. They also highlight that the pandemic has significantly affected elective care and urgent services such as cancer treatment, meaning there is an increasing backlog of demand for treatment.

Difficulties

Dementia and Other Conditions:

A national census of BUPA care home residents conducted by Bowman, Whistler and Ellerby (2004) found that only 22% of residents were rated as having 'normal' mental state, with 64% confused or forgetful, 20% displaying challenging behaviour, and 19% depressed or agitated. These authors concluded that, in terms of reason for admission and diagnoses, "dementia, stroke and other neurodegenerative disease with mental impairment dominate."

Individuals with such challenges may find restrictions particularly confusing and distressing, and may have less frequent visits. In addition to this, care home residents (particularly those with dementia or other cognitive conditions, or with sight or hearing difficulties) may have difficulty recognising and communicating with visitors that are wearing PPE (e.g. face coverings), reducing the benefit of the visits that are allowed. For example, a survey run by the CQC (reported in their State of Care Report) found that people with dementia were least

likely to 'always' understand staff who were wearing PPE. Those who have significant hearing challenges, or deafness, those with a learning disability, people aged over 85, and autistic people also found it particularly difficult to understand staff when they were wearing PPE.

Overall Reduced Activity:

As well as reduced social interaction, care home residents may suffer from a reduction in other activities/stimulation. Care Home Professional magazine reports that Professor Martin Green, CEO of Care England, said the guidance failed to consider the need for residents to be taken on outdoor visits. Staffing difficulties may further reduce care home capacity to provide adequate support and stimulation for residents- the CQC's first C19 Insight Report showed that the agencies they surveyed had on average 9% of staff absent due to the impact of Covid-19.

Unequal Impacts:

It is important to note that not all care home residents have been affected equally. The CQC State of Care report that the proportion of deaths in all adult social care services due to confirmed or suspected Covid-19 was higher for Black (49%) and Asian (42%) people compared with White people (41%) and people from mixed or multiple ethnic groups (41%). This difference increased when looking at care home settings only, where 54% of deaths among Black people and 49% of deaths among Asian people were related to Covid-19 compared with 44% of deaths of White people and 41% for mixed or multiple ethnic groups.

Supported Living

Size of the population

A supported accommodation review conducted by the Department for Work and Pensions, Department for Communities and Local Government and Government Social Research in 2016 defined supported living as the following:

"any housing scheme where housing, support and sometimes care services are provided to help people to live as independently as possible in the community. Supported housing users include those who would otherwise be homeless (including those at risk of domestic abuse); older people and people with disabilities (many of whom would otherwise be living in long-term care or hospital settings)."

They go on to estimate the approximate scale and scope of supported living in Great Britain:

"The review estimates that at the end of 2015, there were approximately 651,500 accommodation-based supported housing units in Great Britain. The majority of which (85 per cent) are in England, with nine per cent in Scotland and six per cent in Wales. An estimated 71 per cent of units across Great Britain accommodate older people; 29 per cent of units accommodate working-age people with a very wide range of support needs. Housing associations are the most prevalent landlords, providing 71 per cent of supported housing units".

Therefore, although older adults make up the majority of those living in supported accommodation, a very diverse population with very different support needs and resources fall under this bracket.

Reductions of Liberty

Scope of Guidance:

The government has provided Covid-19 guidance for supported living. They state that although it is primarily intended for supported living settings, it may also be useful for wider supported housing, including retirement and sheltered housing.

Responsibility and Autonomy:

They also note that often supported accommodation care providers have no responsibility for property, accommodation or environment issues in supported living. Instead, often management's role will be to develop local procedures and work with the people being supported and, with consent, their families, GP, support groups, and care/support providers to ensure that individual plans are in place to protect wellbeing and minimise risks. As such, although guidance may reduce liberty if enforced by care providers, often it will instead be advice that is discussed and agreed or rejected by the individuals in supported accommodation, and as such is not a direct deprivation of liberty.

Some individuals in supported accommodation- such as those with a diagnosis of autism, people with learning disabilities, dementia or mental ill health- may lack capacity to understand and make decisions based on Covid-19 advice. In this situation, the guidance requires that everything possible is done to communicate information in a way that the individual is most likely to understand, as well as all other requirements of the Mental Capacity Act 2005 (MCA).

Visiting Guidance:

This guidance acknowledges that, for some people living in supported accommodation, in-person visits are particularly important, and following government requirements for visiting may be difficult to understand and distressing for the individual. In this situation, the guidance recommends supported living managers and support providers work with the individual and consider options for in-person visits.

As described above, if an individual is assessed as not having capacity to make decisions about visits, the provider should work within the appropriate MCA framework to establish that a visit is in someone's best interests.

If the person has capacity and wants a visit, the provider should:

- advise them about the safest ways to have visitors
- risk assess individual settings and individual vulnerabilities consider risks to other people (if in shared settings)
- encourage, agree and support decision-making regarding visitors

Potential Difficulties

Disruption to Usual Care:

A potential difficulty in supported accommodation settings is interruption to usual care due to Covid-19. This is particularly important, as the government guidance states that "in some supported living models, it is not possible to defer the care and/or support provided to another day without putting people at risk of harm. It is therefore vital that these services are maintained". Difficulties may arise due to guidance to avoid sharing staff between settings, staff shielding and isolating, and staff off sick with Covid-19.

Inside Housing (2020) reports that due to a lack of government guidance for the first five months of the pandemic, funding and provision of PPE and routine testing was not made available, with providers "concerned about finding the funds to pay for PPE and other infection control costs". They report a sense that supported living is deprioritised compared to residential care, despite individuals in supported accommodation often being vulnerable adults with complex care needs.

The Supported Accommodation Review (2016) noted that "regulation of supported housing is less comprehensive in England compared to Scotland and Wales". Therefore, if problems do arise due to Covid-19 restrictions, guidelines or staff or equipment shortages, there may be less oversight and awareness of this in England.

Changes to Activities, Rules and independence:

As with Care Homes, scheduled activities and social events (such as communal dining) may be reduced, replaced or stopped altogether (Inside Housing, 2020). Inside Housing report that a challenge for residents was the withdrawal of services in other sectors, such as community mental health and social care services, with a Mencap survey finding that seven in ten people with learning disabilities had their social care cut during the pandemic.

Therefore, although guidelines may not directly deprive individuals in supported accommodation of their liberties (in terms of their autonomy in decision making around Covid-19 advice), reduced provision of services will inevitably lead to a reduction in their independence. In addition to this, individuals may struggle to adapt to the easing of lockdown measures and social distancing rules, as well as a restoration of their independence; Advance Housing and Support saw an increase in mental health breakdowns, self-harm, alcohol use, property damage and aggressive behaviour in September, according to a report by Inside Housing.

Communication and PPE:

As with Care Home residents, many individuals in supported living- such as those with dementia, hearing difficulties, learning disabilities or autism- may struggle to understand others wearing PPE. Therefore, the government guidance notes that:

"in some circumstances, visors may be preferable to masks, as a means to facilitate the more effective provision of care and social interaction through non-verbal communication, especially with people with advanced dementia or learning disabilities for whom recognition of familiar staff is critical to reducing agitation and distress. The decision to use visors, would need to be risk assessed for the benefit of the person, and would have to balance with additional risk of transmission".

Conclusion: Whilst government guidance on this topic is available, there have been no current, up to date research studies that look at the experiences of people who live within supported living settings. Whilst charities/services can predict and guess what service users difficulties are, this is not something that is known or has been gathered from the service users themselves.

Hospice

Size of the population

https://www.hospiceuk.org/about-hospice-care/media-centre/facts-and-figures

Hospice UK reports that the hospice care sector supports more than 225,000 people with terminal and life-limiting conditions in the UK each year. This does not include their families, which Hospice UK report total around 72,000 additional people who they support (2018-2019).

In April 2020, ITV News reported that hospices were caring for 24,000 people a day; this is three times more than the same period last year. https://www.itv.com/news/2020-04-29/exclusive-hospices-will-run-out-of-ppe-within-days-over-government-refusal-to-grant-access-to-supplies

Reductions of Liberty

Visiting Restrictions: https://apmonline.org/wp-content/uploads/2020/04/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-20-April-2020-2.pdf

The association for palliative medicine (APM) of Great Britain and Ireland has written guidance on visiting and communication with relative during the pandemic, when visitors are not routinely permitted on the ward (palliative care). Restrictions are in place for safety reasons, and it is recognised staff may be unable to communicate with family. To overcome this, the ward should provide a daily communication bulletin for relatives, which can be delivered by a clinical or non-clinical member of staff. Family are also encouraged to stay in touch by phone call, face time call, whatspp and skype; staff should facilitate this where possible.

The exception to these rules are when end-of-life care is in place; the nurse in charge will enable one family member to visit for one hour each day (no sharing of the hour). The family member must wear PPE in the same way as the staff caring for the patient. There should be no exceptions to this rule. APM explain these rules should be governed by principles of infection control at local and population level, but also by moral and ethical principles. APM have therefore created their own set of principles, that are NOT rules to be applied rigidly.

1. All patients who are judged to be dying from COVID-19 or other conditions within hours or days are entitled to receive visitors.

That entitlement is however qualified by the following:

2. Only one family member should normally visit at any time. In some situations however, a visitor may need assistance to be able to attend, and that should be taken into account. Where the required family member requires physical or emotional assistance to visit, the benefits and risks require careful consideration by the responsible senior clinician.
3. To the greatest extent possible, and recognising that visiting can be emotionally and physically exhausting, the same family member should represent the family over the period of the patient's decline and death.
4. When possible, the patient should consent to receive visitors, if not, their previously known wishes or judgement of a legally appointed proxy decision maker or closest relative should be taken into account.
5. When possible, visitors should provide informed consent that they understand the personal risks associated with visiting.
6. In all cases, visitors must agree to undertake the subsequent isolation and quarantine restrictions appropriate to the contact that has occurred in association with their visits.
7. In all cases, visitors must consent to wear Personal Protective Equipment and undertake all other relevant hygiene requirements equivalent to that used by care staff in the specific care facility. Support should be provided to doff and don equipment as necessary.
8. Anyone who is unwell +/- exhibiting symptoms of COVID-19 - a new, persistent cough and fever or high temperature - should NOT visit any patients in a hospital or other care facility.
9. Care facilities are entitled to limit the frequency of visits, duration of visits, or numbers of visitors in accordance with the risk to other patients, other care staff, or other practical considerations in the care setting. However, the reasons for this must be documented and be in accord with the framework outlined above.
10. Clinical teams in more acute settings, particularly ICU and HDU, should receive support in family liaison from other staff members, including chaplaincy, bereavement and counselling services, thus enabling them to focus on direct patient care.
11. Care facilities should support family who cannot visit by providing access to and support in the use of mobile tablet or handheld communication devices to patient and family, particularly if a family cannot provide these for themselves.

If the patient dies, relatives are not permitted to visit after death, and mortuary viewing may also not be possible. Mementoes – locks of hair, handprints – can be taken at the time of death, but not undertaken at a later date.

There is specific guidance for faith deaths – Islam, Christian, Jewish – in relation to preparing bodies and planning for burial/cremation options.

Differences between hospices

Whilst these guidelines are available, each hospice has different restrictions. Some hospices have closed their community and outreach options, whilst others have extended to open up more beds. Through searching hospice/charity websites, it seems that more are providing care in the community where possible but no policy initiative/directive for this has been found.

The BBC (2020) report that in Colchester, there are restricted visiting hours, patients can only be seen by one visitor at a time – if more than one arrives, they must observe an in and out system, with the others waiting outside. Elderly visitors, unless next of kin, are asked not to visit at all. https://www.bbc.co.uk/news/uk-england-essex-52068599

Willen Hospice are allowing one visitor to one patient at any one time, with a maximum of two visitors within a 24 hour period – no overnight visits. Masks must be worn and waiting areas are not provided. Visitors should not attend with symptoms.

The outpatient services, such as the wellbeing service and weekly exercise/walking groups have been postponed to re-deploy staff into other areas. Telephone support is still available. Almost all of the fundraising events have been postponed, but they have introduced virtual events.

https://www.willen-hospice.org.uk/blog/blog-article/coronavirus-advice-on-visiting-the-hospice

Katharine House Hospice (2020) expanded their 10 bed in-patient unit to a 26 beds in response to the crisis; these additional beds were not used, so they have reduced back down. Visiting restrictions remain in place and all group sessions/drop-in sessions/out-patient appointments are still suspended, being replaced with telephone support.

https://www.khh.org.uk/News/coronavirus

Changes to service delivery – children's end of life/palliative care

https://www.togetherforshortlives.org.uk/get-support/supporting-you/family-resources/coronavirus-qa/

Together for Short Lives (2020), a UK charity that supports 99,000 seriously ill children and their families, explains that children should still be receiving good quality palliative care, with more hospices providing care at home and virtually rather than usual methods. Emergency short breaks, symptom management and end of life care are running as usual. Some hospices are restarting planned short breaks and are starting to open up their in house facilities – gardens and hydrotherapy pools, in a careful and controlled manner.

Children can still be accompanied in an ambulance, but by just one parent.

Funding

https://www.itv.com/news/2020-09-24/exclusive-third-of-hospices-on-brink-of-redundancies-and-services-cuts-ahead-of-surge-in-demand

ITV News (2020) reports that a third of all UK hospices are close to making redundancies and service cuts as they cannot sustain the level of care needed in the longer term without more sustainable funding. Hospice UK/Marie Curie expect demand to increase over winter.

BBC (2020) explain that two thirds of hospice income comes from charity shops, fundraising events and donations from the public; all charity shops were closed during the first lockdown measures and are expected to close again in the subsequent lockdown measures and all events are on hold. Bereavement and counselling support has had to move to telephone calls rather than in person visits, and day therapy centres have been closed.

Impact

https://www.theguardian.com/society/2020/jul/09/treating-dying-people-hospices-covid-19-breaking

There are little to no studies or reports that look into patients and family's experiences of hospice/palliative care services during the pandemic. In July, a doctor who remained anonymous, shared his experience with the Guardian (2020). The doctor explained they have to tell patients about their condition, how long they may have, and make plans for their care – whilst they have relatives who previously visited daily, now listen in on the phone. The doctor spoke of how it felt unfair to have blanket visiting rules, when each case had exceptional circumstances, and also when other sectors such as pubs and shopping centres can open.

The doctor explained it is difficult to ask family members to nominate just one visitor for the patient, as they know the emotional toll this has on the patient and the family. They share that this has a long-term impact on people's grief; final moments with a loved one are precious and an integral part of the grieving process. "every single death during this time is affected, meaning hundreds of thousand of bereaved people are suffering even more than they normally would".

The doctor goes on to explain that they and their colleagues are finding it hard too; telling distressed relatives they cannot visit, not meeting people who are significant in their patients' lives, having difficult conversations over the phone.

https://www.cruse.org.uk/coronavirus/grieving-and-isolation

Cruse bereavement care, a UK Charity, offers advice about grieving in isolation. They explain that talking and being with family can be one of the most helpful ways to cope when someone dies, and advice is usually to avoid isolating as this can make the grief much more intense. Additionally, due to coronavirus, people may have to stay, by themselves, in the house they shared with the person who died – potentially within that home – which can bring up painful reminders. Isolation can make it harder to process grief, as can worries about external situations (such as the pandemic) as people can become distracted from dealing with the grief or fully expressing their feelings.

Secure accommodation - Young Offending Institutions/Secure Training Centres

Size of the population

https://www.gov.uk/government/statistics/youth-custody-data

Government data on the custody population of children and young people in YOI's (inc 18) shares that 656 young people were in custody in August 2020. This was a decrease in one young person from the previous month (657 in July 2020). At the same time in the previous year, August 2019, there were 854 young people in custody, which is a difference of 198.

Visiting Restrictions: https://www.gov.uk/guidance/visit-someone-in-prison-during-the-coronavirus-covid-19-pandemic#who-can-visit-a-young-offender-institute-yoi-or-secure-training-centre-stc

To visit someone in a YOI or STC you must be:

- over 18
- related, or a significant person, to the person being visited
    - Siblings who are looked after may need to visit accompanied by a social worker
- 1 adult can visit a prisoner with up to 1 other adult
- if only one adult is visiting, they can bring up to 2 children
- if two adults are visiting, they can only bring 1 child
- all visitors must live together in the same household, expect if they are parents of a prisoner aged under 18 and they live apart.

Coronavirus differences:

- do not visit anyone in custody if you are self-isolating (through choice or track and trace)
- do not visit if you have symptoms of Covid-19
- do not visit if you live in, or are visiting someone held in a 'very high' local covid alert level area – unless the visit has been agreed in advance by the prison on compassionate grounds
- follow all prison COVID guidelines and measures and follow advice from prison staff as needed
- stay over 2 metres away from other people during the visit – no physical contact is allowed – except with regard to adults and or/children who are with you visiting
- wear a face covering
- remove face coverings if staff need to carry out checks.
- no refreshments can be brought to prison unless they are for a baby.

Changes to legislation and policy

https://www.legislation.gov.uk/uksi/2020/508/pdfs/uksiem_20200508_en_001.pdf

The prison and young offender institution (coronavirus) (amendment) (No2) rules 2020 – explanatory memorandum – share the legal and policy changes that allow the implementation of a restricted regime during the coronavirus period. It is also stated that "The modifications to the Prison Rules 1999 and YOI Rules 2000 will cease to have effect two years after the introduction of the Coronavirus Act 2020 on 25th March 2022. This is in line with the fact that the majority of the Coronavirus Act 2020 will currently expire after two years" (Page 3).

This memorandum shares that social visits at all prisons were temporarily suspended on 24th March 2020, and this decision reflected public health advice and government guidelines at the time. During the period of restrictions, prisons are focusing on regimes in a number of areas including prisoner safety and welfare, and family contact. The priority is essential safer custody arrangements such as assessment, care in custody and teamwork (ACCT) which is the care planning process for prisoners identified as being at risk of suicide or self harm, and alternative ways prisoners can maintain contact with friends and family. These arrangements include:

1. Providing 900 locked mobile phones to establishments that do not have telephony

2. Promoting other methods of contact such as letter writing, using the email a prisoner services or the prison voicemail service
3. Introducing secure video calls

Isolation Requirements:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/05/YOIs-SSV-Web-2020-1.pdf the HM Chief Inspector of Prison wrote a report on short scrutiny visits to YOI's holding children – dated 21 April 2020. Three institutions were visited – Cookham Wood, Parc and Wetherby.

'restrictions have dramatically reduced the amount of time all children spent out of their cells interacting with others. While a reduction in time unlocked was inevitable, the variation between establishments was a concern and raised the question of the need for, and therefore the proportionality of, the most restrictive regimes' (Page 7). Only one institutions – Parc – was able to plan and deliver face to face education as it complied with social distancing requirements; this meant children at Parc had over 3 hours out of their cell each day, compared to 40 minutes at Cookham Wood and about an hour at Wetherby.

Children who had newly arrived at the institutions were separated from the rest of the population for 14 days; they continued to received a risk and vulnerabilities interview/health care assessment, but they were only allowed out of their cell for 30 mins of exercise. They had some in-cell activities. Newly arrived children were only allowed to see and speak to people who had arrived on the same day as them; for those arriving by themselves, they had no face-to-face interaction with other children for 14 days. As these children were new, and known, they were not well-supported in managing their behaviour and emotions.

At Parc, one child was isolated with symptoms. Two children were shielded at Wetherby; these children were spoken with as part of the inspection, and shared that they were kept informed about what was happening.

Disparities amongst institutions / how children in (3) YOI's are experiencing the pandemic

All three sites were reported as calm and ordered; staff knew of the potentially negative impact of spending so much time in cells, and were observed interacting with children in caring, patient and professional ways. Self-harm had reduced at Parc and Wetherby, and it remained stabled at Cookham Wood. There was limited specialist secondary mental health services for those who needed them. There had been a significant reduction in bullying and violence at all three sites; this was attributed to less time outside of their cells, and remaining within the same group of three or four.

Children could see a health care professional swiftly and access a GP if needed. Key worker sessions remained regular with staff at Parc and Wetherby, but not Cookham Wood. Regular checks on vulnerable children were undertaken; this was hourly and weekly at Wetherby, daily at Parc and weekly at Cookham Wood. Some CAMHS and psychology support was removed by these services – and Barnardo's advocates.

Many children were frustrated that they could not see their friends and family, although they understood why, and managers had acted quickly to give additional pin phone credit – there was a significant difference in amounts given at each establishment (£5 at Parc, £20 at Cookham Wood and Wetherby – per week) with little reason given for this disparity. Staff at Wetherby spoke with children who had not used their credit, in order to mitigate isolation.

Video calling was slow to be implemented; it had just been set up at Parc, but not yet set up at Wetherby or Cookham Wood. Parc has since embedded skype for both social visits and mental health consultations. Parc has also assessed and introduced communal dining,

maintain social distancing in 'family groups' for roughly 1/3 of the population each day. Communal dining has also been introduced at Cookham Wood.

Children had their meals delivered to them and ate in their cells.

Children reported concerns about not seeing their parents, and this was exacerbated by not knowing how long the suspension would last.

Secure hospitals – psychiatric units – people who have been sectioned

Size of the population

Statistics for the number of people sectioned during the coronavirus pandemic in 2020 have not currently been shared.

The BBC (2020) report that 18,000 people in England live in psychiatric units.

https://www.bbc.co.uk/news/av/health-52943524

The CQC have reported on the number of deaths of people who are detained, or liable to be detained, under the Mental Health Act. This is both people detained within hospitals and also people who remain in the community. between 1 March and 1 May 2020, 112 patients detained under the Mental Health Act have died; for the same period in 2019 there were 56 deaths, in 2018 there were 61 deaths and in 2017 there were 70 deaths. Out of the 112 deaths in 2020, 56 are suspected or confirmed to have had covid-19; 54 of these patients were under the care of a mental health provider, and 2 patients were under the care of non-mental health providers.

https://www.cqc.org.uk/about-us/transparency/transparency-statement-publication-deaths-people-detained-under-mental-health

In 2018-2019, 49,988 new detentions under the Mental Health Act were recorded, but this number is likely to be higher as not all providers submitted full/any data. This is an estimated 2% rise on the previous year. Detention rates declined with age, with the highest known detention rates being within the 18 to 34 group (National Statistics, 2019). https://files.digital.nhs.uk/00/66FBD2/ment-heal-act-stat-eng-2018-19-summ-rep.pdf

Intersectionality

Gov.uk Ethnicity Facts and Figures (2020) shares that between March 2018-2019 black people were 4x more likely as white people to be detained under the mental health act, with 306.8 detentions per 100,000 people compared to 72.9 per 100,000 people. Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'other'). It is estimated that detentions increased by 2% in the year to March 2019.

https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

Reductions of Liberty

Changes to how people in mental health crisis can be sectioned

https://www.mind.org.uk/information-support/legal-rights/coronavirus-and-your-rights/coronavirus-and-sectioning/#collapsec0afa

Under the Coronavirus Bill (2020), rules on detaining people in mental health crisis are being relaxed. Emergency legislation has been designed and introduced to ease the burden on staff, but there are many concerns about the impact it has on people in crisis. The main change is that the Mental Health Act 1983 requires two medical professionals to agree that the patient needs to be detained; under the new legislation, this is reduced to just one medical

professional (MIND, 2020). Additional changes include the removal or extension of time limits in mental health legislation, which could result in people being detained for longer periods without review (MIND 2020).

Being detained/sectioned impacts on a person's liberty; the agreement of two medical professionals provides some safeguard to that person, as agreement has to be reached on the decision and other options may be explored prior to agreement. Additionally, the medical professional is reassured the decision is right - the burden is shared, as this can affect their emotional wellbeing. Changing this decision to one medical professional removes the need for agreement on the circumstances, lessens other avenues of consideration and places the burden of the decision on one professional – potentially affecting their emotional wellbeing. Removing time limits also impacts on a person's liberty, as there is no urgency or monitoring to ensure decisions are being made in the right timescales.

https://www.rethink.org/advice-and-information/covid-19-support/nhs-guidance-on-temporary-changes-to-the-mental-health-act-due-to-coronavirus/

Mental health charity, Rethink, explains that there are 7 main changes within the Department for Health and Social Care's guidance (which accompanies the changes to the MHA).

1. The use of video technology as part of Mental Health Act assessments
2. The use of section 136 of the Mental Health Act
3. The hospital managers panel
4. Mental health tribunals
5. Leave and visiting
6. The provision of independent mental health advocates (IMHA)
7. The provision of second opinion appointed doctors (SOADs)

1. use of video: the Mental Health Act states that doctors must personally examine the patient, and that the Approved Mental Health Professional (AMHP) must have personally seen the person before applying for their detention. Under the new guidance, professionals (the doctor/AMHP) can see and assess the patient via video; this decision needs to be made on a case by case basis. Professionals must consider the patients presentation, if they have complex needs, if the video assessment will make them distressed or very unwell, and if reasonable adjustments can be made to ensure the patient has a fair experience.

The use of video is advised if the three following conditions apply: high risk that you or the professionals may pass on Covid-19, high risk to you or others if the assessment is delayed, and the minimum quality standards and safeguards are met. The Rethink website says "where possible they should try to get your agreement to the video assessment"; this suggests agreement from the patient is not always needed.

Concerns: This is less of a personal experience, an individual might be able to present as okay for a certain period but not consistently. If the person cannot access video calling or needs help with accessing this, the professionals should arrange a face to face assessment as soon as possible.

Video calls should not be undertaken within the community unless they really have to, they can take place in a 'place of safety' if patients are taken there by the police. One professional involved in the assessment should still see the patient face to face. Video calls can happen within mental health hospitals if appropriate guidance and staff are available, video calls should not happen in general hospitals/A&E unless they really have to. Video calls can happen in prison and immigration removal centres.

2. the changes to Section 136 mean that if taken to a place of safety, professionals can talk through video link rather than attending themselves.

3. changes to the hospital managers panel is again that it can be done via video if needed – for both professionals and family members.

4. changes to mental health tribunals are more complex – usually a tribunal must be held within 7 days of a patients application, under the new guidance this is extended to 10 days – the tribunal can also choose to extend this time period. People can use phone or video link for tribunals.

The tribunal can also decide to go ahead with 'paper tribunals' where decisions are made on the paper evidence they have; the patient does not get the opportunity to speak with the tribunal, but may be able to provide a written statement. There are conditions that must be met to have a paper only tribunal.

Tribunals are usually made up of a legal member, a doctor and a lay member; under the new changes, tribunals can heard by a single legal member only and they can make decisions alone.

No pre-hearing assessments will take place during the pandemic (an assessment that examines the patient to form an opinion of their mental condition).

For patients in the community, if a paper tribunal has already been agreed it will go ahead as planned. If it hasn't, the tribunal will be postponed until after the coronavirus crisis has ended.

5. changes to leave and visiting – the responsible clinician (RC) grants permission for the patient to leave, the RC needs to ensure you understand social distancing and public health measures before this is agreed. Patients may only be allowed to leave if they have another person with them. In terms of visiting, patients should be allowed one visitor and hospitals shouldn't have blanket visiting bans, they do need to consider whether each individual patient should have a visitor based on their situation (whether both parties will adhere to non-contact rules). If visiting isn't possible, contact should be maintained via phone or video call.

6. changes to IMHA- this will be done via phone or video call and patients should be supported/given access. If this is difficult, staff should seek to arrange a face to face appointment.

7. changes to SOADs – SOADs will no longer visit patients in hospital, they will review the treatment plan remotely. SOADs will speak to other professionals by phone/video if needed. Patients can talk to the SOADs via phone/video if needed.

Impact

https://www.theguardian.com/society/2020/apr/14/mental-health-ward-not-equipped-coronavirus-feel-sitting-ducks-ppe

An anonymous worker has shared with the guardian (2020) their experience of working in inpatient psychiatry during the pandemic. This person explains that they often offer comfort and reassurance through touch – even just a fist bump – and that patients experience this as a rejection when declined. They make the observation that many patients lack the emotional regulation to process why, in previous months, staff have been present, but currently they seem distant. The combination of patient's psychosis – which includes lacking insight – with a global pandemic, and entrenched belief systems, results in Covid-19 being seen as a

conspiracy, or biological warfare, or entirely staged. Existing fears of being contaminated are validated. Some patients see broadcasts as meant for them, and the writer shares that in psychosis, once beliefs are realised, they are fixed and cannot be shifted. Personal hygiene standards have dropped, so gentle encouragement has been replaced with urgent instruction; people are too unwell to care but need to abide by Covid cleaning routines (hand washing).

The writer reports that psychiatric wards are not designed for physical distancing, environments are contained, and people are in close proximity. Communal spaces are designed to bring people together. Whilst patients are detained, they are not segregated, these wards are about inclusion, participation and connection. Patient leave and visits have ended over lockdown, which can affect the patient's stability and they could experience this as punitive. Therapeutic groups and activities – art, psychology, OT – are all cancelled. As emotions escalate, staff are blamed which places them at higher risk of assault.

Staff do not wear uniforms, and see how quickly it would spread if they brought Covid-19 in on their clothes or personal items. There is little PPE, and staff are reticent as they are locked in spaces with people who do not understand the importance/find it almost impossible to physically distance. Only essential staff remain on the wards, which makes them less able to deal with volatile situations- their option would be to call the police, which raises anxiety. The writer explains that it is no longer shocking to see colleagues breaking down on shift, and everyone is exhausted.

Prisons

Size of the population

Official statistics (2020) shares that there are 79,164 people in prisons in the UK on Friday 23rd October 2020– this does not specify the breakdown or ratio for each prison category. This number has been reducing (perhaps due to early prisoner release); for example, on 28th February 2020 the prison population was 85,037.

Reductions of Liberty

Changes to regime

MoJ (c, 2020) reports that the usual prison regime has been paused temporarily to apply social distancing; prisoners can no longer take part in:

- the usual recreational activities such as the gym
- worship
- going to the library
- only essential workers such as kitchen staff and cleaners will continue

Support for prisoners such as advice on in-cell worship, exercise and managing anxiety will be provided (MOJc 2020).

All face to face Parole Board hearings have been suspended but cases will progress through remote hearings or paper review process, sometimes with case management hearings. New jury trials have started in some courts (MoJ-c, 2020).

Parliament (2020) shares that education provision consists of in-cell work packs and many education departments have closed, with providers withdrawing form prisons. This is variable across prisons, but face to face teaching has largely been suspended.

In April 2020, a report on short scrutiny visits to local prisons, shared that the vast majority of prisoners were locked in for nearly the whole day (23.5 hours) and there were examples of

even greater restrictions; a small number of symptomatic prisoners had been isolated in their cells for 14 days, without the opportunity to come out for exercise or a shower (Parliament, 2020). The current prison regime is consistent with, or very close to, international definitions of solitary confinement, which is around 22 hours or more alone each day. The Ministry of Justice have been urged to set out clear and centrally determined expectations for minimum time spent out of cell, doing activities, with any exceptions requiring justification.

Concerns have been raised for prisoner's mental health, self-harm and suicide. Additionally, there have been some reports in spikes of violence. INQUEST, in a briefing to the committee, shared that restricted regimes have lead to isolation, anxiety, uncertainty alongside restrictions on family visits and potentially more oppressive conditions which raises concerns about self-inflicted death, self-harm across detention (Parliament, 2020).

Visitation

There are numerous restrictions on visiting someone in prison, such as not attending if you are showing any symptoms, following all guidelines to ensure everyone's safety, social distancing and wearing a face covering (MoJ-e, 2020).

Additionally, other means of contact – voice message, email, writing – are being reviewed as options. Secure phone handsets have been given to prisoners at 55 prisons, which allows risk-assessed prisoners to speak to a small number of pre-authorised contacts. At some YOI's, secure video calling has been introduced and this option is free (MoJ-c, 2020).

Parliament (2020) states that video calls – already organised within 10 establishments – will be rolled out in the coming weeks. Video calls can be provided through secure laptops in designated rooms, and prisoners will be allowed one call per month for up to 30 minutes. Building on the MOJ (c, 2020) report, Parliament explain that 900 locked mobile handset have been rolled-out for use in establishments that did not have access to in-cell telephony.

Looked After Children – Children's homes

Size of Population

Ofsted reported that there were 2,304 children's homes of all types as at 31st March 2019. Statistics from the Department for Education report that there were 78,150 looked after children (LAC) as at 31st March 2019, a 4% rise on the previous year. Of these, 75% were under a care order, 18% were under a voluntary agreement, 7% were under a placement order, and less than 0.5% were detained for child protection or under youth justice legal statuses.

Most of these LAC (72%) were in foster placements, with 13% fostered with a relative or friend and 58% fostered with a carer who is not a relative or friend. Of the remaining LAC, 12% were in secure units, children's homes or semi-independent living accommodation, 7% were placed with parents, 4% were living independently or in residential employment, and 3% were placed for adoption.

Reductions of Liberty

COVID-19 Safety Measures:

The government guidance on children's social care services notes that Covid-19 safety measures in residential settings might mean that children's "normal routines are disrupted and the may have less or limited contact with their family, friends and people who are important to them".

Deprivation of Liberty:

Government guidance on children's social care identifies the cases where flexibilities allowed by the Adoption and Children (Coronavirus) (Amendment) Regulations 2020 (which expired on the 25th September) can still be used:

"The amendment made to regulation 20(3) of the Children's Homes (England) Regulations 2015 allowed a children's home to enforce a temporary deprivation of liberty where powers under Schedule 21 of the Coronavirus Act 2020 were being exercised in relation to isolation of a young person who was infectious or suspected of being infectious with coronavirus (COVID-19) to prevent the virus from spreading.

The savings provision means that where a child was being deprived of their liberty in a children's home as permitted by regulation 20(3) on 25 September 2020, this can continue as though the amendment made to regulation 20(3) is still in force. This will only be for the duration of the period that the child is subject to the relevant powers in Schedule 21 of the Coronavirus Act 2020. In general, the permitted maximum period for the exercise of powers in the Coronavirus Act is 14 days, unless the requirement has been set at a shorter period by a Public Health Officer or it is extended by a Public Health Officer. We would expect that any decisions relating to the exercise of these powers will continue to be recorded and there is a requirement for their use to be monitored."

Isolation:

Government guidance on isolation for residential educational settings states that, in the case of a LAC needing to self-isolate due to Covid-19 infection or exposure:

"the assumption should be that they would self-isolate in their children's home. Where possible, the decision should also include consideration of the impact on the child or young person from the disruption of their usual staff relationships and routines."

Government guidance states that restrictions should wherever possible be discussed and agreed with the young person and all professionals involved in their care. However, the guidance also states that:

"If the young person refuses to follow sensible public health guidance, as a last resort, advice can be sought from Public Health England (PHE) on the possibility of imposing restrictions on an individual who is potentially infectious under the Coronavirus Act 2020. This gives Public Health Officers power to impose proportionate requirements (including screening and isolation) on any person suspected or confirmed to be infected with coronavirus (COVID-19). Children and young people have the power to appeal the decision and should be given information about accessing advocacy support."

The guidance states that "restraint should not be used to ensure children and young people comply with social distancing measures."

Family Visits:

Whilst government guidance and advice has been given to separated families regarding children having contact with both parents (BBC, 2020), such clear guidance has not been shared for children in care. The House of Commons Library published a report on 'Coronavirus: separated families and contact with children in care FAQs (UK)'. This report answers the question, can I visit my child in care/residential home (England)? The answer explains that under S34 of the Children Act 1989, the LA must allow 'reasonable contact' between children and their family, but this can be halted for 7 days if the LA believes it necessary to safeguard the child or promote their welfare. The answer then goes on to discuss how the 'coronavirus: guidance for children's social care services' still expects court ordered

contact to be met, however, recognises this is not possible in all circumstances. They suggest that contact arrangements should be decided on a case by case basis and in line with government guidelines; if this cannot be in person, it should be undertaken virtually and children should be reassured this is just a temporary measure. When the circumstances are that the child may not benefit from virtual contact – due to age or communication challenges etc.- LA's should work with families to ensure safe face to face contact.

Similar answers are given for children's homes; there should be somewhere suitable to meet, however, if that cannot happen there should be a phone call, video call or other electronic method of communication. Children and young people must be informed about the decisions being made. One safeguard is apparent; staff must record all uses of this temporary flexibility in individual case notes to explain why the virtual visit was necessary.

For children who see their parents at a contact centre, the FAQ document shares that decisions are being made by the individual centres in adherence with national and local guidance (House of Commons, 2020).

Impact of changing family contact

Nuffield Family Justice Observatory (NFJO 2020) explains that remaining connected with loved ones is important for children who have already experienced disrupted relationships as their feelings of loss and rejections are likely to have already been heightened. They report that whilst everyone is affected by social distancing, children in care are unlikely to have supervised face to face family contact during the crisis. As such, the NFJO (2020) commissioned research into how children and their birth families are keeping in touch during lockdown. Their online survey captured 56 children's social care professionals, 63 foster carers, 37 kinship carers/special guardians, 11 adoptive parents, 14 other carers and 15 birth relatives' views on contact. Semi-structured telephone or skype interviews with 17 professionals, 4 birth parents, 2 foster carers and 1 adoptive parent were then undertaken.

Main findings include:

- Almost all face to face contact with birth relatives was suspended for all groups of children.
- Video calls were used by children in residential, foster and kinship care.
- Some adopted children had video calls if this was already in place prior to the pandemic, or if they were having face to face contact prior.
- Letterbox contact remained the same for most adopted children.
- Children's views on digital contact
    - Video contact was reported by children as preferred to professionally supervised contact, although others missed being able to hug and be physically close to their parents.
    - Video calls more successful when including a child friend fun activity to engage children.
    - More successful when the child feels at ease with their family; some reported being frightened and this was mostly where children's relationships with their parents weren't as good.
        - These children did not want to have contact in their 'safe space'.
    - Some children reported video calls to be less emotionally intense and difficult compared to face to face meetings.
- Foster carers, kindship carers and adoptive parents views on digital contact
    - Foster carers had greater involvement in contact arrangements as they were taking place at home rather than in the community. Carers had to spend time preparing children for and managing video calls.

  - Where communication through email and video call was positive, professionals felt this could lead to better integration of the different aspect of children's lives.
    - Some carers felt it to be an intrusion of their home/lives as the parent was virtually in the home.
    - Hard to manage boundaries with parents.
  - Carers reported unmet support needs around managing contact, boundaries and confidentiality.
  - Additional costs from buying extra sim cards to protect confidentiality.
  - Kinship carers in particular felt least supported.
- Parents views on digital contact
  - The pandemic increased parents worries about their children, and their feelings of loss and separation.
  - Video calls were viewed as 'better than nothing' but missed physical contact; parents did not want video calls to replace physical contact longer term.
  - Parents struggled when children struggled during video calls – with focus or attention. This was easier when parents had realistic expectations and where activities made calls fun.
  - Parents of babies in interim care expressed high levels of concern about loss of physical contact – this was viewed as detrimental to developing or sustaining a relationship and their ability to demonstrate parenting capacity. This could reduce the chances of the child returning home.
  - Some parents found it helpful to communicate with the child's carers whilst others found it challenging or intrusive.
  - Some parents had received good support, others less so; some parents did not have access to a smart phone, computer, data or wifi. (NFJO research report, 2020).

NFJO (research report, 2020) found that the main ways to stay in touch during lockdown were:

Figure 1: Main ways of staying in touch during lockdown

Medium	Key characteristics
Video calls	• Mediated by professional, or by carers, or young person could manage the call. • Just talking or play/activity-based. • Same day/time as before or 'little and more often'. • Common for children in care and kinship care, limited in adoption.
Letters/cards/gifts	• Common in adoption. • Requests by agency or birth parents for adoptive parents to send extra letter. • Delays to existing letters for some. • Used by some across all settings as a preference or add-on to other forms of contact.
Phone calls and messaging	• Common for teenagers who have own phone. • Used by carers to send photos and videos to parents to 'fill the gap'. • Some foster carers/adopters want to keep number confidential (withhold number).
Face-to-face meetings and family time	• Only happening very exceptionally. • Teenagers who may 'vote with feet' if not allowed. • Where need considered to be urgent. • Attempts to apply rule of two-metre 'social distancing'.

Additionally, they report on the pros and cons of video calls during lockdown:

Figure 2: Summary of pros and cons of video calls during lockdown

Positives	Barriers and challenges
• Preferred by some children: feels more relevant or safer. • For some parents and children, better than not being able to see each other at all. • Can create opportunities for better integration between a child's two worlds, though greater involvement of carers in contact. • Can be used flexibly. • Saves travel time.	• Difficulties for babies, under-fives and older children with disabilities. • Fears about impact on parenting assessments. • Parents and children missing physical contact. • Raises new questions about risks. • Some additional stresses for carers. • Upsetting for some children. • Parents, carers and children may not have equal access to digital devices or the internet; some may not know how to use digital methods.

Professional Visits:

Temporary regulations mean that meetings taking place under regulation 22(1) of the Children's Homes (England) Regulations 2015 can now be conducted virtually. This may be confusing, distressing or upsetting to children, especially considering age, disability, learning difficulty or use of English, as well as the established relationship between the child and the social worker.

Additionally, social work visits to children in care prior to Covid-19 were mandated as 6 weekly, in person and the child must be spoken to alone. Through the 10 regulation changes published in the statutory instrument 'The Adoption and Children (Coronavirus) (Amendment) regulations 2020', this has now drastically changed. Social workers are no longer required to see children in person but can speak to them via phone call. Additionally, the duty of ensuring this action takes placed every 6 weeks has been removed. This means social workers are not required to speak to a child in a foster placement within a set timescale (Article 39, 2020). In terms of deprivation of liberty, without speaking with the child, monitoring them and their experience in placement, social workers are unaware of the reality of the child's experiences and feelings. It cannot be confirmed that they are well.

Another established safeguard for children in foster care, prior to Covid-19, was a care review that must be undertaken every six months. The statutory instrument declares that these reviews now do not have a timescale, but must be undertaken within a reasonably practicable time frame. This amendment is particularly concerning when considered with the above changes, as they are in place following the death of a child in care (Dennis O'Neill) at the hands of his foster carers.

Ofsted are required to inspect registered children's homes at least twice a year, however, the new regulations remove this duty. This also applies to fostering and adoption agencies, residential family centres and holiday schemes for disabled children (Article 39, 2020). This reduction of visits applies to children's homes that are graded 'inadequate' or 'requires improvement', leading to further concerns about the care children are receiving – which is not being closely monitored due to the social work visits and care reviews being reduced (Community care, 2020).

A further safeguard for children living within children's home was the requirement for an independent person to visit the home at least once a month; that person writes a report addressing whether children are effectively safeguarded and whether the home promotes children's well being – the report is sent to the LA and Ofsted. This requirement is being relaxed; children's homes providers are simply required to "use reasonable endeavours" to

ensure they occur. This is particularly concerning when around ¾ of children's homes are run by the private sector, and 49% if children live within 20 miles of their home (article 39, 2020).

The final concern for children's homes following the implementation of the statutory instrument is that prior to Covid, children's homes have been required to meet quality standards since April 2015. One standard is in relation to the quality of care; children must be cared for by people who have experience, skills and knowledge to be able to deliver that care, and those staff must be supervised by appropriately skilled and qualified people. The statutory instrument changes this to as far as reasonably practicable. What is most concerning about this move, is considering it in combination with the removal of all of the other safeguards above, and also the reality that no other setting has had such requirement changed (e.g. schools, nurseries etc) (article 39, 2020; communitycare 2020).

Potential Difficulties

Increased Demand:

The Local Government Association warned that the large increase in LAC, combined with funding shortages, is putting unsustainable pressure on councils' ability to support LAC, with a 139% increase in serious cases where the local authority believes a child may be suffering, or likely to suffer, significant harm to 201,170 cases (Guardian, 2020).

The Royal College of Paediatrics and Child Health also states that there is likely to be an increase in safeguarding referrals/assessments and then also an increase in the number of children in care with Initial Health Assessments (IHA) and Review Health Assessments (RHA) (in six to 12 months' time) required.

Children's social care may also suffer from a reduced workforce due to staff illness or isolation, further increasing the demand on services.

Reduced Oversight:

Government guidelines state that the suspension of the minimum intervals for inspection of children's homes, residential family centres, voluntary adoption agencies, adoption support agencies, fostering agencies and holiday schemes for disabled children will now continue until 31 March 2021. This may reduce oversight of any issues that occur in children's social care settings.

Care leavers:

Government guidance highlights that "care leavers are a particularly vulnerable group of young people. Coronavirus (COVID-19) heightens this, because care leavers may be financially vulnerable and at risk of increased levels of anxiety and isolation." Therefore, local authorities should be particularly aware of this group and proactively reach out to and support care leavers.

Become, a national charity for children in care and young carer leavers, has written a report detailing concerns for the impact Coronavirus is having on care experienced young people. Become (2020) said the key issues are in relation to:

- Loneliness and mental health: social distancing is likely to have a significant impact on care experienced young people's wellbeing, especially if they have existing mental health difficulties (almost half do)
    - Care leavers are more likely to live alone and have smaller networks
    - They may not have access to the internet

  - Disrupted family contact can have a huge impact on their emotional wellbeing and create challenges for carers in terms of managing resultant behaviour and mental health issues
  - Contact helps children develop a sense of identity and belonging, it promotes healthy and stable relationships, but not all households have the ability to maintain this digitally
- Safeguarding and stability
  - Around 10% of vulnerable children are in school
  - Lockdown may increase the number of children and young people in care who are reported missing; this is of particular risk to the 32,110 children in out of area placements who are isolated from family and networks
    - Going missing during the pandemic poses additional risks to health and the potential for criminalisation
  - The emergency regulations (implemented in the statutory instrument) reduce the level of care and support that children and young people receive
    - The changes are ambiguous and suggest a reduction in support as local authorities can deviate from their statutory duties
  - Whilst the Education Secretary has requested that LA's do not ask any child to leave care during this period, funding is needed to enable this to happen and ensure that it does not prevent others (those entering care) from accessing safe places to live
- Financial security
  - Many care leavers contact includes concerns about being able to pay for basics – food, household supplies and utilities
    - Most do not have the money to purchase food supplies if they must isolate for 7-14 days, which leads to risking their own and others health
    - Lack of money may push care experienced young people into debt and rent arrears, with homelessness a real risk
    - Care leavers are more likely to be in precarious employment and have less family support to fall back on
    - The current five week waiting period for universal credit is an unnecessary delay to immediate financial relief
- Education
  - Plans for future education, training and employment of young care experienced people have been derailed
    - This is compounded by children in care typically having lower attainment than their peers
    - Calculated grades have the potential to negatively impact care experience children, as previous results are often poor indicators of future potential – especially as teachers can have negative perceptions of these children
  - For care experience children in higher education, they are further affected by social isolation as their friends have been able to return home. There are also concerns about finances and accommodation (Become, 2020).

Respite care

Size of population

Clear statistics of the number of people accessing respite care in general, let alone during the Covid-19 pandemic, cannot be found. Carers UK (2019) share that each day 6,000 people

take on a caring responsibility, which equates to 2 million people a year. 58% of carers are women, 42% are men. 1.3million people provide over 50 hours of care per week and over 1 million people care for more than one person. In 2019, there could be as many as 8.8 million adult carers in the UK. This helps contextualise the need for respite care but does not provide clear numbers of how many individual people require respite.

Respite care can be a crucial part of an approach that supports relationships and enhances wellbeing. Children with additional needs – either disabilities, behavioural issues or in need of end of life care, adults with learning difficulties and adults with dementia/Alzheimer's are amongst those who utilise respite care; this can be for the benefit of the carers, the person, and/or both. Respite provides carers with the opportunity to rest, recharge their batteries, and have an opportunity to stand back and regain perspective (CoramBaaf, 2020). Many people engage in informal respite; family members, friends or neighbours may provide care, however, this becomes difficult during a pandemic due to levels of risk, isolation and government guidance.

For children, Coram Baaf (the Adoption and Fostering Academy, 2020) shared that respite arrangements were not possible under the initial Covid-19 lockdown measures, but through easing restrictions this has become possible. Arrangements between two household are compliant with some of the distancing measures; but this would need to be kept under review when/if guidance changes. To underpin decision making, Coram Baaf suggest the following principles: arrangements need to be relationship based and child centred – not seen as a right for foster carers; children involved in decision making; carers not judged as failing or not coping if they need respite; comprehensive risk assessment for both households, taking into account local restrictions.

A lack of access to respite is concerning, as Carers UK (2019) share that 72% of carers responding to the carers UK's state of caring 2018 survey said they had suffered mental ill health as a result of caring, 61% said they had suffered physical ill health and 8 in 10said they felt lonely or socially isolated (Carers UK, 2020).

Respite options

The NHS (2020) explain that to access respite care, the family must first be assessed. Once respite care is agreed, there are 6 main types of care provided:

1. Day care centres
2. Homecare from a paid carer
3. A short stay in a care home
4. Getting friends and family to help
5. Respite holidays
6. Sitting services.

Service suspension/closure and impact

As seen within the hospice section of this report, many day centres have had to close during the pandemic. Whilst day centres may not be classed as respite care in all cases, it gives that person and their carer time apart, the person gets the opportunity to engage in different activities and see different people, and the carer can use the time as they see fit. Without this opportunity, the person and their carer do not have time away from each other or the realities of care.

Decisions for closure are happening within care homes/hospices/day centres on an individual basis; a brief search shows disparity in options depending on location and affordability.

Carers UK (2020) undertook research in April 2020 titled "caring behind closed doors, forgotten families in the coronavirus outbreak". In relation to care and respite, they found:

- Over a third (35%) of carers are providing more care as a result of local services reducing or closing. This includes day care centre
- 70% of carers are providing more care due to the coronavirus outbreak
- Carers are, on average, providing 10 additional hours of care a week
- 69% of all carers are providing more help with emotional support, motivation, or keeping an eye/ checking in on the person they care for
- The majority (55%) of carers agreed or strongly agreed with the statement "I feel overwhelmed and I am worried that I'm going to burnout in the coming weeks".

Respondents shared statements to contextualise their experience of both informal and formal respite arrangements changing:

- "day centre twice a week is closed and my brother can no longer take my dad out one day at the weekend. I am providing three full days more than I used to – 24 hours a day 7 days a week"
- "prior to this outbreak, I could rely on other family members getting involved in taking my wife shopping or out for a coffee etc. giving me a break and some free time to do activities just for myself. Coronavirus now means I have that responsibility for 100% of the time."

Carers worries and fears were also focused on being able to continue caring for their relative safely and maintaining their own health and wellbeing. One in five (18%) already feel unable to manage their caring role currently, with 55% agreeing/strongly agreeing with the statement 'I feel overwhelmed and I am worried that I am going to burn out in the coming weeks'. Respondents shared:

- "I have no other family members except my parents who I live with and look after. That's pretty damn stressful. If I burnout, who looks after them? Nobody. We have no external support. I am already faltering."
- "I have a support network, but the main support I need is respite (which I usually get when he attends specialist provision) and no one can offer this at the moment. Even therapeutic support is tricky at the moment as son can't cope with me being on the phone".

Determining emergency respite care priorities

The NHS (2020) have provided guidance on determining emergency respite priorities during the pandemic:

• Carry out an individual risk-based assessment on a case-by-case basis for providing emergency respite. The benefits and risks associated with an individual CYP staying at home with no care package or being admitted to a hospice/hospital/respite setting need to be considered alongside the current infection control risks in each clinical setting. With a reduced workforce, child to-staff ratios may need to be markedly altered in various care settings.

• Priority should be given to those CYP with a high degree of clinical risk, eg requiring assisted ventilation, where the clinical situation is unstable or persistently difficult to manage, or social complexity is affecting the care of the CYP.

• Many of these children will meet the criteria for children's continuing care (CCC) and if so, will be entitled to a package of care that will depend on assessed need. However, not all families will choose to have CCC and some may have opted for a personal health budget.

• Some families will choose not to have additional care and will manage the child or young person's needs themselves. However, these children may have a high degree of clinical risk, the family situation could change at any time and a care package may need to be introduced

Changes to children's social work safeguards during short breaks

Changes to short breaks (respite) have been made through the 10 regulation changes published in the statutory instrument 'The Adoption and Children (Coronavirus) (Amendment) regulations 2020. Previously, a child who had a single short break (e.g. in a children's home) that lasts more than 17 days, or has numerous that amount to more than 75 days a year, are protected by social work visits, independent reviews, leaving care entitlements and other safeguards. Due to the changes within the statutory instrument, these safeguards now only apply when the short break days amount to MORE than 75 days a year, with nothing else triggering the safeguards (e.g. a stay of 17 days or longer). The reviews and social work visits are also modified (Article 39, 2020). This means that children can remain in respite placements for up to 75 days without having safeguards in place like social work visits and reviews to ensure their care needs are being met.

Conclusion: Whilst there is likely to be a disruption to the regular respite care children, young people and adults receive during the pandemic, this is not in a manner that reduces their liberty. As with other reports from the C19 Foresight Group, the concerns for lack of respite link to carers mental health, physical health and overall ability to manage their role for the duration of the pandemic.

Looked After Children (LAC)

Some of the main changes for LAC are shared within the section above, however, another important consideration is in relation to children who are or who become privately fostered. Private fostering is where a child under 16 (or 18 if disabled) lives with another family under private arrangements (no involvement from social care). Safeguards have been developed for such instances following the murder of Victoria Climbie in 2000 (Article 39, 2020). Prior to Covid-19, the law required social workers to visit a child within the first 7 days of being notified that there is a plan to privately foster the child. The new amendments changes this visit to whenever is reasonably practicable to do so (Article 39, 2020).

For kinship care – where a child lives with family members or friends – the law prior to Covid-19 stated this could only happen once a placement plan has been agreed for the child (through social care) to ensure the arrangements are right for the child. The new statutory instrument states that this safeguard – the placement plan – is no longer necessary, and again only must be implemented when reasonably practicable (Article 39, 2020).

Currently, LA's are able to approve a child's relative, friend, or other connected person as a foster carer for a period no long than 16 weeks as an emergency foster care placement. The statutory instrument changes 16 weeks (4 months) to 24 weeks (6 months) and removes the requirement that the temporary foster carer has to have an existing family or other connection to the child (Article 39, 2020).

Each of these changes are concerning, as children could potentially be in risky situations without appropriate monitoring and safeguards in place.

Young carers

Size of population

Young minds reports that the BBC estimates there are 700,000 young carers within the UK (Young minds, 2020). A young carer is someone who looks after a family member who is ill, or looking after other family members whilst the ill family member cannot.

Young carers do more chores, cooking, caring for siblings, provide emotional support, learn how to nurse/look after them often include personal care (Young minds, 2020). Many young carers cope well with caring, but also need support and for people to care for them too. Without this, young carers can feel stressed by too much responsibility, physically tired, worried about their relatives health, missing school, not coping with homework, feelings of embarrassment about their situation, problems with bullying, low self-esteem, anxiety, guilt and anger. Young carers miss on average 48d days of school and 68% have been bullied (Young Minds, 2020).

Impact

Carers Trust (2020), a charity for, with and about carers, have undertaken a survey to understand the experiences of young carers during the pandemic (published July 2020). 56.5% of the respondents were young carers aged between 12 and 17, 42.6% of respondents were young carers aged 18 to 25. There were 961 responses in total. The main findings were that, since coronavirus:

- 40% of young carers and 59% of young adult carers say their mental health is worse.
- 67% of young carers and 78% of young adult carers are more worried about the future.
- 66% of young carers and 74% of young adult carers are feeling more stressed.
- 69% of both young carers and young adult carers are feeling less connected to others.
- 11% of young carers and 19.7% of young adult carers report an increase of 30 hours or more in the amount of time they spend caring per week.
    - 58% of young carers and 63.6% of young adult carers are spending on average ten hours a week more on their caring responsibilities.
    - 7.74% of young carers and 14.94% of young adult carers are now spending over 90 hours a week caring.
- 56% of young carers and 39% of young adult carers said their education was suffering
    - 44% of young carers and 39% of young adult carers would like more support with their education.
- 52% of young adult carers feel overwhelmed by the pressures they are facing now.
- 49% of young adult carers are struggling to look after themselves.
- 50% of young adult carers are having to spend more money due to Coronavirus.
- 66% of young carers and 71% of young adult carers are less able to stay in touch with friends since Coronavirus.

As has already been evidenced within this report, respite centres and activities are temporarily shut/postponed; this may affect young carers if their relative usually attends such services, meaning the young person's caring responsibility may increase.

Similarly, as was seen with respite care, the Carers Trust (2020) report shares examples of how family members or friends who may usually support the young person may no longer be able to; either through their own medical concerns, concerns for the person being cared for, concerns for the young carer, social distancing/local area requirements, self-isolating with symptoms or other reasons (Carers Trust 2020). This again may result in the young persons responsibilities increasing with little respite, with a young person sharing that they are caring 24/7 with no support, and the young carers service they attend is closing before lockdown ends, making them concerned about how they will cope.

It has been evidenced in previous reports that children and young people are disadvantaged through academic denial; either by not being able to attend school, or not accessing learning at home. The Carers Trust (2020) findings indicate that this is further compounded for young carers, as many respondents report things such as: school was the time for me, now everyday is the same; I haven't been able to get out and talk to all my friends after school; it has put more stress on me and my education; as well as my education being put on hold, I'm now having to isolate with the person I care for 24/7 without a proper break. Previous reports have shared how school – learning, seeing friends, forming relationships with peers, teachers and staff - benefits children physically, emotionally, educationally and from a safeguarding viewpoint. Young carers are already disadvantaged from attending school less than their non-caring peers (Young Minds, 2020), and the results of this study appear to suggest it is exacerbated during the pandemic (Carers Trust, 2020).

Support

Young carers can request an assessment from the local authority and access services for themselves, or potentially for the person they are caring for (NHS 2018).

Young Minds (2020) offers a 24/7 crisis messenger for young people across the UK who are experiencing mental health crisis; it is a free text service.

Carers UK – offer support through online forums, phonelines and emails.

These methods of support should be able to continue during the pandemic – they are not affected by social distancing measures - as long as they can be done remotely and there is enough staff available to cover the work.

What we do in this analysis, how and why (caution when interpreting)

A data review is undertaken by academics at Nottingham Trent University every week to inform the C19 National Foresight Group. Data related to Covid-19 UK social and economic trends is reviewed to inform, guide and help prioritise discussions at national and local decision-making level (LRFs). The C19 National Foresight Group are keen to ensure that the data included has been ethically governed and structured to adhere to open access, data protection and GDPR regulations and principles. For example, the data is to be manipulated in an ethical manner, and the content and context is to be fit for purpose in terms of the audience and decision timeframe in question.

Activity Completed

The following findings are based on a review of multiple data sources exploring Social, Economic, Psychological, Community aspects of Covid-19 in the UK. These could include:

- ONS: covers wellbeing, perceived financial precarity, objective indicators of UK economy, household financial pressures, perceived impact on work life
- OfCom: Public perceptions of information to help manage Covid-19, perceptions of preparedness and action
- ONS: Deaths from Covid-19
- Gov UK: Relevant contextual information
- Census and geographical data: Geographical/location specifics
- IMD: Socio economic trends associated with spread or primary/secondary impacts
- LG Inform: Population, social, demographic, lifestyle and health data
- You Gov: Public mood
- NTU's own analysis of open source data (lead by Dr Lucy Justice and Dr Sally Andrews)
- Other academic survey work published within the last week

Limitations for Consideration: The National Foresight Group have been keen to quality assure the data assumptions, including the equity and representation of participants.

Internet use data indicates representational issues in older adults

Almost all of the data sets draw from online surveys. With this in mind the statistics behind online access were explored. The following is to be considered in the assumptions taken from the data sets.

The table below shows the estimated number of people who have never used the internet. The data are drawn from ONS 2019 Internet users:

Table 1: estimated number of people who have never used the internet

Age	Estimated number of people who have never used internet	Age	Estimated number of people who have never used internet
16-24	20,000	55-64	389,000
25-34	28,000	65-74	869,000
35-44	46,000	75+	2,482,000
45-54	158,000	Equality Act Disabled Not Equality Act Disabled	2,336,000 1,657,000

Table 1 shows that caution should be applied when considering the inferences made in the rest of the document as older adults could be underrepresented in the samples. The estimated numbers of those that have never used the internet begins to increase around age group category 35-44, the subsequent age categories increase by approximately twice as many non-users as the age category that precedes it. The numbers of 'over 75s' (2,482,000) for example not using the internet equates to almost a million more than the total of the other age group categories (1,510,000).

The interpretation of data should also consider the proportion of people known to be disabled by government agencies who do and do not meet the Act's criteria. These numbers make up 3,993,000 of the population, so this should be considered in the representativeness of the data.

END.

Contact us: If you have any questions about this output please email: C19foresight@ntu.ac.uk
Corresponding editing author Dr Rowena Hill is seconded full time to provide academic representation on the C19 National Foresight Group, and works at Nottingham Trent University.

