UK COVID-19 INQUIRY

MODULE 8: WRITTEN OPENING SUBMISSIONS ON BEHALF OF THE ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH ("RCPCH")

INTRODUCTION

1. RCPCH would like to begin this statement by acknowledging the impact that the pandemic had, and continues to have, on society, our public services and the people they serve. Many patients died of the disease or continue to live with its effects. RCPCH offers its deep sympathies to all those who were or still are impacted by the pandemic. The health workforce, in the broadest sense, was profoundly affected both in the acute phase of the pandemic and to this day, as the UK's health systems seek to return to a pre pandemic state. In the context of children and young people, the impact of the pandemic on access to healthcare, education, socialisation, social care, and the other services normally provided will be long term, and in some cases lifelong. For example, the impact of reduced access to children's community health services during the pandemic continues to be felt today. Community health services, which care for the most vulnerable children in the country, have been overlooked in the post-covid recovery agenda. Average waiting times for community child health services are now some of the longest of any part of the health system, and there is a significant disparity between adult and children's community services.

2. RCPCH welcomes the work of the Inquiry and in particular this module's focus on children and young people. RCPCH believes that children and young people were caused significant and, in some respects, avoidable harm during and after the pandemic. The strains on all services for children caused by the pandemic emphasised how the needs and rights of children and young people were not being met before March 2020. The RCPCH hopes that the work of the Inquiry will ensure

that children and young people's needs and rights are better protected in any future pandemic, and also today

3. Large numbers of documents from other organisations have been disclosed to RCPCH in its Core Participant role. Rather than responding to that evidence in detail at this point, RCPCH will highlight its own concerns and what it feels are the issues the Inquiry may wish to address. In its closing statement. RCPCH may respond to the evidence that the Inquiry will have heard where it seems constructive to do so.

4. RCPCH has provided a witness statement and exhibits on behalf of the organisation. Professor Steve Turner, RCPCH president, will also give oral evidence to the Inquiry. This statement will not seek to summarise this oral evidence, but to provide a top down overview of the RCPCH's position and concerns.

<u>The RCPCH position in a nutshell</u>

5. The RCPCH acknowledges that the pandemic was an incredibly challenging time for decision makers, especially in the early months, when understanding of the illness and its impacts was limited. What follows is not intended to be overly critical of any organisation or of individuals who were no doubt doing what they considered to be their best in difficult times.

6. COVID-19 is a disease whose immediate effects (most obviously and most seriously, mortality) are related to age, and are more serious in older people but only very rarely serious in children. The RCPCH accepts as it must that, particularly in early months and in the acute phases of the pandemic, it was entirely reasonable to prioritise care for severely affected COVID-19 patients, the majority of whom were elderly and frail, and to deprioritise elective care for other patients, including children and young people. (It is less obvious to RCPCH that it would be reasonable to deprioritise non COVID-19 acute care.) It was also reasonable to expect society as a whole to take steps to reduce disease transmission, e.g. lock down, in order to reduce the number of acute cases. The RCPCH also accepts in those very early months, time was of the essence, data were limited and

elaborately deliberative decision making would not have been possible (or productive).

7. With that said, what the RCPCH does not accept is a failure properly to appreciate and weigh the impact in particular on healthcare for children and young people in making, and particularly in maintaining that de-prioritisation. It says that the de prioritisation of children and young people's services went on for too long, and that the indirect impacts of the pandemic on their health were not and still are not being given the weight that they deserve. Children and young people paid the price for better healthcare of others during the pandemic. That was the right thing to do at the outset (although it was not necessarily always done in the best way). But ethics, child rights and equity demands that that sacrifice should have been minimised, and that it should be acknowledged in prioritisation decisions now. Healthcare for children and young people has not been prioritised as it should have been during the recovery from the pandemic. That is a mistake that must not happen again.

8. The RCPCH would particularly highlight the position of children and young people from deprived backgrounds. These children are typically in worse health than the general population in any event, and the impact of the pandemic on them was, as was to be expected, more severe than on children and young people generally. They should be a priority in any recovery plan.

<u>The RCPCH</u>

9. The RCPCH is the UK's professional membership body for paediatricians. It has over 24,000 members nationally and internationally. It is a leading voice for excellence in healthcare for children and young people.

10. During the pandemic, the RCPCH worked closely with NHS England, Public Health England, UKHSA, DHSC, and the Department for Education, as well as with the devolved governments and service delivery organisations in Scotland, Wales and Northern Ireland. It was an advocate for children and young people to be central to decision making, although this message was not always received.

11. The RCPCH influenced shielding guidance, school reopening priorities, and mental health service planning. It contributed to SAGE discussions on COVID-19's impact

on children and to JCVI decision-making whether 5 – 11-year-olds should be vaccinated against COVID-19. In relation to data collections, it launched data tools to monitor service disruptions, staff redeployment, and delayed presentations, it collaborated on evidence reviews and guidance for clinicians and families and set up informal expert groups to inform advocacy and clinical guidance.

12. As to guidance, the RCPCH produced 24 pieces of guidance during the pandemic on various clinical and operational topics, created accessible materials for parents and carers, including traffic light posters and shielding advice, and supported NHS 111 with recruitment of retired paediatricians to improve advice services as well as co-producing guidance on shielding, vaccine hesitancy, and virtual health appointments.

13. The voice of the child or young person is very important, and there is a danger this will be one of the things discarded in any emergency situation. RCPCH engaged over 74,000 children and young people through the RCPCH &Us programme to try to fill that potential gap.

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ISSUES THE RCPCH BELIEVES THE INQUIRY MAY WISH TO ADDRESS

14. The RCPCH is necessarily focused largely but not exclusively on health and health-related issues for children and young people. That is not to suggest or imply that impacts in other areas will not be equally or more important, but the RCPCH is of its nature best placed to assist on health issues in our younger population.

15. Before dealing with specific issues there are two global points to make about healthcare for children and young people. Both can flow from this important and yet often overlooked point: children and young people are not just small adults[1]. They have unique needs and challenges that are different in kind and not just degree from adults.

16. The first point is that healthcare for children and young people is often even more time critical than that for adults. Good or bad (which includes delayed) healthcare can have long term effects that go beyond the immediate impact of illness.

[1] Indeed, even referring to "children and young people" as if they were a homogenous class omits vital detail

Children and young people are developing. If ill health impacts on that development the effects may be long term or permanent. To take one example: shielding (i.e., isolation) for immuno-compromised people of any age will have been a burden. But it is still more of a burden for a child, who needs to be socialising with peers to develop social and developmental skills, who may be unable to attend school (when schools were open) and who cannot fully understand the reasons that that is being prevented.

17. The second is that healthcare for children and young people does not only affect the child or young person themselves. They will almost always have parents or carers who will have to live with the ill health. That is true of physical and of mental ill health. The families of the child with cystic fibrosis who is anxious about shielding, or the families of the teenager self harming who cannot access mental health services, also suffer from a lack of prioritisation of the health of children and young people. And no parent or carer will need to be reminded that the closure of schools did not only impact pupils, but also those who then had to look after them at home.

18. With those general points made we turn to specific issues:

Workforce planning and wellbeing

19. A significant impact on services for children and young people was the redeployment of the paediatric workforce and clinical resources either to care for COVID-19 patients, or to backfill in adult services, or in acute paediatric services. Professor Turner gives evidence on this. In any pandemic, workforce redeployment is inevitable. But the impact of that redeployment will be reduced (and the effects better known in advance) if the NHS workforce is structured by reference to an evidence-based and fully funded plan for the workforce for each of the nations in the UK. It is essential to have enough of the right staff, with the right skills, in the right places, well before a crisis hits. This must take also into consideration that children are a whole population group, and child health therefore requires a whole system and diverse approach to workforce planning. This includes early years, schools, social care and primary and secondary healthcare professionals. This was a need pre pandemic but the pandemic has underscored how important this is.

20. There is also a need for greater understanding of the impact of the pandemic on the NHS and social care workforce and trainees across all four countries. That understanding should specifically inform ways to improve staff wellbeing generally during a pandemic, and in paediatric intensive care units (PICUs) in particular, to maintain recruitment and retention. If staff wellbeing is compromised during a pandemic such that they cannot continue in work full time or at all, suffer lost days through illness, take early retirement, or switch to what they consider to be less demanding and stressful roles, then the quality of care is at risk (and, specifically as regards PICU staffing, the quality of care for UK's most critically unwell children). For the same reasons the impact of the pandemic on training should be examined, particularly as regards specialities that were hard to recruit to in any event such as PICU.

Pandemic planning

21. A holistic child health and wellbeing pandemic preparedness assessment is required. This should not just be a bolt on to a general assessment of pandemic planning although clearly it needs to be integrated with other work. Arising from that assessment a specific child health and wellbeing plan should be developed to undertake the necessary steps to ensure preparedness in the event of a future pandemic with higher rates of acuity in children or young people. Again, this should not be a bolt on. That plan should consider staffing, spaces, systems and equipment including the level of PICU provision. As part of this work, steps should be taken to proactively identify how children with community care-based needs as well as long-term PICU admissions can be appropriately cared for by other services within the healthcare system.

Child and young person impact assessments

22. The pandemic has demonstrated that the rights and perspectives of children and young people do not seem to be adequately protected in law. Neither age as a protected characteristic under the Equality Act 2010 nor the provisions of the Children Act 2004 (both applying to England and Wales only) ensured that the position of children and young people was properly considered at all times during

the pandemic[2]. RCPCH considers that child and young person impact assessments should be carried out and published to accompany all policy decisions or legislation changes which may materially impact them. Equality impact assessments seem to have had at least some effect in safeguarding the needs of adults with disabilities and protected characteristics during the pandemic, but no equivalent mechanism existed for children and young people.

23. An example of an issue where a specific and focused assessment of the impact on children and young people would have improved decision making is school closure. For the most part, infection with COVID-19 does not have a serious impact on children or young people[3]. The principal benefit of closing schools was not to protect children and young people themselves from infection, but to slow transmission in the wider population. From a purely utilitarian point of view that may well have been the right choice, but the RCPCH suggests that in any case where children and young people are being subjected to a disbenefit in order to deliver a benefit to others, a rigorous and public analysis of why that is necessary, what the expected benefits and disbenefits are, and most importantly how the impact on children and young people will be mitigated, is called for. Reassignment of some of the paediatric workforce to adult care is another example.

24. The RCPCH does not believe that this sort of rigorous analysis took place. It further believes that the effect is that children and young people were expected to bear a cost without a proper understanding of what that cost was. This should not be left to chance in the future.

25. A duty to conduct such as assessment would impact on pandemic planning and preparedness but expands beyond this to all other areas of policy which impact children's lives. RCPCH also believes that consideration should also be given to ensuring that the UN Convention on the Rights of the Child is directly part of domestic law, at least by way of a general due regard duty. This is already the case in Scotland where the UNCRC was fully incorporated into domestic law in 2024.

[2] No criticism is made of the children's commissioner here it is the legal framework itself which is unfit for purpose

[3] There are of course exceptions, in particular children and young people with co-morbidities

Improved data and record sharing

26. The pandemic has underlined a need for better data sharing across agencies to improve understanding of population health needs and appropriate service planning and policy development. RCPCH believes there should be a single mandatory-to-use a single unique identifier across all services for children and young people to facilitate joined up service delivery and child/young person protection. It also supports greater use of information technology to deliver services more efficiently.

Child and young person health provision

27. As part of an equitable recovery from the pandemic (and indeed an equitable health service generally) the RCPCH says there should be a Children's Health Investment Standard to address the investment gap between child and adult health services and to ensure all national health funding commitments include a specific proportion that is allocated to children's health services. That proportion should be set after consultation with the public and the professions and in light of the child and young person impact assessment we propose above. Each nation's NHS should be required to report both publicly and to their respective legislature on the delivery of the Children's Health Investment Standard at appropriate intervals.

28. Provision for child and young person mental health services continues to be a particular concern. Demand for these services was greatly increased by the pandemic. There is a very high level of unmet need today. Understandably, limited services tend to be focused on the most acute cases. But early intervention can be highly effective clinically in reducing ongoing harm, and in cost terms, in diverting patients from acute services and from longer term and more serious illness. Substantially increased funding for Child and Adolescent Mental Heath Services (CAMHS) MS should be a priority, as should continued funding for mental health champions, who should be embedded into every paediatric unit.

Communications

29. Clearer communication was needed with the public including tailored information specifically for children and young people, with the medical Royal Colleges involved at a much earlier stage so that ambiguity can be avoided and clear, consistent, useful and accurate information provided. The RCPCH does not believe communications would be issued without considering the needs of, say, people with disabilities, or people from minority ethnic groups. (At least, it would hope not.) Why then is it acceptable to issue communications without considering the needs of children and young people?

Timing

30. Unlike adults, children and young people have time-critical developmental and educational needs. A child who was in reception at the start of the pandemic has now just entered year five. Any learning there may be relating to primary age education will be of little use to them. A young person who had started their GCSE courses at the start of the pandemic is now about to start year two of university or post school education training or work. Any learning there may be relating to secondary education will be of no use to them at all. In future there is a need for a more rapid consideration of the wider impact of pandemics or other disruption on community and local government services that support children and young people and their families Once again, we make the point that children and young people are not small adults.

CONCLUDING REMARKS

31. RCPCH acknowledges that responding to the COVID 19 pandemic would have been challenging for decision makers at all levels. Much was done well. It is inevitable that, in hindsight, areas for improvement will be identified. However, the RCPCH feels that the needs and overall health and wellbeing of children and young people were not considered as they should have been or given the weight that they deserved.

32. Some of that may stem from the nature of COVID-19 as a disease that presented as being much more serious in older patients. Understandable though that is, the impact on services for children and young people of redeployment and backfill or, in some instances the closure or pause of services such as schools or those in the community, deserved more analysis and thought at the time and in planning for a return to “normal”. Some of those impacts on children and young people were themselves urgent and serious. They should not have been overlooked just because they did not stem directly from COVID-19.

33. More broadly, some of this oversight may stem from what the RCPCH feels is a systemic societal under-prioritisation of the needs of children and young people, to which the NHS as a reflection of wider UK society is not immune. The pandemic may have been the specific system challenge that revealed the under-prioritisation, but the opportunity should now be taken to address the root cause.

34. The RCPCH looks forward to assisting the Inquiry with its vital work in this area.