

Impact of COVID-19 on child health services between November 2020 and February 2021 – report

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Introduction

This report outlines the findings from the second phase of the Impact of COVID-19 on Child Health Services project, conducted between November 2020 and February 2021 across the UK. The first phase collected data between April and July 2020, you can [read the full report here](#) and [our letter to the editor of Archives of Disease in Childhood](#).

We launched the second phase to respond to the need for further data about the impact of the pandemic on paediatric services. This consisted of a snapshot questionnaire to clinical leads on Friday 4th December 2021, followed by a short, ten question weekly alert system for fourteen weeks starting on Friday 27th November 2021.

The findings demonstrate that over winter 2020/21, paediatrics was a service under extreme pressure. Paediatric staff and capacity continued to be impacted by the COVID-19 pandemic, despite children and young people rarely having severe illness caused by the virus. Trainees were redeployed to adult services in up to 30% of organisations, and up to 26% cancelled outpatient clinics over winter. There will be a backlog of need that paediatrics needs support to address.

Virtual consultations and clinics were implemented in paediatrics to allow access to services during the lockdown. However, 81% of respondents said that they were concerned about missing safeguarding issues in virtual consultations. This highlights the particular importance of in-person assessments for children and young people.

We found that 12% of inpatient beds were occupied by children and young people admitted due to a mental health issue (up from 6% in 2019). Children and young people suffered from the indirect consequences of the lockdown, and their health must be prioritised in the recovery phase. Paediatricians also need support in caring for children with mental health needs, and there should be clear pathways of care. 38% of respondents said that they did not have effective joint pathways with Child and Adolescent Mental Health Services (CAMHS).

The paediatric workforce has been under a huge amount of pressure, with over 15% of services reporting absence due to stress and 45% of clinical leads reporting concerns about future absences. As across the whole NHS workforce, staff need to be supported to recover from stress and burnout.

Key findings

Weekly alert system

- 30% of services had redeployed paediatric trainees to adult services at the peak in mid-January 2021,
- 13% of services reported paediatric consultants redeployed to adult services at the peak in late January 2021. This is in contrast to the first phase of data collection where less than 1% of those on the Tier 3 (consultant) rota were redeployed¹.
- Up to 11% of services reported that community child health (CCH) trainees were redeployed to another area of paediatrics. This is lower than the first phase, where up to 46% of CCH trainees were redeployed.
- Up to 21% of services reported that consultants were stepping down to cover the junior doctor rota, with a peak at the end of November 2020.
- Up to 26% of services reported that outpatient services had been cancelled that week (not due to planned leave). At the end of data collection, 15% of services were still reporting this.
- Around 10% of clinical lead respondent observed vaccine hesitancy in their staff group, reducing to 7% by the final week of data collection.

Snapshot survey (4th December 2020)

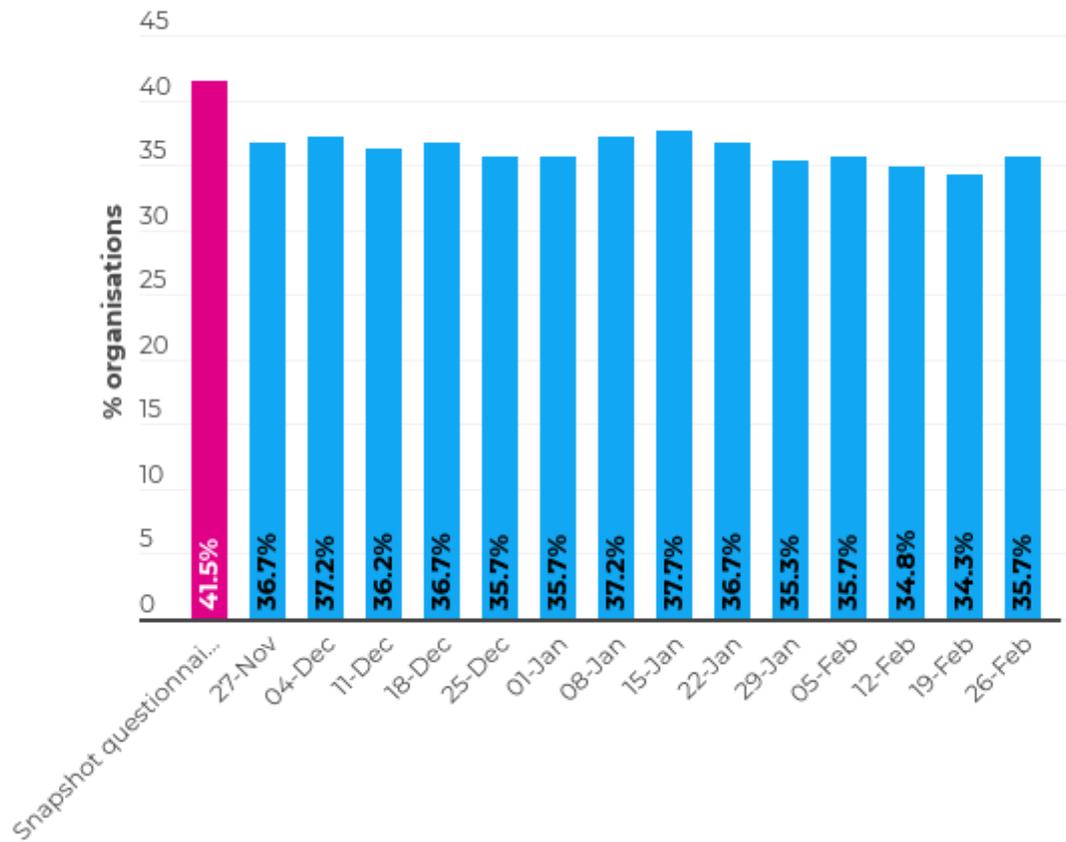
- 11% of services reported losing some physical outpatient space to adult services.
- 15% of services reported that staff were absent due to stress, and 45% of respondents were concerned that there would be future absences due to stress over the next few months.
- In paediatrics, 10% of medical staff were classed as clinically vulnerable to COVID-19 due to personal risk factors and a further 3% were clinically extremely vulnerable.
- At the time of the snapshot in December 2020, 12% of paediatric inpatient beds were occupied by a child or young person admitted due to a mental health problem. This compares to 6% in September 2019.
- Clinical leads' top concern about virtual consultations was missing safeguarding issues.
- 38.4% of organisations stated they did not have effective joint pathways with CAMHS.
- 75.3% of respondents stated that children and young people were mentioned in their organisation's winter planning documents.
- Transfer of care of young people with significant medical complexity to adult services had been paused due to COVID-19 in 30.2% of organisations.

¹ Direct comparisons between the first and second phase of data cannot be made as the questions were asked in a different way. The questions in the first phase asked for estimates of percentages (e.g. "what proportion of trainees were redeployed this week?", response between 0 and 100%), whereas questions in the second phase were all Yes or No responses (e.g. "were any trainees redeployed this week?").

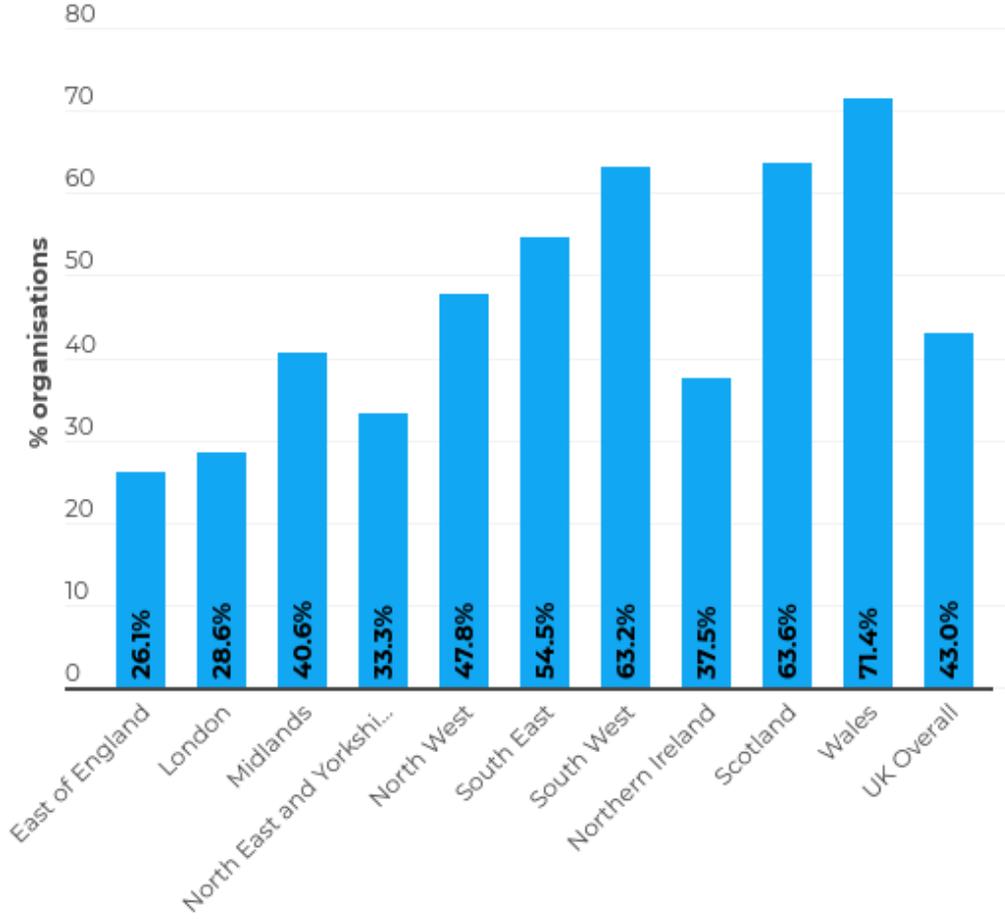
Response rate

We had registered users for 70.4% (148/203) of all the listed paediatric organisations in the UK. However, a smaller proportion submitted data. Response rate per week varied from 30.3% to 41.5%.

Response rate by date and collection type



Response rate by region



Winter weekly alert system (November 2020 to February 2021)

A weekly alert system was launched to track changes over time during winter from 27th November 2020 until 26th February 2021.

In the alert system questionnaires, respondents were asked a series of primarily Yes or No questions. Reported percentages are the proportion of “yes” responses.

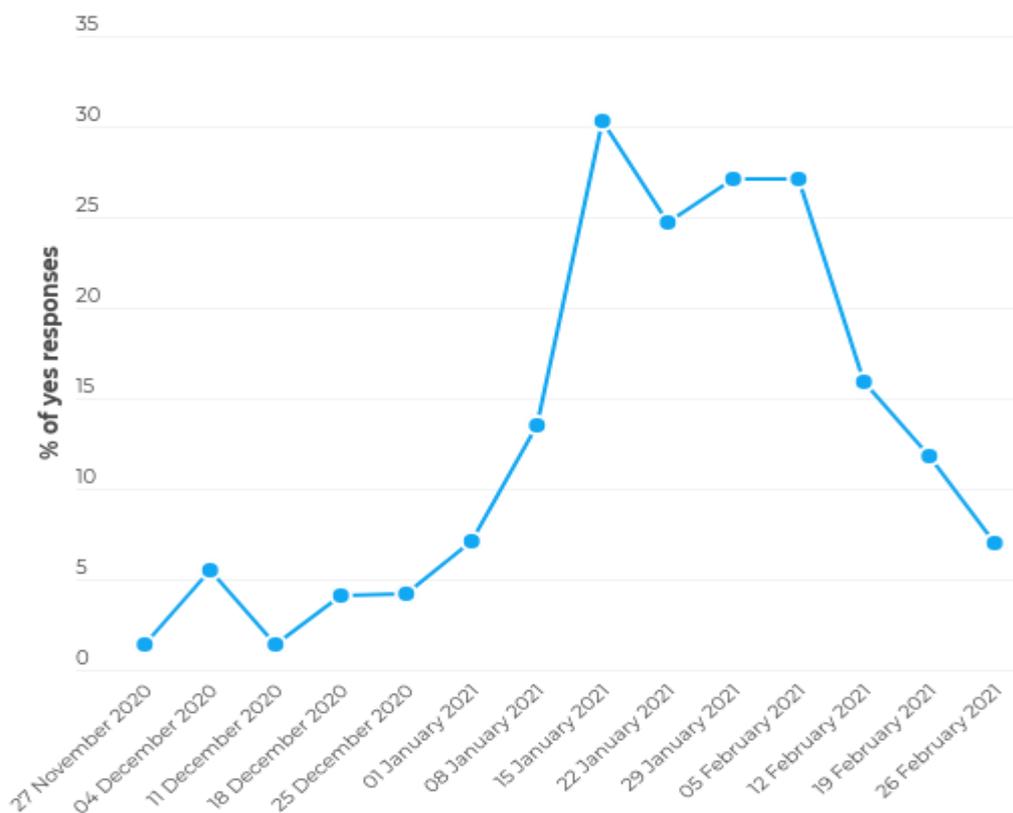
Staffing

Trainee redeployment to adult services

Across December 2020, low numbers of organisations were reporting redeployment of paediatric trainees, with between 0 and 5.5% of respondents responding “yes” to this question.

At the beginning of January 2021 this increased, peaking at 30.3% mid-January, and only falling below 25% and steadily decreasing after the first week of February. As of 26th February, the final day of data collection, this was down to 7%.

Figure 1. % of Yes responses to "are any paediatric trainees currently redeployed to the adult service?"



A free text response noted that loss of foundation doctors, not just specifically paediatric trainees, was having an impact on the paediatric rota.

Another respondent submitted a positive description of the way the paediatric team had worked together to support the wider Trust response to the pandemic:

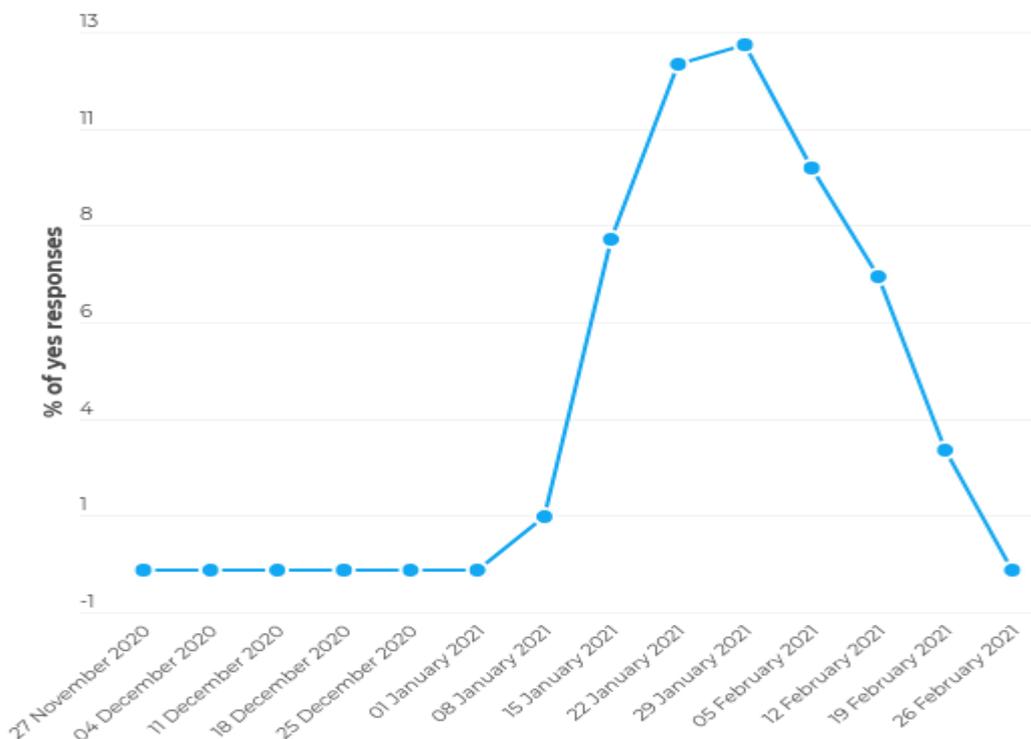
[Trainee redeployment] does have an impact on paediatric trainees in terms of covering workload with less staff than normal but the team have worked constructively together to adjust working patterns in a planned way and thus support the wider Trust COVID response. We are really grateful for the flexibility and professionalism shown by all our doctors.

29 January, North West

Consultant redeployment to adult services

Between the end of November 2020 and the beginning of January 2021, no Trusts or Health Boards reported paediatric consultants being redeployed. This changed at the end of the first week of January with a slight increase (less than 2%), and continued increasing, peaking at 12.7% at the end of January, and then decreasing until by the end of February no consultants were reported as redeployed. This is in contrast to the first phase of data collection between April and July 2020 where between less than 1% and less than 2% of those on the Tier 3 (consultant) rota were redeployed.

Figure 2. % of Yes responses to "are any paediatric consultants currently redeployed to the adult service?"



consultant help on critical care is minimal and ad hoc rather than substantial redeployment

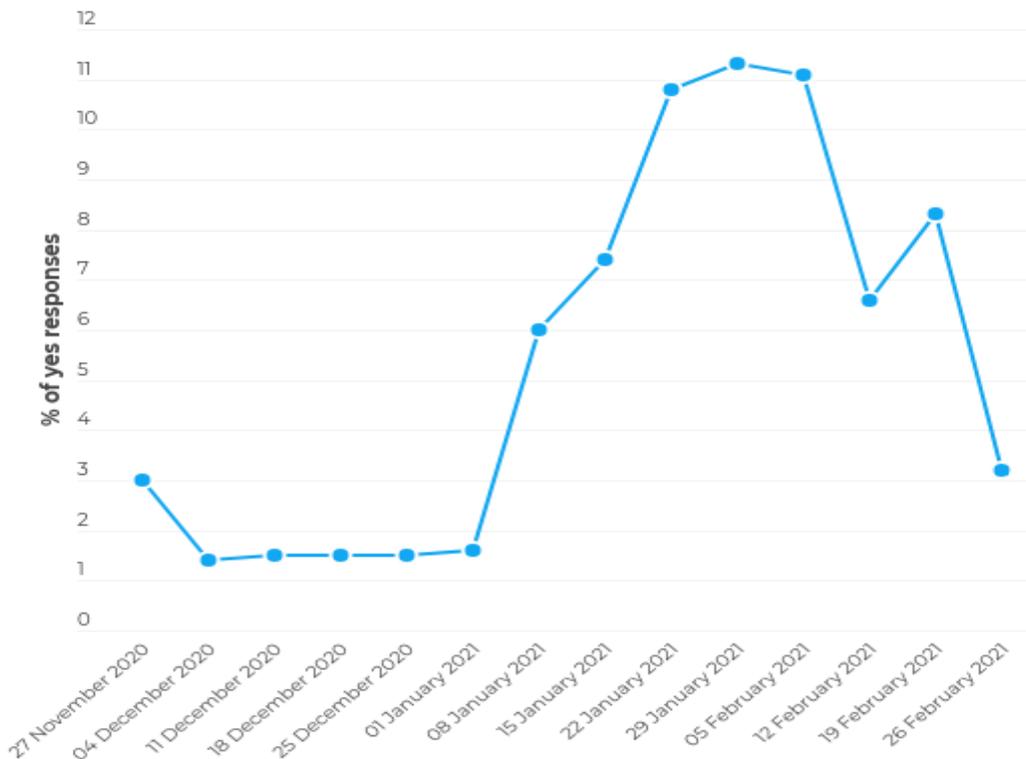
22 January, Midlands

Community trainee redeployment to another area of paediatrics

Across data collection, an average of 5.4% of respondents reported that community child health trainees were redeployed, with a peak of 11.3% on 29 January.

During the first phase of data collection (April to July 2020), there were much higher reports of community trainee redeployment, with a peak of 46% redeployment on 17th April. The questions were asked differently between the two phases of data collection, so they are not directly comparable², but this represents a positive change following the RCPCH's call to protect community staff and services in surge planning³.

Figure 3. % of Yes responses to "Are any paediatric community child health trainees currently redeployed to another area of paediatrics?"



² In the first data collection phase, respondents reported proportion of redeployment whereas in this phase the proportion of Trusts or Health Boards that had redeployment is reported.

³ ADC letter

The winter alert questionnaire did not ask about redeployment of career grade community staff, but one free text response indicated that a consultant in their community Trust had been pulled to do Non-Accidental Injury (NAI) medicals on behalf of an acute Trust where the paediatric staff had been redeployed to adult services.

This comment reveals the knock-on impact of redeployment:

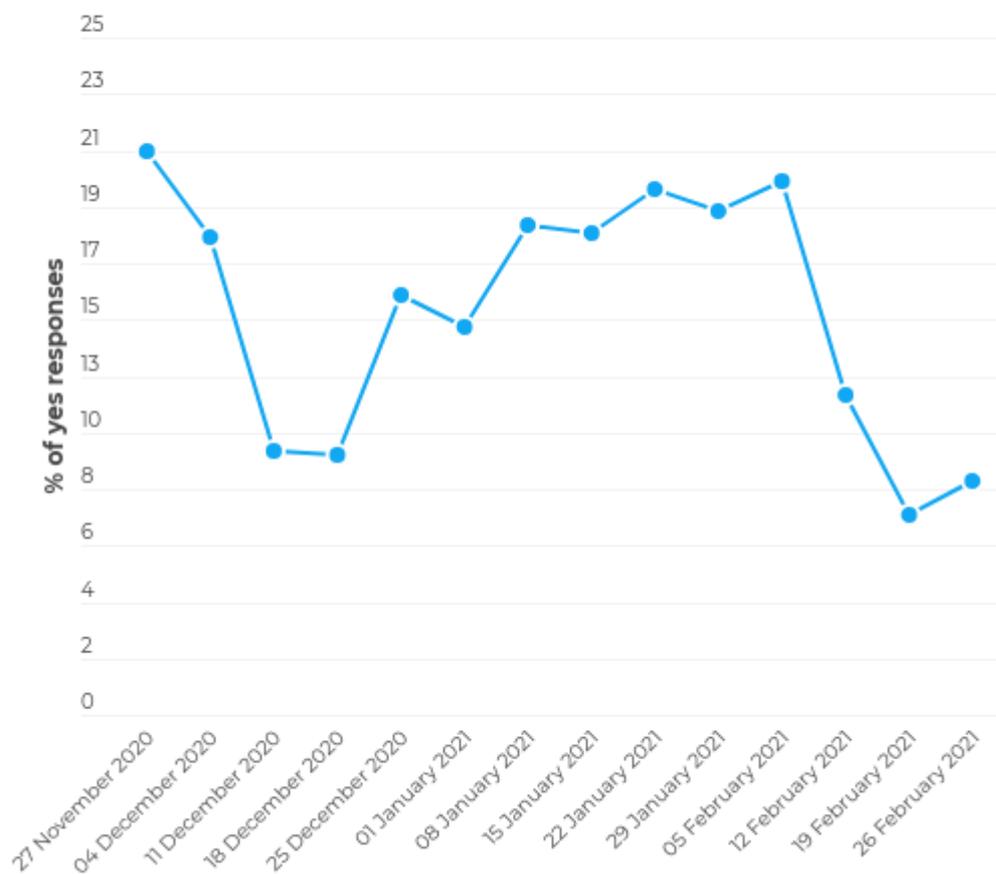
consultants in community trust been pulled into to do NAI [Non-Accidental Injury] medicals on behalf acute trust as they are deployed into adult work

29 January, South East

Consultants covering the junior doctor rota

21% of Trusts and Health Boards reported consultants covering the Junior doctor rota at the end of November 2020. This then decreased to 9.7% mid-December, increasing again mid-January to February (19.7% on 5th February) before decreasing again at around 8% when data collection was closed.

Figure 4. % of Yes responses to "have there been instances of consultants covering the junior doctor rota?"



The free text comment below reveals how this impacts other areas of service provision, such as outpatient clinics:

All Consultant general paediatrics clinic cancelled this week with them covering acute areas for juniors due to COVID-19 sickness.

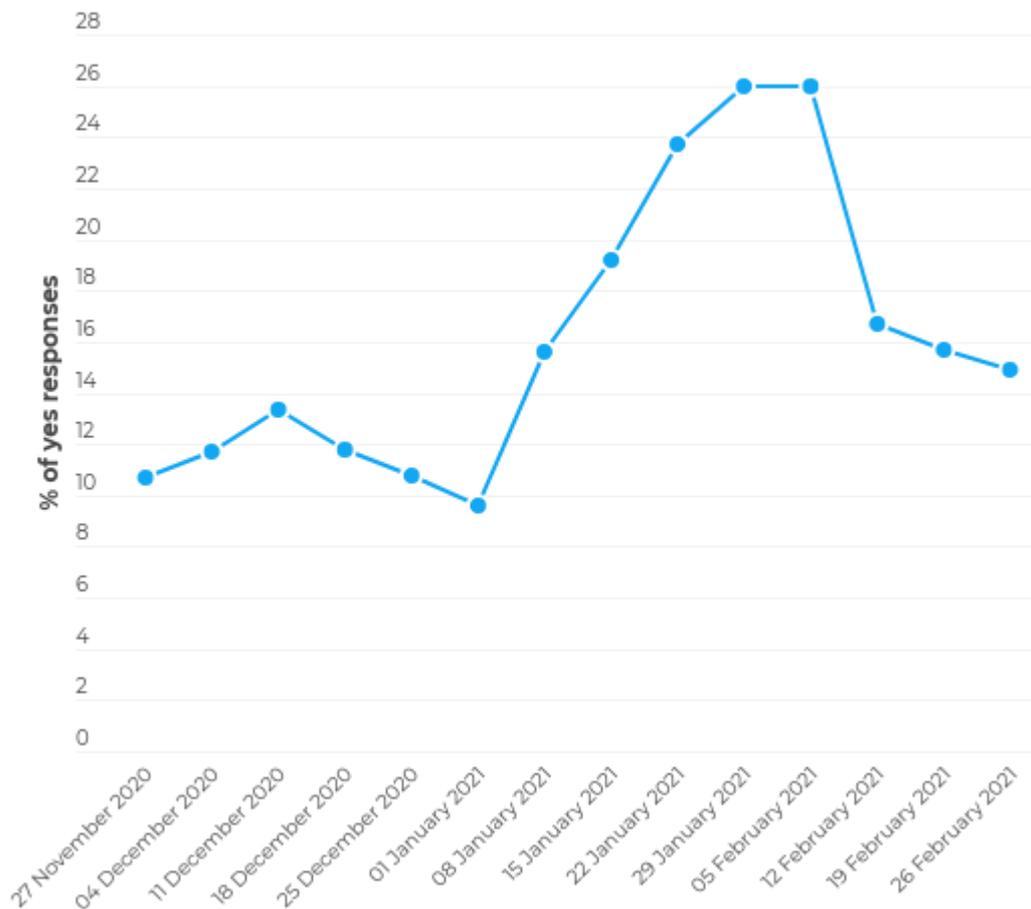
January 29, South East

Activity and facilities

Outpatient service cancellations

Above 9% of all organisations reported that there had been some outpatient service cancellation throughout data collection, with a peak of 26% at the end of January/beginning of February 2021.

Figure 5. % of Yes responses to "have any paediatric outpatient services been cancelled (not due to planned leave)?"



Facilities for appointments

Over 80% of respondents reported having adequate facilities for face-to-face assessments during the first week of data collection; this increased to 90% during the following weeks, and the question was retired on 8th January.

88.2% of Trusts and Health Boards reported having reliable video/teleconferencing systems to provide ongoing remote care and advice to CYP and their parents/carers⁴. This slightly decreased to 82% on 25th December, and then increased again. This might have been a result of adjusting to change and new technologies and ways of working. This question was retired on 8th January.

The free text comment below shows that whilst some patients can be seen in virtual clinics, face-to-face assessments are required for others and fully virtual working creates backlog:

We are not cancelling clinics BUT many are virtual, so we find that we have a very long waiting list for patients requiring face to face vs virtual. We are now addressing this with more virtual clinics. Staff are volunteering to help the vaccination programme, some in their SPA time, but none redeployed.

February 5, Wales

⁴ In response to the question “Is there reliable video/teleconferencing system to provide ongoing remote care and advice to CYP and their parents/carers?” Yes/No options.

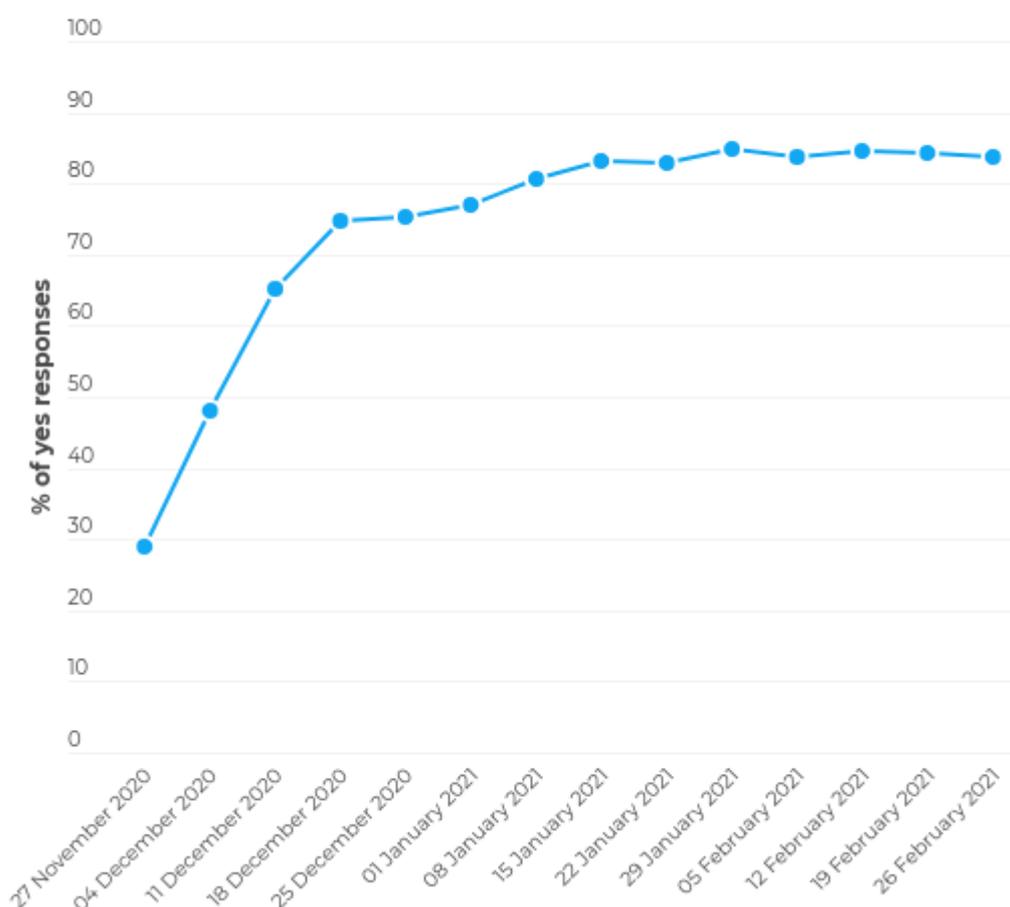
COVID-19 testing and Personal Protective Equipment (PPE)

Testing availability

Symptomatic paediatric medical staff had access to COVID-19 testing in almost 100% of Trusts and Health Boards. This question was retired after January 8th.

Trusts and Health Boards reporting twice weekly testing for COVID-19 for medical staff steadily increased from 28.9% on 27 November to over 80% on January 8th and remained above 80%. However, free-text responses noted that policy on the frequency of testing has changed over time and varied across the UK nations. In addition, testing was often offered on a voluntary basis.

Figure 6. % of Yes responses to "are paediatric medical staff (including asymptomatic) being tested for COVID-19 twice weekly?"



PPE availability

We asked respondents whether paediatric medical staff had access to adequate Personal Protective Equipment (PPE).

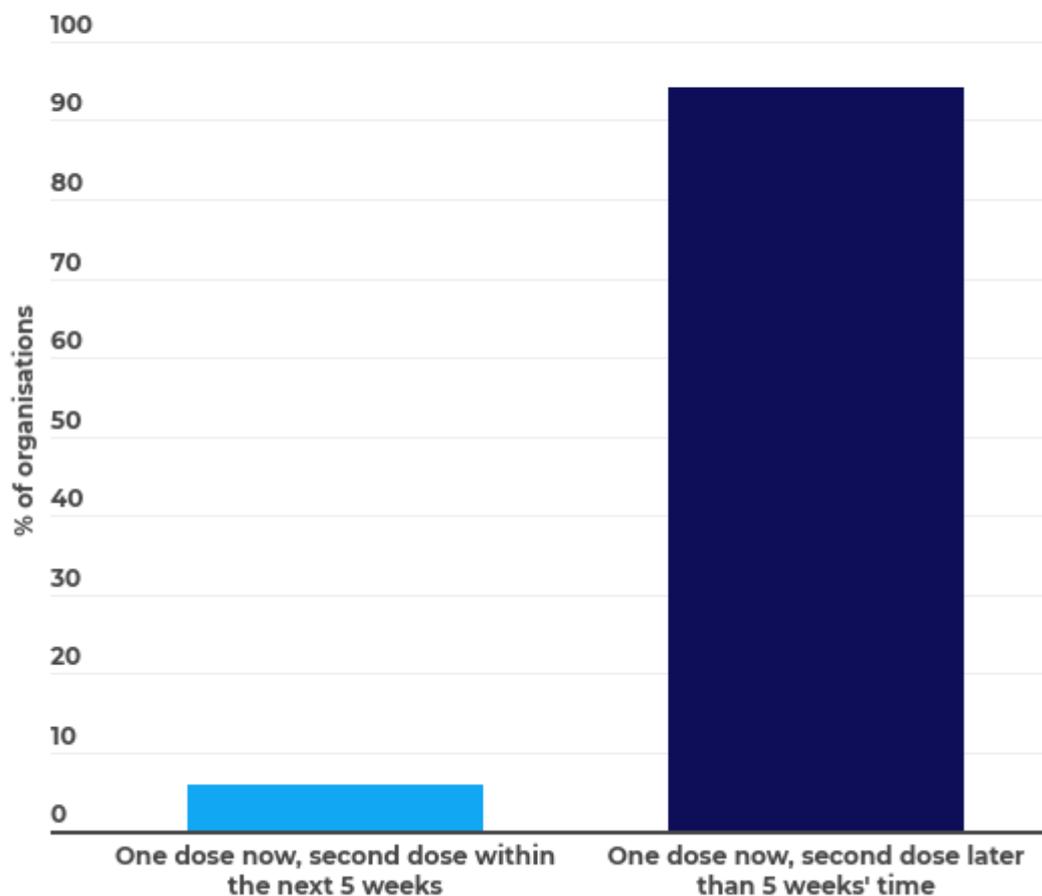
Accessibility to PPE for paediatric staff was almost 100% across all weeks of data collection. This question was retired after January 8th.

Vaccination programme

As the vaccination programme rolled out across the UK in January 2020, we introduced questions on how the vaccine was being administered in terms of time in between first and second dose, satisfaction with the organisations' vaccination plan, observed vaccine hesitancy in paediatric staff.

In terms of the timeline for administering both doses, 94.1% of organisations reported receiving the two doses more than 5 weeks apart from each other.

Figure 7. Overall % of organisations administering both COVID-19 vaccine doses for paediatric medical staff within 5 weeks, and more than 5 weeks apart



Most clinical leads (between 84% and 95% depending on the week) were happy with the vaccination programme. Free text responses revealed that there were some concerns around the time in between jabs, but this was accepted as the norm later in data collection.

vaccination schedule is improving, and seems to be working, but was poorly organised. Second dose 12 weeks after first, no one has received it yet

January 29, Wales

we have 12 week gap between vaccine doses-which is long wait and not evidence based-hence my not being happy

February 5, South East

Initial disappointment over stretch between second dose, now more accepted as National picture.

February 12, South West

Trust has decided not to do any further first vaccinations, but this is impacting some staff who were initially told they could not have due to allergy or were waiting for more data regarding pregnancy. They are continuing to do 2nd vaccinations.

February 19, South East

Overall, across data collection, an average of 9.9% of clinical leads reported observed vaccine hesitancy in their paediatric staff group. This decreased during the data collection period, ending at 6.9% for the final week of collection (26th February).

Snapshot questionnaire (4th December 2020)

Staffing and capacity

Redeployment to adult services

At the time of the snapshot, just 2.1% of Trusts or Health Boards reported redeployment to adult services from the Tier 1 rota, and none reported redeployment from the Tier 2 or Tier 3 rotas. This compares to April 2020 where over a fifth (22%) of those normally on the Tier 1 acute paediatric rota were redeployed to adult services. More senior staff were less likely to be moved to adult services in the first wave, with only up to 3% of Tier 2 and up to 2% of Tier 3 staff being redeployed.⁵

Redeployment within paediatrics

2.3% of community career grade staff, and less than 1% of community career grade staff, were redeployed to another area of paediatrics at the time of the snapshot.

Availability to work

3.3% of paediatric medical staff were not available to do any paediatric work due to shielding, redeployment, illness, etc., and 4% were not available to do face-to-face work but were working in other ways (e.g. working from home). This compares to up to 10% of paediatric medical staff not available to work between April and June 2020.

Academic trainees returned to clinical services

Only one Trust or Health Board (out of 82 responses) reported that an out of programme (OOP) academic trainee had returned to the clinical service to support the pandemic response.

Capacity and physical space lost to adult services

On 4th December 2020, 10.5% of Trusts and Health Boards reported losing some physical outpatient space to adult services.

Less than 2% of paediatric inpatient and outpatient (e.g. clinics) capacity were reported as lost to adult services at the time of the snapshot.

During phase 1 of data collection (April to July 2020), paediatric inpatient space lost to adult services was also small (1-6%), but with reported issues getting space back.⁶

⁵ <https://www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-report-2020>.

⁶ <https://www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-report-2020>.

Staff workload and wellbeing

Absences due to stress

15.3% of Trust and Health Boards reported having paediatric medical staff absent due to stress and 44.7% of clinical leads were concerned that there would be future absences due to stress in the next few months.

We looked at NHS Digital data to compare this to the overall sickness absence rate for NHS staff. However, please note that the findings cannot be directly compared as they are measured in different ways. Our study asked respondents whether there were any paediatric medical staff absent due to stress in the past week (Yes/No), whereas the NHS Digital data captures sickness absence as a proportion of the total workforce.

NHS Digital data show that between October and December 2020, the overall sickness absence rate for England was 5.1% (slightly higher than December 2019, 4.9%). The highest sickness absence rate was reported for support to ambulance staff at 8.1% in December 2020, and for support to doctors, nurses & midwives as the second highest at 7.2%.

Anxiety, stress, depression, and other psychiatric illnesses were the most reported reasons for sickness absence, accounting for 511,000 full time equivalent days lost and 26% of all sickness absence in December 2020. This was slightly down from 26.2% in November 2020.⁷

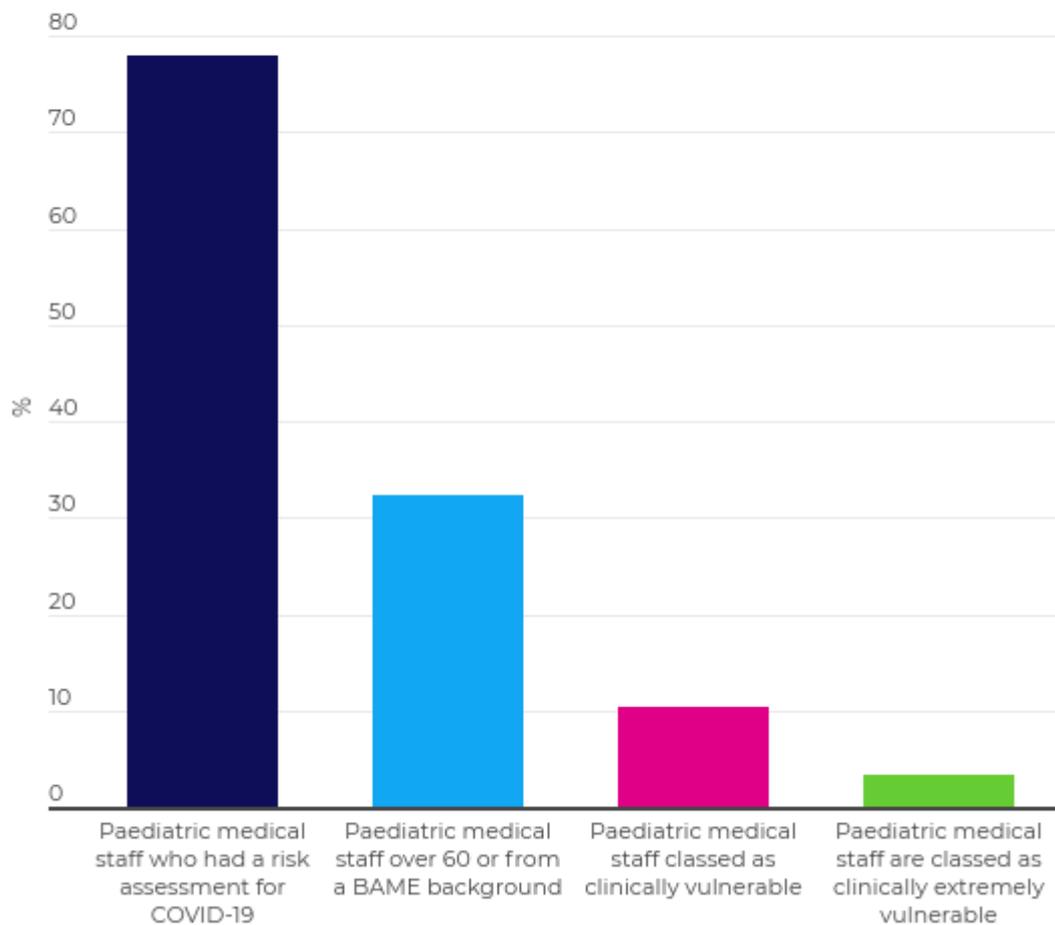
⁷ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/october-2020-to-december-2020-provisional-statistics>

Staff risk assessments

Over 10% of paediatric medical staff were classed as clinically vulnerable due to personal risk factors for COVID-19, and just over 3% were classed as clinically extremely vulnerable.

32% of paediatric medical staff were over 60 or from BAME background; 77% of staff had a risk assessment for COVID-19.

Figure 8. Proportion of staff who had a risk assessment for COVID-19, over 60 or from a BAME background, classed as clinically vulnerable, and classed as extremely vulnerable



Access to Personal Protective Equipment

Paediatric medical staff was able to access Personal Protective Equipment that fulfils government guidelines for over 95% of the time.

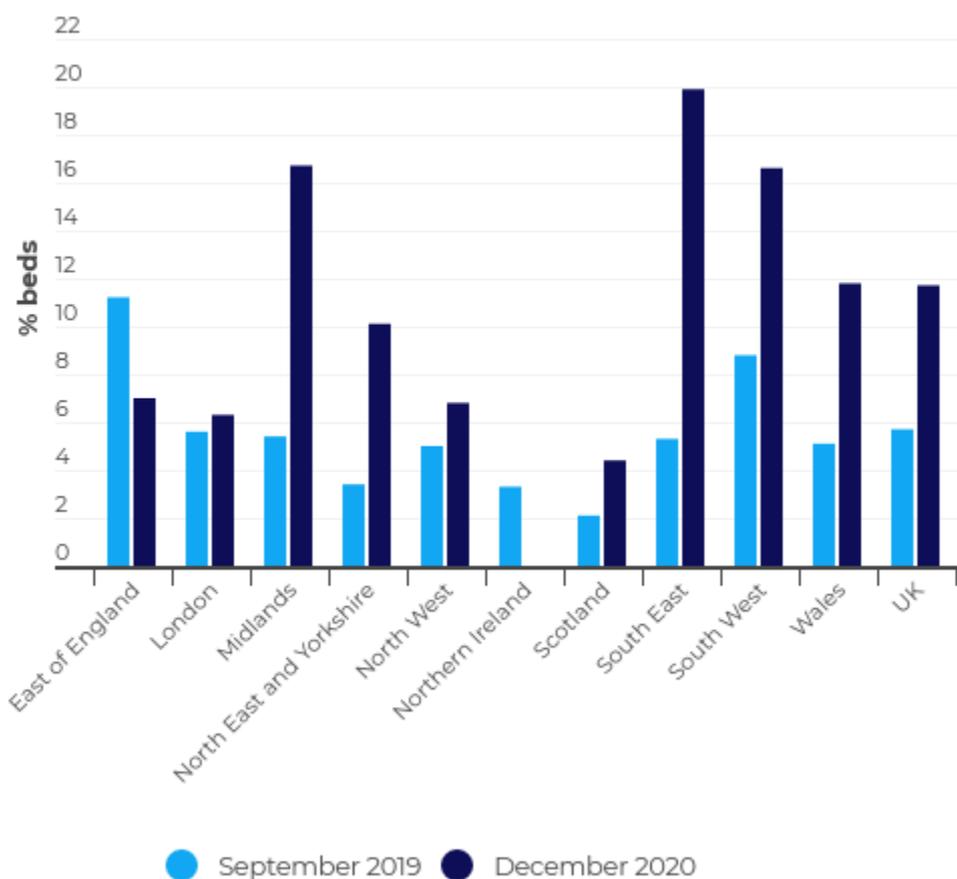
Activity and patients

Mental health admissions

In December 2020, across the UK, 11.7% of inpatient beds were occupied by a child or young person (CYP) admitted due to a mental health need. This question was also asked as part of a Getting It Right First Time snapshot survey in September 2019, where clinical leads across the UK reported 5.7% of inpatient beds were occupied by a CYP admitted due to a mental health concern.⁸

Figure 9 shows a breakdown of mental health inpatient occupancy by NHS England region and devolved nation. This shows a range of variation across regions, with almost all showing an increase from 2019 to 2020.⁹

Figure 9. Proportion of inpatient beds occupied by CYP due to a mental health admission in September 2019 and December 2020



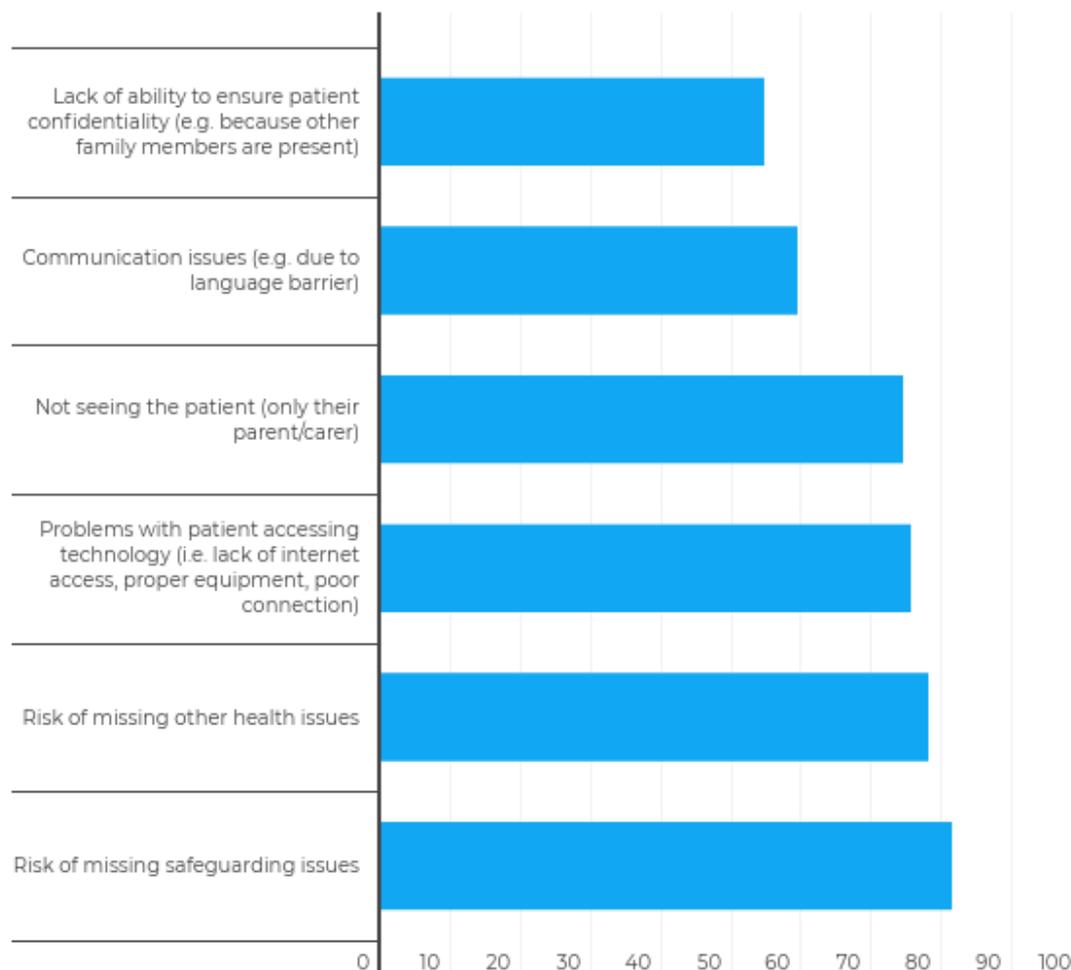
⁸ <https://www.rcpch.ac.uk/resources/snapshot-general-paediatric-services-workforce-uk>

⁹ No data for Northern Ireland in 2020.

Concerns about virtual consultation

Respondents were asked if they had concerns about virtual consultations in their service. The most common concern was the risk of missing safeguarding issues (81.4%), followed by the risk of missing other health issues (77.9%), problems with patient accessing technology (75.6%), not seeing the patient but only their carer/parent (74.4%), communication issues (59.3%), and lack of ability to ensure confidentiality (54.7%).

Figure 10. Main concerns expressed regarding virtual consultations



Free-text responses to this question indicated that clinical leads were worried about missing significant pathologies because of a lack of comprehensive assessments, or objective measurements.

In keeping with Trust guidance we see all children apart from cardiac issues / neonates with jaundice virtually for the 1st consultation. There is risk of missing significant pathology if not examined and therefore do not have comprehensive assessment on

Inability to get objective measurements, such as weight and head circumference

we are doing face to face consultations but with reduced capacity because of all the cleaning required between patients some telephone consultations but very few video mostly due to the nature of the patients in community and parents doing on phones with poor view

Planning and pathways

Joint pathways with Child and Adolescent Mental Health Services (CAMHS)

38.4% of organisations stated they did not have effective joint pathways with CAMHS.

CYP mentioned in organisations' winter planning

75.3% of respondents stated that children and young people were mentioned in their organisation's winter planning documents.

Transition to adult services

Transfer of care of young people with significant medical complexity to adult services had been paused due to COVID-19 in 30.2% of organisations.

CYP seen in the Emergency Department

67.1% of responses stated that CYP were still being seen in the Emergency Department (ED) as usual. In 6.6% of responses, CYP were bypassing ED and going straight to inpatients.

18.4% responded that they had other arrangements. The free text responses indicated that this included CYP triaging in the ED and a rapid transfer to the Paediatric Assessment Unit (PAU), bypassing ED and going straight to inpatient, or seeing in the ED only some cases, depending on how busy they might be at the moment.

"Children are being seen in ED however bypass system still in operation for Paediatric medical/surgical need as necessary and departmental activity requirement"

A combination of some children bypassing ED & going straight to inpatients (which is a constant current offer) & some being seen in ED at quieter periods there

They are being triaged in ED and transferred to paediatric assessment if stable to transfer; children who are sick are being seen in ED following paediatric team being called either by crash call or phone call to registrar on call.

Children with fever/respiratory symptoms go to inpatient ward; other children seen in ED as usual.

The observation bay has reduced capacity to allow for a COVID area in the children's emergency dept, so patients who are not suspected of having COVID are observed on one of the paediatric wards.

Methodology

Procedure

During the first phase of data collection, the software company East Face built a custom online data collection and reporting platform. This was further developed to build the questionnaires and reporting tools for the second phase.

We had built up a database of respondents and users from the first phase, and they were contacted to request participation in a second (winter) phase of data collection. We asked respondents to submit information about their service every Friday from 27th November 2020 to 26th February 2021. Data collection remained open for retrospective submissions until the end of March 2021.

Data were initially collected at the health provider level (i.e. Trust or Health Board) rather than the service level (e.g. hospital) to allow rapid launch. However, some health providers were split into constituent services at the request of leads to allow individual hospitals or community services to respond. At the close of the project, there was a total of 203 organisations listed.

Questions

You can download the full set of questions below. Respondent were asked to submit data about “the 7 days up to 08:00 on [date of Friday in the current collection week]”. Questions were answered as compared to "normal" levels of staffing and capacity, i.e. the same week in previous years. Some questions were changed over the data collection period in response to changing priorities.

Online data dashboard

You can register for an account on our online tool to explore the data in more detail, including maps, regional breakdowns, and downloadable CSV files. To access, you must be an RCPCH member or have another justification to view the data, e.g. working in child health research or workforce planning.

[Register now](#)

Contributors

A huge thank you to everyone who submitted data.

The RCPCH Workforce team lead this work: **Marie Rogers** (Head of Workforce Information), **Nawsheen Boodhun** (Project Manager), **Davide Carzedda** (Analyst) and **Natascha Banziger** (Project Officer).

Dr Nicola Jay (Officer for Workforce Planning and Health Services) and **Prof Nick Bishop** (VP for Research) are the clinical leads.

Emily Arkell (Director of Research and Quality Improvement) is the senior management sponsor.

Mark Bailey at **East Face** developed the online platform.

Thank you to the RCPCH Winter Planning Clinical Advisory Group members for your guidance throughout this work.

Resources

- adc.bmj.com/content/106/6/622
- www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-report-2020
- digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/october-2020-to-december-2020-provisional-statistics
- www.rcpch.ac.uk/resources/snapshot-general-paediatric-services-workforce-uk