IN THE UK COVID-19 PUBLIC INQUIRY

CHAIR: BARONESS HEATHER HALLETT

On behalf of CPHVA

Obi Amadi Statement

First Witness Statement in Module 8

Dated: 31 July 2025

WITNESS STATEMENT OF OBI AMADI

I, Obi Amadi, am the Director of the Community Practitioners and Health Visitors Association ("**CPHVA**"). My office address is Unite House, 128 Theobald's Road, Holborn, London WC1X 8TN.

1. I make this statement on behalf of the CPHVA in response to a letter dated 14 April 2025, sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the "**Inquiry**"). This statement is made for the purposes of Module 8 of the Inquiry, which is examining the impact of the Covid-19 pandemic on children and young people in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 January 2020 and 28 June 2022.

2. This statement seeks to address these fundamental issues, and in doing so, is structured as follows:
    a) Structure and role of the CPHVA;
    b) Pre-pandemic provision of services and support;
    c) The impact of the pandemic on services;
    d) Efforts made by the CPHVA;
    e) The impact of the pandemic on children and young people's health and wellbeing; and
    f) Conclusion, lessons learned and recommendations.

(A) Structure and role of the CPHVA

3. The CPHVA is a professional body and trade union that represents health visitors, school nurses, community nurses, community nursery nurses, district nurses, and other relevant health professionals working in a community setting. We operate across all four nations of the UK and aim to give all community practitioners a collective voice across the UK health sector. The CPHVA campaigns for improved health policy and workforce conditions for its membership. It supports its members with professional development policy guidance and workplace representatives while advocating for high standards in community health practice.

4. In summary, the CPHVA:
    a) provides professional development to members and others from the relevant professions in the form of training conferences and resources on best practice;
    b) lobbies the government and other health bodies on issues that affect community health services and the professionals within their membership;
    c) produces resources and provides the Community Practitioner journal and research which informs members practice;
    d) supports and promotes the importance of early intervention particularly in health visiting and school nursing practice; and
    e) provides members with workplace representation with regards to employment rights pay disputes and working conditions.

5. The CPHVA is both a professional body and a trade union. It sits under the umbrella of Unite the Union, in its health sector, but retains its own professional identity and has its own decision-making body and process. The CPHVA executive committee is the decision-making body, made up of elected representatives from the different regions and countries of the UK. The committee decides on policy positions, sets strategic priorities and professional standards, working with the rest of Unite's health sector committees. It has a particular focus on clinical practice, professional standards, education workforce, research and public health policy.

6. The CPHVA engages with national bodies such as the Nursing and Midwifery Council, UK government and devolved health departments and other NGOs such as the NSPCC and Maternity Mental Health Alliance.

(B) Pre-pandemic provision of services and support

7. The whole population of antenatal women, newborn, children and young people all have access to health visiting and school nursing services. They are unique in that they are universal non-stigmatised health services for all. Before January 2020, CPHVA members, primarily health visitors and school nurses, provided a universal service to babies, children and young people, offering public health services including preventative and early intervention services. The settings for these services were either in the home, in clinics, or in a school, early years or similar setting. Services to families were tiered with increased support depending on the level of vulnerability; however, safeguarding was a core duty.

8. Children and young people accessed health visitor services in the following ways: antenatally, at the new birth visit and during developmental reviews (for example, five-week, or 8-to-12-month checks). These were usually carried out either in the home or in clinics.

9. Children and young people accessed the school nursing service through school-based health assessments (such as growth monitoring, mental health, sexual health and well-being assessments in schools) and immunisation programmes, all supporting children with complex health needs.

10. All CPHVA members (i.e. health visitors, school nurses, community nursery nurses, other public health practitioners) had a safeguarding duty to children under the statutory guidance 'Working Together to Safeguard Children' [OA/001 - INQ000541087] and its three country equivalent documents. This duty involved identifying and reporting on abuse and neglect, working with safeguarding leads and social services to identify concerns, contributing to child protection plans and case conferences and supporting looked-after children and those with child-in-need plans.

(C) The impact of the pandemic on services

11. The demand for community services and support described above increased as a result of the pandemic. This was because the public were in many cases confused, uninformed, and scared. Community practitioners with their training and knowledge of public health were well placed to address this. The CPHVA did raise concerns that any reductions in service would have a negative impact on the health and well-being of families, children and young people [OA/002 - INQ000648967]. The potential impacts were easy to see

because the system was already struggling in terms of shortages of health visitors and school nurses, and the fact that intervals between seeing and assessing children, families and young people had already been increasing. The Department for Education kept schools open for vulnerable children but, due to fear of infection, uptake was low and children went missing. Overall, there was a lack of strategy for this situation.

12. Due to lockdown and the lack of PPE there was reduced face-to-face contact, although, disappointingly, some employers were unsupportive of their staff and required unprotected contact. There was an increased demand for safeguarding and mental health support, as due to financial stress and the close confinement of families there were more concerns around child neglect and abuse. Due to the reduced face-to-face supportive assessments to women after birth, there was a rise in perinatal mental health issues that were not detected early. Some families refused health services due to the fear of infection, meaning developmental assessments were not carried out and it was not known whether those children were meeting their milestones.

13. Services were shifted to telephone contacts or online delivery – this was a positive development in that it enabled contact with families that were engaged, however there is a limit to what can be assessed online or via telephone contact, therefore this was not a suitable alternative but more a holding position. The fact that many clinics were closed as parents were not prepared to bring their children for weighing meant many children were then unseen for periods of time. Efforts were made to prioritise vulnerable children, those with complex needs and disabilities or on child protection plans, but many face-to-face contacts were only for safeguarding emergencies.

14. The redeployment of CPHVA members to Covid testing and vaccination centres or hospital-based working led to more crises in the delivery of services in the community as there was a lack of personnel to offer child health services.

15. This led to an even heavier reliance on virtual contacts and the rise of undetected vulnerabilities in children and young people. Priority was given to safeguarding issues but there was variation across all nations and individual organisations on how well this was done. Due to lockdown, there were concerns about increased parental stress and substance misuse, but with the constraints in place it was difficult to address.

16. In terms of the devolved nations, the Scottish Government had a stronger response. This may be due to the fact that there were less staff shortages and a better service was being

delivered before the pandemic. There also appeared to be more PPE available for community staff to allow for face-to-face contacts. In Wales, services offered were blended, remote and in-person, and the school nursing recovery plan restored face-to-face contacts faster than in England. In schools, there was nursing provision for mental health support. However, safeguarding was a concern. In Northern Ireland, staff experienced a high level of stress in providing services, as face-to-face seemed to be the preferred contact method, although there was some remote contact. PPE provision was sometimes an issue, especially at the start of the pandemic.

17. NHS England diverted health visitors and school nurses away from core roles in favour of the Covid-19 response. This was eventually changed and catch-up programmes for missed immunisations and checks were instigated, but it seemed many organisations supplying the health visitor and school nurse services struggled due to health visitor and school nurse shortages. In Wales, there was redeployment of staff however it was more considered. Staff who had recent clinical activity were encouraged to support Covid-19 centres and immunisation clinics. I believe that redeployment was not implemented fully across the board, it was on a voluntary or mutually agreed basis. The health visitor and school nurse service ran as a skeleton service, prioritising safeguarding, looked after children, new birth visits and high-risk families who were identified as vulnerable.

18. Whilst the redeployment of qualified staff and their students also took place in Scotland, qualified staff returned to practice after roughly four weeks following significant objections by the workforce.

19. In Northern Ireland, there was some variation in provision across organisations but generally health visitors continued to provide a service on a risk assessment basis, either working from home or in carefully managed (limited numbers and activity on a rota basis) office space. Safeguarding and looked after children services continued. School nurses also helped within immunisation teams and Covid centres. Safeguarding and looked after children continued to be supported as well as those identified as having additional needs/high risk/vulnerable.

20. Other healthcare organisations assisted members through guidance, which was appreciated although not enforceable. Some issued guidance singly or jointly to help members. As some local authorities and other commissioning bodies had commissioned fewer services from the health visiting and school nursing service, safeguarding of vulnerable families, children and young people was an issue but provision varied.

(D) Efforts made by the CPHVA

21. CPHVA engaged in consultation and met regularly with Public Health England to discuss attempts to address the impact of the pandemic. Meetings were regular and concerns raised were in particular around the lack of PPE in the community, redeployment of health visitors and school nurses away from the community where they were needed, guidance on how to deliver services for those who were not redeployed and the need to recognise the increased vulnerability around black and ethnic minority people, which the NHS generally was slow to pick up and act on. For example, I exhibit action notes from a 'Professional Organisation' meeting on 1 April 2020 [OA/002 - INQ000648967], where concerns around PPE were discussed. We also exchanged email correspondence on the lack of key worker status for public health workers [OA/003 - INQ000648969], and made comments on draft guidance [OA/004 - INQ000648970].

22. There was a potential for conflict with regards to the interests of our members. Many were concerned at the lack of PPE and increased exposure, as well as the increase in workload and those who were redeployed did not necessarily feel they were confident in their new work settings. We balanced this with the need to make services available to children and young people by lobbying for support for staff in the community with adequate PPE, mental health support and, when available, Covid-19 testing [OA/005 - INQ000648971].

(E) The impact of the pandemic on children and young people's health and wellbeing

23. The pandemic has had a profound impact on children and young people's health. The health offer that was made was not adequate – the Healthy Child Programme 0-5 set out that assessments should be made at specific, set stages: women more than 28 weeks pregnant, a child aged 1 day to 2 weeks, a child aged 6 to 8 weeks, a child aged 9 to 15 months and a child aged 24 to 30 months if there were no concerns. This was reduced to prioritising high concern, the vulnerable and safeguarding. The 5-19 programme was also scaled down, meaning many children were not seen. By reducing the service offer due to staff redeployment, all children were made vulnerable. The ability of our members to assess families, children and young people to the high level they were trained, to identify health issues and to confirm children keeping to their milestones was severely impacted.

24. School closures inevitably disadvantaged some children more than others in terms of their vulnerability, socio-economic factors and ethnicity. This situation was an opportunity to

make use of school nurses to visit at home, which they are trained to do, but it appears this was not considered.

25. Children were not adequately considered; it seemed as though there was a bias towards adults in hospital care. The voices speaking for children were not heard or listened to seriously. Warnings were effectively ignored, and health visiting and school nursing services were already underfunded and in crisis, leaving no capacity and minimal goodwill of staff.

(F) Conclusion, lessons learned and recommendations

26. The work carried out by CPHVA members and the community services and support described above, is vital to many. However, the pandemic increased the demand on an already struggling system to the extent that the provision to many families, children and young people were negatively impacted. This was particularly the case for the vulnerable. Such impacts were foreseeable and yet there was a lack of strategy and planning by government and the relevant bodies. We set out below the steps that need to be taken to ensure these impacts are avoided or mitigated in any future pandemic.

27. In summary, CPHVA calls for an increase in health visitor numbers with consistent funding to keep them in post. The number of health visitors and school nurses should be restored to the health visitor implementation target number of 2015 (10,309), supported and funded by all UK governments. This funding should be specifically ring-fenced.

28. There should be child health emergency situation impact assessments developed, which should include a recovery plan considering:
    a) risk assessments;
    b) safeguarding;
    c) workforce protection;
    d) maintenance of pre-identified services;
    e) early availability of mental health support for staff; and
    f) availability for mental health support for families, children and young people.

29. Remote methods should not be used for any vulnerable or safeguarding contacts – this cannot replace face-to-face contact.

30. In the future there should be a balance between infection control and children's developmental needs. This can be better planned if children and young people's impact assessments are in place.

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

Obi Amadi

Dated: 31 July 2025