Children's COMMISSIONER

Inpatient mental health wards during Covid-19

Briefing

October 2020

Contents

Foreword from the Children's Commissioner for England

Covid-19 and the lockdown period have taken a toll on all children, forcing them to miss out on school, time with friends and other restrictions in their lives. But there are some children who have faced particular challenges during this period. This briefing note – one in a series examining how certain groups of children have fared during the pandemic – focuses on the experiences of children living in mental health wards and shows how Covid-19 and lockdown has affected their hospital experience.

The children on these wards are living with severe mental health disorders, like eating disorders or severe depression and are in hospital because they need more intensive level of care than is possible in the community – often to keep them physically safe from harming themselves. Nevertheless, being in hospital away from home, friends and family and with other children in distress can be traumatic for children. Moreover, our research has found that too many children are spending months or even years in these settings when they do not need to be, often because there is nowhere for them to move on to[1]. There have also been serious concerns raised about the quality of care in some of these institutions.

In response to this, last year the NHS launched a taskforce to drive improvements in young people's hospital mental health care, and I Chair an independent oversight board for this taskforce in order to scrutinise progress and hold the system to account. The NHS now has ambitions to reduce the number of children going into inpatient care, and reduce the overall amount of time they spend there. Despite these plans, we know that as of March this year there were over 900 children living in these wards[2].

To understand more about the experiences of this vulnerable group of children during Covid, we surveyed ward managers and spoke to staff and children in two wards. We found that staffing levels appeared to hold up well during lockdown, and there were even some positive changes reported. Children told us that, on the whole, the atmosphere on their wards was calm, with staff doing their best to allay anxiety. Things that children have been asking for over many years – increased access to mobile phones and the internet – were introduced in order to increase contact with friends and family.

However, there have also been significant challenges, which have made things even more difficult for these children. We found that 71% of wards stopped visits from children's families for at least some of the lockdown period. Even when visits were able to start again in some wards with social distancing rules in place, one child told us how hard it was that:

> '*everyone else can hug their parents, but I can't*'

There was a great deal of disruption to education during this period, with some teachers stopping all face to face contact on the wards, meaning that hospital staff including nurses had to deliver teaching on top of caring for patients. The uncertainty that so many children faced about how exam grades would be awarded was even starker for these children who had been out of their 'home' school for long periods of time.

And although general staffing on the ward held up, visits from external professionals such as family

[1] Far Less than they deserve, Children's Commissioner, 2019
[2] Bespoke extract from the Specialised Mental Health Provisions datasets provided by NHS Digital to Children's Commissioner for England

therapists and advocates dropped alarmingly. Many of these did adapt to working remotely, but online support will often not be an adequate substitute for engaging with children experiencing severe difficulties. Finally, Covid-19 has also hampered arrangements for getting children home when they were ready to be discharged. This is something which can be difficult in the best of times, but 38% of the wards surveyed said they faced challenges with this during the lockdown period, as community support became less available, and children often couldn't have transition periods where they spent more time at home in the weeks leading up to their discharge.

While wards faced very serious difficulties, with one ward even losing a member of staff to Covid-19, many have stepped up to make sure that children could have as much normality as possible. In the event of any future lockdowns, NHS England should share this best practice in new guidance on expectations for providers. Other sectors, like youth custody, could also learn from those hospitals that continued education and visits for children. It is vital that in this ongoing crisis the distinct needs of children are considered and prioritised and that more is done to ensure that along with protection children and staff from the risks of the virus itself that we are mitigating the impact of this crisis on children's wider wellbeing, their freedoms, their relationships and their education.

Anne Longfield OBE
Children's Commissioner for England

Methodology

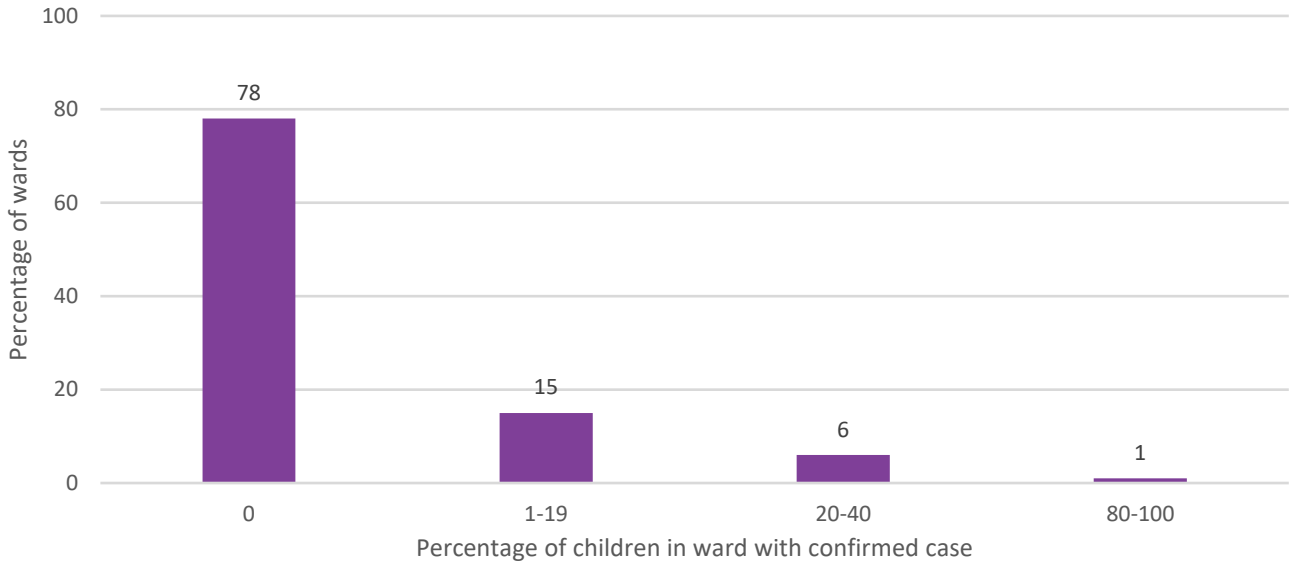
The Children's Commissioner's Office sent out a survey to all inpatient mental health wards for children, to understand the impact of lockdown on the experiences of children in these settings between the 23rd March and 31st May. Overall, we received responses from 104 wards, but as two wards which responded were closed during the period of interest in the survey, the following analysis looks at the responses from the remaining 102 open wards. Of the wards which responded, 61 were run by the NHS and 43 were run by independent providers. We had responses from wards for children under 13, adolescents, those with learning difficulties or eating disorders, and secure wards for children who need very intensive help. Full details of the survey and wards which responded can be found in Annex 1.

We also spoke to eight children in two inpatient mental health wards to hear their experiences first-hand. In addition to the two wards closed throughout the period, 17 wards (17%) reported that they had to close some beds, with 76 beds closed in total – reflecting 7% of the 1,133 beds usually available. One of these wards moved from offering inpatient provision to being only open to day patients. Some wards may have closed prior to our survey being sent out, and not responded for that reason, so this is likely to under-represent the total amount of closures.

Cases of Covid-19

23% of wards reported a confirmed case of Covid-19 among children between 23rd March and 31st May 2020. Across these wards, 11% of children present on the ward at some point in the period were reported as having a confirmed case of Covid-19. The distribution of the percentage of children who had a confirmed case of Covid-19 is shown in Figure 1.

Figure 1. Distribution of percentage of children with confirmed case of Covid-19



Note: Sample for this chart is 100 wards, as two wards did not provide data on number of children in ward. Total number of children calculated as those present on 23/03 plus those admitted between 23/03 and 31/05.

37% of wards reported a confirmed case of Covid-19 amongst staff. In total, there were 100 cases of Covid-19 amongst staff reported. Just under half of all cases among staff occurred on just 7 wards, the distribution of the number of cases amongst staff is shown in Figure 2.

Figure 2. Distribution of number of staff with confirmed case of Covid-19

Note: Sample for this chart is all 102 wards, but count is shown rather percentage.

47% of wards in total reported a case of Covid-19 among children *or* staff (or both).

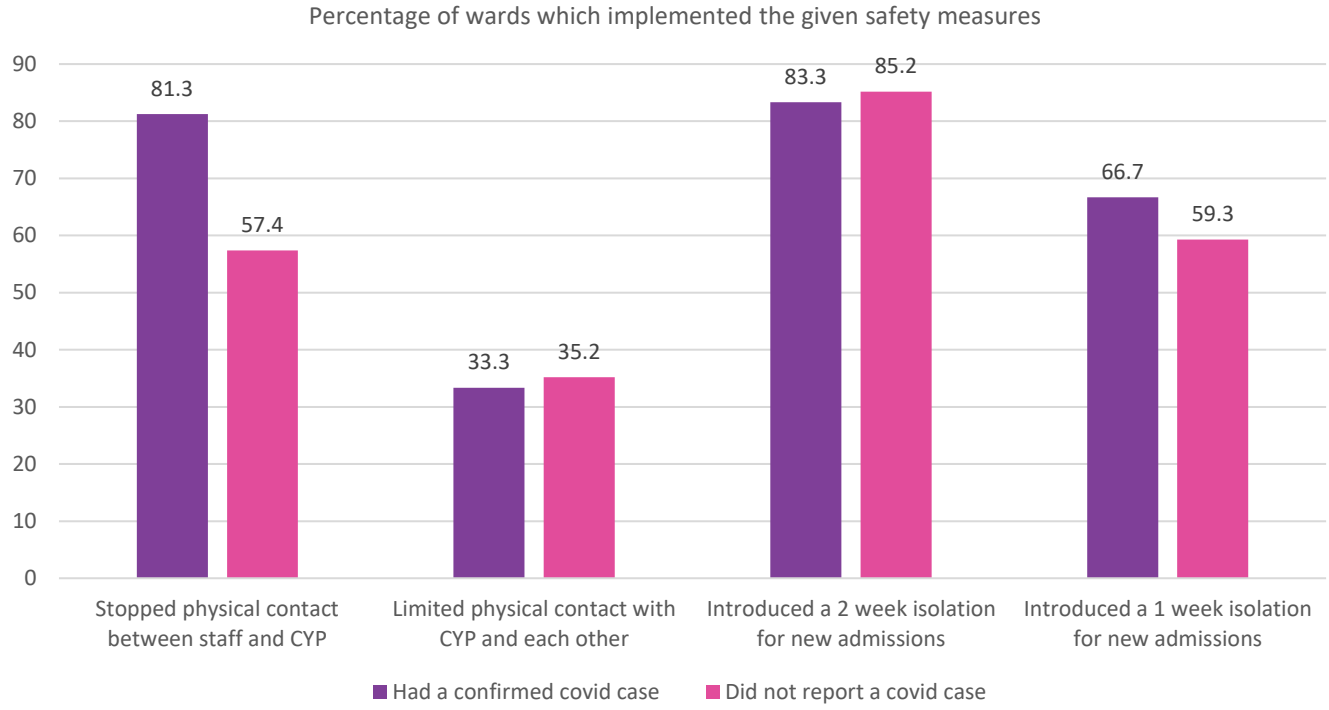
Providers were asked whether they implemented safety measures to limit the risk of Covid-19 transmission. Respondents were able to select multiple from a given list of measures. All but one ward confirmed that they implemented at least one measure. Learning disability wards implemented notably fewer measures, and one of these wards explained that it was particularly hard for some of the children they cared for to understand restrictions.

Table 1 - Percentage of wards which implemented Covid-19 safety measures, by ward type

	Stopped physical contact between children and staff (%)	Limited physical contact between children on the ward (%)	Implemented a two-week isolation period on admission to the ward (%)	Implemented a one-week isolation period on admission to the ward (%)	Mandated that staff wear PPE (%)
Eating Disorder	22	44	11	56	100
Children's Unit	25	75	0	25	100
General Adolescent	49	77	19	43	96
Learning Disability	0	17	17	17	100
Low Secure	0	58	8	33	100
Medium Secure	14	29	14	43	100
PICU	33	75	17	33	92
Other	20	100	20	0	100
Total	31	66	16	37	97

Wards which had a confirmed Covid-19 case were more likely to have also stopped physical contact between staff and children, compared to other wards. Only 57% of wards which did not report a Covid-19 case implemented this measure, compared to 81% of wards which did report a Covid-19 case (Figure 3).

Figure 3



Visits from family

For some of the children we spoke to, not having visits from their family was the most difficult part of lockdown. Even when policies on visits became more flexible, children still faced restrictions – for example only one family member being allowed to visit at a time, and visits having to be socially distanced. As one child said, it was hard knowing that:

'***everyone else can hug their parents, but I can't'.***

Guidance was issued by the NHS on 8th April which stated that all visits to hospitals should be suspended, although parents and carers visiting their children were exempt from this restriction. On 5th June this was replaced with guidance which allowed for local trusts and NHS bodies to exercise their discretion.

Our survey found that more than two thirds of children's mental health wards - 71% - suspended family visits at some point between 23rd March and 31st May, while the rest continued to allow visits to children. NHS providers were more likely to allow visits to continue: 44% of NHS respondents did not suspend visits, compared to only 6% of independent providers.

There was no association between whether there was at least one confirmed case of Covid-19 on the ward among children or staff (between 23rd March and 31st May) and whether the ward stopped visits from family (Table 2 and 3). Table 2 shows that the proportion of wards with a confirmed case – 47% - was the same in both wards which stopped visits and those that did not stop visits. Table 3 makes the same point it the other way around: it shows that the proportion of wards which stopped visits – around 70% - was the same regardless of whether the wards had reported a Covid-19 case among children or staff. This suggests that policies on visits were not necessarily correlated with the level of risk on each ward[3].

Table 2. Proportion of wards with confirmed cases of Covid-19 among children staff, split by whether ward stopped visits

	No confirmed Covid-19 cases among children/staff	Reported a confirmed Covid-19 case among children/staff	Total
Did not stop visits	53%	47%	100%
Stopped visits	53%	47%	100%

Table 3. Proportion of wards which stopped visits, split by whether ward

	No confirmed Covid-19 cases among children/staff	Reported a confirmed Covid-19 case among children/staff
Did not stop visits	30%	29%
Stopped visits	70%	71%
Total	100%	100%

Of the 72 wards which reported that they did suspend visits, 70 (97%) said they had resumed visits by the time of completing the survey (which ran from 18th June to 24th July). One of these wards had been allowing

[3] statistical tests showed no statistically significant association between the number of confirmed cases on a ward, and the suspension of visits

visits on a case by case basis throughout lockdown, and the other provided respite care so family visits did not usually take place.
Across the 72 wards which suspended visits at some point, there were a range of approaches taken:

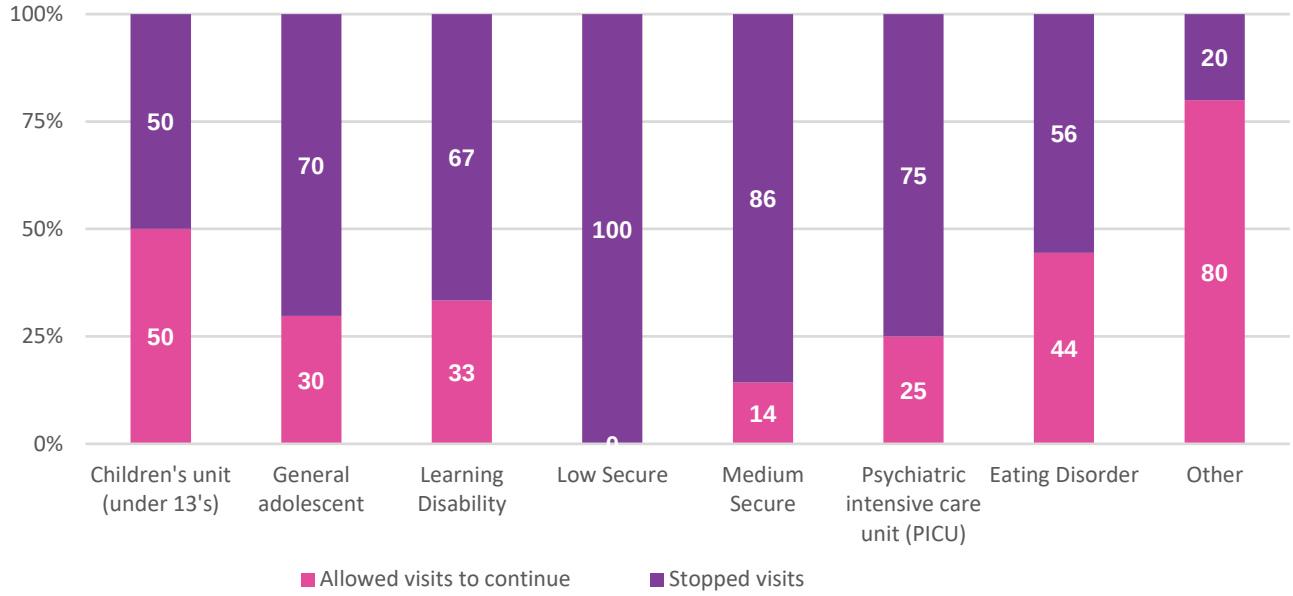
Table 4. Number of wards which took various approaches to the suspension of visits

	Number of Wards	Percentage of Wards
No further information provided	18	25%
Allowed visits throughout for certain children	15	21%
Re-started visits in April	12	17%
Not clear how long visits were stopped for	11	15%
Suspended visits to the ward, but allowed them in a different area	5	7%
Re-started visits in May	5	7%
Suspended visits for the duration/only restarted in June	5	7%
Only suspended visits when there was a confirmed case	1	1%

As the table above shows, there were only five wards (5% of all wards) that reported that visits had been suspended for the entire period.

The approach to stopping visits was not consistent between different types of ward. All low secure wards who responded to the survey stopped visits at some point, compared to only 55% of Eating Disorder wards and 50% of Children's Wards (Figure 4).

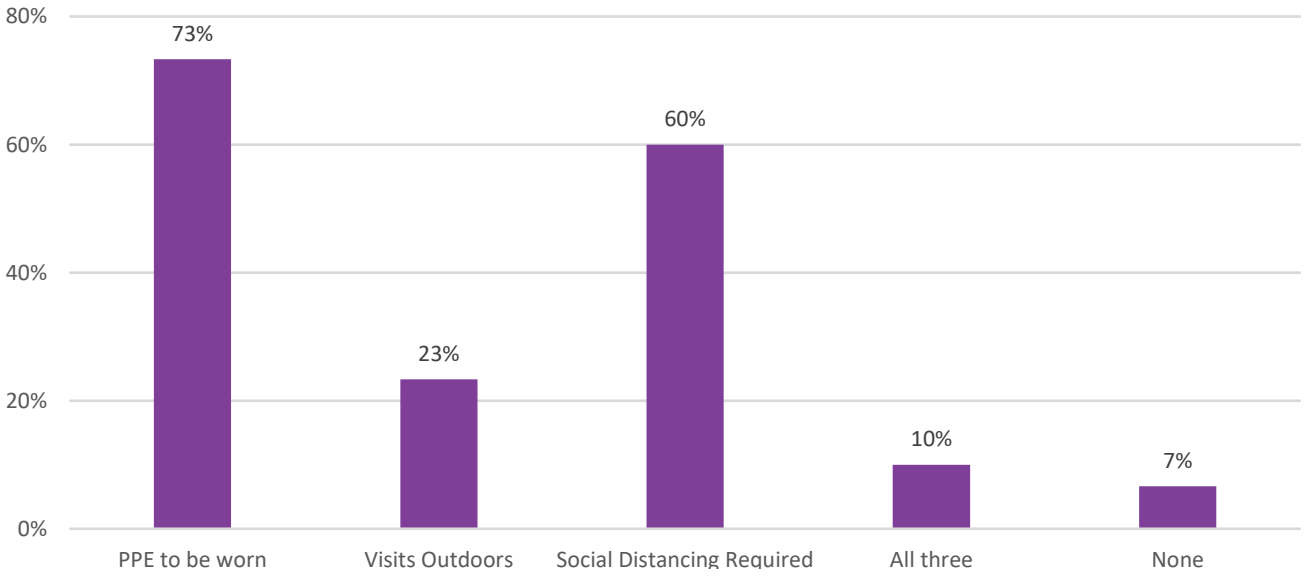
Figure 4. Proportion of wards allowing family visits between 23/03 and 31/05, by ward type



However, even in low secure wards visits usually resumed at some point before the end of May, with only one ward reporting that visits were suspended throughout. Of the six medium secure wards that suspended visits, two stated that these resumed in April, and another two reported that visits were allowed throughout on a case by case basis.

Some wards were able to continue or restart visits quickly by allowing family visits to take place in the garden or a dedicated room which was deep-cleaned between visits, or by ensuring that PPE was worn during the visit. Most of the wards that continued to allow family visits throughout lockdown required one or more forms of precautions to be taken:

Figure 4. Proportion of wards using various safety measures during family visits



Although all wards received the same guidance from Public Health England, there was clearly significant variation in the policies around allowing children to see their families face to face. The first guidance on visits to inpatient wards was not issued by the NHS until 8th April, which would explain variation prior to that point. The guidance stated that parents should be allowed to visit children in hospital, and yet there was still significant variation in how this was applied and when wards managed to facilitate visits.

It is important that under any future local lockdowns guidance clarifies expectations about visits to children in inpatient settings, and that settings learn from those which were able to continue visits in safe ways.

One provider stated that for some children the reduction in contact with family was welcome:

'This was a largely positive experience. Patients were able to choose to have as much video contact as they wished with parents. Only rarely would there be any distress about this. Most of the urgency for visits came from the parents themselves.'

There may be a range of reasons that children find it difficult to see their family, and for some children it may sadly be in their best interests for contact to be limited. However, one child explained to us that seeing family was distressing, but explained that this was because:

'there was so much pressure on the time, and it was hard when they left not to go with them'

Care must therefore be taken not to misconstrue any positive effects of reducing family visits, and consideration must be given to the potentially distressing way in which visits are managed.

Virtual contact with family

Although children spoke about the difficulty of not seeing family face to face, one clear benefit that has emerged during lockdown seems to have been increased flexibility on the use of digital contact through phones, tablets and laptops for children on the wards.

Virtually all (99%)[4] of the wards surveyed reported that children in the ward had been able to contact their family over the phone or via an online platform such as Skype. Nearly half (49%) of wards said that they had changed their policy about phone usage in response to lockdown, with 74% of those wards who changed their policy increasing the amount of time children could spend on their devices. No ward suspended mobile phone use or decreased the amount of time that children could spend on their screens . 76% of independent service providers who had changed their mobile phone policy increased the amount of time that children could spend on their phones, compared to 73% of NHS providers.

Several wards reported that they allowed accessed to video calling for the first time, introduced WiFi, or allowed children to use devices which could access the internet for the first time.
One young person we spoke to said:

'One positive is that I now have video calls – they came in a few weeks after lockdown began, and I hope they continue.'

The manager of their ward confirmed to us that they had also seen the benefit of allowing children to keep in contact with family in this way, and that they would be continuing to do so.

Access to phones and the internet is frequently raised as an issue by children that the Children's Commissioner visits on mental health wards. Wards should consider allowing these changes to continue beyond the immediate crisis as they allow children more flexible contact with family.

[4] The ward which responded 'no' to this question closed on 1st April so was only open for the first week of the 'lockdown' period.

Access to education

There was significant variation in approaches to education during this period, with some wards reporting that their education providers went into 'lockdown' and so would not visit the ward at all, while others reported being able to keep education running almost as normal throughout. For those that reported keeping in-person education going, there were usually some changes such as reduced timetables due to staff shielding or being unwell, or brief periods where staff did not attend.

From the qualitative information we received about education provision, 53 wards gave information about whether their provision was suspended. 28 of these wards (53%) said that they were able to continue face to face education throughout the period, while 25 wards (47%) said that they suspended it for at least some of the time[5].

Where face to face education provision was suspended, in some cases this meant education had to be delivered by ward staff and nurses, which created extra work for these staff, who did not have the appropriate training or qualifications. Some wards also found they had difficulties contacting the schools at which children were enrolled. While some wards moved their education provision online, some reported IT issues or difficulties with engaging children in this format.

The children we spoke to valued the effort made by teaching staff, with one teenager telling us how appreciative they were that college staff continued to come in, and were planning to do so over the summer, as they knew how important education was to them . Another told us that teachers from their school had been calling and emailing regularly, which was very important as school had been their 'safe place'. One teenager who was due to sit exams that year reflected the concerns of many children across the country about how grades would be awarded. She was especially worried about how her grades would be predicted as she had been in hospital and away from school for so long.

[5]An error with this question meant respondents did not have an option to report that education was not suspended – we have therefore based findings on the qualitative responses wards gave to a question about challenges delivering education

Time away from hospital

Children living in mental health wards under normal circumstances are usually entitled to leave the hospital and spend time in the community. This includes those detained there under the Mental Health Act. Of the wards we surveyed, 94% allowed children to go on trips to local towns prior to Covid-19. But nearly all of these wards (98%) suspended these trips during lockdown. One child said how hard it was that she was:

'normally allowed community leave, but am now stuck here 24/7'

Around three quarters (78%) of the wards had since resumed these trips, while 22% had not. Some children we spoke to said that new ways of allowing them off site had been introduced – for example going on a drive with a member of staff, or going out into the countryside rather than into town. One child said that they appreciated this, although it was more stressful than their usual trips.

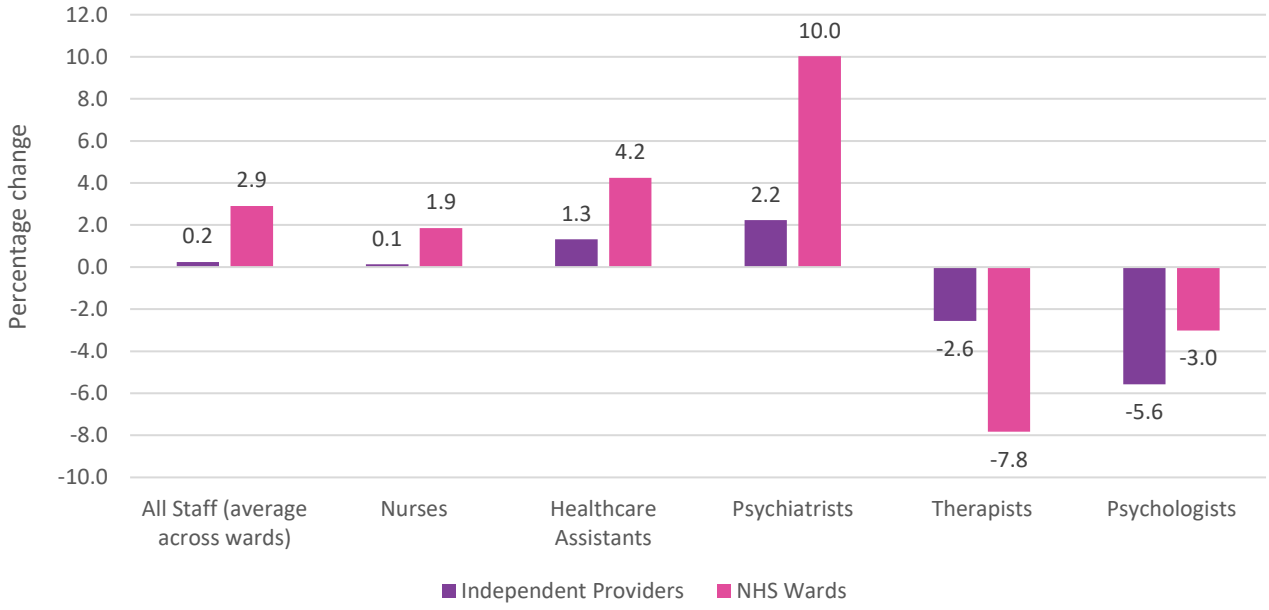
Some children in all hospital wards would normally be allowed to spend time outside the hospital with their family. 78 wards (76%) suspended this family leave over the lockdown period, although 13 (17%) of those wards mentioned that they did allow leave before a child was discharged back into the community, as this was seen as essential. In order to facilitate this safely, some kept certain parts of the ward sectioned off for new admissions and for those for whom family leave prior to discharge was allowed, and others required children to be isolated and then tested on return. One ward stated that they did not allow home leave until the guidance around support bubbles was introduced. Again, this suggests that wards have been interpreting guidance in different ways, leaving children with very different experiences.

Staffing levels

Among the wards that responded to our survey, staffing seems to have largely held up well during the lockdown period; it may be that some of the 20% of wards which did not respond to the survey had already had to close due to staffing pressures. There was an average number per ward of 19.4 FTE staff on the 26th February and 19.7 FTE staff on 27th May. This had remained stable despite the many challenges faced by staff members we spoke to, including their own caring responsibilities and sickness, as well as significant numbers of Covid-19 cases on some wards.

However, there were overall reductions in the numbers of therapists and psychologists available on these wards, shown in Figure 5 below.

Figure 5. Percentage change in average number of weekday staff per ward between 26/02 and 27/05, by staff type and provider type



As Table 5 shows, wards for children under 13 and Learning Disability wards saw the greatest fall in staffing levels between February and May.

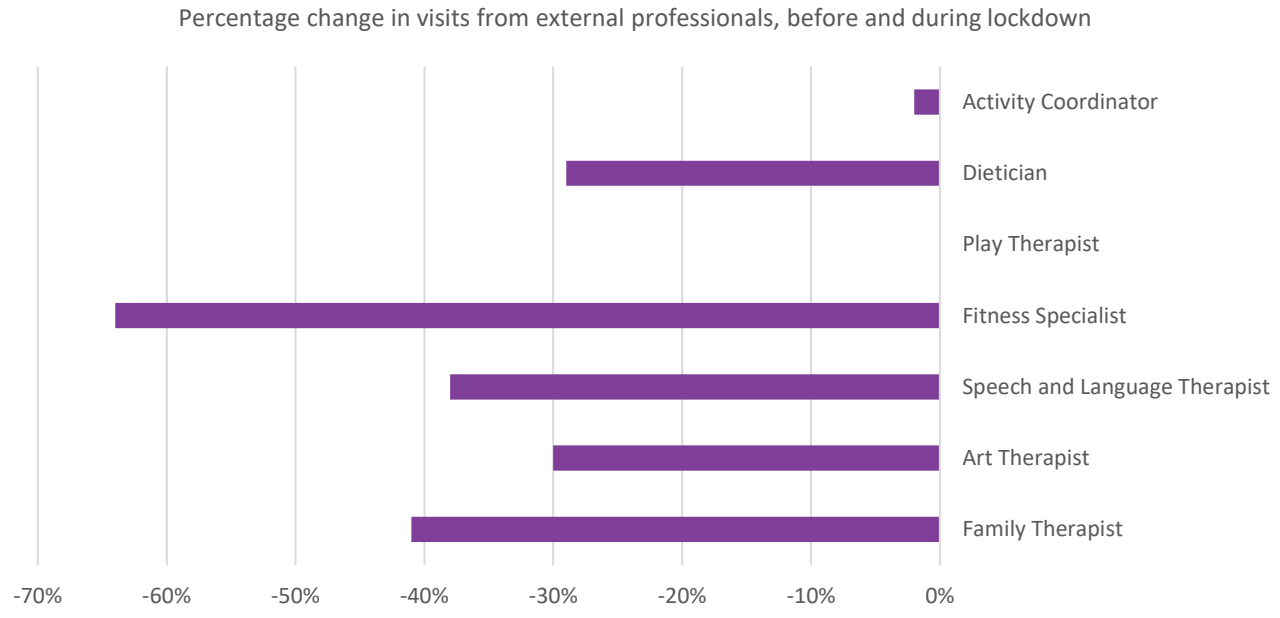
Table 5

Ward Type	Average number of FTE staff for all staff types included on survey per ward				Change 26/02 - 29/02	Change 27/05-30/05	Change 26/02 – 27/05	Change 29/02 – 30/05
	26/02	29/02	27/05	30/05				
Children's Unit	15.8	10.5	13.5	8.8	-33%	-35%	-14%	-17%
GA	17.5	12.2	18.5	13.9	-31%	-24%	5%	15%
LD	22.3	16.5	19.2	15.6	-26%	-19%	-14%	-6%
Low Secure	20.7	16.2	21.0	17.5	-22%	-17%	1%	8%
Medium Secure	20.8	13.0	20.6	15.9	-37%	-22%	-1%	22%
PICU	20.0	15.7	23.0	18.1	-22%	-21%	15%	15%
Eating Disorder	19.7	17.1	19.7	17.9	-13%	-9%	0%	5%
Other	10.0	6.4	14.0	9.3	-36%	-33%	40%	45%

There were also notably fewer staff available on weekends, with 27% fewer staff on the Saturday 29th February compared to Wednesday 26th February and 20% fewer on Saturday 30th May compared to Wednesday 27th May. For the detailed breakdown of staffing changes see Annex 2.

While staffing levels on wards remained broadly stable during lockdown, there was a significant decrease in attendance from external professionals. Many wards have professionals such as family therapists who are not part of the core ward staff but visit the ward to provide additional therapeutic services or activities. Overall, the total number of external professionals visiting wards during lockdown decreased by 39% compared to pre-Covid numbers. The greatest decrease was among fitness specialists (64% decline) followed by family therapists (41% decline), as shown in Figure 6 below.

Figure 6



In many cases, these external professionals did make use of other methods to continue contact with children: 68% of wards reported that external professionals had switched to using video calls. When we spoke to children about receiving therapy or support remotely they said that it was more difficult; one child said:

'in person helps more, especially for therapy… it's easier to pick up on body language'

Another child with hearing difficulties said that the quality of video calls could make lip-reading very hard. Advocacy services were particularly affected. There was a 67% reduction in the number of advocates attending the wards in person during lockdown, with only 33 advocates across the 102 wards. This is particularly concerning when things are likely to have been even more difficult for children, and they may have needed to have their concerns heard more than ever. 62% of wards went from having one or more advocates visiting the ward pre-lockdown, to none during lockdown. This includes 72% of independent sector wards and 54% of NHS wards. Furthermore, 13% of wards reported not having an advocate visit the ward prior to March 2020 at all.

Discharge

In previous visits to mental health wards, we have found that discharges back to the community for children in mental health wards often take longer than they should. This is often due to difficulties in finding appropriate packages of support in the community, and 'step-down' placements where children can move on to. Our research has found that 60% of children with learning disabilities in mental hearth wards do not have a discharge date set[6]. This issue seems to have been exacerbated by Covid-19, with 38% of wards reporting that they faced challenges discharging patients. In the qualitative data, some wards reported increased difficulty in contacting social care or community mental health teams, and were less able to plan a gradual transition back into the community with increasing amounts of home leave. As discussed above, 78 wards (76%) suspended this kind of leave over the lockdown period, although 13 (17%) of those wards mentioned that they did allow leave before a child was discharged back into the community, as this was seen as essential.

Mental Health Act tribunals

Of the wards which provided information about tribunals, 16 (32%) reported that they ran successfully when conducted remotely, and one mentioned that it was more time efficient for staff to have the meetings in this way. However, 11 wards (22%) reported that they had particular difficulty with the technology required to run tribunals online, and 5 wards (10%) mentioned that children found it harder to engage with the process when it was done remotely. Two wards said that sometimes their tribunals were run with one judge rather than a full panel.

[6] https://www.childrenscommissioner.gov.uk/report/far-less-than-they-deserve/

Conclusions

It is not surprising that the lockdown period was a particularly challenging time for all children living on mental health wards, and staff working on them. As one respondent pointed out, things were particularly hard for children with learning disabilities, as staff found it difficult to help them understand why all these new rules were needed. Yet ward staff spoke admiringly about the resilience children showed in the face of difficulties, and the children we spoke to mainly shared the view that although things were '*a bit different, and a bit stressful*' the atmosphere was largely positive. One teenager mentioned that the new staffing rotas introduced and reduced admissions had actually created more stability which they valued, although in other wards increased reliance on bank staff due to staff shielding appeared to increase children's anxiety. One clear positive response to the crisis for children appears to be increased access to phones and video calling, and ward managers should consider whether some of these changes could remain in place after the restrictions have ended.

There is clearly a great deal for the NHS and other providers to learn about the different ways that wards responded to restrictions, with some able to continue education and family visits throughout the lockdown, while others stopped entirely. It is very positive that compared, for example, to youth custody there was not a blanket rule enforced stopping all such contact. In the case of any future lockdown or local restrictions NHS England should provide clearer guidance about how wards should safely continue education, visits and other activities as far as possible, illustrated with best practice examples. The Government must ensure that the 'Rule of Six' does not prevent children living in mental health wards from having family leave with their whole family, even if that means they are a group of more than six. It would also be helpful if the Care Quality Commission would consider the efforts made by some wards to keep life as close to normal as possible for children during Covid-19. We will share the detailed results of this survey with them.

Although each ward will have faced different circumstances and risks, some wards appear to have avoided excessive restriction during this time. The NHS Gardener Unit (part of Greater Manchester Mental Health Trust) reported that they had maintained family visits and education during lockdown, and Newbridge House did so except for a three week suspension of face to face education – and both had no confirmed cases of Covid-19 among young people or staff. There have been other innovative responses to the challenges faced by inpatient mental health wards, for example Great Ormond Street Hospital opened a new paediatric ward specifically for children presenting to hospitals within North Central London with acute mental health presentations during the first wave of Covid-19. This brought together specialist mental health professionals and paediatrics, providing short term support for crisis presentations, joined up with local crisis teams in the region to deliver multi-disciplinary care for children, young people and their families dealing with mental health crises during the pandemic

This survey looks exclusively at wards' response to the Covid-19 pandemic, but it is important to acknowledge the wider context, namely the need to dramatically improve the quality of inpatient mental health provision, and to increase the support services available in the community to avoid mental health crisis where possible. It is important to remember that for children who are detained under the Mental Health Act, there is no clear end to 'lockdown' in sight as they will still be detained after lockdown is lifted in the wider community. The Children's Commissioner's Office has consistently called for more early intervention mental health services, so that no child needs to end up in detention. As one child we spoke to succinctly put it, ***'if CAMHS had helped back then, none of us would be here'.***

Annex 1: Additional detail on survey methodology

The survey was designed by the Children's Commissioner's Office to capture information on the experience and practices of Tier 4 CAMHS inpatient wards during the period of 23rd March to the 31st May 2020.

The data was collected using the Children's Commissioner's powers under Section 2F of the Children Act 2004[7].

The survey was circulated to the Chief Executive Officers (CEOs) of providers of Tier 4 CAMHS inpatient services and ran from the 18th June to the 24th July.

Data was collected at ward level with one survey response per ward and was completed by ward managers and/or information managers.

Download and view the full questionnaire

Overall, we received responses from 104 wards (comprising 59 NHS wards and 43 independent wards). This equates to an overall response rate of 80% (comprising 74% of NHS wards and 88% of independent wards). 2 wards were closed for the duration of lockdown, between the 23rd March and 31st May. These wards have been removed from the base for the calculation of percentages, so percentages are calculated only for those wards which remained open.

Summary of all wards that responded to the survey:

Table A1 - Number of units which responded to the survey, by ward and provider type

Provider Type	Eating Disorder (ED)	General Adolescent (GA)	Learning Difficulty (LD)	Low Secure	Medium Secure	Children's Unit	PICU	Other	Total
Independent	6	14	2	10	2	0	8	1	43
NHS	3	33	4	2	5	5	4	5	61
Total	9	47	6	12	7	5	12	6	104

Table A2 - Average number of beds per unit, by unit and provider type

Provider Type	Eating Disorder (ED)	General Adolescent (GA)	Learning Difficulty (LD)	Low Secure	Medium Secure	Children's Unit	PICU	Other	Total
Independent	13	11.1	10	10.4	10	0	10.1	8	10.8
NHS	16	13.2	8	10	8	4.8	6.8	8.2	10.9
Total	14	12.6	8.7	10.3	8.6	4.8	9	8.2	10.9

[7] https://www.legislation.gov.uk/ukpga/2004/31/section/2F

Annex 2: Additional detail on changes in staffing levels

Table A3. Average number of staff by staffing type and provider type

Date	Provider Type	Average number of staff per ward (across 102 open wards, Full Time Equivalent (FTE))						
		All Staff	Nurses	Healthcare Assistants	Psychiatrists	Therapists	Psychologists	Av. Number of staff per bed
26/02	IS	19.0	3.1	11.1	1.0	1.8	1.0	1.8
	NHS	19.7	5.3	8.3	1.4	2.4	1.3	1.7
29/02	IS	15.3	3.0	10.6	0.4	0.5	0.3	1.4
	NHS	13.4	4.5	8.0	0.3	0.4	0.2	1.2
27/05	IS	19.1	3.1	11.3	1.1	1.8	1.0	1.8
	NHS	20.2	5.4	8.7	1.6	2.3	1.2	1.8
30/05	IS	16.3	3.0	11.3	0.4	0.5	0.3	1.5
	NHS	15.3	4.8	9.3	0.3	0.5	0.2	1.4
Change 26/02 – 29/02	IS	-19.6%	-3.1%	-5.1%	-58.6%	-72.3%	-75.3%	-19.6%
	NHS	-31.7%	-15.5%	-3.4%	-80.4%	-83.9%	-83.6%	-31.7%
Change 27/05 – 30/05	IS	-14.8%	-2.0%	0.0%	-59.5%	-72.9%	-73.9%	-14.8%
	NHS	-24.4%	-11.0%	6.6%	-81.3%	-76.5%	-83.4%	-24.4%
Change 26/02 – 27/05	IS	0.2%	0.1%	1.3%	2.2%	-2.6%	-5.6%	0.2%
	NHS	2.9%	1.9%	4.2%	10%	-7.8%	-3%	2.9%
Change 29/02 – 30/05	IS	6.3%	1.3%	6.8%	0%	-4.6%	0%	6.3%
	NHS	14.0%	7.2%	15.1%	4.7%	34.3%	-1.7%	14%

*IS = Independent Service Provider
*NHS = NHS Foundation Trust Provider

Figure A1. Percentage change in average number of weekend staff per ward between 26/02 and 27/05, by staff type and provider type

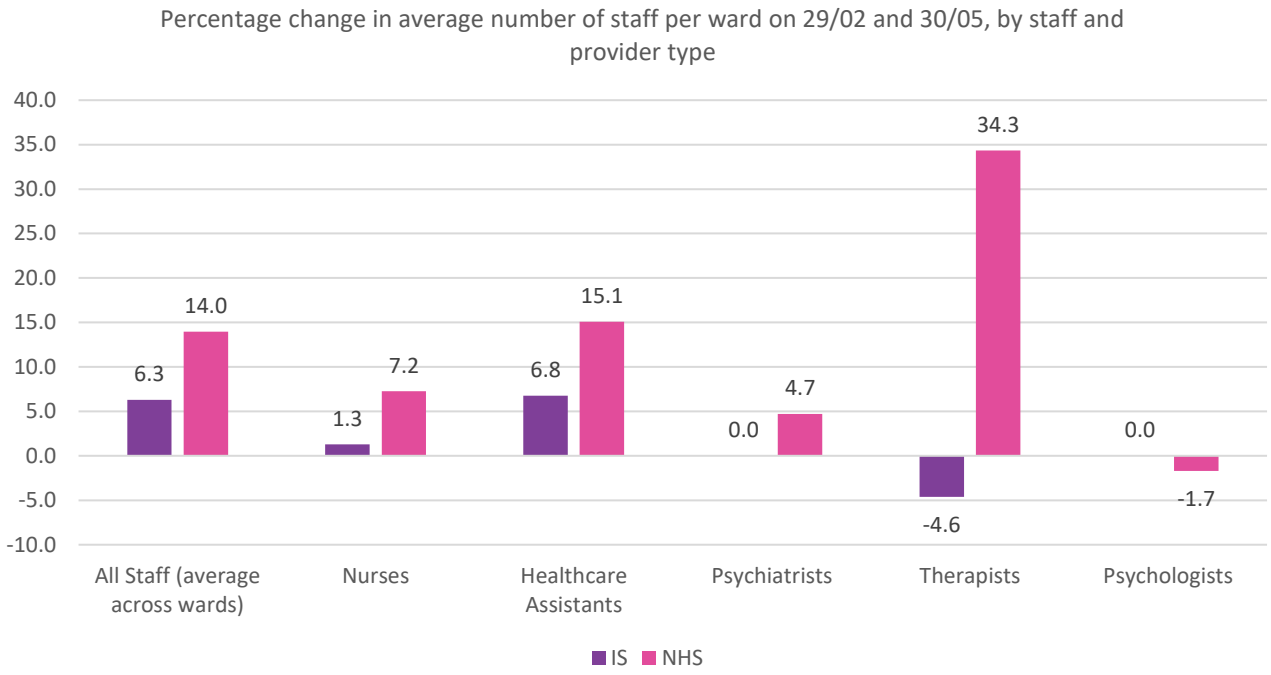


Table A4. Average number of FTE staff per bed for that ward type, and ward type

Ward Type	Average number of FTE staff for all staff types included on survey per bed				Change 26/02 - 29/02	Change 27/05- 30/05	Change 26/02 – 27/05	Change 29/02 – 30/05
	26/02	29/02	27/05	30/05				
Children's Unit (under 13's)	2.6	1.8	2.3	1.5	-33.3%	-35.2	-14.3%	-16.7%
GA	1.5	1.0	1.5	1.2	-30.2%	-24.1%	2.5%	11.4%
LD	2.6	1.9	2.2	1.8	-25.8%	-19.0%	-13.6%	-5.6%
Low Secure	2.1	1.7	2.2	1.9	-19.6%	-15.3%	3.5%	9.0%
Medium Secure	2.4	1.5	2.4	1.9	-37.5%	-22.5%	-1.4%	22.2%
PICU	2.4	1.9	2.6	2.2	-21.7%	-14.0%	9.2%	20%
Eating Disorder	1.4	1.2	1.4	1.3	-13.2%	-9.3%	0%	4.5%
Other	1.2	0.8	1.7	1.1	-35.9%	-33.5%	39.8%	45%

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