Witness Name: Elizabeth Ketch
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UK COVID-19 INQUIRY

FOURTH WITNESS STATEMENT OF ELIZABETH KETCH

MODULE 8 CORPORATE STATEMENT D
IMPACT ON CHILDREN AND YOUNG PEOPLE'S HEALTH AND HEALTHCARE

I, Elizabeth Ketch of the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 9 December 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a corporate statement on behalf of the Department of Health and Social Care (the Department) providing information on the role it played with regard to the UK Government's response to the COVID-19 pandemic, as it pertained in relation to the impact of the pandemic on children and young people between 1 January 2020 and 28 June 2022.

2. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. As a corporate statement, involving many different areas of policy within the Department, information has been gathered from many sources. It has been reviewed by myself and by a corporate team who have examined a very large number of documents. This statement is to the best of my knowledge and belief, accurate and complete at the time of signing, in line with responding as far as possible with the Inquiry's deadlines. Notwithstanding, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality, the

additional material will of course be provided to the Inquiry, and a supplementary statement will be made if need be.

3. Currently Director for Early Years, Children and Families, I joined the Department in October 2020 to lead the Early Years Healthy Development Review and later set up the Start for Life Unit in April 2021. Prior to the pandemic, I held the role of Director for Civil Service Strategy in the Cabinet Office from May 2018. My civil service career has included roles in His Majesty's Treasury (HMT), the Office of the Deputy Prime Minister (now the Ministry for Housing, Communities and Local Government), the Prime Minister's Delivery Unit, the Home Office and the Foreign and Commonwealth Office (now the Foreign, Commonwealth and Development Office).

4. This statement is structured as follows:

   a. Section 1: A general picture of children's health before and after the pandemic.

   b. Section 2: Access to specific children's healthcare services during the pandemic.

   c. Section 3: A short section on Long COVID.

   d. Section 4. A brief section covering children and young people's use of social media and online resources.

   e. Section 5: A chronology of key decisions with which the Department was involved regarding children's access to healthcare. Decisions relating to children's services were operational and so I refer the Inquiry to NHS England (NHSE) for further details.

5. The Department will provide additional statements setting out an overview of the response to the pandemic in relation to children and young people, addressing the use of data, expert advice and lessons learned, together with a chronological narrative in relation to Module 8.

6. The pandemic brought about unprecedented challenges for children and young people. While the risks to these groups from COVID-19 were much smaller relative to adults, their lives were disrupted dramatically by COVID-19 and the measures used to contain it. The impact on their education, mental wellbeing and physical health was profound.

7. The Department repeats its thanks to all those in the healthcare sector, to every person working in the NHS, together with those in the private, charitable and voluntary sectors who assisted the NHS. The Department would also like to recognise and thank all those working across the education sector, including nurseries, schools, colleges and higher education

institutions. The Department recognises that the pandemic made significant demands of those working in healthcare and education (whether front line or support staff) and that this has had a significant impact upon their health, welfare and resilience.

8. Further information about the NHS and the Department's relationship with it can be found in Statement A of this module.

SECTION 1: CHILDREN'S HEALTH BEFORE AND AFTER THE PANDEMIC

9. In this section I set out the overall picture of children's health in England before and after the pandemic. For more detailed analytical data I refer the Inquiry to the Department's Statement B for this Module.

10. The following section sets out the picture of children's health, before and after the pandemic, under the following themes:

    a. general overview of children's health;

    b. mental health; and

    c. work undertaken to assess the impact of the pandemic, and present rates of children's ill health.

General Overview of Children's Health

11. On 11 September 2018 Public Health England (PHE) published the '*Health Profile for England: 2018*', the second annual report giving a broad picture of the health of people in England in 2018. Further information about PHE and the Department's relationship with it can be found in Statement A of this Module. The report includes a chapter on the '*The health of children in the early years'* **(EK4/1 - INQ000593431; EK4/2 - INQ000593430)**. The main messages of this chapter were:

> *"What happens during pregnancy and the first few years of life influences physical, cognitive and emotional development in childhood and may have an effect on health and wellbeing outcomes in later life. Overall, child health in England has continued to get better, with many indicators of health and development outcomes showing sustained improvements in recent years.*

The percentage of women who smoke throughout pregnancy has fallen over time to 10.8% in the financial year 2017 to 2018. Data from the new Maternity Services Dataset shows that 21% of women were classified as obese during the early stages of pregnancy in December 2017. Smoking and obesity during pregnancy increase the risk of poor outcomes such as stillbirth, low birthweight and infant death, and are important areas for public health action.

There were 3.9 infant deaths per 1,000 live births in England in the period 2014 to 2016. Among babies born at full term, 2.8% had a low birthweight in 2016. Both of these indicators have shown improvement in recent years.

Breastfeeding provides the best nutritional start in life for a baby. In England, 74.5% of all babies received breast milk for their first feed in the financial year 2016 to 2017, but by 6 to 8 weeks this fell to 44.4%.

Teenage pregnancy rates have fallen since the early 2000s, but this still carries a number of risks for both mother and child. The most recent data available showed that younger mothers (under the age of 25), were more likely to smoke during pregnancy and not to breastfeed.

By age 5 years, 22.6% of children were overweight and 23.3% had tooth decay in the academic year 2016 to 2017; both of which are preventable. In addition, 29.3% of children at this age were not ready for school, having not reached expected levels of development. However, although there have been sustained improvements in the percentage of children who had reached a good level of development at age 5 years, considerable inequalities between population groups remain.

In the academic year 2016 to 2017, 34.2% of 10 to 11 year olds in England were overweight or obese, a statistically significant increase over the last eight years, up from 32.6% in the academic year 2008 to 2009. Time series analysis suggests that this percentage is likely to continue to rise in the next few years.

Children who live in more deprived areas were more likely to be exposed to avoidable risks before birth, to get off to a less healthy start from birth and to experience poor outcomes by the time they start school, compared with children who live in less deprived areas. Health inequalities are seen across all indicators presented, including recently published evidence of a social gradient in early child development at age 2

to 2 and a half years, an emerging inequality which is especially noticeable in the development of communication skills."

12. On 11 September 2019, PHE published '*The Health Profile for England: 2019*', the third annual profile giving a broad picture of the health of people in England in 2019. This publication took a difference approach to reporting. Where available, data, tables and some charts were updated **(EK4/3 - INQ000593436)**. The main findings and notable changes since the previous year were then published alongside the data. For children this included the following section:

> *"Ensuring that every child has a good start in life is the foundation for our future health.*
>
> *Recent decades have seen overall improvements to many aspects of early-years health, including a decrease in teenage conceptions, smoking in pregnancy, the proportion of babies with low birthweights and infant deaths.*
>
> *However, over the last few years some of these improvements have started to slow down, with no improvement seen in infant mortality rates or the proportion of low birthweight babies. Tooth decay, the biggest cause of hospital admissions for children aged 6 to 10 years, also remains a serious problem despite being largely preventable.*
>
> *Some children don't enjoy the same start in life as others. In the most deprived areas of England, the latest data show teenage conceptions and child tooth decay rates were around three times higher and the infant mortality rate was more than double that in the country's least deprived areas."*

13. The findings in the 2019 health profile were supported by the following statistics **(EK4/4 - INQ000625176)**:

    a. In the academic year 2016/17, 23.3% of children aged five years had tooth decay;

    b. In the financial year 2018/19, the percentage of women who smoked throughout pregnancy was 10.6%; and

    c. A graph demonstrating that infant mortality rates since 2001/03 had been slowly declining, though there was a slight increase in 2015/17. This also showed that mortality rates were higher for those from deprived areas.

14. Other useful statistics included the following:

a. Life expectancy rates were continuing to increase, though beginning to level out, with life expectancy at birth at 79.6 years for males and 82.3 years for females; and

b. In the academic year 2017/18, 22.4% of children aged between 4 and 5 years were overweight or living with obesity, with that figure rising to 34.3% for 10 to 11-year-olds.

Obesity

15. The National Child Measurement Programme (NCMP), established in 2006, collects annual measurements of the height and weight of more than one million children in Reception (age 4 to 5 years) and Year 6 (age 10 to 11 years) in primary schools across England. Although the COVID-19 pandemic affected how much data was collected, around 300,000 children were measured annually during the pandemic; this is around 25% of a usual full measurement year and consequently is a sufficient sample to maintain a comparable time series for monitoring trends across the period.

16. On 27 April 2022, OHID published a report titled '*NCMP changes in the prevalence of child obesity between 2019 to 2020 and 2020 to 2021*' which examined the changes in the prevalence of obesity between academic years 2019/20 and 2020/21 using data from the NCMP. I have summarised the analysis from this report in relation to age, sex and ethnicity and sex below.

Age

17. Between 2006/07 and 2019/20, the prevalence of obesity among Reception children had been relatively stable, with small fluctuations year to year, ranging from 9.1% to 9.9%. In 2020/21, during the pandemic, obesity prevalence increased by 4.6 percentage points (pp) to 14.4%. Prevalence then decreased to 10.1% in 2021/22 and to 9.2% in 2022/23, before increasing to 9.6% in 2023/24. This increase was comparable to the projected trend based on pre-pandemic data.

18. Between 2009/10 and 2019/20 the prevalence of obesity in Year 6 children increased from 18.7% to 21.0%. In 2020/21, during the pandemic, prevalence increased by 4.5pp to 25.5% and has decreased annually since then. Prevalence in 2023/24 decreased by 0.6pp to 22.1%, from 22.7% in 2022/23. The 2023/24 prevalence is in line with the level expected if the pre-pandemic increasing trend had continued **(EK4/5 - INQ000593489).**

Sex

19. Obesity prevalence in boys was higher than girls for both age groups. Among Reception children, the gap between boys and girls has been reducing over time (1.6% in 2006/07 to 0.4% in 2019/20). During the pandemic, obesity prevalence increased to 14.8% for Reception boys and 14.1% for Reception girls (from 10.1% and 9.7% respectively in 2019/20) and in 2023/24 prevalence remained slightly higher in boys (9.9%) than girls (9.4%).

20. The difference between boys and girls in Year 6 is much larger than in Reception and has been increasing over time (3.4% in 2009/10 to 5.2% in 2019/20). Comparing the obesity prevalence figures pre-pandemic (2019/20) to during the pandemic (2020/21), the boys in Year 6 had a larger increase in obesity (5.6pp from 23.6% to 29.2%) compared with girls (3.3pp, from 18.4% to 21.7%). Prevalence in both boys and girls has decreased since 2020/21 and the most recent data in 2023/24 showed prevalence of 24.5% for boys and 19.6% for girls.

Ethnicity and Sex

21. The NCMP breaks down data by the following ethnic groups: Bangladeshi, Indian, Pakistani, Asian other, Black African, Black Caribbean, Black other, Mixed White/Asian, Mixed White/Black African, Mixed White/Black Caribbean, Mixed other, White British, White Irish, White other, Chinese, Any other.

22. Pre-pandemic obesity prevalence varied by ethnic group. During the pandemic, obesity prevalence increased for both boys and girls in reception from Bangladeshi, Indian, Pakistani, Black African, Black Caribbean and White British ethnic groups. Greater increases were seen in some groups of children. In Reception, Black African girls had the highest obesity prevalence and the largest increase in obesity prevalence (7.9pp, from 15.7% in 2019/20 to 23.6% in 2020/21). This was around twice the percentage point increase seen among White British girls (3.9pp, from 9.5% in 2019/20 to 13.4% in 2020/21). Bangladeshi (8.3pp, from 13.1% in 2019/20 to 21.4% in 2020/21) and Pakistani (8.2pp, from 10.6% in 2019/20 to 18.8% in 2020/21) Reception boys had the largest increase in obesity prevalence.

23. In Year 6 girls, the pandemic data (2020/21) showed prevalence of obesity increased for White British, Indian and Pakistani girls, with the largest increases in obesity prevalence seen among Pakistani (5.7pp increasing from 21.4% in 2019/20 to 27.1% in 2020/21) and Indian girls (5.1pp increasing from 16.4% in 2019/20 to 21.5% in 2020/21). For Year 6 boys,

Black African boys experienced the largest increase in prevalence of obesity (7.6pp, increasing from 31.2% to 38.8%).

Physical Activity

24. Data for the physical activity levels of children and young people are collected through the '*Active Lives Survey*'. Data collection did mostly continue during the pandemic, though methodology did adapt, particularly in the first part of 2020.

25. Overall, from 2018/19 to 2019/20 the proportion of 5 to16 year-olds reporting doing 60 minutes of physical activity every day decreased from 47% to 45%. Levels then remained at 45% in 2020/21. However, the impact across this period was not equal across population groups. The proportion of boys meeting 60 minutes every day fell from 51% in 2018/19 to 47% in 2019/20 and again to 45% in 2020/21, whilst girls was maintained at 43% in both 2018/19 and 2019/20 before increasing slightly to 45% in 2020/21. The changes across 2019-20 and 2020-21 coincide with the restrictions imposed during the pandemic.

26. Over the longer period, there remains growth in children's and young people's physical activity levels. In the academic year 2023/24, compared to 2017/18, the proportion who are active has increased by 4.5%, meaning there are 508,000 more active children and young people compared to six years ago, while the proportion who are less active has decreased by 3.3%, or 114,000 fewer less active children and young people. There are still an estimated 2.2 million children and young people who are doing less than 30 minutes every day.

Cancer

27. Childhood cancer refers to cancer cases in children aged 0 to 14 years at the time of diagnosis. According to NHS Cancer Registration Statistics, childhood cancer is thankfully rare, affecting around 1500 children in England annually and therefore accounting for less than 1% of all cancer diagnosis in England each year.

28. NHSE collects and publishes data on childhood cancer incidence, mortality and survival. A summary of the available data over the course of the specified periods is provided below:

Period	**Incidence** (excluding non-melanoma skin cancer)	**Mortality**	**One-year survival rate**	**Five-year survival rate**

Prior to January 2020	2017 – 1536 2018 – 1404 2019 – 1517	2017 – 212 2018 – 205 2019 – 206	2017 – 92.9% 2018 – 93% 2019 – 93.6%	Not available – latest published data is for 2016
January 2020 to 28 June 2022	2020 – 1432 2021 – 1489 2022 – 1451	2020 – 187 2021 – 185 2022 – 182	2020 - 93.3%	Not available – latest published data is for 2016
Since 28 June 2022	Not available – latest published data is for 2022	Not available – latest published data is for 2022	Not available – latest published data is for 2020	Not available – latest published data is for 2016

29. The available data does not indicate any significant impact of the pandemic on childhood cancer incidence or survival in England. There appears to be a small decrease in mortality during the peak of the pandemic. The cause of this decrease is unknown.

30. The Department has not undertaken any specific work to assess the extent to which there is a correlation between the impact of the pandemic and present rates of children's ill health in relation to childhood cancer incidence, mortality or survival in England.

Mental Health

31. As set out in Statement A of this Module, the Department's key source for pre-pandemic levels of prevalence of mental illness among children and young people is the '*Mental Health of Children and Young People in England survey'*. The survey reported that:

    a. One in eight (12.8%) 5- to 19-year-olds had at least one mental disorder when assessed in 2017.

    b. A slight increase over time in the prevalence of mental disorders in 5- to 15-year-olds (the age-group covered on all surveys in this series), rising from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017.

c. Follow-up surveys conducted during the pandemic covered different age ranges as the cohort involved in the study aged and used only one of the assessment approaches utilised in the full 2017 survey. For ease of reference and comparison with future years, this approach estimated the rate of having a probable mental disorder amongst 8- to 16-year-olds in 2017 as being 1 in 8 (12.5%).

32. The Department funded four follow-up surveys to the '*Mental Health of Children and Young People in England 2017*' report to help understand changes in prevalence of mental illness at a national level: Wave 1 for 2020, Wave 2 for 2021, Wave 3 for 2022 and Wave 4 for 2023.

33. Although caution is needed in interpreting findings given changes in survey design, the follow-up surveys indicate that in children aged 8 to 16 years, rates of a probable mental disorder rose from 12.5% in 2017, to 17.1% in 2020 to 19.0% in 2022. Data from the Wave 4 2023 follow-up to the 2017 national prevalence survey indicates that about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder.

    a. This was 20.3% of 8- to 16-year-olds, 23.3% of 17- to 19-year-olds and 21.7% of 20- to 25-year-olds; and

    b. Rates of probable disorder were similar for males and females at the 8- to 16-year-old range (20.8% in males, 19.8% in females), but significantly different in the 17- to 19-year-old range (15.4% in men, 31.6% in women).

34. As set out in Statement A of this Module, the Department also asked PHE to produce surveillance reports on emerging evidence of the pandemic's impacts on mental health and wellbeing. These reports were published from September 2020 and included a focus on children and young people **(EK4/6 - INQ000593470).** This resource was last updated on 12 April 2022 and presents a high-level summary of the best evidence available at the time on the experience of children and young people of the pandemic, from a mental health and wellbeing point of view. It is based on a range of evidence sources of differing methods and quality. As such, many of the findings presented need to be considered as indicative and not conclusive evidence of impacts.

Impact of the Pandemic on Mental Health

35. In addition to commissioning the '*Mental Health of Children and Young People*' prevalence surveys, the Department commissioned the Mental Health Policy Research Unit and the National Institute for Health and Care Research Policy Research Programme to commission

and disseminate findings from a programme of research into mental health impacts of the pandemic, leading to several academic papers.

36. One publication directly related to the prevalence of mental health conditions among children and young people is the peer-reviewed publication '*Mental health in Europe during the COVID-19 pandemic: a systematic review*' - The Lancet Psychiatry (published 23 June 2023). However, much of the other research, such as that looking at experiences of loneliness, staff and patient experiences and the longer-term impacts of the pandemic on people with mental health problems, may also inform understanding around the prevalence increase.

37. New in-year referrals to Children and Young People's Mental Health Services increased by 39%, from 839,570 in 2020/21 to 1,169,515 in 2021/22. Numbers for 2019/20 were similar to 2020/21 at 850,741. These increased to 1,255,836 in 2022/23 and 1,305,948 in 2023/24. Eating disorder services were seeing 59% more children and young people in 2020/21 (23,136) compared to 2019/20 (14,525). This increased to 30,364 in 2021/22, then fell to 25,941 in 2022/23, rising to 26,156 in 2023/24. This increase in referrals and access reflects a combination of a measurable and sustained increase in need, population growth and Government communications and investment to expand and transform children and young people's mental health services, as part of the NHS Long Term Plan. Note, due to the impacts of a cyber incident, 22-23 data should be treated with caution.

Suicide rates

38. A study by Odd et al. (2021), *'Child Suicide Rates during the COVID-19 Pandemic in England',* which used data from England's National Child Mortality Database, found 'weak evidence' in 2021 that childhood (aged 0 to 17 years) suicide deaths were higher in the first lockdown period (April to May 2020) than in the corresponding period in 2019. There is no evidence that this increase was sustained, and the overall rates in 2020 were similar to following years.

39. Using ONS occurrences data we can compare suicide rates by the year they occurred.

    a. In Males aged 10 to 24 years, the rate in 2020 was not statistically significantly different to previous years. In 2020, it was 8.2 occurrences per 100,000[1], 8.8 per 100,000 in

[1] CI [7.4, 9.0]

2019[2], and 8.6 per 100,000 in 2018[3], In 2021, the rate fell to 7.4 per 100,000[4] which was not a statistically significant difference.

b. In Females aged 10 to 24 years, the suicide rate in 2020 was not statistically significantly different compared to previous years. In 2020, the occurrences rate was 3.4 per 100,000 in 2020[5], 3.0 per 100,000 in 2019[6] and 3.3 per 100,000 in 2018[7]. In 2021, the rate was 3.2 per 100,000[8].

40. A table summarising occurrences of the age-specific suicide rate in males and females:

Year of death occurrence	**Male 10-24 Rate per 100,000**	**Male 10-24 LCL**	**Male 10-24 UCL**	**Female 10-24 Rate per 100,000**	**Female 10-24 LCL**	**Female 10-24 UCL**
2022	6.3	5.6	7.0	2.7	2.2	3.1
2021	7.4	6.7	8.2	3.2	2.7	3.7
2020	8.2	7.4	9.0	3.4	2.9	3.9
2019	8.8	8.0	9.6	3.0	2.5	3.5
2018	8.6	7.8	9.4	3.3	2.8	3.8

[2] CI [8.0, 9.6]

[3] CI [7.8, 9.4]

[4] CI [6.7, 8.2]

[5] CI [2.9, 3.9]

[6] CI [2.5, 3.5]

[7] CI [2.8, 3.8]

[8] CI [2.7, 3.7]

2017	7.9	7.1	8.6	3.3	2.8	3.8
2016	7.1	6.4	7.8	2.4	2.0	2.8
2015	7.5	6.7	8.2	2.7	2.2	3.1
2014	6.7	6.0	7.4	2.1	1.7	2.5

41. ONS data should be read alongside the following caveats:

    a. We have used occurrence data as it better reflects when suicides actually happened, as opposed to when they were registered. Analysis by the ONS on registration data (2025), '*Impact of registration delays on mortality statistics in England and Wales*', found that in recent years there has been an increase in registration delays, i.e. the time between a death occurring and being registered. This has meant that the percentage of suicides occurring within a given registration year has reduced. In 2023 only 39% of registered suicides had a date of death that was also in 2023 (for comparison, in 2002, 67% of suicides registered in 2002 also occurred in 2002). ONS use suicide registrations as the lead measure of suicide rate, so the statistics in this note will not align with that.

    b. Occurrence data can change in the years following publication due to significant delays in inquests and official registrations. Therefore, the data for 2022 in particular may change in future releases.

    c. In July 2018, the standard of proof used to determine whether a death was caused by suicide was lowered to the "civil standard", which is the balance of probabilities. Previously a "criminal standard" was applied, which is beyond all reasonable doubt. This may have impacted the reported suicide rate data. This change is for suicides *registered* after this data, meaning that suicides which occurred before this date may also be affected by this (i.e. a suicide which occurred in 2017 but was registered after July 2018 would be under the new standard of proof, but if that same suicide was registered before 2018, it would be under the old standard of proof).

Self-harm

40. A study by Trafford et al. (2023), '*Temporal trends in eating disorder and self-harm incidence rates among adolescents and young adults in the UK in the 2 years since onset of the COVID-19 pandemic*', used health records from the UK Clinical Practice Research Datalink to calculate the monthly incidence rates of self-harm. Based on trends in the ten years prior to the pandemic, actual cases of self-harm in girls were higher than expected between March 2020 and March 2022. Cases were lower than expected for boys over this same time period.

    a. For girls aged 10-24 years, from March 2020 to March 2022, the observed incidence of first self-harm episodes was 16,817, which was 18.6% higher than expected.

    b. For boys aged 10-24 years, from March 2020 to March 2022 the observed incidence of first self-harm episode was 5,678, which was 11.5% lower than expected.

41. However, these figures should be treated with caution. There were small samples for this study and so the level of certainty regarding the figures is not strong.[9] Furthermore, self-harm figures are usually based on hospital attendance. Therefore, incidences which don't result in hospital attendances can be missed and factors which affect attendance (i.e. Willingness to seek support, less attendance during COVID) can have an impact.

Dental health

42. The Department is responsible for coordinating the National Dental Epidemiology Programme which provides biennial surveys of 5-year-olds. These surveys show that tooth decay and poor oral health is a long-running problem for children in England. However, from 2008 to 2017 there was a clear trend of significant improvement in the prevalence of tooth decay in 5-year-old schoolchildren in England, from 30.9% in 2008 to 23.3% in 2017 **(EK4/7 - INQ000610447)**.

43. In 2021, 23.7% of 5-year-old children in England had tooth decay. This was similar to the prevalence in 2019 (23.4%). However, the number of children examined in 2021 was markedly lower than in 2019. There was a large decrease in tooth extraction episodes for children in the financial year ending 2021, likely due to services being affected by the COVID-19 pandemic.

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[9] The confidence interval for girls was 10.2–27.6 and for boys was 3.6–18.7.

44. Tooth decay remains a serious problem and the most common reason for hospital admissions in children aged between 5 and 9 years. There has been no continuation of the decrease in prevalence of tooth decay seen between 2008 and 2017. The proportion of 5-year-old children in England with experience of tooth decay was 22.4% in 2024. Prevalence was similar in girls (22.0%) and boys (23.4%). Children living in the most deprived areas of the country are more than twice as likely to have experience of dental decay (32.2%) as those living in the least deprived areas (13.6%). There are also disparities in the percentage of children with tooth decay by ethnic group, which was significantly higher in the Other ethnic group (45.4%) and the Asian or Asian British ethnic group (37.7%). Children from Asian or Asian British ethnic groups and Other ethnic groups have higher prevalence of tooth decay relative to the average regardless of deprivation level. There has been an increase in tooth extractions since 2021, likely due to the continued recovery of elective care services following the pandemic. In the financial year 2023-24, the rates of children and young people in the most deprived communities needing to have one or more teeth extracted due to decay was nearly 3.5 times that of those in the most affluent communities.

45. The prevalence of tooth decay in 5-year-olds has not significantly changed during or since the pandemic. It is not possible to predict how the prevalence of tooth decay would have differed in the absence of the pandemic and there is limited data on the oral health of older children. However, evidence published by Stennett et al. in the British Dental Journal, entitled '*The impact of the COVID-19 pandemic on oral health inequalities and access to oral healthcare in England* (published 28 January 2022), suggests a likely widening of oral health inequalities during the pandemic due to access to dental care, changes in health behaviours (diet, smoking, alcohol and oral hygiene) and disruption to oral health improvement programmes. Data is not available on the rates of tooth extraction episodes by sex or ethnic group.

The health of children with, or at risk of developing, alcohol and/or drug problems

46. Data from NHSE's *Smoking, drinking and drug use among young people in England* (2023) show a long-term decreasing trend in the proportion of school pupils reporting that they had ever taken drugs or had an alcoholic drink. It is not possible from available data to assess the impact the pandemic had on prevalence.

47. According to the National Drug Treatment Monitoring System data, there were 11,013 children in contact with alcohol and drug services between April 2020 and March 2021. This was a 23% reduction from the previous year (14,291). The COVID-19 pandemic was likely

to have contributed significantly to the reduced number of children starting treatment in 2020 to 2021, compared with the previous year. In particular, school closures and reduced face-to-face contact across all children and young people's services meant that there were fewer opportunities for children to be referred to substance misuse services **(EK4/8 - INQ000610483)**.

48. Treatment numbers have since returned to pre-pandemic levels. However, this has been the result of a concerted effort to reverse the steady decline in numbers over many years preceding the pandemic.

The health of children of parents/carers with alcohol and/or drug problems

49. The health of a child or young person can also be impacted by whether their parent or carer has alcohol and/or drug problems. Analysis of serious case reviews related to parental alcohol/drug use, taken from an National Society for the Prevention of Cruelty to Children (NSPCC) briefing entitled '*Parents with substance use problems: learning from case reviews'* (December 2023), demonstrates that children may die or be seriously injured from sudden infant death associated with co-sleeping, chronic neglect, accidents or harm due to a lack of supervision, or parents or carers deliberately giving their child drugs or alcohol. According to the Child Safeguarding Practice Review Panel's annual report 2023/24, of the 37 reported incidents of Sudden Unexpected Death in Infancy during 2023 to 2024, nearly two-thirds (65%) involved a parent who had alcohol and/or substance addiction or misuse recorded.

50. Assessments under Section 17 of the Children Act 1989 focus on determining if a child is in "in need", i.e. the child is unlikely to achieve or maintain a reasonable standard of health or development without LA services. It also considers if the child is disabled or if their health or development is likely to be significantly impaired without intervention.

51. Data show that pre-pandemic (2019/2020), 13.9% of such assessments were related to parental alcohol use and 13.6% parental drug use. During the pandemic (2020/2021) these increased to 14.9% and 14.5% respectively. Since then, there has been a decrease but levels remain higher than pre-pandemic, with the latest estimates (2023/24) being 14.3% and 14.0% respectively.

52. During the pandemic, there were increasing reports of parents or carers drinking or using drugs more to cope with isolation and stress and domestic abuse related to parental alcohol use. Among the key publications were NSPCC's '*Isolated and struggling: social isolation and the risk of child maltreatment'* (June 2020) and '*Still here for children: Sharing the*

experiences of NSPCC staff who supported children and families during the COVID-19 pandemic' (December 2020). Additionally, the Department funded an evaluation by the Tavistock Institute of Human Relations and IFF Research on the Children of Alcohol Dependent Parents Innovation Fund, conducted between October 2018 and March 2022. Its findings were published in a report by the Department on 1 June 2023. Lockdowns and social isolation disrupted many of the protective factors for vulnerable children, such as regular school attendance, exposing them to heightened risks. Studies and practitioners noted reduced visibility to safeguarding authorities, contributing to elevated concerns about child safety.

53. Additional data show an increase in concern among children in relation to their parents' drug or alcohol use during the pandemic. In a typical week, the NSPCC helpline receives around 200 reports related to parental alcohol and drug use concerns. Between April 2020 and January 2021, this had increased by 66. The NSPCC published figures on its website on 10 February 2025 indicating that numbers have since returned to near pre-pandemic levels, with an average of 31 calls per day.

Palliative and End of Life Care

54. The Department does not hold or collect data on the number of children accessing palliative or end of life care services, and therefore I cannot state whether this number changed significantly during the COVID-19 pandemic.

55. Figures published in the Journal for Palliative Medicine in 2021 reported there were 86,625 children and young people in England with life-limiting or life-threatening conditions.

56. Meanwhile, *Together for Short Lives*, a children's palliative care charity that provides support to children with life-limiting or life-threatening conditions, estimated in 2024 that 99,000 children were living with life-limiting or life-threatening conditions in the UK. The charity reports that this number has tripled in the past 20 years and is set to grow by a further 50% over the next decade.

57. The Office for National Statistics (ONS) keeps record of the number of child and infant deaths each year in England and Wales:

    a. In 2017, there was a total of 3,628 child and infant deaths (992 children aged 1 to 15 years and 2,636 infants aged under 1 year).

b. In 2018, there was a total of 3,461 child and infant deaths (973 children aged 1 to 15 years and 2,488 infants aged under 1 year).

c. In 2019, there was a total of 3,297 child and infant deaths (907 children aged 1 to 15 years and 2,390 infants aged under 1 year).

d. In 2020, there was a total of 3,015 child and infant deaths (789 children aged 1 to 15 years and 2,226 infants aged under 1 year).

e. In 2021, there was a total of 3,175 child and infant deaths (852 children aged 1 to 15 years and 2,323 infants aged under 1 year).

f. In 2022, there was a total of 3,368 child and infant deaths (1,019 children aged 1 to 15 years and 2,349 infants aged under 1 year).

58. As per the ONS data above, the number of child and infant deaths (from all causes) was on a downwards trajectory from 2017 until 2021 but has shown a slight increase since 2021.

Assessment of the impact of the pandemic on children's health

59. During the course of the pandemic, the Department either undertook or commissioned a number of reports on the impact of the pandemic on children's health. Summaries of these reports are set out below.

The Department and the ONS, 'Direct and Indirect Health Impacts of COVID-19 in England' (17 September 2021) ***(EK4/9 - INQ000220215)***

60. The Department and the Office of National Statistics (ONS) published a detailed analysis in September 2021 of the short and long-term health harms arising as a consequence of infections and mitigating behaviours between March 2020 and spring 2021, where data was available. It found that

> *"(y)oung people, particularly under 11 years, saw the largest fall in consultation rates and were most likely to have reduced GP appointments relative to older age groups. In addition, initially, from Feb 2020 to April 2020, there was a drop in mental illness referrals of around half in 0-18 year olds; compared to around a third in adults (19+), but these recovered and were above pre-pandemic levels after September 2020".*

61. The authors reported estimates of the amount of education lost to that point in the pandemic and found that:

"The immediate lost education may not be sufficient to result in considerable long-term physical health differences across all students. However, the resulting fall in attainment for groups at the margin of, for example, attending higher education, may result in increased rates of poorer health associated with lost education in the future (…)

(T)he loss of face-to-face teaching will have had significant wellbeing impacts on young people in education, as reflected in increasing rates of younger people accessing mental health services and increase in average General Health Questionnaire (GHQ) score for younger age groups. PHE find that between March and September 2020, some children and young people coped with life satisfaction only slightly reduced and happiness remaining relatively stable. However, young females with pre-existing health issues experience negative impacts to their mental health. Similarly, PHE data shows an increase in wellbeing/mental health difficulties in January 2021 but these had subsequently decreased by March.

Children with Special Educational Needs, girls, pupils from minority ethnic groups, pupils with pre-existing mental health needs and pupils from disadvantaged backgrounds were all more likely to report poorer mental health and wellbeing during the pandemic relative to their peers. Similarly, the OECD232 examine the influence of education on health for OECD countries 1995-2015. They find that adults with higher educational attainment have better health and lifespans compared to their less educated peers (…)

Therefore, there may be a future health impact of the lost education experienced by children and young adults during the COVID-19 pandemic which will not be realised for several decades. It may be seen particularly in groups that sit at the margin of attending higher education, with higher numbers not attending in the future if the impact on their attainment is persistent. As areas with higher rates of deprivation lost the most amount of face-to-face teaching time, the health impacts are likely to be more substantial in these areas, without considering previously existing health inequalities)."

Public Health England, 'The Impact of Covid-19 on London's Children and Young People' (June 2021)

62. PHE conducted a rapid evidence summary of the wider impacts of COVID-19 on children and young people, and used the Department's public health database, Fingertips, to

summarise the wider impacts on children and young people in London. The report, an informal publication not published by the Government, focused on child poverty, pregnancy, birth and early weeks, infant and child deaths, early years, education, safeguarding, children with special educational needs and disabilities (SEND), oral health, nutrition, physical activity, mental health, sexual health, access to health services and vaccination uptake. It reported that lockdown and social distancing measures had significant impacts, increasing the likelihood of mental health illness, obesity, parental conflict and anxiety and poverty, and increasing children's vulnerability and risk **(EK4/10 - INQ000078545):**

> *"Whilst most children and young people (CYP) with COVID-19 rarely have severe illness, the longer term impact on education, mental wellbeing, health service provision and poverty is profound and has exposed the fragile circumstances that many children live in. These indirect effects are expected to effect [sic] disadvantaged CYP disproportionally.*
>
> *Although children and young people (CYP) are generally less clinically vulnerable to COVID-19 than are adults, the wider effects of COVID-19 policies have disproportionately and negatively affected them. CYP are experiencing additional harm due to social isolation, lack of protective school placements, increased anxiety and a drop in service provision from the NHS, education and social services. This is particularly true for the most vulnerable children. The risks to children's health, wellbeing and futures are profound."*

The Department and the ONS, 'Direct and indirect health impacts of COVID-19 in England: emerging Omicron impacts', (4 August 2022)

63. On 4 August 2022, the Department and the ONS published '*Direct and indirect health impacts of COVID-19 in England: emerging Omicron impacts'*. This paper gives a high-level overview of the short-term and long-term health harms that have arisen as a consequence of COVID-19 infections and mitigating behaviours. It covers from the start of the pandemic in March 2020 to June 2022, where data permits, and uses the latest available data otherwise. Section C covers: Indirect impacts of COVID-19 on population health due to living through a pandemic and restrictions.

Office for Health Improvement and Disparities, `The Impact of COVID-19 on Children and Young People in the East Midlands' (October 2022)

64. The Office for Health Improvement and Disparities produced a similar report to its predecessor PHE on the impact of the pandemic on children and young people in the East Midlands. Although informal and not published by the Government, its findings included:

    a. *"Prior to the onset of the COVID-19 pandemic in the UK, CYP with vulnerabilities were experiencing poorer health outcomes than those without. The wider impact of the pandemic is likely to have exacerbated these vulnerabilities and increased the number of children experiencing vulnerabilities, either temporarily or in the longer term.*

    b. *The COVID-19 pandemic may have increased infant and child mortality indirectly as a consequence of strained health systems, household income loss and disruptions to care seeking and preventative interventions like vaccination.*

    c. *Reduced capacity in health visiting services and limited face-to-face contacts (following COVID-19 restrictions) coupled with limited access to early years settings may have resulted in emerging needs and vulnerabilities of families and children being missed during the pandemic.*

    d. *Children with Special Educational Needs and Disabilities (SEND) may have been disproportionately impacted by the pandemic. The impacts for some CYP at some points in the pandemic may have included: reduced access to services and disruption of healthcare such as cancellation of routine rehabilitation appointments and delays for new equipment such as leg gaiters to enable physical therapy at home.*

    e. *The COVID-19 pandemic left more people than before struggling to afford or access nutritious food. This is associated with negative health and educational outcomes that include: nutrient deficiencies, increased risk of obesity, increased risk of tooth decay, poor mental health and poor academic performance.*

    f. *Some CYP have experienced greater negative impacts on their mental health and wellbeing. These groups include: girls; young carers; CYP from poorer households; CYP with pre-existing mental health needs; CYP with SEND and neurodevelopmental conditions; and CYP from black and minority ethnic groups.*

g. *The disruption to health services and reduced capacity to treat CYP for conditions other than COVID-19 is likely to have affected the health of young people both directly and as the children of those parents or carers who are affected.*"

Technical Report on the COVID-19 Pandemic in the UK (1 December 2022)

65. The *Technical Report on the COVID-19 Pandemic in the UK* was authored by the Chief Medical Officers and Deputy Chief Medical Officers of the four nations of the UK and included a chapter on education settings. The report highlighted that:

> *"There were important differences in the pandemic experience for different types of schools. For example, special educational needs and disabilities (SEND) schools generally have higher numbers of children with clinical vulnerabilities, and experienced greater challenges implementing [Non-Pharmaceutical Interventions] such as face coverings or regular testing due to the additional needs of the children and young people."*

66. The report described the health and wellbeing impacts of limiting attendance in educational settings to priority groups as "substantial". They include:

    a. Missed learning;

    b. A reduction in non-COVID-19-related healthcare utilisation; and

    c. Exacerbation of existing inequality for both children and parents.

67. The report highlighted the mental health impacts of pandemic restrictions, including an 81% increase in the number of referrals to Child and Adolescent Mental Health Services and a 4-fold increase in demand for eating disorder treatment in the period April to September 2021 compared to the same period in 2019.

> *"There is also evidence that pandemic restrictions impacted the behaviours of children and young people with evidence of poor and disrupted sleep, increases in screen time and reductions in physical activity. Additionally, the National Child Measurement Programme interim data collection in 2021 identified a substantial increase from 2020 in the prevalence of obesity in primary-aged pupils in England.*
>
> *Survey data found a greater proportion of higher education students reporting dissatisfaction with their academic experience and limited opportunities for social or recreational activity. For many children and young people, attendance at education*

and childcare is not only vital for learning but also for access to food and nutrition, physical activity opportunity, and health and therapy services.

Restrictions on school attendance also gave rise to additional childcare and home-schooling responsibilities for parents and carers, leaving less time for work and leisure activities and impacting parental mental health. The long-term effects for children and families are not yet known."

68. For information regarding the impact on health, general wellbeing or development between male and female children and young people, I refer the Inquiry to NHSE for data on any differences in numbers of referrals to health services. For information on mental health please see paragraphs 31 to 41 and 127 to 134 below.

SECTION 2: ACCESS TO SPECIFIC CHILDREN'S HEALTHCARE SERVICES DURING THE PANDEMIC

69. Throughout the pandemic, and particularly at the outset, decision-making was concentrated to the centre of government. Policy decisions were required to be implemented quickly. Highly impactful decisions had to be considered, taken and - on occasion - reconsidered at an unusually rapid pace based on scientific understanding and the data available at that particular point in time. As healthcare services across England were shut down to the general population, this also had an impact on children and young people's ability to access those services. As a result, it was not possible in most cases to specifically consider the impact of any one action on children. In many instances, specifically when considering measures to prevent the spread of the virus, the impact on children's health was not a deciding factor in decision-making. This was because the risks to children of the virus were generally much smaller relative to adults.

70. The need to reduce transmission as far as possible had to be balanced with that of enabling continuous access to public services, including enabling children and young people to continue to access education and other services they required.

71. NHSE is, and was during the relevant period, responsible for the operational delivery of NHS healthcare, whilst the Department holds NHSE to account. This statement covers activity undertaken or commissioned by the Department. Questions or requests for information

regarding the operational delivery of healthcare services or restrictions on services should be put to NHSE.

72. NHSE operationally merged with NHS Improvement (NHSI) in 2018. Throughout the relevant period, the two bodies functioned as one integrated organisation, albeit they retained their five individual legal and financial responsibilities. They were referred to jointly as NHSEI, though for the purposes of this statement I sometimes refer to them by their separate titles. Further details on the relationship between the Department and NHSE/I, together with that of other Arms-Length-Bodies (ALB), can be found in Statement A of this Module.

73. The following section sets out the impact of the pandemic on the access to the following children and young people's healthcare services:

    a. dental health services;

    b. outpatient and midwifery services;

    c. health visiting services;

    d. school nursing services;

    e. mental health services;

    f. learning disability support and neurodevelopmental services;

    g. drug and alcohol services; and

    h. palliative and end of life care.

74. The following services did not employ a child-specific response to the COVID-19 pandemic and as such their response would have been targeted at the general population, including children and young people. I refer the Inquiry to NHSE for more detailed information due to their responsibility for the provision of services:

    a. inpatient and critical care;

    b. urgent primary and elective care;

    c. general practice services;

    d. pharmacy services;

e. eyecare;

f. community health services (including speech and language services, occupational therapy and physiotherapy); and

g. cancer treatment services.

Dental Health Services

75. Primary care dental treatment for children and young people is primarily provided through NHS dental contracts held between local Integrated Care Board (ICB) commissioners and a 'provider', typically a lead dentist at a dental practice. As such, the impact of the closure of practices in the initial phases of the pandemic, followed by a gradual reopening, follows the same timelines for children.

76. NHS dental practices, including those providing orthodontic services, began a phased reopening from 8 June 2020, after being closed from 25 March 2020. Practices were asked to deliver a reduced volume of NHS dentistry in return for their full contract value, to reflect the additional time needed for increased Infection, Prevention and Control (IPC) procedures. NHS practices providing general dentistry were asked to return to providing their full volume of services from July 2022, with orthodontic practices from April 2022.

The impact of the pandemic on dental health services

77. Dental services, including orthodontics, were particularly affected during the pandemic due to the infection risk associated with aerosol generating procedures that are commonplace in dental care.

78. Orthodontic treatment usually starts after most of a child's adult teeth have started to come through. This is usually when they are about 12 years old.

79. The reduction to urgent care during the first national lockdown period and subsequent phased reopening created a backlog of routine care. According to NHS dental statistics, in the 12 months to June 2021, courses of dental treatment had dropped 68% when compared with the previous year, with the number of children seen dropping from 6.3m to 3.9m in the same period.

80. These figures have started to recover since, with more children seen in the year up to June 2024 (6.7m) than in the same period in 2020. Similarly, activity delivered as part of orthodontic contracts has shown significant recovery, with activity in 2022/23 and 2023/24

being 7.9% and 8.6% higher respectively than in 2019/20. The Department does not hold dentistry data specifically on children and young people and I direct the Inquiry to NHSE who may hold this data.

Outpatient and community midwifery services

81. On 16 March 2020, the Chief Medical Officer placed pregnant women in the vulnerable group category **(EK4/11 - INQ000610457).** The vulnerable group category included people at the highest risk of severe morbidity and mortality from COVID-19: people who were aged 70 or older (regardless of medical conditions), under 70 with underlying chronic long-term health conditions, a weakened immune system or on medicines such as steroid tablets or chemotherapy, overweight (a BMI of 40 or above) and pregnant women. The Department, NHSE, and Royal Colleges collaborated to create guidance for healthcare professionals, pregnant women and their families on COVID-19 infection and pregnancy in March 2020 **(EK4/12 - INQ000610454).**

82. Services delivered in the community, including maternity services, were advised to use digital and remote technologies to provide support, prioritising higher needs families. Maternity services were encouraged to act as the key contacts between the health system and families.

83. NHSE and NHSI and partners including the four healthcare professional regulators and the Nursing and Midwifery Council published a range of guidance and public communication messages for pregnant women to help maternity services meet the challenge of the pandemic.

84. Pregnant women were previously asked about their smoking status at antenatal appointments and were offered support if needed. However, on 23 March 2020 **(EK4/13 - INQ000610453),** it was recommended to temporarily pause carbon monoxide testing of pregnant women during this period as a precautionary measure because of concern about the risk of disease transmission at this time.

Maternity Staff

85. Staff shortages within maternity services were identified, as a result of redeployment, staff illness, shielding or self-isolating **(EK4/11- INQ000610457).** To boost capacity in March 2020, four healthcare regulators, including the Nursing and Midwifery Council, established emergency registers of former midwives to increase capacity and emergency education

standards were also introduced to allow undergraduate midwifery students to complete supervised clinical placements in their final six months **(EK4/14 - INQ000610594).**

Visitor restrictions

86. From late March, strict visitor restrictions were implemented in maternity units, preventing birth partners and supportive people (life partners, family, friends, or doulas nominated by the mother to accompany her to antenatal and hospital appointments throughout pregnancy, labour and birth) from attending routine antenatal appointments or staying with women on antenatal or postnatal wards. This sparked an online petition to allow birth partners to be present at all stages of labour. NHSE lifted the suspension of hospital visiting on 5 June 2020, with visiting subject to local discretion. On 8 September 2020, NHSE and NHSI Improvement published a Framework to assist all NHS trusts in reintroducing access for one asymptomatic partner, visitor and other supporters of pregnant women to accompany at appointments and scans. By 13 October 2020, up to four visitors could be permitted to accompany women (**EK4/15 - INQ000610467)**. Guidance published in December 2020, and then updated in April 2022, provided detailed actions for NHS providers to facilitate support for pregnant women at antenatal appointments and during labour, and for parents of babies on neonatal units to have access to their babies.

87. The Government made twice-weekly rapid (lateral flow) testing available to everybody from 9 April 2021 and tests could be ordered online **(EK4/16 - INQ000625200).** Women and their support people were advised to order tests through this method and perform them at home on the day of their appointment, reporting results online immediately. Guidance published by NHSE on 15 April 2021 stated that NHS trusts needed to implement alternative arrangements for women who faced challenges with home testing, particularly for those who might need to attend a maternity unit at short notice.

88. With regards to increasing the number of visitors/birth partners, as outlined in the government's 'COVID-19 Response: Summer 2021' guidance, health and care settings were asked to continue to maintain appropriate IPC processes as necessary and this was reviewed continuously.

89. In January 2022, NHSE and NHSI reissued guidance on supporting pregnant women using maternity services. This set the expectation for all trust boards to continue to enable partners to accompany women to all appointments, and throughout birth, while continuing to ensure the safety of services. All providers in England reported that they were following this guidance. Where any issues with compliance arose, NHSE and NHSI's regional teams,

including the regional chief midwife, worked with individual trusts and appropriate support towards compliance was provided.

90. NHSE updated their guidance on 16 June 2022 and asked all trusts to continue to enable women to have a support person of their choice at every point throughout their maternity journey and to facilitate unrestricted access for parents of babies on neonatal units. Providers were no longer expected to ask for evidence of a negative COVID-19 test before allowing access to maternity or neonatal units. However, if a support person or parent of a baby on the neonatal unit tested positive for COVID-19, then they could not attend. People attending clinical settings (support people and parents of babies on neonatal units) were asked to wear a face covering or mask, following a local risk assessment. Women continued to be tested for COVID-19 following admission to a maternity setting. Women who had symptoms of COVID-19 or who tested positive, continued to be able to have a support partner present for their maternity attendances.

Neonatal units and newborn care

91. From March 2020, neonatal units implemented varying visiting policies and restrictions, limiting visits to one parent at a time, allowing both parents at different times or durations, and restricting visits to 5-15 minutes per day **(EK4/17 - INQ000610479).** Some trusts offered parents video access to their baby during self-isolation. Updated guidance published in April 2021 emphasised the importance of parental involvement in neonatal critical care, stating that parents are partners in care and should not be considered to be visitors.

92. By April 2020, NHSE advised trusts to put plans in place for when a parent of a baby on the neonatal unit had symptoms of or tested positive for COVID-19. Trusts were asked to offer parents video access to their baby if they were unable to attend the unit for this reason. However, if the visit was considered essential for compassionate (for example, end of life) or other exceptional reasons, a risk assessment was undertaken, and mitigations put in place to support parental presence wherever possible.

Black, Asian and Minority Ethnic women in maternity care settings

93. On 27 June 2020, NHSE's Chief Midwifery Officer issued four specific actions for maternity units to minimise disproportionately higher COVID-19 risks for black, Asian and minority ethnic pregnant women and their babies. These included having a lower threshold for reviewing, admitting and escalating care, and recording ethnicity and other risk factors (e.g.,

postcode, comorbidities, BMI, age over 35) in maternity information systems to identify those most at risk.

94. On 6 September 2021, NHSE published '*Equity and Equality guidance for Local Maternity Systems*', which focused on actions to reduce disparities for women and babies from Black, Asian and mixed ethnic groups, and those living in the most deprived areas, alongside £6.8 million investment to support implementation of local action plans.

Health Visiting Services

95. The NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out the statutory responsibility of local authorities' (LAs) statutory responsibility for commissioning universal public health services for children and young people up to 19 years old. Public health services include health visiting and school nursing.

96. On 19 March 2020, guidance was sent to all providers of community services from NHSE on prioritisation of services to release clinical staff capacity to support the COVID-19 response. Health visiting was partially stopped with the exception of guidance to maintain home visits for those identified as being vulnerable or having clinical needs. Safeguarding work also continued including via Multi-Agency Safeguarding Hubs, (MASH), statutory child protection meetings and home visits. In addition, health visitors continued with all new birth visits, follow up of high-risk mothers, babies and families, antenatal visits and support (though they were to consider using virtual methods for antenatal services if appropriate). They would also continue phone and text advice, digital signposting to other services and blood spot screening for childhood conditions. Antenatal, new birth and support for high-risk mothers' babies and families therefore continued.

97. In relation to health visiting services, under section 253(1A)(d)(iii) of the National Health Services Act 2006 (Emergency Powers), as in force during the relevant period, the Secretary of State has the power to direct anybody or person, other than an NHS body, providing services in pursuance of arrangements made by a local authority (LA) for the purpose of the exercise of its functions under or by virtue of section 2B or 6C(1) or Schedule 1 of the National Health Services Act 2006. Certain elements of health visiting services, such as supporting the health and development of children, are likely to fall under this remit. As such, the Secretary of State has a power under section 253(1A)(d)(iii) to issue directions for the suspension of these services and to redeploy resources to other areas of the healthcare system.

98. In addition, under section 253(1A)(d)(iv) of the National Health Services Act 2006, as in force during the relevant period, the Secretary of State has the power to direct clinical commissioning groups and local authorities providing public health functions under section 7A of the National Health Services Act 2006. Where health visiting services are provided as part of public health functions, the Secretary of State has a power under section 253(1A)(d)(iv) to issue directions for these services to be suspended.

99. The guidance of 19 March 2020 was updated on 2 April 2020, and the advice was changed to stop visiting except:

    a. Antenatal contact (virtual);

    b. New baby visits (or when indicated virtual contact); and

    c. Other contacts were assessed and stratified to allow those with vulnerable or clinical need (such as maternal mental health) to continue. These included interventions for identified vulnerable families, MASH safeguarding support, statutory child protection meetings and home visits. Health visitors also continued phone and text advice, and digital signposting to other services. It recommended considering increasing the use of digital services over face-to-face.

100. On 3 June 2020, as part of phase 2 of the NHSE response a letter was sent from NHSE, superseding the previous guidance, and providing a framework for the restoration of services. The framework included guidance on the prioritisation of services being fully restored, with these changes being dependent on capacity.

101. On 7 October 2020, a letter was sent from NHSE and PHE to directors of nursing at LAs advising that "*professionals supporting children and families should not be redeployed to other services*" **(EK4/18 - INQ000610466)**.

Workforce

102. Since 2015, the Public Health Grant (PHG), which funds Health Visiting Services, has been reduced in real terms by 24%, with most of the cut coming pre-pandemic in the 2015 to 2020 Comprehensive Spending Review period. PHG allocations fell 21.3% in real terms between 2015/16 and 2019/20. It fell 2.4% in real terms between 2019/20 and 2025/26 **(EK4/19 - INQ000610441; EK4/20 - INQ000610444; EK4/21 - INQ000610489; EK4/22 - INQ000610456; EK4/23 - INQ000610490; EK4/24 - INQ000610475; EK4/25 -**

INQ000610485; EK4/26 - INQ000421446; EK4/27 - INQ000468613; EK4/28 - INQ000610513).

103. According to NHS workforce statistics, NHSE-employed health visitors fell from 10,257 Full-Time Equivalent (FTE) in March 2015 to 6,901 FTE in December 2019 immediately prior to the pandemic, though some capacity will have been replaced with registered nurses and support staff. In June 2022 there were 5,929 FTE NHSE-employed health visitors. These workforce figures do not include those health visitors working in social enterprises, private provider organisations or LA in-house service providers used by 13% of LAs, as the Department does not hold this data. In January 2025, the latest statistics available at the time of drafting, there were 5,609 FTE.

Coverage of health and development reviews

104. All families with children in England aged 0 to 5 are under the care of the health visiting service in their local area. Part of the Healthy Child Programme is completion of five health and development reviews mandated for all eligible children antenatally, at birth, and at ages 6 to 8 weeks, 12 months and 2 to 2 ½ years. LA metrics on proportions of babies receiving these reviews in the years leading up to the pandemic are presented in the table below **(EK4/29 - INQ000593488).**

Period	**Proportion of infants receiving new birth visits**	**Proportion of infants receiving 6-8 week review**	**Proportion of children receiving a 12-month review**	**Proportion of children receiving 2 to 2 ½ year review**
2017 /18 **(EK4/30 - INQ000610448)**	97.8%	84.3%	82.6%	75.7%
2018 /19 **(EK4/31 - INQ000610450)**	98.2%	85.4%	82.3%	77.6%
2019 /20 **(EK4/32 - INQ000610468)**	97.5%	85.1%	83.6%	78.6%
2020/21 **(EK4/33 - INQ000610482)**	97.6%	80.2%	76.1%	71.5%

2021/22 **(EK4/34 - INQ000347051)**	97.4%	81.5%	81.9%	74.0%
2022/23 **(EK4/35 - INQ000610500)**	97.7%	79.6%	82.6%	73.6%
2023/24 **(EK4/29 - INQ000593488)**	97.8%	81.8%	86.5%	78.4%

105. LA metrics on proportions of babies receiving these health and development reviews indicate all the reviews have improved from the 2020/21 levels either near or back to pre-pandemic levels with the possible exception of the 6-8 week visit **(EK4/37 - INQ000593492),** demonstrating consistent performance despite a reduction in NHSE-employed health visitors. However, it is not possible to comment on the quality of the reviews or the amount of additional support that could be provided when needs were identified as the Department does not hold this data. Since health visitors work in teams with lower banded staff, it is likely that there has been an increase in these other roles and therefore total staff numbers working with families may not have changed as much, but the Department does not have data for the pre-pandemic period to make direct comparisons.

106. 2023/24 data indicates there is variation in the level of uptake by deprivation **(EK4/29 - INQ000593488).** In the most deprived areas of England (two most deprived deciles of upper tier LAs) the coverage of health visitor reviews is consistently above the England average. This holds for the four health visitor reviews delivered during infancy and childhood and for completion of the Ages and Stages Questionnaire third edition (ASQ-3), which is the final review on a child's development when a child is 2 to 2 ½ years of age. This indicates that some LAs may be targeting services in more deprived areas, which is in line with guidance and expectations on need for additional support within families.

107. There is no current data available for pre- and post-Covid comparison of receipt of health visits by specific characteristics.

Remote service and delivery

108. A 2024 study funded by the National Institute for Health and Social Care Research (NIHR), *'Realistic Review: Health visiting in light of the COVID-19 Pandemic Experience (RReHOPE)'*, found that during the pandemic, health visitors were primarily concerned with maintaining face-to-face contact with families by any means possible due to worries about missing health and development concerns early on. They made use of remote and digital methods of communication to keep in contact with families, but some felt these were not a direct substitute. For families requiring additional support, health visitors continued to conduct home visits, navigating the constraints of the pandemic response.

109. The study found that remote contacts could "*sometimes enable useful information to be gathered, and that this information can support an assessment of needs. However, face-to-face contacts play a crucial role since they can gather information through physical observations and interactions which might otherwise be missed.' The study's data highlighted practitioners' concerns about `not being able to assess a family properly remotely*."

Child Development

110. When a child is 2 to 2 ½ years of age, they receive a final review from health visitors on their development. The review includes the application of the ASQ-3 to assess developmental progress **(EK4/38 - INQ000610445)**.

111. The ASQ-3 assessment covers 5 domains of development, including:

    a. Communication;

    b. Gross motor skills;

    c. Fine motor skills;

    d. Problem solving; and

    e. Personal social skills.

112. Children are considered to have 'reached a good level of development' if they reach the expected level in all five domains.

113. The table below outlines the proportion of children aged 2 to 2 ½ years receiving ASQ-3 and those who were assessed as achieving a good level of development **(EK4/39 - INQ000593494; EK4/40 - INQ000593497).**

Period	**Proportion of children aged 2 to 2 ½ years receiving ASQ-3 as part of the Health Child Programme or integrated review**	**Percentage of children achieving a good level of development at 2 to 2 ½ years**
2017/18	90.2%	83.3%
2018/19	90.3%	84.1%
2019/20	92.6%	83.3%
2020/21	85.2%	82.9%
2021/22	90.3%	81.1%
2022/23	92.5%	79.2%

114. Numbers of children aged 2 to 2 ½ years receiving the ASQ-3 dropped during the pandemic, but post-pandemic have since returned to 2019/20 levels. However, the percentage of children assessed as achieving a good level of development through the ASQ-3 has been at a lower level from 2020/21 onwards compared to the years prior.

115. There were statistically significant decreases in outcomes for children across all domains of development at 2 to 2 ½ years, especially for children born during the first stages of the pandemic, including the first lockdown. The percentage of children in the 2022/23 cohort achieving the expected levels is lower than the pre-pandemic cohorts, especially for communication skills.

School Nursing Services

116. On 17 March 2020, the Department's Permanent Secretary Sir Christopher Wormald led a meeting with officials from across government on school closures, the clinical position for vulnerable children and staff in school, and the drawing up of guidance for vulnerable children and parents **(EK4/41 - INQ000610451).** On 18 March 2020, the Secretary of State for the Department for Education (DfE) announced that schools, colleges and early years settings in England would close after 20 March, except to children in priority groups (as detailed below) **(EK4/42 - INQ000625177)**.

117. As per paragraph 96, on 19 March 2020, guidance was sent by NHSE and NHSI to all providers of community services on the prioritisation of services to release capacity. The guidance set out that all school nursing services were to stop, with the exception of the phone and text service, safeguarding and specialist school nursing support. In addition, it asked that if schools were shut, the redeployment of staff should consider supporting other schools or the vulnerable who needed support at home. For further information on schools and the protection of vulnerable children, I refer the Inquiry to DfE. For further information regarding nursing services at special schools, I refer the Inquiry to NHSE.

118. In relation to community services, such as school nursing services, these are generally commissioned by LAs. At the time of the pandemic, services were typically provided through clinical commissioning groups (function now performed by ICBs). As referred to in paragraphs 97 and 98, the Secretary of State has powers under section 253(1A)(d)(iii) and (iv) of the National Health Services Act 2006 (Emergency Powers), as in force during the relevant period, to issue directions to anybody or person, other than an NHS body, which includes issuing directions for these services to be suspended and to redeploy resources to other areas of the healthcare system.

119. The guidance of 19 March 2020 was updated on 2 April 2020 with the addition of advice that changes to services commissioned by LAs should be agreed with Directors of Public Health and, where appropriate, they should consider the COVID-19 guidance on vulnerable children and young people.

120. As per paragraph 100, on 3 June 2020, as part of Phase 2 of the NHSE response, a letter was sent from NHSE to restore community health services for children and young people, including fully restoring school nursing services, superseding the previous guidance.

121. On 7 October 2020, as per paragraph 101, a letter was sent from NHSE and PHE to Directors of Nursing, at LAs advising that school nurses *`should not be redeployed to other services and should be supported to provide services through in pregnancy, early years (0-19) and to the most vulnerable families'* **(EK4/18- INQ000610466)**.

Workforce

122. According to NHSE workforce statistics, there was a 27% decline in NHSE employed school nurses from 2015 to 2024. Most of this decline was pre-pandemic, with only a 3% decrease between January 2020 and January 2024. There was a slight shift in the percentage of staff who were qualified school nurses from 44% in 2019 to 42% in 2024. These workforce figures do not include those school nurses working in social enterprise, private provider organisations or LA in-house service providers used by 13% of LAs, as the Department does not hold this data.

The National Child Measurement Programme

123. As explained in paragraph 15, the NCMP collects annual measurements of the height and weight of children in Reception (age 4 to 5 years) and Year 6 (age 10 to 11 years) in primary schools across England. It is mandated and LAs have a statutory function to deliver the NCMP funded through the Public Health Grant. In most areas delivery of the programme is commissioned as part of school nursing services or to other provider organisations. The NCMP is a very small proportion of the role of school nurses.

124. The NCMP was disrupted in 2019/20 and 2020/21 due to school closures because of the pandemic. The 2019/20 collection was incomplete, but the data is still comparable to other years at a national level. In 2020/21 the NCMP data collection was delayed due to the COVID-19 pandemic response. In March 2021, LAs were asked to collect a representative sample of data because it was not feasible to expect a full NCMP collection so late into the academic year. Statistical weighting was applied to the data to produce an estimate of obesity prevalence at national level **(EK4/43 - INQ000610495; EK4/44 - INQ000610494).**

125. NHSE publishes statistics on the reach of the NCMP programme each year:

	Participation rate by school year		**Percentage of children by school year**	
	Reception	Year 6	Reception	Year 6

2018/19	95.3	94.5	49.6	50.4
2019/20	Unavailable		47.9	52.1
2020/21	Unavailable[10]			
2021/22	92.8	91.9	48.2	51.8
2022/23	93.8	92.7	47.6	52.4

Impact on services

126. Research by the School and Public Health Nurses Association (SAPHNA) found that 60% of school nurses reported that contact with children and families reduced during the pandemic and more than 79% reported that their ability to work with known vulnerable children and families was negatively impacted. An increase in child protection referrals resulted in a shift towards reactive practice and reduced the opportunity for preventative work, resulting in later identification of more complex issues. The study also reported that school nursing services were unable to reach children during the pandemic because of reduced capacity in services and that school-aged childhood immunisations (the uptake of which had started reducing pre-pandemic) showed 'a concerning and downward trend' post-pandemic.

Mental Health Services

127. Prior to the pandemic, NHS Children and Young People's Mental Health Services were not well-matched to the needs of the population and there was a substantial 'treatment gap'. This means that many children and young people with a 'diagnosable' mental health condition were not receiving support from NHS services.

[10] 2020/21 and 2019/20 data collection years were not full collection years because of school closures due to the COVID-19 pandemic response but are considered comparable to other years at a national level.

128. The '*Five Year Forward View for Mental Health*' (2016) set a national target, which built on 'Future in Mind' (2015) and was confirmed in the NHS Long Term Plan (2019), for the NHS to reach at least 70,000 more children and young people annually by 2020/21. This was intended to increase access from meeting around 25% of children and young people with a diagnosable condition, based on 2004 prevalence estimates, to at least 35%.

129. The Government's 2017 Green Paper on '*Transforming children and young people's mental health provision*' and the subsequent NHS Long Term Plan, had committed to roll out innovative NHS mental health support teams (MHSTs) to reach 20% – 25% of schools and colleges by end 2022/23 **(EK4/45 - INQ000610446).**

130. Implementation was progressing well prior to the pandemic, but in March 2020, access to MHSTs was limited. Although comprehensive data on waiting times was not available, and no waiting time standards were in place for most services, there is evidence that many children and young people faced long waits to access support.

131. The pandemic, together with the Government's non-pharmaceutical interventions (NPIs) or restrictions, had significant impacts on NHS mental health service provision for children and young people:

    a. There were significant dips in the number of referrals to services during periods of school closure, due to a breakdown of referral routes and changes in help-seeking behaviours. This was particularly acute in the initial emergency response phase;

    b. Driven by a combination of this supressed demand and rising prevalence of mental ill-health, referrals to children and young people's community mental health services exceeded historic levels in periods in between lockdowns;

    c. More children and young people presented to services later, when they were more acutely unwell; and

    d. There was a surge in the number of children and young people being seen by eating disorder services, and a rise in waiting times for treatment in these services.

132. These conclusions have been informed by NHS performance data.

133. There has been record growth in access to NHS children and young people's mental health services, supported by NHS Long Term Plan (LTP) investment. NHSE records indicate that

approximately 55% more CYP accessed mental health support in December 2024 compared to December 2019.

134. However, the Department estimates that even with this growth, only approximately 45% of 0–17-year-olds with mental health conditions are currently accessing support. This figure is based on estimated children and young people's mental health prevalence survey estimates, ONS mid-year population estimates and the mental health service monthly statistics publication.

Learning Disability Support and neurodevelopmental services

135. The Department's decisions (in respect of the pandemic response) were focussed on children and young people in the round. While decisions may have had a bearing on learning disability support or neurodevelopmental services, decisions were not taken with specific regard to these services. The input was broadly directed to adult social care work or NHS provision and I refer the Inquiry to NHSE as the lead organisation for that work and guidance.

136. The Department supported and inputted into DfE's work to issue a modification notice regarding Section 42 of the Children and Families Act 2014, which came in to force on 1 May 2020 **(EK4/46 - INQ000610458)**. This outlined the duty to secure special education provision and healthcare provision in accordance with an Education, Health and Care (EHC) Plan. This modification enabled greater flexibility regarding how services were delivered so that as much support could be provided as possible even if it wasn't feasible to meet all EHC plan requirements.

137. Some provision specified in EHC plans, such as therapies, could be delivered remotely but the legal framework at the time did not allow for such alternative provisions to be made. The Department provided input into DfE's guidance to help those involved understand and implement the changes. The Department also worked with NHSE to make sure that their revised community services guidance reflected SEND requirements.

138. On 8 April 2020, the Chancellor announced that the charities sector would receive £750m of support. This included £360m to be allocated by government departments to charities providing key services and supporting vulnerable people during the pandemic. The Department received £17.84m to distribute in grants. This amount was boosted by at least 20% match-funding from existing departmental budgets, giving grant recipients more than £22m in total. The Department awarded a total of £1.2m funding across seven learning

disability and autism charities. The funding was intended for a variety of purposes, including expanding existing helplines and digital support to meet increased demand, providing digital support groups and developing tailored guidance.

139. The Department awarded a further £2.4m in grants through a second funding round in March 2021. Some grants were issued to the original organisations funded from 1 April 2020 to 31 October 2020, with the remainder of the money issued as new grants for wider disability organisations.

Impact on Neurodevelopmental assessments

Attention Deficit Hyperactivity Disorder (ADHD)

140. There is, at present, no single, established dataset that can be used to monitor waiting times for assessment and diagnosis for ADHD nationally or for individual organisations or geographies in England. There is therefore no formal data available to indicate the condition of the services prior to the pandemic, including in respect of waiting lists, or to indicate the impact of the pandemic on these services.

Autism

141. The number of patients aged 0 to 17 with an open "suspected autism" referral has been increasing since before, during and after the pandemic. In April 2019, the number of patients aged 0 to 17 with a referral in the month was 11,798. This figure increased by 85% to 21,781 by the start of the pandemic (March 2020). During the pandemic, this figure increased by 68% to 36,581 (March 2021). In March 2025, this figure was 137,977, a 277% increase compared to March 2021.
142. According to NHSE statistics, in April 2019, the median waiting time for patients aged 0 to 17 where their first care contact was in the quarter was 104 days. This increased by 21% to 126 days at the start of the pandemic (March 2020). During the pandemic this figure increased by 157%, from 126 days (March 2020) to 324 days (March 2021). In March 2025, the median waiting time for patients aged 0 to 17 where their first care contact was 542 days - a 67% increase compared to March 2021.

143. It should be noted that data on children and young people in the NHSE dataset exhibited above is expected to be an underestimate and caution should be used when interpreting these statistics since they are experimental rather than official statistics. A proportion of children assessed for autism in England are seen in child development services which are

out of scope of this dataset. This means the published figures will underestimate the volume of referrals and associated waiting lists. Waiting times for autism assessments are an operational matter and so I refer the Inquiry to NHSE for further information.

Other published sources

144. The Department commissioned the National Institute for Health and Care Research's (NIHR) Policy Innovation Research Unit to undertake research into the impact of the COVID-19 pandemic on autistic people, including children and young people, and their families. This was published in May 2021. In respect of health services, the report highlighted findings from a survey of health and educational professionals which suggested that autistic individuals experienced a disruption to services as a result of the pandemic. It also highlighted concerns that the pandemic would increase waiting times for an autism diagnosis.

Alcohol and drug services

145. During the lockdowns, face-to-face meetings and visits by drug and alcohol workers or child social workers were mostly replaced with online video platforms and/or calls. This made it difficult to fully assess child safeguarding.

146. Many families engaging with treatment responded well to online/video chats – they are platforms many children are comfortable with. However, the Tavistock Institute, which evaluated the Children of Alcohol Dependent Parents programme, reported in their '*Life during COVID times'* post that there were challenges to offering only remote support during the pandemic, which included:

    a. younger children not having unsupervised internet access or a smartphone;

    b. children and parents not having a safe space in the home where they could talk openly or engage fully in therapeutic activity;

    c. young people finding it difficult to explore thoughts and feelings about their parent or carer's drinking or drug use within hearing distance of them; and

    d. some parents and children hiding problems that were not revealed until they reached crisis point.

147. Research by the Early Intervention Foundation and Action for Children, '*COVID-19 and early intervention'*, published on 16 June 2020, found that many young people in treatment for

alcohol and/or drug problems said they were not able to freely discuss issues on the phone with workers while they were in their family home.

148. In March 2022, PHE published the guidance '*Substance misuse: providing remote and in-person interventions*' to give advice on the appropriate use of remote and in-person interventions for different service user groups. This covered support for children and families provided by treatment services and was updated in October 2023 **(EK4/47 - INQ000610488)**. These messages were reiterated during monthly calls with providers and commissioners of alcohol and drug services.

Palliative and End of Life Care

149. Since the Health and Care Act 2022 was enacted, ICBs have a legal duty to commission children's palliative and end of life care services to meet the needs of their local population. In order to support ICBs in this duty, NHSE has published statutory guidance titled '*Working in partnership with people and communities: Statutory guidance*' and a service specification for children and young people **(EK4/48 - INQ000610492)**

150. The Children and Young People's Hospice Grant has provided additional funding to children and young people's hospices since 2006/07, with the following amounts disseminated since 2015. Since 2022/23, individual allocations of the grant have been determined using a prevalence-based model, enabling allocations to reflect local population need.

151. The following table summarises the grants that have been awarded annually since 2015/16:

Year	Grant amount awarded
2015/16	£11,000,000.00
2016/17	£11,000,000.00
2017/18	£11,000,000.00
2018/19	£11,000,000.00
2019/20	£12,000,000.00
2020/21	£15,000,000.00
2021/22	£17,000,000.00
2022/23	£21,000,000.00

2023/24	£25,000,000.00
2024/25	£25,000,000.00
2025/26	£26,000,000.00

SECTION 3. LONG COVID

152. The paragraphs below provide details on the impacts of Long COVID in children and young people, together with the treatment in this area, and research that has been carried out to date.

Health impacts of Long Covid in Children and Young People

153. It has not been possible to pinpoint when discussions regarding children and young people and Long COVID first occurred at the Department.

154. However, the Department recognised early in the pandemic the need for research on the emerging issue of Long COVID. On 31 July 2020, the Secretary of State commissioned a literature review on early evidence of a possible longer-term impact of COVID-19 and hosted an expert roundtable including a paediatric specialist into long-term impacts **(EK4/49 - INQ000292628).**

155. On 7 October 2020, the NHS announced £10 million to be invested that year to help kick-start and designate Long COVID clinics that would be available to all patients in England, including children.

156. On 16 December 2020, the ONS announced plans for estimating the prevalence of, and risk factors for, Long COVID symptoms and health complications following coronavirus (COVID-19) infection. An initial set of early experimental results was also released.

157. This research provided early information on the differences in Long COVID symptoms and prevalence between adults and children and young people. Further surveys also provided information about differences in ongoing symptomatic COVID-19 between children and young people and adults.

158. On 25 March 2021, the National Institute for Health and Care Research (NIHR) launched a second call for research proposals, which included research into children with Long COVID who had not been unwell enough to be admitted to hospital **(EK4/50 - INQ000283429).**

159. In April 2021, the ONS found that, for the period 26 April 2020 to 6 March 2021, self-reported symptom prevalence at five weeks was significantly lower in children aged 2 to 11 years (9.8%) or 12 to 16 years (13%) compared to adults aged 35 to 49 (25.6%) and adults aged 50 to 69 (25.1%).

The impact of Long COVID symptoms on children compared to adults

160. On 15 October 2020, the NIHR published an article which recognised that ongoing COVID-19 symptoms are experienced by all age groups, including the youngest children **(EK4/51 - INQ000475507)**.

161. An expert group was jointly set up by UK Research and Innovation (UKRI) and NIHR to identify key research needs in non-hospitalised patients. In the autumn of 2020, they launched a jointly funded open call for institutions to apply for research funding, focusing on understanding Long COVID in the community. This included the CLoCk study (non-hospitalised children and young people with Long COVID, £1.9 million) which explored the prevalence of Long COVID in children, and the symptoms most likely to persist weeks after initial infection and tried to provide an operational definition of COVID-19 in children and young people **(EK4/52 - INQ000625199)**. It is the world's largest study of Long COVID in children and young people, with over 31,000 participants enrolled.

162. In April 2021, a Cabinet Office paper stated that evidence from the ONS and academic literature indicated that Long COVID was likely to have disproportionate effects on certain groups of people. Groups previously considered at 'low risk' from COVID-19 that were being affected by Long COVID included children and younger adults.

163. The 2021/22 Long COVID commissioning guidance, published in June 2021, recognised a unique response in children to COVID-19 – Paediatric Inflammatory Multisystem Syndrome (PIMS). The guidance also flagged that the impact of Long COVID on the child and family as a whole unit should be assessed and also the importance of mental health support and safeguarding.

164. Long COVID also had an impact on children's education and I refer the Inquiry to the DfE in respect of the impact of Long COVID on children's access to education.

165. In a briefing prepared for the COVID-O meeting of 7 July 2021 **(EK4/53 - INQ000625626)**, officials raised Long COVID in children as a risk that the Department would focus on for the summer, autumn and winter. They reported that early evidence suggested that many of the post-COVID symptoms experienced by adults were also shared by children. However, data and studies on Long COVID in children were limited. ONS estimates of prevalence of self-reported Long COVID (in the 4-week period ending 6 June 2021) were that 962,000 people of all ages had on-going symptoms at least 4 weeks after COVID-19 infection, of which 33,000 were aged 16 years or under.

166. On 9 November 2021, officials from the Department's Science, Research and Evidence Directorate shared a briefing paper with the Chief Medical Officer and the Department's Chief Scientific Adviser entitled '*Vaccination and Long COVID and Long COVID and Children*' **(EK4/54 - INQ000625627)**. It included the findings of a research study from Germany which found that, while incidence rates in children and adolescents were generally lower than those in adults, they may be at risk for a broad spectrum of medical conditions, including malaise/fatigue/exhaustion, cough, throat/chest pain, adjustment disorder, somatisation disorder, headache, fever, anxiety disorder, abdominal pain, and depression. The initial findings of the UK-based government-funded CLoCK study were also included, which suggested that up to one in seven children and young people who had COVID-19 may have symptoms linked to the virus 15 weeks later.

167. On 11 November 2021, the National Institute for Health and Care Excellence (NICE) published its '*COVID-19 rapid guideline: managing the long-term effects of COVID-19 Guidance*'. The guidance both made new recommendations and updated existing recommendations on Long COVID identification, planning care, multidisciplinary rehabilitation, follow up, monitoring and discharge, and service organisation. NICE also updated the list of common symptoms of Long COVID, emphasising that these may be different for children. It noted that the following symptoms and signs were less commonly reported in children and young people than in adults: shortness of breath, persistent cough, pain on breathing, palpitations, variations in heart rate and chest pain.

Approach to paediatric treatment of Long COVID compared to adult treatment

168. In late 2020, all support services available to patients with Long COVID would also have been available to children. However, it does not appear that they had been separated out as a group that needed differential support at that time.

169. In October 2020, NICE released a scoping document stating that the recommendations that it planned to publish as part of its December 2020 rapid guidelines would also cover children.

170. As more evidence emerged regarding children and young people and Long COVID, the NHS rapidly stood up dedicated children and young people's services in early 2021, guided by the NHS publication of the '*National Guidance for post-COVID syndrome assessment clinics*' in November 2020. This included the expectation that Long COVID clinics should have age-appropriate arrangements in place for managing children and young people with post-COVID syndrome including support for psychological needs.

171. Children and young people may also be assessed and treated in standard paediatric services where appropriate. NHSE Commissioning guidance sets out the expected approach as follows:

> *"The guidance refers to CYP as those aged up to and including 17 years. People aged 18 years and over are referred to as adults. The early assessment can be carried out by a GP or, if required, by a general paediatric service. Support should be offered where possible at the earliest opportunity to reduce symptoms and concerns and improve the quality of life."*

172. As with adult services, some children and young people may need further therapeutic input, rehabilitation, psychological support, specialist investigation and/or treatment once they have been assessed and patients should have access to relevant local services.

173. Additional information regarding children with special educational needs is also included in the NHS commissioning guidance for post-COVID services for adults, children and young people published on 7 December 2023.

174. As the treatment of Long COVID is an operational matter, I refer the Inquiry to NHSE for further details on how far the treatment is similar for adults and children.

Funding for the research of Long Covid in children

175. The Department has invested more than £2.2m in Long COVID research for children and young people. This research includes the CLoCK study detailed above at paragraph 161 and other research on the impact of Long COVID linked to school experiences for children and young people and the effect of Long COVID on diagnostic testing and therapeutics.

176. For further details on the treatment of children and young people with Long COVID I refer the Inquiry to NHSE.

SECTION 4. THE IMPACT OF CHILDREN AND YOUNG PEOPLE'S ACCESS TO OR USE OF SOCIAL MEDIA AND ONLINE RESOURCES DURING THE PANDEMIC

177. The impact of children and young people's use of social media and online resources during the pandemic was explored by a joint publication in November 2020 from the Scientific Pandemic Influenza Group on Behaviours (SPI-B) and DfE **(EK4/55 - INQ000625204).** It outlined the key evidence and considerations associated with the closure of schools and the introduction of online learning, and reported that:

> *School closures increase the time exposure of children to the internet with potential negative consequences such as increased susceptibility to digital dependency, online abuse, harassment and bullying, and exposure to violent content and pornography…*
>
> *It is not clear that online interactions make up for the social isolation and lack of face-to-face interactions resulting from school closures. Data from the Co-SPACE study found that over 80% of children and 40% of adolescents had not communicated with friends via social media in the previous week during the first lockdown when schools were closed, indicating marked reduction in social contacts.*

178. In 2022, OHID's informal report on the impact of the pandemic on children and young people in the East Midlands found that:

> *School closures may have increased children's use of the internet which is associated with some negative consequences such as: increased susceptibility to digital dependency; online abuse; bullying; exposure to violent content and pornography, safeguarding and vulnerable children* **(EK4/56 - INQ000593472)**.

179. Following the pandemic, the Department has not made assessments of the impact of children and young people's use of social media and online resources. The Department for Science, Innovation and Technology is the lead department on social media policy, and I refer the Inquiry to that department accordingly.

SECTION 5. A CHRONOLOGY OF DATES REGARDING CHILDREN'S ACCESS TO HEALTHCARE

180. Below is a chronology of key decisions with which the Department was involved regarding children's access to healthcare. Decisions relating to children's services were operational and so I refer the Inquiry to NHSE for further details.

Date	Event
16 March 2020	The Chief Medical Officer placed pregnant women in the vulnerable group category. The Department, NHSE, and Royal Colleges collaborated to create guidance for healthcare professionals, pregnant women and their families on COVID-19 infection and pregnancy.
17 March 2020	The Permanent Secretary attended a Department-led COBR-M meeting with cross government officials regarding measures for school closures. The purpose of the meeting was to provide clarity on the clinical position for vulnerable children and staff in school and draw up guidance for vulnerable children and parents.
19 March 2020	NHSE, with the Secretary of State's agreement, allowed GP practices to suspend the following activities, if necessary, to free up capacity to support the COVID-19 response: (a) New patient (including alcohol dependency) reviews; (b) Over-75 health checks; (c) Routine medication reviews (except where a patient was being regularly monitored); (d) Clinical reviews of frailty; (e) The requirement to report to commissioners about Friends and Family Test (FFT) returns (in line with the suspension of this requirement across wider NHS services); (f) The requirement to engage with and/or review feedback from Patient Participation Groups (PPGs); (g) The requirement on dispensing practices to cleanse (quality check) their dispensing lists.
01 May 2020	Modifications to Section 42 of the Children and Families Act 2014 came into force, enabling greater flexibility regarding how services were delivered for children with an Education, Health and Care Plan.

22 May 2020	The Department announced more than £22 million in cash grants would be awarded to health and care charities providing vital services to ensure they could meet increased demand as a result of COVID-19.
08 June 2020	The Secretary of State commissioned a literature review on early evidence of a possible longer-term impact of COVID-19 and hosted an expert roundtable including a paediatric specialist into the long-term impacts of Long COVID.
17 November 2020	The Department published a cross-government winter plan for mental health and wellbeing, entitled '*Staying mentally well: winter plan 2020 to 2021*'. This set out the immediate support available in the second wave of the pandemic, including for children and young people.
14 December 2020	The Department published guidance for pregnant employees entitled '*Occupational Health advice for pregnant women in the workplace*'. This was in collaboration with the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Health and Safety Executive and the Department for Business, Energy & Industrial Strategy.
30 March 2021	The Department published a cross-government '*COVID-19 Mental Health and Wellbeing Recovery Action Plan*', designed to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022.
04 June 2021	The Department held the first quarterly Mental Health Recovery Board meeting to oversee delivery of the Action Plan. The Board was chaired by the Minister of State for Care and Mental Health and consisted of senior members from NHSE, Health Education England, PHE (and later the Office for Health Improvement and Disparities), No 10 Policy Unit and His Majesty's Treasury.
31 August 2021	The Government published '*Build Back Better: Our Plan for Health and Social Care*' which covered the high-level investment and associated commitments to recover the COVID-19 backlog in elective and cancer care.

24 December 2021	The Department published guidance on how to find help and support for people with Long COVID, including advising parents or carers to speak to their child's school or college about support.

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: Elizabeth Ketch

Date: 11 August 2025