

Witness Name: Douglas Simkiss

Statement No.: 1

Exhibits: DS

Dated: 6th August 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Douglas Eric Simkiss, Chair of the British Association for Community Child Health

I, Douglas Eric Simkiss, will say as follows: -

1. I am Chair of the British Association for Community Child Health (BACCH) and have been in that role since October 2021. I trained as a Consultant Community Paediatrician and I was also Chief Medical Officer and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust until I retired from that role in October 2023.
2. I write this statement in response to the letter from the Inquiry dated 15th April 2025. The letter asked me to comment on the impact of the Covid-19 pandemic on children and young people in England, Wales, Scotland and Northern Ireland across the specified period between 1 January 2020 and 28 June 2022.

The nature, role, remit and purpose of the British Association for Community Child Health (BACCH)

3. The British Association for Community Child Health (BACCH) is a charity whose purpose is to promote and protect the good health of children and their families in their communities. Its role is as the professional membership organisation for doctors and other professions working in paediatrics and child health in the

community. Most of its membership are paediatric doctors specialised in community child health and it operates across all four nations of the United Kingdom.

The structure of BACCH including its relationship to the Royal College of Paediatrics and Child Health.

4. BACCH has three trustees, an executive committee made up of the Chair, Convenor, Treasurer, Workforce Officer, Specialist and Associate Specialist representative, two national trainee representatives, Academic Convenor and representatives from its affiliated groups. The affiliated groups are the British Academy of Childhood Disability (BACD), the British Association for Child and Adolescent Public Health (BACAPH), the Child Protection Special Interest Group (CPSIG), the Association for Paediatric Palliative Medicine (APPM), the British Association of Paediatricians in Audiology (BAPA) and the Paediatric Mental Health Association. The BACCH office is run by an Executive Officer and an Assistant Administrator.
5. BACCH is one of the largest specialty groups of the Royal College of Paediatrics and Child Health (RCPCH) and is a member of the RCPCH Specialty Board. As chair of BACCH I met regularly with the RCPCH President on a one to one basis and I was part of a small group of experts from different paediatric disciplines convened in the specified period to offer advice and support to the President.

Services and support provided to children and young people by BACCH members prior to January 2020

6. (a) The detail of service configurations vary in different NHS Trusts in England and across the four nations of the United Kingdom, but at a high level, Community Paediatricians provide services and support to children with disabilities including children with cerebral palsy, children with neurodevelopmental conditions such as autistic spectrum disorders and Attention Deficient Hyperactivity Disorder, children with genetic conditions such as Downs Syndrome and children with learning disabilities. Many of these children are seen outside of hospital in special schools or Child Development Centres. In addition, most Community Paediatricians see and support children where there are safeguarding concerns. This includes children in

need, children referred for Child Protection Medical Assessments and the multi-agency processes that follow an assessment, children in care and children with a plan for adoption. Some Community Paediatricians are involved in palliative care, mental health or audiology provision. Community Paediatricians are also involved in child public health, with important links to Health Visiting and School Nursing and often have operational roles as Named Doctor for Safeguarding or Looked After Children or strategic roles as Designated Doctor for Safeguarding or Looked After Children or as Designated Medical Officer for Special Educational Needs and Disability.

7. (b) Children and young people accessed or were referred to these services and support by various routes. Some were referred by their General Practitioners, others were referred by other clinicians such as Health Visitors, School Nurses or Allied Health Professionals such as physiotherapists, speech and language therapists or occupational therapists and some services will have referrals from school teachers or families themselves. For safeguarding issues or for looked after children, referrals were usually from social workers. Children and young people access these services in different settings. These include Child Development Centres, Special School clinics, hospital clinics and family homes.
8. (c) BACCH members commonly have safeguarding roles in relation to children and young people. This includes seeing children where there is a safeguarding concern for a child protection medical assessment and writing a timely and comprehensive report on the findings, named doctors for safeguarding (who have an operational role in managing and developing the service in a NHS trust), to designated doctors for safeguarding (who have a strategic role in governing and assuring safeguarding practice in a local system such as an English Integrated Care System or Welsh / Scottish Health Board or Northern Irish Health and Social Care Trust).

Whether and how the pandemic impacted or changed the services and support

9. (a) Community paediatricians work in a complex multi-disciplinary team and with colleagues in education and social care. The pandemic affected the way health visitors worked and closed schools which dramatically impacted on referral patterns

from health visitors and school nurses and referrals from social workers and teachers. Redeployment of Allied Health Professionals (AHP's) such as physiotherapists, speech and language therapists and occupational therapists disrupted the multi-disciplinary team supporting children with disabilities and their families.

10. (b) Provision of services changed radically in the pandemic. Many clinics moved to telephone or web-based consultations which reduced the face-to-face contact between Community Paediatricians and their patients. These innovations had positive elements; reducing travel time and cost for families, providing some contact with professional support when face-to-face access was restricted. But there were negative elements too; families with no or limited access to digital technology were disadvantaged and in children where there were concerns about potential maltreatment, no examination could take place. Mitigations were quickly developed to reduce the impact of these disadvantages; face-to-face clinics were provided and children could be examined in these clinics, but this was not possible for all patients.
11. (c) Redeployment of BACCH members was more common within NHS Trusts rather than between Trusts. Community Child Health services are provided by a number of different types of organisation including acute hospital trusts, mental health trusts, community trusts and Community Interest Companies. BACCH members within an acute trust providing services for adults with COVID were more likely to be redeployed than the same staff in an organisation that did not provide acute services for adults. Community paediatricians work in multi-disciplinary teams and with colleagues in education, social care and the voluntary sector. Redeployment of other NHS staff had an impact on BACCH members. For example, some Health Visitors and Allied Health Professionals such as physiotherapists or speech and language therapists were redeployed reducing the provision of services and support to children and creating significant emotional toil for some redeployed staff.
12. (d) The pandemic did impact the safeguarding role of BACCH members. NHS England advice during the pandemic sought to protect the provision of safeguarding services to children, but the closure of schools and nurseries led to a reduction in referrals of children because of safeguarding concerns. Several BACCH members

reviewed the impact of the pandemic on child protection medical assessments. The paper by Garstang *et al* is called 'Effect of COVID-19 lockdown on child protection medical assessments: a retrospective observational study in Birmingham, UK' and is exhibit DS/01 [INQ000651577] in the Exhibit Schedule submitted with this statement. This paper showed there were 78 Child Protection Medical Examination (CPME) referrals in 2018, 75 in 2019 and 47 in 2020, this was a 39.7% (95% CI 12.4% to 59.0%) reduction in referrals from 2018 to 2020, and a 37.3% (95% CI 8.6% to 57.4%) reduction from 2019 to 2020. There were fewer CPME referrals initiated by school staff in 2020, 12 (26%) compared with 36 (47%) and 38 (52%) in 2018 and 2019, respectively. In all years 75.9% of children were known to social care prior to CPME, and 94% of CPME concluded that there were significant safeguarding concerns. A conclusion of the paper was that school closure due to COVID-19 may have harmed children as child abuse remained hidden. The paper recommended either mandatory attendance at schools or viable alternatives be found in future crises.

13. These impacts were foreseeable as schools and nurseries are a vital part of a child's life and provide real support to all children, but particularly children with disabilities and children in need. They also provide support to families and carers. Steps were taken by NHS England and Governments across the four nations to mitigate the impact of school closure, but the impact for all children is seen in the reduction in school readiness (the percentage of children ready for school at school entry) and speech and language skills in particular.
14. The President of RCPCH represented all paediatricians in discussions with NHS England, the Department of Health and Social Care and the Department of Education. BACCH was not consulted directly by these or the other organisations listed in question 5 of the Inquiry letter to me. However, as chair of BACCH, I was part of a small group of experts from across different paediatric specialties convened by the RCPCH President to regularly provide her with advice for her meetings with the organisations listed.

Community Child Health during and since the pandemic

15. (a, b, c) The BACCH submission to the UK Government Education Committee's inquiry on the impact of Covid-19 on children's services is reproduced in full below in italics. The bold font was used in the original submission so I have repeated it here:

BACCH response to the Education Committee's inquiry on The impact of COVID-19 on education and children's services (Submitted: 20/07/20)

*1. We would like to submit some comments to the Select Committee on the persistent challenges facing community paediatricians in providing health advice to meet SEND expectations. **Many of our members are Designated Medical Officers and nearly all provide medical advice related to SEND.** We were interested to see comments from other groups to the enquiry recognising how shortfalls in health provision to support for children with SEND can impact on their support. We completely agree with their concerns. While we focus our comments on our own specialty of community paediatrics, the same applies to other health services like health visitors, school nurses and therapists. We would argue that alongside the Select Committee's understandable focus on Education, there needs to be a focus on the health aspects of SEND if the current situation is to improve.*

2. Capacity shortfalls

2.1 The Covering All Bases report (1) highlights serious shortfalls in the capacity of community paediatricians to provide timely SEND advice. In response, the BACCH workforce strategy (2) puts forward ideas to improve capacity in community paediatrics. Waiting lists more than twice the standard of 18 weeks, and a failure to meet statutory timescales for statutory advice and reports, are still far too common. Unfortunately, Covid 19 is likely to worsen these difficulties, because of the requirements for social distancing and enhanced hygiene, and staff absence due to illness and self-isolation. Some assessments also are very difficult to provide using PPE.

2.2 As indicated by other informants, re-deployment to support acute services has been an issue during the current crisis: at its peak nearly half of all community paediatric trainees and 15% of trained staff (consultants and SAS doctors) were re-deployed away from their community posts into acute hospitals (3). We are pleased to see that the NHSE has responded to our concerns and modified its guidance so that re-deployment should now occur only 'if required' rather than 'where possible'.

2.3 It is inevitable that there will be a backlog of work which will present in the months ahead as schools reopen (as many of our referrals are initiated by schools and nurseries). If this is not anticipated and mitigated, it will cause even further delays in providing medical advice. **We would recommend that health services focus on the need to build capacity into the system now to deal with the backlog and to consider how community services can be protected from redeployment in order to meet this need. This is likely to need investment in capacity, training and skills.**

3. Child mental health and safeguarding

3.1 We are aware of the stresses Covid 19 has caused to children and young people (CYP), parents and families. During the pandemic restrictions, community paediatricians adapted their ways of working to include telephone and video consultations so that they could remain in touch with families who need their support during this time. We would like to point out that community paediatricians provide a lot of emotional and behavioural support for CYP with disabilities and neurodevelopmental difficulties, thus avoiding referrals to other stretched services like Child and Adolescent Mental Health Services (CAMHS). We see many calls for increased CAMHS capacity to deal with the mental ill-health Covid 19 may have caused. However, if CAMHS capacity were to increase, without a corresponding increase in community paediatric capacity, it is likely that cases who would usually get support from community paediatrics will simply be referred to CAMHS instead, thus using up any increased CAMHS capacity. We saw the reverse some years ago when CAMHS resources were reduced, flooding community paediatrics with new referrals previous sent to CAMHS. **We recommend that community**

paediatrics and CAMHS need to be looked at together to deliver real improvement.

3.2 We entirely agree with the comments already made in oral evidence about the risks to children who are not attending school. RCPCH figures show that many services saw a decrease in statutory work including safeguarding referrals during the pandemic period (3). This is a pattern we also see during school holidays. Unfortunately, a report has already been published from one institution showing a significant increase in serious child abuse (severe head injury) (4). This pattern would be entirely consistent with reduced recognition of less serious abuse (either because CYP are not being seen or because services are so stretched they are unable to respond) leading to more serious abuse presenting late. These issues, and the tendency to re-deploy community staff to acute settings, need to be reconsidered in any resurgence to avoid further harm.

4. Consequences of fragmentation of effort

4.1 One of the key challenges we face is the fragmentation of effort and, as highlighted in some of the oral evidence, that joint commissioning is not happening as envisaged. Indeed this is reflected in the focus of the committee's own enquiry. We assume detailed investigation of health aspects are beyond the committee's remit. **We recommend that future enquiries should consider working jointly with the Health Select Committee to provide a joined up approach.** This fragmentation occurs not only at government level but also within local government and the NHS. **We agree that better cooperation/joint commissioning will be needed to improve quality in SEND assessments and provision.**

4.2 It is also reflected in the performance management and inspection. Thus, timescales and targets in education and social care legislation is often not reflected in NHS performance measures, making it very difficult for low profile services such as ours to gain management attention. For example, although there is a 42 day expectation for medical advice to be submitted for EHCP, this standard appears nowhere in NHS quality assurance frameworks, nor does any measure of satisfaction with the quality of the advice provided. A recent analysis of inspections

*(C Ni Bhrolchain, submitted for publication) shows that inspection of community paediatric services is patchy and inconsistent, making it very difficult for services to benchmark themselves against their peers. It is therefore not surprising that health services are unable to meet their requirements. **We recommend that community paediatrics is specifically included in all the relevant health and joint inspection frameworks (Trust inspections, SEND inspections, Joint Targeted Area inspections and Children Looked After and Safeguarding inspections) to ensure quality.***

References

1. Royal College of Paediatrics and Child Health. *Covering All Bases. Community Child Health: a paediatric workforce guide. RCPCH 2017, (DS/16 [INQ000620898]).*
2. British Association for Community Child Health. *A workforce strategy for community paediatrics. BACCH 2019, (DS/17 [INQ000620899]).*
3. Royal College of Paediatrics and Child Health. *Impact of COVID 19 on child health services tool, (DS/02 [INQ000651578], DS/18 [INQ000620900], DS/19 [INQ000268033])*
4. Sidpra J, Abomeli D, Hameed B, et al. *Rise in the incidence of abusive head trauma during the COVID-19 pandemic. Archives of Disease in Childhood (DS/20 [INQ000652209])*

(d) BACCH had no response and is not aware whether the recommendations were actioned by the relevant bodies.

Covid 19 changes in community settings

16. A paper summarizing the results from the survey on Covid 19 changes in community settings is provided as document DS/02 [INQ000651578]. Figure 2 on page 6 of the report shows that a high proportion of community child health staff were redeployed within paediatrics. This affected 46% of community trainees, and up to 14% of community career grade doctors. Concerns were shared on page 12 of the report; most respondents did not have any serious concerns. Where concerns about their service were reported, the most common theme was worries

about safeguarding and hidden harm in children. One of the key impacts of the pandemic was an increase in waiting time for all NHS services. The pandemic is not the only reason for long waits for community child health services, but it certainly contributed. Community child health services were excluded from the NHS England elective recovery plan which meant that the resources supporting a reduction in waiting time in hospital based services were not available to community based services. BACCH, with RCPCH and the Royal College of Speech and Language Therapists and the Royal College of Occupational Therapy, has lobbied on this issue (DS/03 [INQ000651579], DS/04 [INQ000651580] and DS/05 [INQ000651581]). In 2024 NHS England set up a Clinical Advisory Group for transforming community children' services that I co-chair and there is input to the Scottish Government and Welsh Assembly from BACCH members in those countries. This group is making progress in addressing waiting for community children's services.

17. The summer 2022 meeting of the West Midlands BACCH regional group was on 1st July that year. I attended that meeting personally. Most of the agenda was not relevant to the Covid Inquiry. One presentation was called 'Covid timeline 2019-2022 what have we learned?'. This gave a timeline of events in the pandemic and was an opportunity for people to share the impact on them, their patients and their services. No notes were taken. The second relevant presentation was 'Mental health in the pandemic for children with neurodevelopmental difficulties, eating disorders, low mood and deliberate self harm'. This paper was presented by two Child and Adolescent Mental Health Practitioners.
18. The slides and notes from the presentation given by Professor Peter Sidebotham on "Child safeguarding during the pandemic: what have we learnt from serious incident notifications?" are provided in DS/06 [INQ000651582]. Professor Sidebotham has added a few notes to the slides, drawing on his memory but I hope these add some clarity. In addition, an article Professor Sidebotham wrote for BACCH News on the same subject is given in DS/07 [INQ000651588]. The quantitative data were not published, but the qualitative findings were reported in a briefing paper (DS/08 [INQ000651589]) and as a section of the 2021 annual report (DS/09 [INQ000103841]). Professor Sidebotham's aim was to prevent people

reading too much into an apparent increase in notifications, but at the same time to recognise the very real impact of the pandemic and lockdowns on vulnerable children as demonstrated in the qualitative work.

19. In terms of other submissions, surveys, reports or other work carried out by BACCH, or within its knowledge, relating to the impact of the pandemic on children' and young people's health and wellbeing, I was appointed by the National Institute for Health Research (NIHR) to chair the research steering committee for a project led by colleagues at Newcastle University called 'Resetting Services for Disabled Children'. The Principal Investigator tells me that outputs from the project have been sent to the Inquiry, but I am submitting them here too as they are relevant. The researchers interviewed disabled young people, their family members and professionals to develop recommendations on how to manage services to disabled children in any future pandemic. DS/10 [INQ000651591] gives parent carer and disabled young people's perspectives on the impacts of changes to service provision for children and young people in England during the COVID-19 pandemic and DS/11 [INQ000651592] gives professional perspectives on the facilitators and barriers for high quality provision of health, education and social care services to disabled children in England during the COVID-19 pandemic. DS/12 [INQ000651593] summarises a series of recommendations for action developed by parent carers, disabled young people, and health, education, and social care professionals together through a Delphi process. I endorse these recommendations.

Were children adequately considered when decisions about the response to the pandemic were made by central governments across the UK

20. At the start of the pandemic, with no information about the natural history of the SARS-CoV-2 virus in humans, it was prudent to assume that the most vulnerable; the elderly, the infirm and children would suffer most when infected. This assumption was true for the elderly and the infirm, but children were remarkably resilient when infected, so the direct impact of infection on them was very limited. However, it was also important to understand the impact of SARS-CoV-2 infected children as reservoirs of infection for the elderly and infirm. This led to the closure

of nurseries and schools except for children of key workers. The negative impact on children's development is clear with a sharp reduction in the percentage of children ready for school of 13 percentage points before and after the pandemic. For children with English as an additional language, this difference rose to 16 percentage points (cited on page 14 of DS/13 [INQ000649629]). It is my view that opening nurseries and school for all children should have had a higher priority in the response to the pandemic made by central governments across the UK. The community child health services that keep children healthy (such as Health Visiting and School Nursing) and support vulnerable children, such as those with disabilities and those with safeguarding concerns, could have been re-established earlier. This requires staff from across other agencies such as education, social care and the voluntary sector too. DS/13 [INQ000649629] sets out an evidence-based approach to supporting children in the preschool years in more detail and makes key policy recommendations; practitioners working with families, both new and experienced, need access to high quality training opportunities and we must work differently across silos to make the public sector work effectively for families, making early intervention effective to improve lives of children and young people.

Measures to mitigate any negative impact of the pandemic

21. The NHS elective recovery plan excluded children's community services. This contributed to the growing waiting lists and times and poor service recovery across community child health services (DS/03 [INQ000651579], DS/04 [INQ000651580], DS/05 [INQ000651581]). A targeted community service recovery campaign would have had a positive impact. The NHS England Long Term Workforce Plan, committed to a 92% increase in adult nursing but 0% increase in children's nursing, and had little focus on the children's community services or on paediatrics more generally. The Long Term Workforce Plan modelling did not take into account increased medical complexity, survivorship beyond infancy, and demand for children's health services.

22. The University College London Institute for Health Equity report into the impact of the Covid -19 pandemic was called 'Build Back Fairer' (DS/14 [INQ000651595]). It set out evidence that the pandemic was having an unequal impact across the social

gradient and key protected characteristics. In his first report published in 2010 called 'Fair Society, Healthy Lives' (DS/15 [INQ000620408]) Marmot made a series of policy recommendations to reduce the impact of the social determinants of health and the most important of these in 2010 remained the most important for the 'Build Back Fairer' report; '*Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. **For this reason, giving every child the best start in life is our highest priority recommendation.***' Implementing the policy recommendations from the Marmot reports remains a key intervention for children and young people.

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.

Personal Data

Signed:

Dated: 6th August 2025

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