Witness Name: Steve Turner
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF Professor Steve Turner, President, Royal College of Paediatrics and Child Health

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I, Professor Steve Turner, will say as follows: -

1. I am President of the Royal College of Paediatrics and Child Health (RCPCH or "the College") and I have been in this role since March 2024. Prior to that, I was RCPCH Registrar from Spring 2021 to Spring 2024 and RCPCH Officer for Scotland from 2016 to early 2021. I am a consultant paediatrician in general and respiratory paediatrics at Royal Aberdeen Children's Hospital.

2. I am providing this statement in response to a Rule 9 request dated 4 April 2025 for the purpose of Module 8 of the UK Covid-19 Inquiry ("the Inquiry") investigating the impact of the pandemic on children and young people. As noted in this Rule 9 request, a witness statement by Dr Camilla Kingdon, former RCPCH President, for Module 3 of the Inquiry includes information relevant to Module 8 [ST/01 - INQ000411507]. Therefore, I note that my witness statement reproduces extracts of Dr Kingdon's statement including paragraphs 1 – 28 and 41 – 44 and, where requested by the Inquiry, includes supplementary information.

The Royal College of Paediatrics and Child Health's role, function and aims

3. RCPCH is the membership body for paediatricians, and we have over 24,000 members across the UK and internationally. It is responsible for education, training and setting professional standards and informing research and policy. It works to

transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

4. The College is governed by our Board of Trustees, with a particular focus on assurance around risk, financial issues, and ensuring fulfilment of charitable objectives, and Council, which is the representative body of the members and supports the Executive Team to develop the College's strategy and annual business plans. It also considers reports from our Vice Presidents and the Officers reporting to them (all of whom are members) on four major areas of work: training and assessment, education (including international work), health policy and science and research.

5. The College includes members across the four nations of the UK and, as such, Council includes an Officer for Ireland, Scotland, and Wales respectively. Supported by a small team of staff, these Nation Officers lead on managing external relations with stakeholders and policymakers including in their respective governments and civil servants. In England, this work is led by the President and Vice-Presidents who are supported by Officers and the College staff.

6. The College had regular engagement with a wide number of public bodies and NHS organisations throughout the relevant period. RCPCH engaged with NHS England, Public Health England (now Office for Health Improvement & Disparities), the UK Health Security Agency, the Department of Health and Social Care and the Department for Education throughout the pandemic to ensure children and young people were central to key decision making. College Officers in the Devolved Nations also engaged with devolved governments, NHS / Health and Social Care Northern Ireland and public health authorities via established structures with frequency. At the time of the pandemic, the structure and state of transformation in Northern Ireland meant engagement was less frequent than in other devolved nations. A named Paediatric Advisor to Scottish Government and Senior Medical Officer for Maternal & Child Health for Welsh Government exists which supports coordination at central government level, this was not the case in Northern Ireland.

7. The extent to which these public bodies ensured children and young people were central to decision-making varied throughout the pandemic. Ultimately, while there were examples of good practice and engagement which I will refer to in this statement, on the whole the public bodies and NHS organisations with which the College engaged did not sufficiently ensure children and young people were central to their decision-making during the pandemic period and there is a need to ensure this does not happen again. The College had good engagement when it came to specific issues that impacted children including on shielding, delayed presentations to accident and emergency, multisystem inflammatory syndrome in children ("MIS-C" or "PIM-ST"), and vaccinations for 5 – 11 year olds. This enabled the College to respond effectively to emerging issues, for example through the production of advice posters for parents and carers during the pandemic [ST/02 - INQ000620588]. However, beyond these specific examples, it is the view of the College that more could and should have been done by the UK Governments and Assemblies and other public bodies to ensure children and young people were central to decision-making throughout the pandemic. The effective closure of community and public health services and schools, all of which provide a vital function for children's physical and mental wellbeing, are evidence of the need for this. The College also sought for children and young people to be more central to public comms in the pandemic including by, for example, joining a call [ST/03 - INQ000620589] for the Prime Minister to host a briefing on children and young people and it was disappointing that this suggestion was not taken up. The College also wrote to the then Secretary of State for Health and Social Care, Matt Hancock, to meet with children and young people who did not take this offer up. [ST/04 - INQ000620590].

8. The College also had ad-hoc engagement with expert groups including the Scientific Advisory Group for Emergencies (SAGE). This was primarily focused on the epidemiology of COVID-19 with respect to children and young people and any risk factors that indicated children were being harmed directly by the infection. This engagement was primarily through Dr Camilla Kingdon, College President from May 2021 to March 2024 and prior to this, through Professor Russell Viner, College President between 2018 and 2021. However, Professor Viner's involvement in SAGE was in his capacity as an academic at University College London (UCL)

rather than as President of RCPCH and therefore, I am unable to comment on his engagement particularly in respect of the epidemiology of COVID-19 and whether evidence was gathered or analysed on the extent to which children and young people or their schools were significant drivers of community transmission. Dr Kingdon's engagement with SAGE is further outlined in paragraph 10-11 of this witness statement.

9. The College itself set up an internal clinical academic expert reference group to help inform and shape our advocacy and policy positions throughout the pandemic. This was informal and designed to enable the College's Senior Officer team to horizon scan for critical issues for members, and children and young people. Officers in the Devolved Nations established informal rapid information sharing and intel for Clinical Leads groups in Wales and Scotland. These were designed to allow staff leads in the nations to maintain links with the College National Officer, the given College National Executive Committee and with members.

10. I understand the inquiry is aware the College is a member of the Academy of Medical Royal Colleges (AoMRC) and I note that some of our engagement with public bodies was conducted through them, for example on mandatory vaccination for staff.

Monitoring impact of COVID-19 on children, access to paediatric care and redeployment of staff

11. The College plays a role in enabling and promoting high quality research, supports the development of paediatric researchers and contributes to the wider evidence base. The College did not conduct its own primary research on the rates of severe illness in babies and children with COVID-19, how this changed during the relevant period, nor on how scientific understanding of the impact of the virus on babies and children changed during the relevant period. However, the College did play a role in data collection and analysis on the impacts of the pandemic more broadly. This was used to collate evidence, to support members and to advocate on. For example, there were early signals from South Africa that the Omicron variant appeared to be causing far more hospital admissions in babies from December 2020. Dr Kingdon raised concerns directly with Sir Chris Whitty which then led to

two meetings of SAGE to discuss the Omicron variant and its potential impact on young children. This was followed by a joint press-conference hosted by the Science Media Centre.

12. Dr Kingdon's assessment of her engagement with SAGE on the Omicron variant was that it exceeded expectations with Sir Chris Whitty and others showing genuine interest and concern. Dr Kingdon has provided an email exchange which I have exhibited here that highlights the engagement from Sir Chris Whitty and other stakeholders on this topic [ST/05-INQ000620591]. This engagement ultimately led to the Science Media Centre briefing to coincide with the publication of SAGE minutes and associated papers. This sought to be transparent about early signals of omicron and to provide reassurance to the public [ST/06 - INQ000620592].

13. In partnership with paediatric education charity Don't Forget the Bubbles, RCPCH produced a summary of key evidence regarding COVID-19 in children and young people. The aim of this work, which was available publicly on the College website, was to provide paediatricians, paediatric healthcare workers and providers and policy makers with the most up-to-date evidence regarding COVID-19 in neonates, children and young people. The initial phase of this rapid review (April-June 2020) involved a comprehensive look at published and pre-print studies regarding COVID-19 in children and young people. Studies were categorized into four main topics: epidemiology therapeutics, clinical features, and neonates. The resource was accessed 128,492 times between then and 30 June 2020, cited in numerous academic publications and policy documents from the WHO.

14. I refer the inquiry to guidance the College produced on the condition known as multisystem inflammatory syndrome in children ("MIS-C" or "PIMS-Ts") which was first published on our website on 1 May 2020, an example of the College's advocacy during the pandemic. In addition to the guidance produced for clinicians, the College also produced information for families which remains available on our website. The College understood the severity of COVID-19 in children, including how this changed as new strains emerged via information from public health agencies, including Chief Medical Officers, and signals from clinical academics

and epidemiologists through its informal expert reference group. The College was clear early in the pandemic that COVID-19 did not severely harm the vast majority of children and young people; the exceptions to this rule were a small number of groups each of whom included a small number clinically extremely vulnerable and immunocompromised individuals and cases with PIMS-TS.

15. In terms of our activity on long COVID in children, on 3 August 2021, the College responded to a study [ST/07 - INQ000620593] on long lasting symptoms in children with COVID-19, published in The Lancet on 3 August 2021. This study noted that children who develop symptoms of COVID-19 typically get better after six days and the number who experience symptoms beyond four weeks is low. Dr Liz Whittaker, infectious disease lead at the College and Senior Clinical Lecturer in paediatric infectious diseases and immunology at Imperial College London noted this would be reassuring for children and young people but that it remained important that those who do experience persistent symptoms can access care. However, the College did not conduct research on long COVID in children more widely.

16. The College repeatedly drew attention to the impact of COVID-19 on access to and provision of health care to children and young people with conditions other than COVID-19 during the relevant period. Throughout the relevant period, children and their health services were considerably impacted due to the redeployment of paediatric staff and paediatric facilities, including inpatient and clinic space, away from their usual roles to provide for adult COVID-19 patients. I draw attention to the College's response to the UK Parliament's Health and Social Care Select Committee (HSCSC) inquiry into tackling backlogs, submitted by the College in September 2021 to the Health and Social Care Select Committee and which I exhibit here [ST/08 – INQ000620594], where it is noted in the second peak of COVID-19 30% of services had to redeploy paediatric trainees to adult services.

17. The submission to HSCSC outlines that child health services were substantially affected by the pandemic and are more likely to bear a longer-term impact for reasons including data on children's health and wellbeing being collected in a variety of settings, by different agencies in different locations which creates additional complexities. The impact of this, the submission notes, is universal but

particularly felt amongst those from deprived backgrounds who already have worse health outcomes than their peers. The submission made several recommendations to ensure the effective recovery of children's services post-pandemic. The extent to which these recommendations have been fulfilled is variable:

a. Provide a multi-year settlement for the NHS to allow them to plan and prioritise their approach to the backlog of children waiting to be seen: A commitment was made this by the current UK government and NHS England, through its elective recovery plan published in 2025, to improve elective care equitably and inclusively for adults but the College will continue to make the case for equitable funding for child health services to help their recovery post-pandemic, for example through the implementation of a Children's Health Investment Standard.
b. Provide ring-fenced funding of Child and Adolescent Mental Health Services (CAMHS) and inpatient paediatric mental health services that reflects local service demand: The need for increased funding has grown, rather than reduced, with recently published data published by the Lancet Child Health and Adolescent Journal and referenced in a response by the College that I exhibit [ST/09 - INQ000620595] showing that there was a 65% increase in the number of children and young people being admitted to general acute medical wards in hospitals in England because of a mental health concern between 2012 and 2022. Waiting lists for CAMHS and in-patient mental health treatment continue to rise, indicating that pandemic recovery has not yet occurred or even begun. This year, we have seen further cuts, for example recently announced planned cuts for children and young people's eating disorder services such as those laid out by the Royal College of Psychiatrists in exhibit [ST/10 - INQ000620596]. This highlights that over half of Integrated Care Boards have reported planned spending cuts in eating disorder services. for 2024/25.
c. Urgently increase funding to Local Authorities. Provide sufficient funding for Local Authorities commensurate to local population need including restoring the £1 billion of real-terms cuts to public health: funding to Local Authorities continues to be stretched with the Health Foundation noting that

a recent increase of 3% in real terms meaning that the allocation per person is still 26% smaller in real terms per person than in 2015/16. The 40 per cent reduction in the health visiting workforce, as acknowledged in a publication from the Local Government Association, between 2015 and 2022 is just one example that highlights the impact of this cut.

d. Provide assurance that the statutory guidance accompanying the Health and Care Bill mandates a strategic children's lead in every Integrated Care System (ICS): The Health and Care Act 2022 included important measures that aimed to help local areas improve child health outcomes. Integrated Care Boards (ICBs) will be required by primary legislation to set out the steps they will take to address the needs of children and young people under the age of 25 in the forward plan. NHS England was also required to issue statutory guidance that states that each ICB must nominate an executive children's lead, ensuring leadership for babies, children and young people on every ICB. There remain challenges including the fact, according to analysis from the National Children's Bureau, that less than half (45 per cent) of ICBs had identified specific actions the ICB would undertake in their planning documents for babies, children and young people. In response, the College sets out further recommendations on integration for national and local decisions makers in its Blueprint for Child Services [ST/11 - INQ000620597].

e. Implement an overarching child health strategy, multi-departmental approach to help ensure existing health inequalities are not entrenched by COVID-19. The College continues to call for an overarching child health strategy with health inequalities at the centre.

18. Early in the pandemic, there was a significant drop in paediatric attendance to acute and community care settings, as was advised at the time by national governments. However, RCPCH members became quickly alive to the potential harms of children and families delaying when they present to NHS services, either via NHS 111 / Direct or to their GP or emergency department. In response, the College organised a survey of paediatricians to understand these delays, using the British Paediatric Surveillance Unit (BPSU) which is a specific surveillance tool usually employed for understanding data of rare and infectious diseases. The

results of the survey, as well as some commentary and analysis, are available in a letter that was published in the Archives of Disease in Childhood and exhibited here [ST/12 -INQ000620598]. In this, the authors note the widespread professional concern about delayed presentations. Further conclusions to the survey were shared in an article submitted to British Medical Journal opinion on August 6 2020 and which I exhibit [ST/13- INQ000620599]. This notes that the reasons for delayed presentations included parents strictly adhering to the "Stay at Home" messaging by government, parental concerns about getting infected in hospitals and not wanting to disturb doctors during the pandemic. Later on in the pandemic (Winter 2020/21), demand on NHS 111 / NHS Direct services increased significantly, and further concerns were raised about wait times on calls, and the available paediatric clinical advice in 111 / NHS Direct.

19. The College developed materials to support babies, children, young people and their families to navigate pathways of care for urgent or emergency care needs during the pandemic - these were informally known as 'traffic light posters'. The RCPCH also supported NHS England to recruit retired or shielding paediatricians to work in NHS 111 call centres to improve paediatric advice during the pandemic. This trial was taken forward in 2020, and the study '621 Establishment of a national NHS 111 Paediatric Clinical Assessment Service (PCAS)' published promising results in the BMJ in August 2022 around quality of advice given, and divergence away from primary and acute care settings.

20. The impact on the workforce should not be considered in isolation from the care and provision to babies, children and young people. The College collected information on availability to work, redeployment of paediatric staff and trainees, availability of Personal Protective Equipment (PPE) and testing, and inpatient and outpatient activity. There were also gaps in acute rotas which affected both service and training due to paediatricians who were vulnerable having to be shielded – including pregnant members and members who had COVID-19. In April 2020, the College launched a project to understand the unintended consequences of the pandemic and lockdown measures. The College was aware that plans to redeploy paediatric staff and use paediatric inpatient and clinic space for adult COVID-19 patients would affect children's services. During data collection, the information

was passed on to various decision makers at local and national level as well as other stakeholders. The College used the findings to support planning for local services ahead of winter and as an influencing tool with the governments across the UK.

21. With regards to re-deployment of paediatric staff, the main findings of the first phase of this project, which ran from April and July 2020 and which I exhibit [ST/14 - INQ000620600], were:
    a. Up to 10% of all paediatric staff were not available to work, e.g. due to shielding. A further ~13% were working in different ways, e.g. remote working.
    b. Up to 46% of community trainees were redeployed to acute paediatric care, and by end of data collection in July 2020, 10% were still not working in community settings. Up to 14% of community career grade doctors were also redeployed. This is worrying because of the importance of community services for vulnerable children, and the backlog of work such as child protection medicals.
    c. Paediatric inpatient space lost to adult services was small but important (1-6%), with reported issues getting space back.
    d. At the start of data collection, in April 2020, over a fifth (22%) of those normally on the Tier 1 acute paediatric rota were redeployed to adult services. By the end of data collection in July 2020, 2% of Tier 1 staff had not yet returned. More senior staff were less likely to be moved to adult services, with only up to 3% of Tier 2 and up to 2% of Tier 3 staff being redeployed.
    e. As well as redeployment to adult services to support the coronavirus response, paediatric staff were also redeployed within paediatrics, often moving to the acute service, possibly to backfill the loss of Tier 1 staff as detailed above.
    f. Furthermore, 7 to 11% of sub-specialty paediatric staff were moved to the acute rota, and 9% still had not returned by the end of data collection in July 2020.

22. With regards to the impact on services, the findings from the April to July 2020 period included:
    a. The loss of paediatric inpatient space was relatively small throughout the data collection period, ranging from 3 to 6%. However, over 3% of paediatric inpatient space was still lost to adult services on 3rd July 2020.
    b. Loss of outpatient and clinic capacity was not a specific question. However, it was a common theme in the concerns raised by respondents in the free text submissions about concerns for services and areas that are struggling to restore.
    c. Concerns tended to be about catching up on the backlog of cases they have not been able to see, and the long-term harm that may arise from children missing appointments. There were also worries that moving to virtual appointments is not appropriate for all consultations and may result in missing safeguarding cases or other issues.

23. A second report was published which focused on the impact of Covid-19 on child health services between December 2020 and February 2021 and which I exhibit here [ST/15 - INQ000620601]. This phase was launched to respond to the need for further data about the impact of the pandemic on paediatric services. It consisted of a snapshot questionnaire to clinical leads on Friday 4 December 2020, together with a short, ten question weekly alert system for fourteen weeks starting on Friday 27 November 2020. On redeployment, key findings included:
    a. 30% of services had redeployed paediatric trainees to adult services at the peak in mid-January 2021.
    b. 13% of services reported paediatric consultants redeployed to adult services at the peak in late January 2021. This contrasts with the first phase of data collection where less than 1% of those on the Tier 3 (consultant) rota were redeployed.
    c. Up to 11% of services reported that community child health (CCH) trainees were redeployed to another area of paediatrics. This is lower than the first phase, where up to 46% of CCH trainees were redeployed.
    d. Up to 21% of services reported that consultants were stepping down to cover the junior doctor rota, with a peak at the end of November 2020.

e. 11% of services reported losing some physical outpatient space to adult services.

24. Paediatric ICU (PICU) was particularly impacted by this issue, as staff were redeployed to adult units and, in some cases, PICUs were converted to treat adult patients. Studies, which have now been carried out to begin to understand the long-term impact of this [ST/16 - INQ000620602]. Emerging themes include:
    a. Reduction in quality of care
    b. Employee wellbeing
    c. A lack of training and support
    d. Attrition of staff as a result of all three of the above.
    e. 30% of staff in one study felt that redeployment of paediatric critical care staff had impacted the safety of care delivered to paediatric patients.

25. Paediatric critical care is already commonly cited as a 'hard to staff' area and recruitment and retention of staff into the PICU is an issue consistently highlighted by the Paediatric Critical Care Society. Future pandemic preparedness measures must consider ways to improve staff wellbeing in this space in order to maintain recruitment and retention, or the quality of care available to the UK's most critically unwell children is at risk.

26. A number of care pathways were interrupted due to the aforementioned workforce changes including care for newborn babies and immunisation, the cessation of all but the most urgent elective children's surgical cases and all community health services. These services deliver care to children with complex neurodisability, autism, safeguarding concerns and Looked After Children, amongst other services. A considerable number of paediatric community health trainees were redeployed throughout the relevant period as noted in previous paragraphs. I reiterate the College's position that the deprioritisation of community services, which were already neglected prior to the pandemic, means these areas have been slow to recover with waiting lists continuing to climb. Just this week, the College published an analysis highlighting that there are now over 300,000 children waiting for community health services across England [ST/17 - INQ000620603].

27. The College recognises that necessity meant that services had to be reconfigured or paused including the redeployment of child health professionals to adult services and recognises that this was the right thing to do initially. However, the College was alive to the potential impact of these changes to children's services from the outset of the pandemic. College guidance, which I exhibit [ST/18 - INQ000620604] on rotas published March 2020 stated that "Community paediatricians should not be transferred to acute services unless absolutely necessary. There will likely be an increase in demand.". Despite this, there was a significant redeployment of clinical staff from community to acute services. As noted, up to 46% of community trainees were redeployed to acute paediatric care, and by end of data collection in July 2020, 10% were still not working in community settings. Later in the pandemic, by the end of January 2021, 13% of services also reported paediatric consultants redeployed to adult services. This is worrying because of the importance of community services for vulnerable children, and the backlog of work such as child protection medicals. The College maintains that its voice, which was the voice of its members and their patients was not heard and that the rights and needs of children were not heard until very late in the pandemic. In any future pandemic it would be important regularly to consider the impact of infection protection control measures on the wellbeing of the nation's children.

28. The inquiry has asked for details regarding the reluctance of patients or their parents to attend or a delay in attending healthcare settings. Data and evidence from the College show that a small but important number of late presentations were reported within the relevant period. These included diabetic conditions, child protection concerns, mental health issues, and sepsis. Late presentations of these issues and conditions could have lifelong impacts, including in some cases being fatal, for children and young people. Furthermore, responses – including free text comments - from clinicians to surveys on the wider impact of COVID-19 reveal a profound impact of changes to the healthcare system due to COVID-19 particularly affecting vulnerable children and families often seen by community services.

29. Throughout the relevant period, the College sought in various ways to address the challenges identified previously. This includes both formal and informal routes of communication and advocacy with relevant stakeholders, the production of

guidance to support clinicians and the production of information to support families. In total, the College published 24 pieces of guidance for paediatric services during the relevant period such as supporting at-risk patients, guidance for planning paediatric rotas, support for high-risk staff, working in remote services, winter pressures and on PIMS-TS and Respiratory syncytial virus (RSV). Through this work, the College played an important role drawing attention to and supporting the needs of children and young people.

30. With regards to the involvement the College had with CAMHS, I note the College played an advocacy role rather than strict 'involvement with CAMHS' per se. For example, it was clear from colleagues and our members that more children and young people were in distress and that CAMHS services were struggling to keep up with unprecedented demand. This in turn resulted in an increase in children and young people presenting to Emergency Departments with complex psychosocial crises. The College sought to highlight with government officials across the UK particularly in NHS England the increase in acuity and demand for children in distress, drawing attention to variation in being able to access specialist mental health services during the relevant period. As we raised the profile of these issues, especially eating disorders, through discussions with officials and the media this resulted in a piece of work on crisis presentations from NHS England that the College and other stakeholders were involved with and that ultimately led to a joint statement [ST/19 - INQ000620605] published in December 2021 from us, the Royal College of Psychiatrists, and the Royal College of Emergency Medicine as the primary output. Together we recommended through this statement that services work together to meet the mental health needs of children and young people so they receive the right treatment, in the right place, at the right time.

31. The College can point to several examples where some progress has been made in accordance with our recommendation for services to work together to meet the mental health needs of children and young people. In 2022, NHS England published 'Supporting children and young people (CYP) with mental health needs in acute paediatric settings: A framework for systems', which I exhibit [ST/20 - INQ000620606]. However, our members tell us that implementation looks different in different areas. RCPCH welcomed the news in 2023 that funding would be

provided by NHSE to appoint a Mental Health Champion in every provider that admits children. These roles have proved vital in joining up the care delivered between physical and mental ill health. However, we are aware that this funding did not lead to a mental health champion being appointed in every unit, and we are concerned to learn that this funding may be discontinued as of 2025, and that the decision to allocate funding to a mental health champion will be deferred to ICBs. Ultimately though, as this role is for acute paediatric settings and not mental health specific services, it does not adequately address the need for improved funding for CAMHS. Therefore, it is the College's view that children and young people still do not reliably receive the right treatment for their mental health, at the right place, at the right time.

32. The College was vocal on safeguarding issues during lockdown and the needs of vulnerable children not being met. With regard to lockdowns, we took a principled position that schools should be the last to close and the first to open. The College was also firm and visible with our position in 2020 [ST/21 - INQ000620607] on the need for schools to be open, with an open letter to the Prime Minister signed by over 1,500 paediatricians generating significant media attention [ST/22 - INQ000620608] in June 2020. We acknowledged the role school plays in the lives of children and young people especially in highlighting those who may be in difficulty. In written evidence to the Education Select Committee submitted in June 2020, the College made clear the importance of safeguarding when noting that schools play a vital role in identifying and referring vulnerable children to statutory services. The rise in behavioural issues in school with children after periods of lockdown is inextricably linked with both mental health as well as the growing waiting lists we now see for neurodevelopmental assessment. This is contributing to a rise in crisis presentations including those who then find themselves on general paediatric wards with nowhere else more appropriate to be cared for. I make this point here as it is representative of the contributors to children's mental health during the relevant period.

33. I think it is opportune to highlight here the issues experienced by vulnerable children and young people who were shielding. The College was pleased that the UK Government adopted our guidance on shielding for babies, children and young

people recommending that most children and young people did not need to shield, which was published by the College in June 2020 [ST/23 - INQ000620609]. The government's official guidance was subsequently published in July 2020 by the Department for Health and Social Care. This was especially important once it became clear that many babies, children and young people who had been shielding may not have needed to continue doing so. It noted that the majority of children with asthma, diabetes, epilepsy, and kidney disease do not need to continue to shield and could, for example, return to school as they reopened. It also noted the inclusions of many children with conditions such as cerebral palsy and scoliosis, for whom the benefits of school – in terms of access to therapies and developmental support – outweigh the risk of infection. It set out two groups of shielded patients with patients in Group A having to continue to shield and patients in Group B requiring a case-by-case discussion to decide whether they should be advised to continue to shield. I think it is opportune to highlight here the issues experienced by vulnerable babies, children and young people who were shielding. Governments and public health agencies issued all-age guidance and advice for clinically extremely vulnerable people, i.e. those considered to be at the highest risk of severe disease from SARS-CoV-2 infection. The College understood that this guidance was likely only applicable to adults and given COVID-19 was not harming children in the same way as adults it was our view that additional work was required to produce tailored criteria for children. As a result, the RCPCH reviewed the evidence base around the impact of the SARS-CoV-2 infection on children and young people with comorbidities, concluding that the vast majority of children with conditions including asthma, cystic fibrosis, diabetes, epilepsy and kidney diseases were not clinically extremely vulnerable. The College took forward intensive work with their members and NHS and public health bodies, to ensure children who could come off the list were communicated with effectively. We advised Dame Jenny Harries, at the time Deputy Chief Medical Officer for England, and her office who then organised a meeting with CMOs across the UK. The College notes, and welcomed, that the UK Government adopted our guidance on shielding for children and young people.

34. In April 2020, the College launched a new data collection and reporting tool to track the impact of COVID-19 on child health services. A blog published on 15 April 2020

by my colleagues Dr Nic Jay, our then Officer for Workforce Planning and Health Services and Professor Nick Bishop, then Vice-President for Science and Research, notes this reporting tool was established to consider how the major service and staffing changes put in place to support adult critical care have affected health outcomes for children more broadly. I note that the detailed findings of the two reports that resulted from this data collection are documented on our webpage. I cover the main findings in the following two paragraphs.

35. During the first period from April 2020 – July 2020, the main findings included a substantial number of paediatric staff redeployed, an increase in PPE and testing, a decrease in activity across all types of paediatric care, a small but important loss of paediatric inpatient space, a small but important number of late presentations and a suggestion of a high backlog of cases.

36. During the second phase, from November 2020 to February 2021, the main findings show that paediatric services were under extreme pressure. Paediatric staff and capacity continued to be impacted by the COVID-19 pandemic, despite children and young people rarely having severe illness caused by the virus. There was continued redeployment of trainees to adult services and over a quarter of organisations cancelling outpatient clinics resulting in backlogs. During this period, we also saw innovation with virtual consultations and clinics implemented. We also noted the increase in mental health presentations amongst children and young people as well as an increase in paediatricians caring for children with mental health needs. This was due to pathways with CAMHS that had become ineffective as demand and acuity rose above pre-COVID levels with many children subsequently left in a state of unmet need. The College sought to address this by developing a resource in October 2020 outlining the role of paediatricians in supporting children and young people's mental health. This included a recommendation that all paediatric teams should have a nominated lead for mental health. I note that paediatric workforce stress and burnout were also a key feature of this period.

Staffing capacity

37. Paediatricians worked diligently and flexibly to support the healthcare system through the relevant period. There were significant changes in the availability of healthcare professionals specialising in paediatrics and child health during the relevant period. Like other healthcare professionals, paediatricians and the capacity within the specialty of paediatrics were significantly impacted by COVID-19. Paediatricians – including paediatric trainees – worked long hours, many covering very significant gaps in their rotas and often covering a wider range of patients often outside their core competencies and supporting the shielding of many vulnerable babies, children and young people. Many were redeployed to other wards, were required to care for adult ICU patients and communicate with their relatives, facilitated the shielding of doctors doing different roles and of course joined the wider healthcare workforce to deliver COVID-19 vaccinations.

38. As previously mentioned, one of the biggest impacts we saw was the redeployment of paediatric staff and the use of paediatric inpatient clinic space for adult COVID-19 patients. The College recognises that this was justifiable given what was known at the time with regards to the greater likelihood of adults experiencing severe illness from COVID-19 in comparison to children and young people. However, our members felt that they were very often on the back foot in dealing with the many consequences on their patients. The impact on children and young people and their families was often lagging behind in both policy and operational delivery. In some areas, clinical space lost has yet to be returned to paediatric services.

39. Paediatric Intensive Care Units (PICUs) were particularly impacted by the redeployment of staff and of intensive care beds. In England, seven PICUs out of 23 were repurposed for adult services, while neighbouring PICUs increased their bed capacity to maintain overall numbers for children. There is a growing body of research demonstrating the impact on staff and services of this redeployment, both with regard to staff wellbeing, training needs and learnings for the future.

40. The College has detailed the likely impact of the re-deployment of paediatric staff to other areas of healthcare during the pandemic on children and young people. Our report, Impact of COVID-19 on child health services between April and July 2020, outlines some of the concerns including safeguarding and hidden harm in

children, followed by the lack of face-to-face contact, and then delayed presentations of unwell children.

41. RCPCH has identified a number of care pathways that WERE interrupted because of workforce changes. This is largely linked to the deprioritisation of community services. Along with the Institute for Health Visiting, RCPCH published advice for parents who may not be able to attend the six-week check for newborn babies [ST/24 - INQ000620611] In a British Medical Journal opinion piece commenting on findings related to the College's impact of Covid-19 on child health services, it is noted that "paediatric oncologists have reported a reduction in referrals for cancer assessment which raises concerns about undiagnosed cancer in the community and late presentations in the coming weeks. Similarly, in addition to the reported delays in presentations of child protection cases, community paediatricians have raised concerns about the lack of referrals for child protection assessment at a time when many parents struggle to cope with staying at home. Reports of poor mental health, including depression and anxiety, domestic violence, and concerns about suicide, all increased during the lockdown, again disproportionately affecting the most disadvantaged families."

42. The College also worked with children and young people (16 – 25) throughout 2020 and 2021 to make sure their voices were heard and could inform and influence decision makers. Through this, children and young people told us they had issues with getting reviews for long-term conditions or follow-ups after surgeries that happened just before lockdown, regular face-to-face counselling sessions or CAMHS appointments being disrupted due to services not being able to adapt quickly.

Our work with children and young people

43. Children and young people are central to the College's work, driving everything we do, and this principle was no different during the pandemic. The RCPCH &Us programme sought to ensure children's and young people's voice made a real difference during the pandemic to child health and healthcare. Children and young people – and their families – were able to work with us and our member community

to shape the College's policy and advocacy approach with stakeholders including DHSC, PHE, NHS England and other organisations UK wide. Key projects involving children and young people throughout the relevant period included but were not limited to:

a. 360 children and young people were engaged by RCPCH in sharing their challenges, concerns, hopes and ideas about the pandemic or contributed to publications, guidance and recovery plans both within RCPCH as well DHSC, PHE and other organisations UK wide. The voices and views of these children were collated through online group work and sessions across all four nations. Specific activity, which is exhibited in turn, included:
    i. RCPCH Recovery Plans by young people for NHS staff [ST/25 - INQ000620612] in which RCPCH &Us young people spoke to paediatricians, medical directors, policy leads and national programme leads for child health to understand more about how to help Trusts and planning for the following six months. The young people created a poster on the priorities that emerged from this including the need for: child- and youth- accessible, friendly and relevant information about accessing health services and staying safe through the pandemic, increase access to mental health services to support children and young people impacted by the pandemic and creating the best virtual health experience possible.
    ii. RCPCH young volunteers inputting into NHS England guidance on shielding. I have provided an exhibit [ST/26 - INQ000620613] which shows an email response detailing the thanks from NHS England given to our young people for attending a shielding focus group in June 2020 and how this helped informed a report that was shared with colleagues in NHS England and the government.
    iii. Input into email briefings on vaccine hesitancy amongst children and young people that were provided to Chief Medical Officers across the UK.
    iv. A review conducted by RCPCH &Us for DHSC of the Covid-19 vaccination programme guidance for children and young people for parents.

b. 74,000 children and young people's voices were peer reviewed by RCPCH young volunteers to identify themes relating to life in lockdown, recommendations for service reconfiguration and looking at vaccine hesitancy. These volunteers produced guidance and briefings for internal and external decision makers on the recommendations and findings, publishing recovery plan guidance on mental health provision, pandemic information and virtual / digital first health appointments and vaccination programme guidance. These were widely disseminated within the health sector and were used to brief CMOs and DHSC.
c. The development of guidance on virtual health appointments for young people alongside the Royal College of General Practitioners, British Association for Sexual Health and HIV and the Royal College of Psychiatrists. This sought to support children and young people to know their rights in terms of accessing healthcare, to emphasise the NHS was still open and to respond to concerns about sharing images between children, young people, parents and carers and clinicians [ST/27 - INQ000620614].

The College's role in the pandemic

44. The College played a key role in supporting public bodies, College members helped other members of the healthcare profession and parents and carers in responding to the pandemic to ensure children and young people, and the workforce that supports them, were adequately considered. As noted elsewhere in this statement, the College engaged throughout the relevant period with relevant bodies on a range of issues impacting children and young people. It is my view that, where sought, the College's engagement with public bodies as well as our advocacy role was able to secure a better outcome for children and young people and their families and carers. For example, whether that be addressing concerns about A&E attendance, school closures, vaccinations, mental health and a range of other issues. Internally, the College was able to effectively reprioritise its work and focus to ensure it could play a meaningful role both for its members and children's health.

45. The College recognises that by its nature a pandemic will come with its own unique set of circumstances and so it is hard to comment on whether RCPCH could be better prepared to continue or adapt its role in the event of the future pandemic. Certainly, informed by the experiences of the COVID-19 pandemic, it is possible to assess that the College engaged as fully as it could to respond. The College will always seek to play a role that is aligned with our charitable objects – to improve the health and wellbeing of children and young people across the world, by supporting paediatricians, shaping policy and improving practice.

Summary and recommendations

46. The overriding message from the College is that pandemic planning cannot simply deal with people who became most unwell with the virus which in this case was mostly adults. As the future generation, babies, children and young people, regardless of the direct impact on this group, must be prioritised. The direct impact of the COVID-19 virus on babies, children and young people was minimal, but the indirect impact on their physical and mental health and well-being, their education and their health services is still very acute, We are now seeing how damaging a lack of prioritisation can be to the holistic needs of babies, children and young people.

47. Like other healthcare professionals, paediatricians and the capacity within the specialty of paediatrics were significantly impacted by COVID-19. Paediatricians – including paediatric trainees – worked long hours, many covering very significant gaps in their rotas and often covering a wider range of patients often outside their core competencies and supporting the shielding of many vulnerable children and young people. Many were redeployed to other wards, were required to care for adults ICU patients and communicate with their relatives, facilitated the shielding of doctors doing different roles and of course joined the wider healthcare workforce to deliver COVID-19 vaccinations.

48. During the pandemic there was understandable (given what was known at the time regarding the impact of COVID-19 on adults) focus on treating the many very

sick adults with COVID-19. The impact on babies, children and young people, and their families was often lagging a long way behind in both policy and operational delivery. Our members felt that they were often 'on the back foot' in dealing with the many consequences for their patients.

49. Based on this, there are number of lessons that ought to be learned and recommendations we make. Our main recommendation is that children and young people must be at the centre of policy making and preparation for future pandemics whether or not they are included in the group most directly clinically affected by the pandemic disease. In addition, we recommend:
    1. For the NHS in each country of the UK to be underpinned by an evidence-based and fully funded plan for the workforce (required pre-pandemic but heightened by occurrence).
    2. That a comprehensive paediatric pandemic preparedness assessment is undertaken and a plan prepared to undertake the necessary steps to ensure preparedness in the event of a future pandemic with higher rates of acuity in children. This should consider staffing, spaces, systems and equipment including the level of PICU provision. To facilitate this, steps should be taken to proactively identify how children with long-term ICU admissions can be appropriately cared for by other services within the healthcare system.
    3. That regular children's rights impact assessments should be carried out and published to accompany all policy decisions or legislation changes which impact them. This includes pandemic planning and preparedness but expands far beyond this to all other areas of policy which impact children's lives. Children are 25% of the population but 100% of the future and we want all UK nations to ensure the UN Convention on the Rights of the Child is part of domestic law.
    4. For better data sharing across agencies to improve population health needs and appropriate service planning and policy development (required pre-pandemic but heightened by pandemic) by rolling out a single unique identifier across services for children and young people.
    5. Clearer communications planning with the public, including tailored information to children and young people, at a much earlier stage and with medical Royal

Colleges and others fully brought into those discussions so that ambiguity can be avoided.

6. Recognition of the positive impact that greater and differing use of technology can have on delivery of services.
7. Embed paediatric advice and assessment within every NHS 111 service (PCAS).
8. Ensure a greater understanding of the impact of the pandemic on the NHS and social care workforce and trainees across the four countries.
9. Future pandemic preparedness measures must consider ways to improve staff wellbeing generally and in PICUs to maintain recruitment and retention, or the quality of care available to the UK's most critically unwell children is at risk.
10. Conduct a more rapid consideration of the wider impact of such pandemics on community and local government services that support children and young people and their families.
11. Introduce Children's Health Investment Standard to address the investment gap between child and adult health services and ensure all national health funding commitments include a specific proportion that is allocated to children's health services.
12. Continue funding for mental health champions, ensure these are embedded into every paediatric unit and increase funding for CAMHS.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 01/07/2025