

How complete is the Community Services Dataset for understanding health visiting service delivery?

Why this research was needed

The Community Services Dataset (CSDS) contains individual-level information for all publicly funded community services delivered in England.

The CSDS is a potentially valuable data source for research, policy, and planning, but analyses are considered experimental as it is not fully developed.

We examined the strengths and limitations of the CSDS for research into delivery of health visiting (HV) contacts, a core component of the 0-5 public health investment.

What we did

We analysed anonymised, national CSDS data for children under 5 across a 4-year period pre-pandemic from financial years 2016/17 to 2019/20.

To assess the completeness of HV activity recorded in the CSDS, we compared counts of the postnatal mandated HV contacts at local authority (LA) and financial year-quarter level to those reported in government published, publicly available metrics. When agreement was +/-15%, we considered CSDS data to be 'complete' for that LA and quarter.

To address under-recording of mandated contacts in the CSDS, we developed methods to supplement recording based on a child's age at time of contact.

To understand the utility of the subset of 'complete' CSDS data, we explored the representativeness, longitudinal completeness and levels of missing data for key HV variables. Work is ongoing to explore completeness of child development (ASQ) data.

To understand the barriers to submitting complete data to the CSDS and to identify possible solutions, we consulted data managers and other relevant professionals across three LAs or NHS Trusts in England.

What we found

Only 24% of postnatal mandated HV contacts reported in government metrics were recorded in the CSDS in 2016-2020. This increased to 45% after we applied our age-based supplementation methods.

Almost half (42%) of England's 150 LAs had complete CSDS data for at least one quarter in 2016-2020. LAs with complete CSDS data were broadly representative in terms of region, deprivation and indicators of childhood adversity, but not ethnicity.

A small number of LAs (11) had at least 5 consecutive quarters of data, allowing longitudinal, child-level analyses from birth to age 15 months, during which 3 mandated contacts are delivered.

Variables related to key contact characteristics, such as duration, medium and location were well-recorded overall. However, variables related to staff mix were largely unavailable (up to 98% missing).

Consultees identified a range of contextual factors affecting data completeness, such as unclear national policies and understaffed HV teams. They highlighted issues at each stage of the data process that can lead to missing or duplicate CSDS data.

Implications

This work demonstrates that the CSDS 2016-2020 can be used to research delivery of HV contacts, carried out on a subset of complete data. A much smaller sample of LAs could be used for longitudinal analyses. The data did not shed light on other HV activity, such as referrals to other services.

Data completeness is improving over time. However, until all HV contacts are recorded in the CSDS, the government metrics are essential to assess completeness and develop a reliable data subset.

Clearer feedback from the CSDS to HV providers, and less frequent data returns may reduce the barriers to data submission and help realise the research potential of CSDS for policy and planning.

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