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- Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic

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Categories: Public

This report looks at mental health care of children and young people in 7 areas of England in June and July 2021.

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Introduction

Issues around mental health care and support for children and young people are not new. We have previously raised our concerns about the quality of mental health care and support children and young people receive. For example in our 2018 report *Are we listening?* [<https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services>], we highlighted the barriers that many children and young people faced in getting the right mental health care and support when they needed it, with too many children and young people finding themselves at ‘crisis point’ before getting help. Other issues raised included long waiting lists; inappropriately high eligibility criteria; and gaps in service provision.

While we recognised the steps already taken to improve access to care, we raised concerns that the pace of change was too slow and needed to be accelerated.

In the two-year period following the publication of our report before the pandemic, many of the changes we called for in our report had not been implemented. Our follow-up report, Children and young people mental health review: Update on local actions [<https://www.cqc.org.uk/publications/themed-work/children-young-people-mental-health-review-update-local-actions>], published in October 2020, highlighted that more work was needed to make sure our recommendations were being acted on.

To keep the spotlight on these issues, we have looked at the mental health care and support for children and young people up to 18 years old during the pandemic as part of our >provider collaboration reviews [<https://www.cqc.org.uk/publications/themes-care/provider-collaboration-reviews>]. This includes children and young people seeking help from mental health services for the first time, as well as those receiving continued mental health and care support.

We know that the COVID-19 pandemic has presented services with additional challenges and, in many cases, exacerbated pre-existing challenges, gaps and poor-quality care. Through our review, we aim to shine a light on where systems need to focus improvements, as well as share the learning and innovation where we have found good examples, to ensure that the national effort to improve mental health services for children and young people continues.

What we did

In June and July 2021, we carried out reviews in seven areas of England. We also carried out specific activities to get to the heart of children and young people's experiences. Through these activities we heard from just over 1,700 children and young people.

The local areas and organisations we covered included:

- Birmingham and Solihull Integrated Care System (ICS)
- Bristol, North Somerset and South Gloucestershire ICS
- Buckinghamshire, Oxfordshire and Berkshire West ICS
- Hertfordshire and West Essex ICS
- North London Partners in Health and Care ICS
- Nottingham and Nottinghamshire ICS
- South Yorkshire and Bassetlaw ICS

We carried out the following activities:

- Interviews and focus groups with providers, system leaders, and community groups representing people using services across the seven areas of focus.

- Analysis of available data around local systems, including demographic information, inequalities data, COVID-19 outbreak analysis, and mental health data.

- Case tracking of children and young people with mental health needs – we looked at the experiences of 40 individuals.

- Commissioned Participation People [<https://participationpeople.com/>] to engage with children and young people using services. This included focus groups with 72 young people, 18 one-to-one interviews, and a survey of children and young people with mental health needs, which enabled us to hear the views of 1,624 children and young people aged 10 to 18.

- Remote access to 149 electronic patient records/management computer systems with consent from general practices.

We are clear that our report is only reflective of what we found in the areas we looked at, during a specific period of time. However, many of the themes and issues arising are not new and may resonate with other people, providers and systems across the country.

Throughout the report, we refer to the 'systems', 'system partners' and 'system leaders' who participated in our review. By this we mean the integrated care systems who participated in our review, health and social care providers and patient representative bodies, local authorities, schools, voluntary sector services, police and fire services, and the leaders of these organisations.

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Key findings

The COVID-19 pandemic has had an enormous impact on the mental health of children and young people, and has led to an increased demand on services, particularly eating disorder services.

While leaders responded quickly to try and ensure that there were enough staff with the right skills in the right places, services have also struggled to meet demand. Not only did this increase the risk of children and young people's symptoms worsening and reaching crisis point, it also led to them being cared for in unsuitable environments.

Across all areas, we have seen positive examples of systems working collaboratively together to ensure continued access to mental health support. However, there were some concerns around silo working. Communication, both between services and with families, was mixed, with some people not always aware of what support was available.

The pandemic has also shone a light on, and exacerbated, health inequalities faced by some children and young people, in particular those people living in deprived areas. While some areas were taking steps to tackle this, more needs to be done.

Digital technology enabled services to adapt almost overnight, ensuring continuation of care and, in some cases, increasing support for children and young people in comparison to pre-pandemic levels. But alongside this we heard about the associated risks to children and young people's safety, for example staff missing cues or issues that would have been picked up face-to-face, as well as unseen risks within the home environment.

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Key challenges

With the increasing demand for services, the urgent need for change that we highlighted in 'Are we listening?' is now more important than ever. Systems need to take action to ensure that children and young people are receiving the right mental health support early on, before they reach crisis point. This includes ensuring they have the right staff, with the right skills to meet the needs of children and young people. Providers and systems must continue to reduce silo working and improve how they work together. This includes improving communication both between providers and with families, as well as other system partners including local authorities, schools and charities.

There needs to be a continued focus on addressing health inequalities. This includes tackling health inequalities for children and young people with mental health needs experiencing deprivation, those from Black and minority ethnic backgrounds, as well as those who identify as Lesbian, gay, bisexual, and

transgender (LGBT+), and/or have physical, sensory and learning disabilities.

While digital technology has given some children and young people access to services they may not previously have had, this is not the right approach for everyone. Children and young people must have a choice in how they access care and support, whether online, face-to-face or a combination of both.

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Hearing the experiences of children and young people

Through our review, we wanted to ensure that we heard from children and young people about their experiences of mental health care, particularly during the pandemic.

As part of our activities we worked with the organisation Participation People [<https://participationpeople.com/work-for-us-youth-engagement-programs-participation/>] to gather the views of children and young people. For this project, Participation People recruited a diverse group of Young Researchers, with different lived experiences of mental health. The six researchers, aged between 15 and 21, were actively involved in co-designing a survey, co-facilitating focus groups with 72 young people who were less likely to take part in the survey, and leading one-to-one interviews with 18 young people.

In addition to this work, we carried out case tracking reviews of 40 individuals across the areas in our review. Together, these activities have enabled us to hear the views of just over 1,700 children and young people, including children and young people from Black and minority ethnic backgrounds, young people who identified as Lesbian, gay, bisexual, and transgender (LGBT+), and young people with disabilities. We capture some of their feedback here and include reference to their experiences throughout the report.

Through this work, we heard how important mental health services are to children and young people in providing them with the help and support they need. They described how services gave them a safe space to talk, and that they were confident that what they said would be kept confidential. They also gave them techniques for managing their conditions. For example, comments shared included:

"I love my therapist as she helps me express how I'm feeling using art and sculpture and even photos now. It works for me and I know I can look after myself even when our time together ends."

Young man, 16

"Mental Health support, when it works well, saves lives. Rehab especially helped me understand that I have a mental health illness, but that doesn't have to stop me from living a fairly normal life."

Young woman, 17

But we heard from some children and young people that they were not always able to get the help and support they needed, when they needed it. One young person described how this made them feel like they were being "brushed off". In other cases, like Zeb's story below, we heard how not getting help early enough could lead to children and young people's conditions deteriorating, and only getting help when they had a crisis.

Zeb's story

Zeb's family told us about their frustrations in obtaining care and support at an early stage for Zeb. They

told us that they had asked for help for Zeb for several weeks before going to A&E, but it had been refused as they did not meet the required criteria. We heard how this made Zeb feel like he almost had to die in order to get the help he needed. He told us that he was not really aware about what was going on, and that he felt that if he had been offered support earlier then he wouldn't be in the same position.

During the pandemic, we heard from children and young people that it was taking longer for them to get an appointment. This was exacerbated by changes made in response to the pandemic, with 29% of the 1,624 respondents (aged 10 to 18) to the Participation People survey saying that they had had appointments cancelled since March 2020.

We heard how this and other changes made in response to the pandemic, such as fewer face-to-face appointments, an increase in video and telephone appointments and the need to wear masks, made children and young people feel. While 40% said they were fine with these changes, 45% did not feel fine with them, of which 25% said that the changes made them feel terrible. Half of respondents (50%) also said that they had not been told why changes to their care had been made.

When asked what they would change about how mental health services were run, children and young people spoke of the need for better communication and lower waiting times.

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Access to care

Key points

The COVID-19 pandemic has had an enormous impact on the mental health of children and young people, and has led to an increased demand on services, particularly eating disorder services.

Across all areas, we have seen positive examples of services working collaboratively – including with schools and voluntary sector organisations – to ensure continued access to mental health support.

Often services were struggling to meet demand. This meant that children and young people experienced delays in accessing care and increased the risk of their symptoms worsening and/or them being cared for in inappropriate environments.

The quality and effectiveness of communication, both between services and with families, was mixed.

While some areas spoke of improved communication during the pandemic, some people reported a lack of information and that they were not always aware of what support was available.

Increased demand

Aiyah's story

Aiyah had been receiving mental health care and support for a number of years. During the pandemic, she had a crisis and presented at her local emergency department with suicidal thoughts. Her family were told that someone would be in touch within 24 hours, but Aiyah and her family waited for a number of days before then having to chase the child and adolescent mental health service (CAHMS) to find out what was going to happen. Aiyah and her family found this wait overwhelming given how concerning her

symptoms were. This meant that the family's anxiety levels were heightened and Aiyah was left feeling unsafe and unsupported during such a distressing time.

As highlighted in our annual State of Care report 2020/21 [<https://www.cqc.org.uk/publications/major-report/state-care>], the pandemic has had a significant impact on the mental health of children and young people. Data from Childline showed that between April 2020 and March 2021, the service carried out more than 73,000 counselling sessions about mental and emotional health. Of these, more than 5,000 were for children aged 11 or younger. This was an increase of nearly a third (29%) compared with the year before.

Throughout our review we heard how, for example, social restrictions and lockdowns introduced in response to the pandemic had had an impact on children and young people's mental health. This was compounded by the closure of mainstream schools and youth groups, which put additional pressure on children and young people and their families. In some cases this led to children and young people experiencing their first episode of poor mental health.

Our findings are supported by NHS Confederation's report Reaching the tipping point [<https://www.nhsconfed.org/sites/default/files/2021-08/Reaching%20the%20tipping%20point%20Final.pdf>], which suggests that 1.5 million children and young people may need new or additional mental health support as a result of the pandemic. It highlights the uncertainty and anxieties caused by the lockdowns, the closure of schools, isolation from peer groups, bereavement, and the stresses and pressures on families as contributing factors to rises in mental health problems in children and young people.

The report presents data from an online counselling app which showed that during the early stages of the pandemic there was a 9.2% increase in the rate of young people from Black and minority ethnic groups presenting with depression, compared to a 16.2% fall in the rate among their white counterparts. It also included data from Just Like Us, an LGBT+ charity for young people, which showed that 68% of LGBT+ young people said that their mental health had worsened since the pandemic, compared to 49% of their non-LGBT+ peers.

While nationally referrals to child and adolescent mental health services (CAMHS) initially fell in the early stages of the pandemic, all the areas we looked at in our review reported that they had seen an increase in demand for children and young people's mental health services in 2021. This corresponds with the national picture as well. In May 2021, NHS Providers conducted a short pulse survey of 35 mental health trust leaders. All respondents to the survey said that the demand their trust or local system was experiencing for children and young people's services was significantly or moderately increasing compared with six months previously.

As well as a rise in the number of referrals to CAMHS, we heard there had been an increase in the number of children and young people presenting to emergency departments with mental health needs. In some cases, we heard of an increase in children and young people presenting with thoughts of suicide. The impact of this is discussed in the section on 'Care in unsuitable environments'.

These concerns are echoed in a June 2021 report by the Samaritans. 'One year on: how the coronavirus pandemic has affected wellbeing and suicidality' [https://media.samaritans.org/documents/Samaritans_Covid_1YearOn_Report_2021_BJCM8rI.pdf] highlighted an increase in contacts with young people about using self-harm due to the pandemic. Increased family tensions, a lack of peer contact and negativity about their future prospects were cited factors that led to mental health problems worsening. While most people who self-harm will not necessarily go on to take their own life, it is a strong risk factor for suicide.

Focus on eating disorders

Maya's story

Maya received good support from the eating disorder service caring for her. We heard that the team consulted frequently with the local mental health support team (MHST). This ensured Maya's plans could be targeted towards supporting her with particular behaviours that would help her manage her relationship with food.

During the pandemic, we heard that there had been a surge in children and young people with eating disorders. Through our review, most areas told us that they had experienced a rise in demand for eating disorder services, which was having an impact on waiting times for community services and urgent care.

One area reported that referrals of young people with an eating disorder increased by 35% from July to September 2020 compared to the same three months in 2019. In another area, a mental health trust told us that referrals for their eating disorder services had increased by 45%. As a result, over 80 patients were waiting for help, when before the pandemic there had been no waiting list.

We heard that these increases reflected a national trend. In its report 'Reaching the tipping point [<https://www.nhsconfed.org/publications/reaching-tipping-point>]', NHS Confederation reported that the number of young people completing an urgent pathway for eating disorders has increased by 141% between January to March in 2020 and April to June in 2021 (based on data collected by NHS England). These figures from NHS England also show that four times more children and young people were waiting for routine eating disorder treatment at the end of June 2021 than the previous year. A further 207 children were still waiting for urgent treatment – the highest total in records going back to 2016.

Working together to ensure access to care

Jaime's story

Due to their level of risk, Jaime was given a care coordinator to act as lead professional and coordinate the support provided. As a result, there was effective collaboration between the professionals supporting Jaime with different interventions and significant progress was made. Jaime told us that in their experience, they had not felt listened to. However, they explained that their care coordinator was a really strong advocate for them, and that with their support they felt they were able to have a say in what happened.

We heard about improved collaborative working during the pandemic. For example, in one area trusts were working jointly with the local authority to raise awareness around mental health, particularly eating disorders. In other areas, we were told that providers worked with local authorities and education providers to look at out of hours support and other ways of preventing attendances to the emergency department due to a surge in children and young people with eating disorders.

Where children and young people lived affected their access to mental health services. In a couple of areas we reviewed, we heard that children and young people from deprived areas had poorer access to mental health services compared to people in more affluent areas. In other areas we reviewed, providers told us that

access to services, particularly face-to-face appointments was a problem for children and young people living in rural villages. There were some concerns that the economic impact of the pandemic would make these existing health inequalities worse.

Most areas spoke about the important role that voluntary sector organisations provided in supporting children and young people. We heard how one community trust had collaborated with the voluntary sector to develop a helpline for children and young people, which had a suite of resources for young people to be signposted to. In another area, third sector organisations were part of the local integrated CAMHS partnership, which increased support options available to young people aged 14 to 25.

Schools were similarly mentioned as key players in identifying and supporting children and young people with mental health needs. We heard how senior leaders in one area had reviewed school policies on discipline to ensure that schools could work in a trauma-informed way and ensure that young people's previous trauma was considered. We also heard from several areas that they had provided training specifically in the education sector to allow staff in schools to better identify and support children and young people with mental health needs.

A few systems spoke positively about Mental Health Support Teams (MHSTs) where these were in place. Jointly delivered by NHS England and Improvement, Health Education England and the Department for Education, MHSTs work in schools and colleges providing evidenced based interventions for pupils and students with mild to moderate mental health issues such as anxiety, as well as supporting education staff to establish a whole schools/college approach to mental health. They also liaise with school/college staff and other services to help students get wider support if needed.

MHSTs are being rolled-out across England. The original ambition to cover 20% to 25% of the country by 2023 will be achieved 12 months early, with coverage estimated to reach 35% of pupils by 2023.

One area told us about a campaign set up and jointly run by the MHST, CAMHS and the Educational Psychology Service to support families and young people returning to school in September 2020, and to relieve some of their anxieties. Promoted via 'outdoor summer schools', support offered included a helpline for parents and podcasts.

Collaborative working was reported to have had a positive impact on children and young people. In one area, we heard that the ambulance service had collaborated with other providers to improve closure of 111 calls for children, and reduce unnecessary use of the ambulance service. This resulted in calls regarding children under 12 being diverted to the GP out of hours service, where staff would also have access to patient records.

In another area, we heard how the pandemic had highlighted the need for partner agencies and services to have a greater understanding about each other's roles and work, and examples were shared of how this was happening. As a result, providers are now thinking differently about how best to support children and young people with mental health needs. We heard that they had put collaborative care plans in place for those waiting for inpatient beds.

Cross-sector challenges

Aaron's story

Aaron had previously had two referrals to CAMHS, but these had been declined as he did not meet the criteria. While Aaron's mental health had started to deteriorate before the pandemic, it got worse during

the pandemic so his GP and paediatrician made a third referral to CAMHS, which was accepted. Aaron's parents explained that his school did not understand their concerns, and as his condition deteriorated Aaron was no longer able to cope with going to school. We also heard that communication between his paediatrician and CAMHS was not always effective. As a result, Aaron's parents ended up calling the CAMHS support line about his deteriorating mental health.

Despite the examples of collaborative working to ensure continuity of care, we heard that it was a challenge to meet the increased demand with the available resources. This, combined with the closure of schools and youth groups, led to concerns that children and young people were not being identified early enough or were having to wait a long time to be seen, creating the risk that their condition could deteriorate.

Through our engagement activities, we heard that many children and young people had sought help and support from their GP or school (49% and 48% respectively of 1,624 people aged 10 to 18). For some, 7% out of 1,624, this was the first time of needing to access this support.

However, how quickly people were seen could vary. For example, in one area, our review of a sample of GP patient records showed that some children and young people needing an urgent referral after seeing their GP could wait a week for it to be actioned. There were also delays in secondary care services responding to referrals. In one system, we were told that staff from a GP out-of-hours service felt there was no point in referring on to CAMHS as demand and thresholds were so high.

This was supported by findings from the engagement with children and young people who use services, with one young person describing how, "Mental health services have no space – your wellbeing has to be so bad to be seen – that those in the middle, like me, get forgotten about." In addition, transfers to adults services are not always planned, with 59% (16 of 27) of GP records of 16 to 18 year olds we reviewed not having any evidence that action had been taken to facilitate transfer to adult services.

In particular, we heard that there were difficulties in accessing specialist inpatient care, with a lack of CAMHS inpatient beds available. We were told that this was an ongoing national issue, which had been made worse by the pandemic. In one area, a child had to be detained under the Mental Health Act (MHA) in an acute hospital because there were no CAMHS inpatient beds available. The clinician responsible believed that detention under the MHA would not have been necessary if a bed had been available in the right environment.

We also heard about long waiting lists for gender identity services in one particular area. The gender service, which was open to young people aged 17 and above, was subject to a three-year wait at the time of our review. While a local independent networking group was available to support young people who were gender questioning, there was little else available locally that could support young people on a one-to-one basis. One young person we met told us that they felt frustrated at what they saw as an insufficient understanding of how they were affected by the lengthy waiting time.

Care in unsuitable environments

While children and young people were waiting for a CAMHS inpatient bed or a specialist eating disorders bed, they were often having to be cared for in unsuitable environments, such as emergency departments, acute medical units, adult mental health wards or general paediatric wards. We heard that staff in some of these services did not feel equipped to meet their needs, and that in some cases it had led to increased use of medicines to control people's behaviour and restraint.

Providers we spoke with recognised how challenging and potentially unsafe these environments could be for children and young people and their parents or carers. In all areas, we heard how providers were working together to address this. This included work to source inpatient mental health or specialist eating disorder beds during the pandemic, as well as taking action to minimise and/or mitigate the impact of any delays on individual children and young people.

For example, in one area we were told that the CAMHS team spoke to staff in acute settings on a daily basis to offer support, ensure the needs of the young person were met and plan for discharge. The team also provided training to the children's hospital on ligature point awareness and how they could mitigate these risks on the paediatric ward. We also heard of acute trusts working with mental health trusts to provide updated or new guidance and training around the use of medicines to control people's behaviour. This was to improve staff knowledge in this area and to reduce how frequently these medicines were used.

In another area, clinical commissioning groups (CCGs) were working with local charities and had arranged additional funding for eating disorder charities to provide early intervention and coping strategies for children and young people waiting for beds. They also utilised local charities' mental health ambassadors to carry out a survey on the impact of COVID-19 on children and young people with mental health problems to assess gaps and identify areas of improvement.

Other positive examples included children and young people attending emergency departments being assessed quickly by appropriate CAMHS staff, and creating bespoke safe rooms and quiet areas where children and young people could be monitored while waiting for care.

Communication and information sharing

Femi's story

Despite professionals working closely together to support Femi, at times there was a disconnect between the professional team and her parents. Femi's mum told us that she felt there was a lack of support for parents and/or carers caring for children and young people with complex needs. She reported that they felt they had been left to navigate complex health, social care and education systems by themselves.

Our report 'Are we listening?' highlighted that children and young people were more likely to engage effectively in their care and treatment if they are given choices about their care.

Through our provider collaboration review, we found that how effectively information was shared, both between providers and with families, varied.

In many areas, changes made in response to the pandemic had led to better communication and sharing of information, which benefitted children and young people. This was supported by some children and young people using services and their families we spoke with who told us that they felt consulted and informed. For example, in one area children and their families told us that they had been involved as key partners in their care planning and were enabled to make choices about their treatment. In this area, we found that this child-focused planning was supported by routine information sharing and regular consultation between services.

However, in some areas we found issues and concerns were raised around the lack of information sharing and joined-up working, which could have negative implications on the quality of care children, young people and their families receive. For example, in one area we heard that communication and information sharing

between the CAMHS inpatient service to both the specialist community mental health professionals and the parents of one child was underdeveloped. Staff reported a lack of liaison and difficulties in accessing information. This disjointed working meant that the CAMHS inpatient staff did not fully understand the child's needs and risks, which could increase the risk of harm to the child.

In some areas, better links were made with community pharmacy at a strategic level, for example information was shared through the local pharmaceutical committees (LPCs). Where enhanced discharge services were used effectively, communication flowed well. However, other LPCs told us that they felt disconnected, which made it more difficult to help people.

Some families reported that during the pandemic they did not feel involved and/or were unaware of what was happening with services. For example, in one area we heard that families were not always aware of new arrangements put in place, with some feeling their children had missed out on vital therapies. In another area, we heard that there was a reliance on parents and family members to pass information between services to ensure it was shared appropriately to meet their child's needs.

In 2020, the Carer's Trust published new guidance on supporting carers of children and young people with mental health needs. The Triangle of Care for Children and Young People's Mental Health Services [<https://carers.org/resources/all-resources/66-the-triangle-of-care-for-children-and-young-people-as-mental-health-services-a-guide-for-mental-health-professionals->] complements their 2013 guidance, 'Triangle of Care', and aims to help mental health professionals in children and young people's mental health services to be better able to identify, understand and support carers.

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Inequalities in mental health care

Key points

The COVID-19 pandemic shone a light on, and exacerbated, health inequalities faced by some children and young people, in particular those living in deprived areas. Some areas had started to put steps in place to tackle these inequalities.

While the increased reliance on digital technology supported some to access care, children and young people without access to digital devices or the internet, or who did not have the skills to use this technology risked being excluded.

Some areas were using equalities monitoring data to identify children and young people who may be in need of mental health support. However, this data was not always routinely or effectively captured, resulting in missed opportunities to recognise health inequalities and to adapt care planning to children and young people's individual needs.

As attention turns to recovery planning, more needs to be done to tackle health inequalities. While we saw some evidence of this in action, there was a lack of long-term and cohesive strategic planning focusing on children and young people with mental health needs who experience inequalities, including LGBT+ and Black and minority ethnic young people.

Unequal impact of the pandemic

The COVID-19 pandemic has shone a light on, and in some cases exacerbated, inequalities faced by some children and young people with mental health needs. We found that there were a number of reasons for this, both social and economic.

Deprivation in particular had a negative impact on children and young people's mental health. For example, providers in one area told us that they had seen an increase in the number of children and young people from deprived areas being referred to mental health services during the pandemic.

There were also indirect consequences linked to deprivation, such as an increase in concerns around safeguarding. In one area, we heard that poor adult mental health as a result of deprivation from job losses had led to an increase in child protection plans. Another area highlighted concerns about the increasing impact of domestic abuse, and how social restrictions, including school closures, meant that there were fewer 'eyes' on the most vulnerable children and young people.

Some areas told us they were taking action to support people experiencing deprivation which may have benefited children and young people's mental health. This included, for example, sharing resources with people via food banks, and a parenting programme that supported parents at high risk of experiencing inequalities to develop positive parenting skills, and better manage poor health.

More broadly, improved partnership working and collaboration across sectors had helped some areas to identify children and young people in need of mental health care and support, including people from Black and minority ethnic groups, asylum seekers and Travellers. For example, in one area an NHS trust was working with colleagues in social care during the pandemic to engage with Travellers to identify children and young people of mutual concern, and to provide them with the necessary support.

We also heard about the steps that local areas had taken to keep children and young people who had been identified as experiencing health inequalities informed about available services. For example, in one area a CAMHS team had recruited staff from Black and minority ethnic groups. This helped children and young people feel supported and able to speak more openly and ask more direct, sometimes culturally sensitive questions, with staff from the same ethnic groups.

Digital inequality

The use of digital technology provided alternatives to day services and crisis support, and ensured that care services continued and remained accessible for children and young people. Through our engagement activities we heard that some children and young people welcomed the increased use of digital technology and remote appointments. For example, we heard:

"Being online made me feel less anxious. I didn't have to worry about getting lost or if I saw someone I might know."

Young woman, 17

"I think it was good to move to online appointments. Meant I didn't spread it (COVID-19) to my family."

Young woman, 16

However, one young person told us that remote appointments did not work for them:

"Phone consultations just didn't work, I didn't feel I could ask for help so my therapist just kept talking at me."

Young woman, 16

The systems in our review recognised that using digital technology was not suitable for everyone, and that it was important to be able to offer people a meaningful choice of engagement methods to meet their needs. They were also aware of practical barriers for some people in accessing online care. Issues included children and young people having limited or no access to equipment; a lack of internet connectivity and data; not knowing how to use the internet or digital devices; and the lack of a safe space at home to speak in private.

It was widely reported that increased reliance on digital technology risked some people not being able to access the support they needed. Some areas felt it had also led to health inequalities experienced by children and young people widening. In one area, the public health director feared that this may contribute to a growing backlog of children and young people in need of mental health support.

However, we also heard about steps being put in place to mitigate these risks. This included providing children and young people and their support networks with access to digital equipment and digital learning, and improving the usability of online services. For example, staff in one area told us how they bought data packages for children and young people's mobile devices so they could access services. The local authority also ensured that looked after children and children at risk were given digital devices at the start of the pandemic. In addition, we heard that many areas offered face-to-face appointments where appropriate, for example for people who were deemed most vulnerable, to ensure continued access to services.

Equalities monitoring data

Across a number of systems, providers were using data to identify and support children and young people with mental health needs who may be affected by health inequalities. For example, in one area system leaders monitored the demographics of children and young people accessing a 24/7 helpline operated by Mind. They then used this data to target their communication to areas where children and young people were potentially being missed.

Another area told us that their analysis of data had shown that large proportions of children and young people from Black and minority ethnic groups were missing appointments or not attending school during the pandemic. In response, they worked with community safety partnerships, schools and youth hostels to share information, targeting areas of high diversity and deprivation.

However, we found that recording of children and young people's protected characteristics, such as the ethnicity of children and young people, was not always routinely captured or used effectively. This meant that when planning and delivering care, services may miss any vulnerabilities associated with health inequalities.

For example, through our case tracking review we heard that in one area as a result of inconsistent recording of protected characteristics a number of children did not have their ethnicity or LGBT+ status captured by services. In the case of one young person, we heard that the CAMHS team were unaware that she identified as LGBT+ and, as a result, had potentially missed an opportunity to adapt her care package to ensure that it was meeting her full range of needs.

Inequalities and recovery planning

The NHS third phase response letter published in July 2020, recognised the impact that COVID-19 has had on certain sections of the population and how it has served to expose some of the health and wider inequalities in our society. Throughout the letter, it set out recommended actions that providers and systems need to take to reduce health inequalities.

During our review, we heard examples of how some systems were already attempting to tackle health inequalities. For example, in one area, the Health Executive Group had set up a network that brought system partners together to address health inequalities and ensure that services were in place to meet the needs of the local population. In another area, the clinical commissioning group (CCG) had received funding for public health and mental health support in schools. This enabled practitioners to meet the needs of people from minority groups in areas with high levels of school exclusion and poverty. A third area had commissioned an independent review of mental health and learning disability services, with a focus on deprivation and reducing digital exclusion.

While providers across all systems recognised the need to address health inequalities, the evidence we found did not amount to long-term, system-wide strategies that aimed to tackle inequalities affecting children and young people with mental health needs. For some systems, this may be due to a lack of understanding about inequalities in their area.

Looking forward, it is important for systems to continue to increase their focus on addressing health inequalities. This includes tackling health inequalities for children and young people with mental health needs from Black and minority ethnic backgrounds, young people who identify as LGBT+, and/or those who may have physical, sensory and learning disabilities. Not only will this help ensure that all children and young people have good access to quality mental health support, it will also contribute to systems' wider efforts in tackling existing, and preventing future, health inequalities affecting children and young people.

A key part of this will be improving how data to monitor equalities is captured and used. Limited and/or inconsistent data may affect how well a system is able to recognise and address health inequalities. This could make it more challenging to track any progress or impact of any work related to health inequalities.

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Leadership response and system working

Key points

Most systems felt leaders were strong, visible and supportive of staff throughout the pandemic. In many areas, the use of gold, silver and bronze command structures facilitated decision making, and allowed issues to be escalated promptly and consistently.

Systems recognised the heightened risk of harm to children and young people during the pandemic. Across all systems, we heard about an increase in cross-sector working to protect and promote the welfare of children and young people.

Systems also came together to review and make changes to the way services and pathways were set up to ensure that children and young people received the support they needed.

However, there were still some concerns around silo working, and in particular a lack of contact with, or involvement of, GPs. This limited opportunities to provide holistic care for children and young people.

Leadership response

As part of our review, we looked at how the leaders of systems, that is the integrated care systems who participated in our review, health and social care providers and patient representative bodies, local authorities,

schools, voluntary sector services, police and fire services, worked together to respond to the challenges presented by the pandemic.

Most systems felt that leaders were strong, visible and supportive throughout the pandemic, making decisions quickly and then supporting their implementation.

In many areas, we heard that the use of gold, silver and bronze command structures had facilitated this decision making, and allowed issues to be escalated promptly. For example, one area had daily gold meetings that were clinically-led, with regular additional cross-service meetings held throughout the pandemic. This meant that leaders knew about emerging risks and could take decisions quickly to ensure that children and young people with mental health needs were safe.

Throughout the review there was also a sense of strengthened relationships and partnership working across the areas we looked at. System leaders in one area told us how the pandemic had encouraged a reduction in bureaucracy and breaking down of boundaries. We heard that this had led to closer working, including developing relationships with services they had not previously worked with.

For example, in one area several providers told us how the system had responded quickly by setting up a 'mental health cell'. The cell, which included over 60 system partners and voluntary sectors, worked together to coordinate care for children and young people, as well as identify gaps in provision.

In some areas, specific boards, groups or committees had been set up during the pandemic to plan and deliver services. This included sharing risks and learning and addressing any issues.

During our review, we heard that many systems were also commissioning work to review what worked well through the pandemic, how service provision has changed, and what lessons can be learned. It was felt that this will support recovery plans as systems can continue to work in ways that have had positive impacts and learn from areas that have not worked as well. For example, in one area leaders had established a programme to review learning and consider changes to services in CAHMS. This should influence how children and young people's mental health services are developed in the integrated care system for the future.

However, the increase in demand and complexity of children and young people with mental health needs was felt to be a challenge for systems. We heard that some providers felt they were not yet in a recovery stage and did not have the capacity to develop future plans due to increasing workloads and increased referrals, combined with concerns around staff shortages and staff burnout.

Focus on safeguarding

Bertie's story

Bertie was having thoughts about ending his life. He received weekly support and intervention from his case co-ordinator, as well as individualised care plans and safety planning. This, together with the advice and guidance provided to staff in the multi-agency network, including school, was essential to reducing risks to Bertie. This meant that when Bertie was admitted to hospital, it was on an informal and voluntary basis and he was able to retain some control. Without this level of support from a trusted professional, it was highly likely that Bertie would have had to be detained under the Mental Health Act.

Early on, providers and other system partners recognised the impact of the pandemic and the need to ensure

continued access to services to keep children and young people with mental health needs safe.

Across all systems, we heard about an increase in cross-sector working to protect and promote the welfare of children and young people. This included, for example, the development of new or existing multi-agency groups and meetings with representatives from voluntary sector organisations, schools, the police and fire service. These multi-agency meetings had often been in operation from early on in the pandemic to share information and good practice, identify vulnerable children and support planning and decision making.

For example, in one system there was an effective multi-agency collaboration in place, which enabled care and treatment to be well coordinated through multi-agency plans. We heard that support was planned and delivered through looked after children plans, child in need plans or early help plans. For each of these children, their multi-agency teams, including mental health and social work staff, met or consulted regularly. This helped practitioners to share information and to plan support packages in a holistic way that met children's social needs as well their emotional or mental health needs. Families reported that they had consistent messaging from the different parts of their network and this showed that communication 'behind the scenes' worked well.

Systems particularly recognised the heightened risk of harm to children and young people during the pandemic, with some referring to an increase in safeguarding referrals. A couple of areas told us that safeguarding was kept at the top of everyone's agenda, supported by designated safeguarding leads throughout the system. We heard that they had put joint protocols in place between health and social care, which had developed strong working alliances and pathways.

Other systems also told us that they had provided training and support for staff on safeguarding in the context of the pandemic, including conferences around recognising domestic abuse and managing online safety. In addition, we heard that a range of approaches had been put in place to identify and target support for children and young people, and their families, who may be at risk of harm. For example, several systems told us that they had dedicated support in place in hospital emergency departments to target young people affected by violence and exploitation.

Working together to make system-wide changes

During the pandemic, systems came together to make changes to the way services and pathways were set up to ensure that children and young people received the support they needed.

This included setting up helplines, crisis hubs and mental health liaison services in emergency departments. For example in one area, services collaborated to introduce a 24/7 CAMHS crisis line. The line, which acted as a single point of access for professionals and children and young people and their families, was staffed by experienced practitioners who could assess the needs of children and young people and ensure they were directed quickly to the most appropriate team.

Since our review, we understand that NHS England now has crisis lines like this one available across all areas of the country [<https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline>].

In response to social distancing and other measures, such as enhanced infection prevention control, introduced following the start of the pandemic, some systems also sought to move care away from acute settings. One area told us that at the start of the pandemic, the system came together to make rapid changes to the paediatric pathway, with three acute trusts combining their paediatric emergency department services on one site.

Several systems told us about the development of new care models and pathways for children and young people with eating disorders, such as Hospital at Home, which provides intensive support to young people in the community.

Systems also told us that they had built on and strengthened existing partnership working through the pandemic. For example, one acute trust we spoke with had worked with their local mental health trust to develop a mental health strategy. While this had been initiated before the pandemic, it had enabled greater system working and relationship building during the pandemic.

Another area told us about their local NHS-led provider collaborative [<https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/>], which had been operating in shadow form since 2019 and went live on 1 April 2021. The provider collaborative took over the commissioning and quality monitoring of CAMHS inpatient services. The provider collaborative held weekly meetings to look at referrals, bed availability, and assess a young person's clinical urgency need. Case managers were asked to help liaise with social care to help move young people on who no longer needed to be in inpatient care. As a result, the number of children and young people from the system placed in out-of-area beds had reduced.

Silo working

Libby's story

In one system we heard how a lack of effective multi-agency working had affected Libby. Limited information was passed between the health professionals and education partners, meaning that Libby had to repeat her 'story' to her teachers at college, even though she was actively engaged with the child and adolescent mental health service. Libby felt that her health professionals could have helped with this transition as she found it difficult.

While there were lots of positive messages around improved collaboration, cross-sector working and strengthened partnerships, we found evidence that there are still pockets of silo working.

In a couple of areas, our case tracking review showed that collaborative working between different services and agencies was inconsistent and underdeveloped. We found that information was not being shared between health professionals and education partners.

Although we did find some examples of closer working between primary care and CAMHS, there were also concerns that GPs were not being involved in cross-sector working. For example, in one area we heard how GPs with specialist interests in eating disorders were working alongside the CAMHS team to monitor patients and provide support to children and young people on the waiting list. However, conversely through our case tracking review we found that there was a lack of direct contact between GPs and other health or social care professionals. As a result, there were concerns that silo working limited the opportunity for children and young people to be cared for holistically.

This was supported through our review of 149 GP records. In this, we found that only 15% of records showed evidence that the GP practice was actively involved in mental health multidisciplinary team working. Of these, only 59% showed that the young people had a multidisciplinary team mental health care plan in the patient records.

Leaders recognised that further work was needed to improve cross-sector working. For example, in one area

some teams, such as the inequalities team, had only recently been established, with more work needed to improve cross-organisational working. In another area, it was noted that organisational boundaries can still be a barrier to progress, and that different commissioning arrangements can be challenging.

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Workforce

Key points

During the pandemic, while leaders responded quickly to try and ensure that there were enough staff with the right skills in the right places to support children and young people with mental health needs, this was not always successful.

There were concerns around staffing shortages. We heard that pre-existing challenges around staffing were being made worse by the pandemic, and there were not always enough staff to meet demand.

To ensure continuity of care, services had increased their use of bank and agency staff, upskilled existing staff and provided training and support to non-mental health staff.

Staff shortages and difficulties in recruitment led to concerns about staff resilience and the risk of staff burnout. We heard of many positive examples of services prioritising wellbeing, including 'wobble rooms', wellbeing clinics and counselling sessions.

Staff redeployment

At the beginning of the pandemic, while leaders responded quickly to try and ensure that there were enough staff with the right skills in the right places to support children and young people with mental health needs, this was not always successful.

In some areas we heard of staff being redeployed between and within services to address this need. For example, in a couple of areas community staff were moved into crisis teams and inpatient wards to help manage demand. In one area, we were also told that senior managers had stepped into clinical roles when required.

Overall, the extent of redeployment varied. For example, one area told us that they had prioritised mental health services and as a result staff had not been redeployed from their usual roles. Prioritising in this way mitigated the impact of the pandemic on mental health services. Our case tracking showed that not having to redeploy staff meant that children and young people had continuity of care during an uncertain time.

However, we also heard that redeployment could have a negative impact on children and young people. For example, in one area we heard that there was a large redeployment of staff into critical care settings. Not only did this increase pressure on mental health services, it also meant that children and young people did not have continuity of care.

Staffing shortages and upskilling

Issues with staffing in mental health care are not new. In our 2019/20 annual State of Care report [https://www.cqc.org.uk/publications/major-report/soc201920_4e_mental-health-care], we highlighted our

concerns around the mental health workforce, and the ongoing decline in the number of inpatient mental health nurses. During our review, we heard continuing concerns around shortages of trained nurses and staff with the specialist skills to care for children and young people with mental health needs. This was recognised as a nationwide problem.

There has also historically been limited specialist medicines support for inpatient and community CAMHS. During the pandemic, pharmacy teams told us that they were asked to focus on supplying medicines rather than providing clinical services.

In some areas we heard how COVID-19 had made staffing issues worse, and posed a direct challenge to staffing levels due to self-isolation, shielding, and caring responsibilities. Some systems told us that due to a lack of trained staff, children and young people were ending up in inappropriate places, such as emergency departments. In other cases, a lack of staff led to some wards needing to be closed for safety. In one area, we heard that this caused problems for people needing access to a CAMHS inpatient bed.

Systems took a number of steps to try and mitigate staffing shortages. Most systems told us that they used bank and agency staff to provide additional resource and manage shortages.

Other areas spoke about how they had 'upskilled' new and existing staff to try and meet demand and manage shortages. One area described how they were employing people with a lower level skill set, and were working on an induction and skills package to ensure they had the skills they needed before working with children and young people. An acute hospital in another area told us that they were looking to develop staff in lower grades, for example healthcare assistants, to fill existing gaps and meet changing needs. This included, for example, providing training around eating disorders so that they could support people with an eating disorder and their parent or carer.

In some cases we heard that staff working outside their normal role as a result of redeployment had led to them developing new skills. For example, in one area the local authority had seconded staff from the local CAMHS team to work alongside social workers. These posts were jointly-funded between CAMHS and social care and resulted in upskilling social workers, which helped to alleviate pressure on the CAMHS system.

We also heard positive examples of how providers worked together to provide training and support for non-mental health staff to ensure they were able to appropriately identify, treat, and support children and young people with mental health needs. For example, one area provided paediatric staff with specific training to help them manage the increase in children and young people presenting with eating disorders, particularly those who required nasogastric tube feeding. In another area, we heard that the liaison psychiatry team provided a one-day course in the care of mental health patients for non-mental health care staff. They also produced checklists for guidance and prompts when supporting people with mental health needs.

Staff burnout and wellbeing support

In May 2021, the Health and Social Care Select Committee on Workforce burnout and resilience in the NHS and social care described the impact of the COVID-19 pandemic on health and social care staff. Many witnesses for the committee described workforce burnout as the highest in the history of the NHS. It highlighted figures from an NHS Providers survey that showed 92% of trusts were concerned about staff wellbeing, stress and burnout following the pandemic.

We saw evidence of this during our review, with concerns raised around staff resilience and burnout, as well as concerns about capacity to continue delivering the current levels of service provision. Some providers also

told us that they were not yet in a recovery stage and did not have the capacity to develop future plans due to increasing workloads and concerns around staff shortages and staff burnout.

All systems reported a wide variety and availability of innovative resources and initiatives to support staff wellbeing. This included psychology or counselling support, daily check-ins, reflective sessions and 'wobble rooms' for staff to go to when they needed to take a break. In one area, we heard that the wobble rooms available to staff were calming environments with plants and soft lighting, as well as refreshments, chocolates and colouring books for staff to take. We heard that staff also left positive feedback messages for their colleagues in the emergency department staff room. In some systems, we heard how this led to staff feeling that their mental health and wellbeing had been a priority.

Other examples of support included increased supervision and one-to-ones, mindfulness sessions, virtual coffee mornings and coaching sessions. We also heard how staff felt supported and appreciated by management, and felt able to raise concerns. For example, in one area a trust held twice monthly live webinar sessions with the executive directors. This gave staff the chance to ask questions and for a real conversation to take place. The trust told us that this was very successful and planned to continue these sessions.

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Digital

Key points

Digital technology enabled services to adapt almost overnight, ensuring continuation of care and, in some cases, increasing support for children and young people in comparison to pre-pandemic levels. With this change, we heard that staff were provided with IT equipment, training and guidance to be able to provide care remotely.

The introduction of remote consultation, apps and helplines enhanced children and young people's access to care, and in some cases gave them access to resources that they previously didn't have. Digital technology made it easier for professionals to collaborate and share information, but in some cases incompatible computer systems created a barrier to services being able to share information securely. To mitigate these risks, systems had effective governance structures in place.

There were also safeguarding concerns associated with the increased use of digital technology. This included concerns around missing cues or issues that would have been picked up face-to-face, as well as unseen risks within the home environment, for example uncertainty around who else may be in the room and what impact this could have on the assessment.

Davina's story

During lockdown Davina's school moved to online learning. Due to an issue with students misusing cameras during lessons, the school made the decision that children were not able to have their cameras on. Although there were no obvious signs that Davina was hiding anything, because the teachers were not able to see her they did not find out that she had lost a significant amount of weight until a number of months later. This may have been a barrier to her seeking help.

Importance of digital technology

In response to the COVID-19 pandemic, services rapidly adopted digital solutions in order to be able to continue to provide care for children and young people with mental health needs. We heard that the introduction of virtual consultations, apps and helplines enhanced children and young people's access to care, and in some cases gave them access to resources that they previously didn't have. For example, in one area this had enabled an individual to access counselling services after they had been trying to get help for 12 to 18 months before the pandemic.

It was widely reported that video and telephone calls, as well as video conferencing systems, were used to provide virtual appointments and consultations. This was reflected in the results of the survey by Participation People, in which more than half (58%) of the 1,624 respondents said they had telephone or video call appointments. Providers also described using websites and social media to provide information and advice, as well as signpost to crisis services, self-referral pathways, and instant chat platforms.

In particular, a few areas spoke about the introduction of a new online counselling community and app. This offered children and young people the opportunity to seek professional support anonymously with immediate access to professionals, seven days a week with no need for a referral and no waiting lists. It also allowed children and young people to self-report ethnicity, gender identity and sexuality, which gave providers more comprehensive data about the young people making use of the service.

While some areas told us that they experienced challenges in the availability of equipment in the early stages of the pandemic, we heard that staff were given laptops and tablets, with support and training, to ensure that services were able to deliver care remotely. In one area, intranet pages were developed to provide staff with guidance on using various platforms to interact with children and young people.

As well as being able to better support some children and young people, all systems told us that digital technology had had a fundamental impact on communication, collaboration and information sharing.

Systems described how digital technology made it easier for professionals to attend meetings. For example, professionals in one area told us that they were now better able to join for part of a meeting or able to attend those called at short notice due to the use of digital technology. This was echoed in another area where staff told us that being able to hold multidisciplinary and safeguarding meetings virtually made it easier to get all the necessary agencies together to discuss the patient's care and treatment, including discharge plans.

In a couple of areas we heard that digital technology also helped to increase engagement and involvement of children and young people's support network, including family members.

In addition, we heard how digital technology supported the delivery of services. For example, in one area staff explained how digital technology had enabled them to switch to providing virtual meal planning for children and young people receiving support for an eating disorder. We also heard how digital technology enabled services to share learning and development.

However, as discussed in our section on 'Digital inequality', all systems in our review recognised that digital technology was not suitable for everyone, and that there needed to be a balance of remote and face-to-face appointments based on clinical presentation and risk, as well as other factors such as individual preferences and access to technology.

The children and young people involved in our review highlighted their mixed experiences of using digital

technology. For example, we heard:

"Online appointments were simple to access and often my therapist was on time, not like face-to-face appointments where I have to wait, in the waiting room."

Non-binary young person, 14

"Face-to-face appointments still felt more private and more sincere from professionals struggling with tech."

Young man, 17

"...the bad thing about telephone is I don't know who the other person is. Another bad thing is I have to be very quiet in order to express my feelings..."

Young person, 18

Data security and governance

Across the areas in our review, there were governance structures in place at a provider level to ensure data security and mitigate risks linked with the increased use of digital technology. For example, providers told us that data safety policies, General Data Protection Regulation (GDPR) and NHS-wide guidance effectively supported and assisted their use of digital technology.

Some systems told us that they had put additional measures in place to support formal governance structures. This included allocating a dedicated 'champion' to manage and uphold information security, and carrying out data protection impact assessments to identify and address any risks. One area also told us that staff had access to yearly information governance training, which had been updated in light of the new digital ways of working through the pandemic. However, we heard little about system-level governance – the examples we were told about were often at an individual provider level.

However, in some areas staff experienced challenges and barriers in sharing information and keeping data secure as their computer systems were not connected or were not compatible. In some cases we heard about how this led to unsecure communication platforms being used. One area told us that as a result of incompatible systems all personal data had to be removed and sent as password protected documents.

Safeguarding risks

Cleo's story

Cleo told us that her appointments were set at a time that did not suit her so she had to miss the same lesson each week, which drew attention to her at college. Cleo said that the CAMHS team knew she was busy on that day but offered no flexibility. She also felt that it was not a safe space for her to conduct the appointment as people were walking past and the content was sensitive so there were challenges related to confidentiality. Cleo's mum also highlighted that virtual appointments meant that they missed a lot of her body language so she often had to explain things to professionals as they could not fully see what was going on.

The increased use of digital technology posed risks to children and young people's safety. This included concerns that safeguarding risks may be being missed that would have otherwise been detected had appointments been face-to-face. For example, one area told us about an incident whereby a young person had self-harmed during a remote appointment. The practitioner reported that this would never have happened

had the contact been face-to-face. We heard that appropriate action was taken to ensure the young person was safe. This included reviewing the way contacts were delivered in future sessions.

There were also concerns around potential 'unseen risks' in the home environment. This included uncertainty about who else was in the room with the child or young person during the online appointment, and what impact this could have on their assessment. In one area, we heard how they had put in place a pre-call process to address this risk. The aim of this was to make sure that children and young people were aware of the rules around parental attendance, and that everyone attending the meeting needed to be visible on camera.

As highlighted in Cleo's story above, in some cases we heard that children and young people did not have a safe environment where they could make the call. For some children and young people this was a barrier to them attending the online session.

Most systems also told us about the steps they were taking to make sure that children and young people were staying safe online. This included training for staff around how to prevent any possible risks or exploitation, as well as education, guidance and support for children and young people. For example, in one area providers and safeguarding leads were working closely with schools to inform them of risks identified with certain digital platforms. In another area, providers were holding individual conversations with children and young people regarding safe and acceptable use of technology, particularly those in inpatient settings.

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Conclusion

Our provider collaboration review has yet again shown the impact that the pandemic has had on the mental health of children and young people. Feedback from children and young people themselves has highlighted how important it is that they receive the right care at the right time, and the consequences of not getting this help.

Through our review, we have seen how system partners came together to prioritise the mental health needs of children and young people. We have also seen how changes introduced in response to the pandemic, for example the increased use of digital technology and online access to care, has ensured continued access to care and given some children and young people access to care they would not have had previously.

These positive developments cannot be lost as systems' focus starts to move towards recovery. However, this review has reinforced the need to accelerate the improvements in children and young people's mental health care that were highlighted in 'Are we listening?'. In particular the need to improve access to care and communication both between services and with families.

We've also seen the impact of health inequalities faced by children and young people with mental health needs, and that tackling these needs to be a key priority for local systems.

However, it is important to reinforce that any changes to children and young people's mental health services in the post pandemic environment must be person-centred and focused on the individual needs of children and young people.

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