Changing childhoods. Changing lives.

THE CHILD HEALTH EQUITY MONITORING FRAMEWORK

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Cheshire and Merseyside
Health and Care Partnership

South Yorkshire and Bassetlaw Integrated Care System

INSTITUTE of HEALTH EQUITY

Contents

BACKGROUND

Purpose and intended audience

To improve child health and reduce inequalities, local health and care systems need to understand the scale and nature of the problem and know what works to address it. This Monitoring Framework – a set of key indicators aligned with the Child Health Equity Framework[1] – is designed to help local health and care systems track progress and take action on child health inequalities. It supports local partners to identify areas where outcomes for children, young people, and their families appear to be improving, and where further attention or evaluation may be needed.

While this resource is primarily intended for local health and care systems - including local authorities and Integrated Care Systems (ICSs) - it also includes recommendations for national bodies and government on how to support local areas, particularly in addressing gaps and limitations in the available data and indicators.

The national blueprint for a model Integrated Care Board (ICB)[2] highlights prevention, health inequalities, and the use of population health data and analytics as areas for development, and sets out ICBs' role as strategic commissioners for population health. These priorities apply across local health and care systems, where ICBs, local authorities, and wider partners share responsibility for improving population health. National policy - including the Health and Care Act 2022[3] and Fit for the Future: 10-Year Health Plan for England[4]- emphasises this shared accountability and the importance of prevention. This framework helps local systems turn these priorities into practice, recognising that effective prevention and reducing inequalities must start in childhood.

Rationale for developing the Child Health Equity Monitoring Framework

In the three ICS areas working with the Children and Young People's Health Equity Collaborative (CHEC), we heard that local health and care systems often collect and monitor a wide range of indicators on child health, inequalities, and the wider social determinants of health. However, these indicators usually sit in separate data sets and are not integrated. As a result, many systems lack a complete and clear understanding of child health equity across their areas. This makes it harder to see where progress is being made, where challenges remain, and where action or more detailed evaluation might be needed.

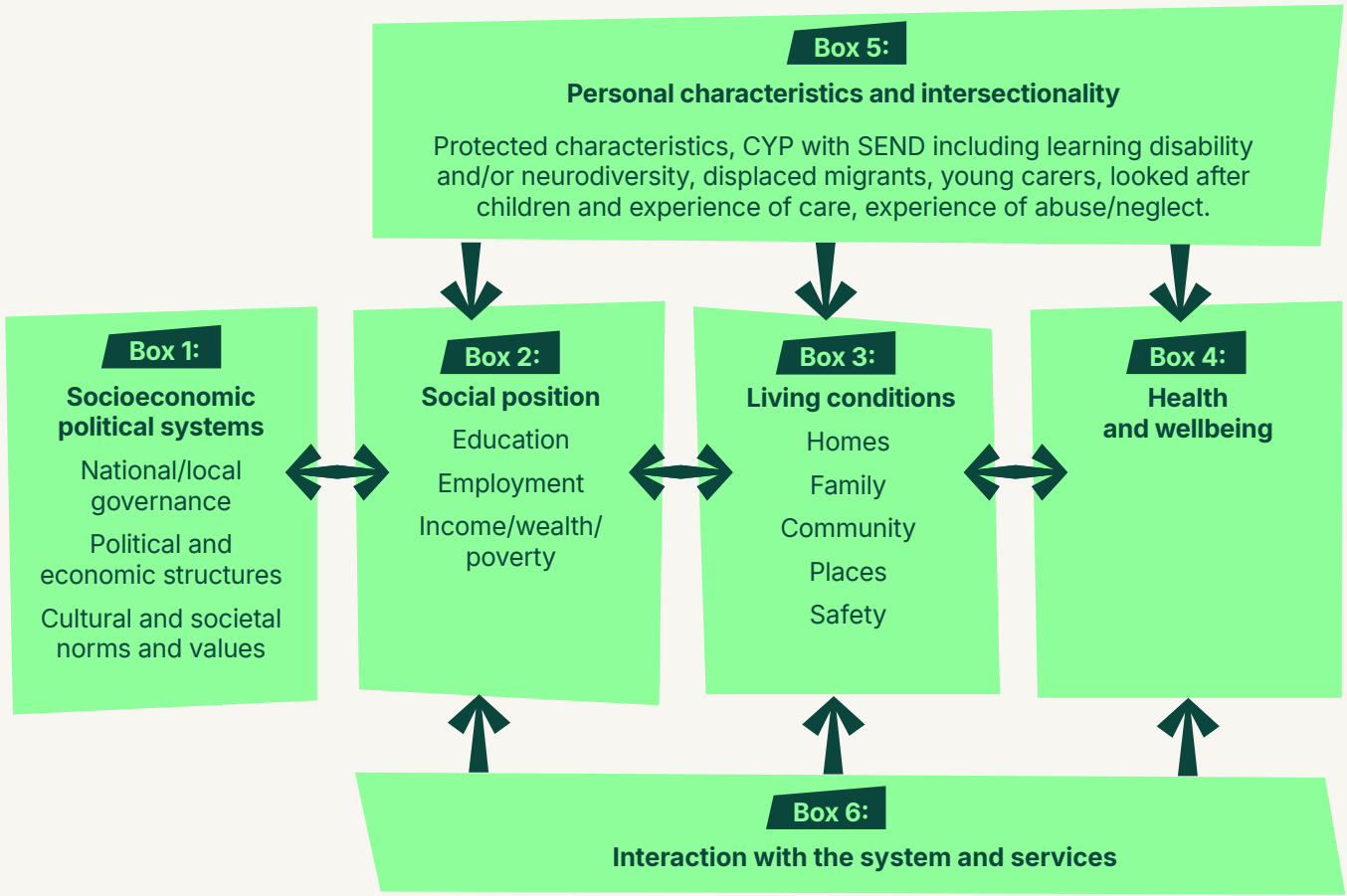
The Child Health Equity Monitoring Framework was developed to address this, providing a common set of indicators and a shared language for understanding child health inequalities. This supports collaboration across organisations and sectors, and therefore encourages more joined-up action to ensure that efforts to improve child health and reduce inequalities are better coordinated and more effective.

We also heard that indicators are often not available in a form that allows them to be broken down by key equity factors such as geography, levels of deprivation, free school meal eligibility, ethnicity, and gender. Without this disaggregation, it is much more difficult for local systems to understand and act on child health inequalities. Wherever possible, we have therefore identified indicators that can be disaggregated. Where this is not currently possible, we make recommendations on how gaps should be addressed.

Finally, the indicators also reflect what children and young people themselves say matters for their health and wellbeing, making this framework more child- and young people-centred than other approaches. This is important because many of the factors that children identify as most affecting their lives - such as safety, belonging, and love - are rarely captured in standard data sets or public health frameworks, which tend to focus on what is routinely measured, such as income, education, and health. While these remain critical drivers of child health equity, they are also areas that health and care systems already monitor and understand. This Monitoring Framework seeks to address this gap by providing a more complete picture of what shapes children's and young people's lives and health. We hope it will encourage better data collection on under-reported issues - including mental health, perceptions of safety, and the quality of parent–child relationships - and support local health and care systems to take more meaningful, child-centred action.

The Child Health Equity Framework

The Child Health Equity Framework: Framework for Drivers of Health and Wellbeing among Children and Young People



The Child Health Equity Framework is a theoretical framework that identifies the key factors influencing child health equity. It is aligned with the 'Marmot Eight' principles and draws together insights from:

The latest data and evidence,

over 300 children and young people, and

professionals and practitioners.

The Child Health Equity Framework was developed by CHEC members and partners with four main goals:

1

Guide routine data collection and analysis

The Framework underpins the selection of indicators in this Monitoring Framework. A complementary paper, What Good Quality Child Health Data Looks Like, provides further guidance on ethical and methodological considerations related to child health equity data quality.

2

Inform service and intervention design

Helping local health and care systems develop services that address child health inequalities.

3

Encourage action on wider determinants of health

Supporting efforts to improve the conditions that shape children and young people's lives.

4

Strengthen collaboration

Promoting partnerships between healthcare, public health, councils, communities, and children, young people, and their families.

The Child Health Equity Framework is based on the Conceptual Framework from the 2008 Global Commission on the Social Determinants of Health[5], adapted for the UK context and ICSs. The final version was refined with input from partners, the views of children and young people, and the Children and Young People's Health Equity Board.

Children and young people's input led to significant changes to the Child Health Equity Framework. They clearly understood and articulated how living conditions (Box 3) affect their health and wellbeing, and highlighted important gaps in the evidence base, which often does not include their perspectives.

Overview of the Child Health Equity Framework

Box 1:

Structural forces: Shows the wider societal forces that shape children's lives.

Box 2:

Social position: Highlights key areas of inequality, including education, employment, income, and wealth. These factors are driven by structural forces and affect living conditions.

Box 3:

Living conditions: Home, love, family, belonging, community, and safety are the foundations of children's and young people's health and wellbeing.

Box 4:

Health outcomes: Differences in living conditions can lead to differences in children's and young people's physical and mental health, such as birthweight, asthma rates, and overall wellbeing.

Box 5:

Discrimination and exclusion: Shows how these deepen health inequalities.

Box 6:

Health system role: Explains how healthcare can support children, young people, and families, and reduce inequalities.

Boxes 2–6 represent areas where local health and care systems can act directly to address child health inequalities, while also advocating for changes to wider structural forces (Box 1).

A detailed description of the Child Health Equity Framework is available in an accompanying paper on the Barnardo's and Institute of Health Equity (IHE) websites.

In the following chapter, we explain how we used the Child Health Equity Framework to select priority and secondary indicators for inclusion in this Monitoring Framework. These indicators are intended to guide local health and care systems on which child health equity data to collect and analyse to support a better understanding of, and response to, child health inequalities.

How we identified the indicators – our selection proces

We began by compiling a longlist of potential indicators aligned with the Child Health Equity Framework. This was developed through manual searches of national databases.

To prioritise this list, we applied a quality assurance process using criteria agreed by the CHEC Data Working Group. These criteria drew on commonly used data quality dimensions. Indicators were assessed against the following:

- Relevance to child health equity.
- Balance across health status, wellbeing, process measures, and the social determinants of child health.
- Alignment with other national approaches and frameworks (e.g., Core20PLUS5, Public Health Outcomes Framework).
- Routine collection and publication.
- Availability at least to local authority level in national data sets.
- Completeness and quality of data.
- Potential for disaggregation (e.g., by age, sex, ethnicity, geography).
- Timeliness, clarity, accuracy, and reliability of the data.
- Comparability across local health and care systems, enabling benchmarking of need and progress.

The final set of priority and secondary indicators was then reviewed by the CHEC Data Working Group.

Where there are important data gaps, we recommend that local health and care systems consider developing and running local surveys. These should use validated measures and established scales or adopt questions from high-quality existing surveys. Alongside quantitative data, we also highlight the importance of collecting and using qualitative insights from children, young people, and their families, and the community and voluntary sector. This can help local systems interpret and act on what the data is showing.

The agreed priority indicators are presented in the next chapter.

The priority indicators

Below is a set of priority indicators that we recommend all local health and care systems routinely collect and monitor to improve understanding of, and action on, child health inequalities. We encourage a balanced mix of indicator types, including process, outcome, and access measures, to provide a comprehensive picture of both service delivery and population-level outcomes.

The figure below illustrates how these priority indicators map to each box of the Child Health Equity Framework (boxes 2–6), which are considered under the control of local health and care systems, and also highlights their alignment with the 'Marmot Eight' principles.[6]

Annex 1 provides additional details for each priority indicator, including links to publicly available national data to support monitoring, and also presents a set of secondary indicators that local systems can choose to use fully, partially, or not at all, depending on local priorities. In the Annex, indicators are colour-coded to show uptake across CHEC ICS partners: green means all ICS partners currently include the indicator in their child health equity dashboards, amber means some do, and red means none do. We recommend aiming for a proportionate mix of indicators across all domains of the Child Health Equity Framework to provide a more complete and nuanced view of child health equity locally.

The subsequent chapter provides practical guidance on implementing and using the Monitoring Framework to understand and address local child health inequalities.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 2: Social Position **Education** Aligned to Marmot Principles: 2, 7 **Education indicators should be disaggregated by key equity dimensions - including free school meal eligibility, ethnicity, gender, special educational needs and disabilities (SEND), and locality.**	School readiness: percentage of children achieving a good level of development at the end of reception.	Children are defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children.
	Key stage 2 pupils meeting the expected standard in reading, writing and maths.	Percentage of key stage 2 pupils meeting the expected standard in reading, writing and maths.
	Average Attainment 8 score.	Average Attainment 8 score for all pupils in state-funded schools, based on local authority of pupil residence.
	Grade 5 or above in English and maths GCSEs.	Percentage of pupils achieving a grade 5 or above in English and maths GCSEs.
	Persistent absentees - primary school.	Percentage of primary school enrolments classed as persistent absentees (defined as missing 10% or more of possible sessions).
	Persistent absentees - secondary school.	Percentage of secondary school enrolments classed as persistent absentees (defined as missing 10% or more of possible sessions).
	Widening participation in higher education.	Proportion of pupils progressing to higher education by age 19, broken down by pupil characteristics and school type, covering pupils aged 15 in state-funded and special schools, and pupils aged 17 taking A levels or equivalent qualifications.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 2: Social Position **Employment; Income / Wealth / Poverty** Aligned to Marmot Principles: 1, 7	Children in relative and absolute low income families (under 16s).	Percentage of children (aged under 16 years) in a local area, living in absolute and relative low-income families.
Indicators of social position - employment; income/wealth/poverty should be disaggregated by key equity dimensions - including ethnicity, gender, family type, disability, and locality.	Children living in long-term workless households.	Annual UK estimates of the number of children living in households where all adults have not worked for at least 12 months.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 3: Living Conditions **Home** Aligned to Marmot Principles: 1, 5, 7. **Living condition indicators should be disaggregated by key equity dimensions - including ethnicity, disability, household type, and locality.**	Children living in overcrowded housing.	Percentage of families with dependents aged under 16 years living in overcrowded accommodation.
	Children living in housing with damp problems.	Percentage of households with dependent children living in homes with damp or condensation.
	Energy efficiency (warmth) of housing.	Households with an adequate EPC rating (A-C).

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 3: Living Conditions **Family / Community / Place / Safety** Aligned to Marmot Principles: 1 - 8.	Number of close friends a child or young person can talk to if in trouble.	Measures the perceived availability of close friends whom the child or young person feels they can confide in or seek support from when experiencing difficulties. Includes the number of friends or the degree of social support available.
Indicators of family, community, place and safety should be disaggregated by key equity dimensions - including ethnicity, disability, household type, and locality.	Frequency of talking to a parent about things that matter.	Measures the frequency with which a child or young person communicates with a parent or guardian about important personal matters, capturing a key dimension of familial support and connectedness. For monitoring, responses indicating communication more than once per week can be highlighted.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 4: **Children and Young People's Health and Wellbeing** Aligned with Marmot Principles: 1, 2, 5, 6 and 7. **Health and wellbeing indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation, and locality.**	Child mental wellbeing.	Local health and care systems should ensure that validated measures of children's and young people's mental wellbeing are included in their surveys. This can be done by using established scales such as WEMWBS or ONS personal wellbeing questions, or by using questions from existing school surveys such as BeeWell, OxWell, or from the School Health Education Unit, depending on local context.
	Rate of teenage mothers (conceptions to females aged under 18).	The number of live births to females aged under 18 per 1,000 females aged 15–17 resident in the local area.
	Low birth weight (<2,500 g) among term babies.	Proportion of live births at term (≥37 weeks gestation) in which the baby weighs less than 2,500 grams.
	Percentage of physically active children and young people.	Proportion of children and young people meeting the recommended physical activity guidelines (at least 60 minutes of moderate-to-vigorous physical activity per day for ages 5–18).
	Child overweight and obesity rates (reception and year 6).	Proportion of children classified as overweight or obese based on BMI percentiles according to the UK90 reference population. Data are collected for children in reception (ages 4–5) and year 6 (ages 10–11), capturing early and late primary school stages.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 5: **Personal Characteristics and Intersectionality (see also Box 6)** Aligned to Marmot Principles: 1-8 **Data on personal characteristics should be disaggregated by key equity dimensions - including ethnicity, gender, deprivation, and locality.**	Proportion of children with special educational needs (SEN).	The percentage of children identified as SEN, including those with an education, health, and care (EHC) plan or receiving SEN support.
	Children, registered with a GP, with a learning disability.	The percentage of children and young people registered with a general practice who have a recorded learning disability.

Domain of the Child Health Equity Framework	Indicators	Definitions
Box 6: **Interaction with the System and Services** Aligned with Marmot Principles: 1, 2, 5, 6 and 7 **System and service interaction indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation and locality.**	Percentage of children receiving the 2–2.5 year developmental check.	The proportion of children aged 2-2.5 years who have received a health review using the Ages and Stages Questionnaire 3 (ASQ-3) as part of the Healthy Child Programme.
	MMR vaccine coverage.	The percentage of children who have received the first dose of the measles, mumps, and rubella (MMR) vaccine by specific ages.
	Hospital admissions for children and young people with asthma.	The rate of emergency hospital admissions for children and young people (aged 0–18) with a primary diagnosis of asthma.
	Children entering the youth justice system (10-17).	The number of children aged 10 to 17 who enter the youth justice system for the first time, measured by the number receiving their first caution or sentence.
	Children in need and child protection plans.	The number and proportion of children who are identified as in need or subject to a child protection plan under the Children Act 1989. This includes children who require additional support from social services due to vulnerability, neglect, abuse, or other safeguarding concerns.

Practical use of the Monitoring Framework for local health and care systems

Using the Monitoring Framework for action

Local health and care systems can use the Monitoring Framework to build a more complete picture of child health equity in their areas. Mapping local data against the framework helps systems identify what is working well and where challenges exist.

The Monitoring Framework can be used to develop or strengthen child health equity strategies, covering health outcomes, inequalities, and wider determinants such as early child development and poverty. It can also guide the design and commissioning of services to address identified gaps and ensure that resources are targeted effectively. For example, Camden Council used the Child Health Equity Framework to align local indicators and produce a diagnostic report on children's health equity[7] which is now guiding planning and service development. In addition, local systems can use the framework to link social determinants of health to national priorities such as the NHS Core20PLUS5 programme, supporting early and targeted action.

Further examples of how ICS areas have collected and used child health equity data to inform evidence-based decision-making and address child health inequalities are included in the supporting CHEC evaluation report.

Ensuring the framework resonates locally

As a first step, local health and care systems should sense-check the Monitoring Framework with key stakeholders including children and young people, families, and the community and voluntary sector. This helps ensure that the indicators reflect local circumstances.

While the Monitoring Framework provides a recommended set of priority and secondary indicators, local systems may wish to supplement or substitute these with others linked to the 'Marmot Eight' principles or to social determinants of health that are particularly important in their area.

Engaging local stakeholders in deciding what to measure and how to measure it is best practice. Participatory indicator selection - involving the community and key partners in confirming priority indicators and choosing appropriate supplementary ones (see Annex 1) - will help ensure the framework is meaningful, practical, and actionable.

Disaggregating data to understand inequalities

Where possible, data should be broken down by factors such as age, sex, ethnicity, disability, geography, and deprivation to help understand and address child health inequalities. Disaggregating data can reveal differences between groups and show where structural factors - such as racism, discrimination, or poverty - may contribute to unequal experiences and outcomes. Looking at data through an intersectional lens highlights how multiple factors combine to affect children's health and wellbeing. When quantitative data is limited, qualitative information - such as local knowledge and the lived experiences of children, young people, and their families - should be used to provide context and ensure that actions are guided by the voices of those most affected by inequality.

Measuring racism, discrimination and their impacts

There is a gap in validated, age-appropriate indicators and tools that can directly measure racism, discrimination and their impacts. Local health and care systems can begin monitoring these issues using a combination of approaches. Quantitative proxies, such as disparities in access to services, health outcomes, or school exclusions, can indicate where systemic inequalities exist. Qualitative information, including interviews, focus groups, and participatory research, can capture the lived experiences of children, young people, and families. Using both approaches can give a clearer picture of how racism and discrimination affect children's health and wellbeing, and help guide effective action to address these inequalities.

Data sources

When implementing the Monitoring Framework, we recommend that national data is the starting point because it is consistent, comparable across areas, and publicly available. However, where local data sets offer added value - such as being more up to date or providing more granular insights (for example, broken down by ward, ethnicity, or level of deprivation) – these can be used in addition.

Where local data is used, indicators should be harmonised with the national data sets. This ensures they measure the same things in the same way, so comparisons remain valid, and the data can still link back to national indicators.

Data collection and analysis frequency

Data should be collected and analysed regularly to track local patterns of need, monitor changes over time, and assess the impact of policies and strategies. This allows systems to see whether inequalities are widening, remaining static, or improving.

Combining quantitative and qualitative data and insights

Alongside quantitative data, qualitative insights should be gathered regularly. Speaking with children, young people and their families, as well as professionals from a wide range of disciplines - including those in the community and voluntary sector - helps explain the context behind the indicators and can highlight underlying factors or areas for improvement.

Not all aspects of child health equity - especially those that matter most to children and young people - can yet be easily quantified. Local health and care systems should therefore supplement quantitative data with additional surveys (such as BeeWell or Oxwell) and consistently value and integrate qualitative insights to fully implement the Monitoring Framework.

Tools and capacity for implementation

Developing or building on existing dashboards or digital tools can help bring together indicators, trends, and qualitative insights, making monitoring and communication easier.

We acknowledge that this Monitoring Framework is being introduced at a challenging time for local health and care systems, with ongoing cuts and reorganisations. Nevertheless, local teams will need the right skills and resources to collect, analyse, and interpret child health equity data effectively. This Monitoring Framework is an important tool to support ICBs as they move into their formal roles as strategic commissioners for population health and to grow their functions in prevention, tackling health inequalities, and population health data and analytics. It also helps partners across the system use shared data and insights to coordinate action and make joint decisions, reflecting the shared accountability emphasised in national legislation.

Lessons from practice: From framework to action – how local systems are building child health equity dashboards

Here we describe how our three ICS partners are beginning to put the Monitoring Framework into practice by developing or refining existing child health equity dashboards that track progress and inform decision-making. Although this work is still at an early stage, reflections from ICS data leads highlight both the challenges and opportunities of implementation. Their work provides valuable lessons on how the indicators can be embedded in local practice, how to navigate data and partnership barriers, and how the framework can act as a lever for systems change and improvements in child health inequalities.

Data access, integration, and granularity

One of the most consistent challenges raised by ICS partners was data access and integration. While health-related indicators were relatively easy to access through NHS systems, many of the broader indicators linked to domains such as education, housing, or social care were harder for ICB staff to obtain. We heard how the majority - 60–70% - of indicators required new or additional data flows. This challenge was particularly acute in large ICSs that spanned multiple local authorities. For example, to populate its dashboard, Cheshire and Merseyside ICS, which covers nine local authorities, must establish nine separate data flows to link health and local authority data sets at the system level.

There was also a lack of consistency in how indicators were measured across local authorities. For the drivers of child health and wellbeing that mattered most to children, such as emotional wellbeing, data was often collected differently in different places, making it difficult to achieve comparability.

Another major challenge for successfully implementing the Monitoring Framework is the limited granularity of nationally available public data, which is rarely broken down by key dimensions such as ethnicity, deprivation, or geography. This makes it difficult to fully understand local inequalities and highlights the importance of supplementing national data with local sources that provide richer insight into population characteristics and local inequalities.

Barriers to data sharing

Data sharing across health and local authority partners remains a long-standing challenge. Education and housing departments were identified as particularly hard to access, and GP practices may be reluctant to share patient data due to concerns about data protection. Even when data sharing agreements were formally in place, technical barriers – such as incompatible data systems or the lack of a common child identifier across health and local authority data sets – often prevented data flows, leaving systems without access to key data sets despite willingness on both sides.

Partners also spoke of siloed structures within councils, which made it unclear for ICB staff to know who to approach for specific data sets. This lack of clarity significantly delayed the process of obtaining data to populate the dashboards.

Technical and capacity challenges

The ICS data leads involved in the CHEC project highlighted the need for a common data model to support integration of indicators from multiple sources. In its absence, progress was slow, and teams struggled to align data sets in a way that supported dashboard development. Developing such a model locally required significant time and technical expertise.

Efforts to create a ‘single view of the child’ in one ICS, by bringing together health, education, and social care data into one record, were underway, but these were proving more complex and time-consuming than anticipated. Each transfer of data between organisations required approval, pseudonymisation, and technical adjustments, creating significant delays.

These challenges were compounded by capacity constraints, with many data teams under pressure from wider NHS cuts, reorganisations, and competing priorities.

We are also aware that some indicators in the Monitoring Framework draw on school-based data, which may not fully reflect the population of children living in a local area. School data sets can include children who live outside the local authority, while some resident children may be home-schooled, attend schools outside the local authority, or attend private school, and therefore may not appear in the available data sets.

Local health and care systems, when implementing the Monitoring Framework, therefore need to be clear about which population the data represents and use appropriate denominators when calculating rates. ICSs highlighted the importance of recognising these limitations when interpreting data to guide local planning and decision-making.

What matters to children and young people

ICS data leads highlighted the gap between what children and young people say matters most to their health and wellbeing - such as love, belonging and safety - and the data currently available. They acknowledged that their current dashboards typically reflect what data is available, rather than what would be most meaningful and impactful in addressing health inequalities.

This Monitoring Framework is being used by partners as a lever to highlight these gaps and to make the case for new data collection approaches that better reflect children and young people's priorities. For further information, please refer to the CHEC evaluation report.

Building partnerships and relationships

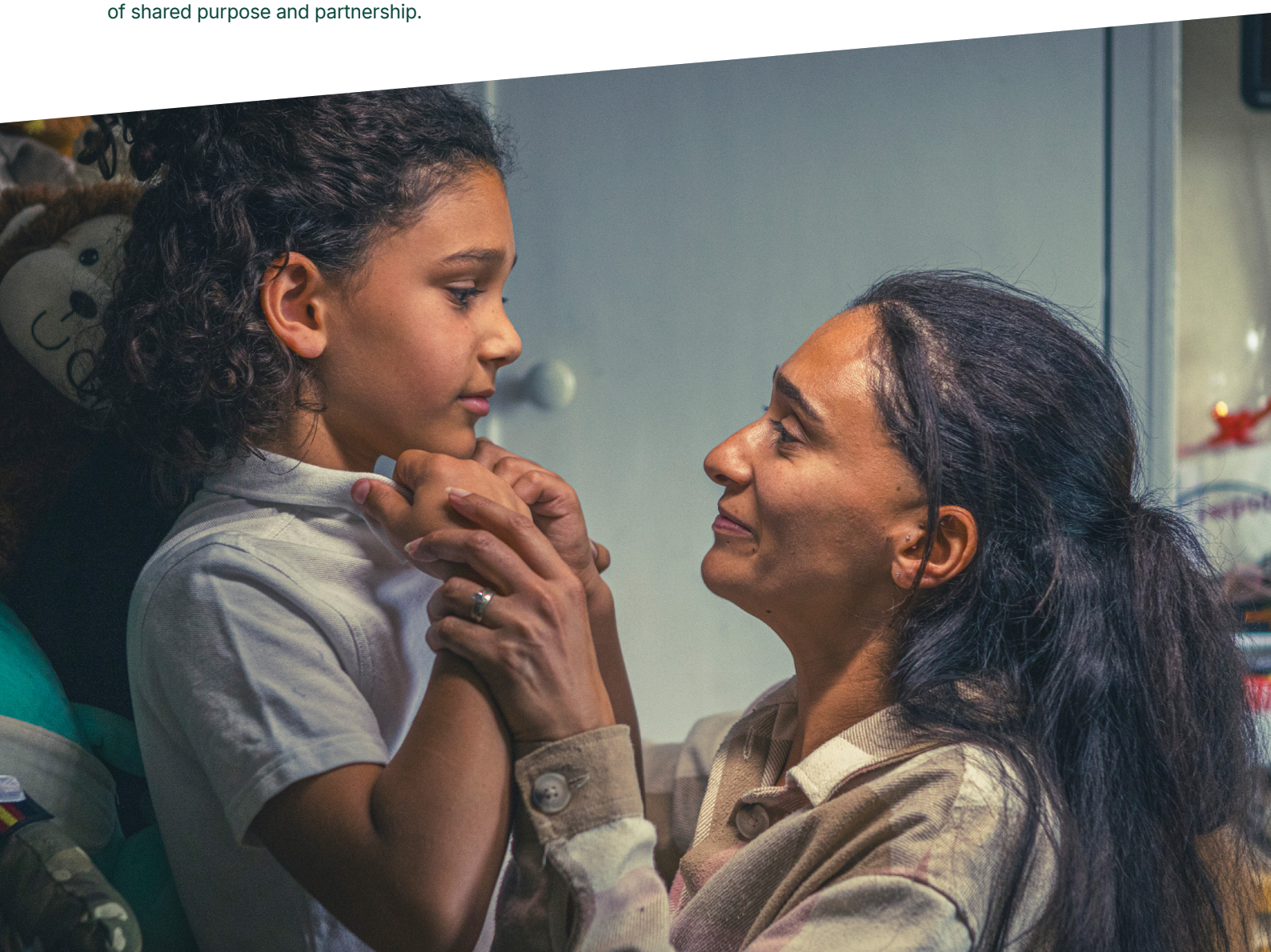
Successful dashboard development and implementation of the Monitoring Framework depended on building strong relationships with a wide range of partners. Public health teams were identified as particularly valuable allies, as they often hold extensive data sets, have expertise in accessing and interpreting data, and can act as facilitators between health and local authorities.

Co-leadership between ICBs and local authorities was also seen as critical to avoid the perception that ICBs were imposing demands. Instead, joint leadership created a sense of shared purpose and partnership.

Managing expectations and alignment

Several ICS data leads warned of the risk of 'dashboard overload', with multiple teams and projects requesting new dashboards at the same time. Integrating the Monitoring Framework into existing tools and avoiding duplication was seen as essential to avoid overburdening staff and partners.

Our ICS partners also reflected on the importance of clarifying shared responsibilities for different domains of the Monitoring Framework. For example, child poverty data does not sit solely with public health or children's services but spans multiple departments. Helping all partners understand how their data contributes to child health equity outcomes was seen as an important part of embedding the framework.



Recommendations for successful implementation and use of the Monitoring Framework

Key recommendations for local health and care systems

1. Develop a shared data model early in the process to enable integration of indicators from multiple sources.

2. Prioritise partnership building, particularly with public health teams, to facilitate data access and ensure co-leadership with local authorities.

3. Collect, analyse, and use existing data broken down by factors such as income, gender, age, ethnicity, disability, and geographical location to identify inequalities. Where data for these factors are missing or incomplete, advocate for improvements to strengthen local monitoring.

4. Actively develop and use indicators - both quantitative and qualitative - to capture the lived, interpersonal, and structural forms of racism and discrimination and their effects on children, young people, and their families. Quantitative data (e.g., surveys on experiences of racism and discrimination) combined with qualitative data (e.g., focus groups, interviews), can help local partners identify where, and which, children, young people, and families are most affected, and where further action or evaluation may be needed to reduce inequalities linked to racism and discrimination.

5. Use the Monitoring Framework as a lever to highlight data gaps in the areas of health that matter most to children and young people, the 'Marmot Eight' principles, and the social determinants of health, and make the case for new data collection approaches.

6. Understand which children are included in school-based data, recognise the limitations this creates for interpreting child health inequalities, and use appropriate denominators or supplementary local data where possible.

7. Supplement national data sets with local data if it is more up-to-date or provides greater detail (e.g., by ward, ethnicity, or deprivation), ensuring it aligns with the national data so comparisons remain valid, and it can be linked back to the national indicators.

8. Data from the community and voluntary sector should be used when it identifies inequalities not covered by other sources and is validated. For further information about the benefits of using data from the community and voluntary sector, please see the supporting paper What Good Quality Child Health Equity Data Looks Like.

9. Align where possible with existing dashboards and tools to avoid duplication and manage expectations around dashboard development.

10. Invest in workforce capacity for data collection and analysis, ensuring that implementation teams have the skills and resources needed to collect, analyse and use data effectively across all domains of the Monitoring Framework (e.g., housing, income, poverty, education).

Key recommendations for national bodies and government

These recommendations are directed at national bodies and government departments with responsibilities for children's health, wellbeing, education, and social care. This includes, but is not limited to, the Department for Education (DfE), the Department of Health and Social Care (DHSC), the Office for Health Improvement and Disparities (OHID), the Department for Work and Pensions (DWP), and the Department for Levelling Up, Housing and Communities (DLUHC). Other relevant bodies, such as local authorities and agencies involved in children's services, may also play a role in implementing these recommendations.

1. Establish a national programme to measure children's wellbeing, including key aspects that matter most to children and young people such as belonging and safety.

2. Improve alignment between school and resident populations in key data sets to ensure more accurate local monitoring.

3. Support the ongoing rollout of the unique child identifier across health, education, and local authority data sets, providing guidance, resolving technical barriers, and ensuring consistent adoption to enable reliable data sharing for monitoring child health inequalities.

4. Increase the availability of high-quality, timely, and reliable child health equity data, disaggregated by key characteristics such as income, gender, age, race and ethnicity, disability, geographical location, and other context-specific factors.

5. Develop and implement standardised, age-appropriate indicators to directly measure racism, discrimination, and their impacts, on children, young people, and families.

6. Provide clearer guidance and support on data flows between health, education, housing, and social care, reducing local barriers to data sharing and legislating where necessary to ensure secure, consistent access to key data sets.

7. Standardise indicator definitions and measurement to ensure consistency across local areas and enable meaningful comparison.

8. Support the development of a national data model that can be adapted locally to underpin implementation of this Monitoring Framework, linking data across health, education, and local services.

9. Define national metrics for the government's vision of the healthiest ever generation of children, ensuring these measures align with child health equity and can guide both local and national action.

Acknowledgements

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Thank you in particular to NHS Birmingham and Solihull, NHS Cheshire and Merseyside and NHS South Yorkshire and the Data Working Group for their support in the development of this framework.

Annex 1

Priority and Secondary Indicators

Annex 1 provides further details on the priority indicators and presents a set of secondary indicators that local systems may choose to use according to their priorities, along with the data sources for each indicator (latest as of August 2025). It also shows how local systems are beginning to implement the Monitoring Framework in practice through the development or refinement of existing child health equity dashboards. To illustrate current practice, indicators are colour-coded to show uptake across our ICS partners and Camden Council, which commissioned the Institute of Health Equity to produce a diagnostic report on children's health equity using the Child Health Equity Framework: green means all ICS partners currently include the indicator in their child health equity dashboards, amber means some do, and red means none do. Note that partners have also incorporated additional indicators or supplementary measures in their own dashboards or reports as part of this evolving work; these are not included here.

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 2: Social Position **Education** Aligned to Marmot Principles: 2, 7 **Education indicators should be disaggregated by key equity dimensions - including free school meal eligibility, ethnicity, gender, special educational needs and disabilities (SEND), and locality**	Priority indicator: School readiness: percentage of children achieving a good level of development at the end of reception	Children are defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children.	https://www.gov.uk/government/collections/statistics-early-years-foundation-stage-profile
	Priority indicator: Key stage 2 pupils meeting the expected standard in reading, writing and maths	Percentage of key stage 2 pupils meeting the expected standard in reading, writing and maths.	https://explore-education-statistics.service.gov.uk/find-statistics/key-stage-2-attainment
	Priority indicator: Average Attainment 8 score	Average Attainment 8 score for all pupils in state-funded schools, based on local authority of pupil residence.	https://explore-education-statistics.service.gov.uk/find-statistics/key-stage-4-performance
	Priority indicator: Grade 5 or above in English and maths GCSEs	Percentage of pupils achieving a grade 5 or above in English and maths GCSEs	https://explore-education-statistics.service.gov.uk/find-statistics/key-stage-4-performance
	Priority indicator: Persistent absentees - primary school	Percentage of primary school enrolments classed as persistent absentees (defined as missing 10% or more of possible sessions).	https://www.gov.uk/government/collections/statistics-pupil-absence
	Priority indicator: Persistent absentees - secondary school	Percentage of secondary school enrolments classed as persistent absentees (defined as missing 10% or more of possible sessions).	https://www.gov.uk/government/collections/statistics-pupil-absence

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 2: Social Position **Education** Aligned to Marmot Principles: 2, 7 **Education indicators should be disaggregated by key equity dimensions - including free school meal eligibility, ethnicity, gender, special educational needs and disabilities (SEND), and locality**	Priority indicator: Widening participation in higher education	Proportion of pupils progressing to higher education by age 19, broken down by pupil characteristics and school type, covering pupils aged 15 in state-funded and special schools, and pupils aged 17 taking A levels or equivalent qualifications	https://www.gov.uk/government/collections/participation-measures-in-higher-education
	Secondary indicator: Permanent pupil exclusion rates	The number of permanent pupil exclusions per 100 pupils. Rate per academic year across state-funded primary, secondary and special schools.	https://explore-education-statistics.service.gov.uk/find-statistics/suspensions-and-permanent-exclusions-in-england/

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 2: Social Position **Employment; Income / Wealth / Poverty** Aligned to Marmot Principles: 1, 7 **Indicators of social position - employment; income/wealth/poverty should be disaggregated by key equity dimensions - including ethnicity, gender, family type, disability, and locality.**	Priority indicator: Children in absolute and relative low-income families (under 16s)	Percentage of children (aged under 16 years) in a local area, living in absolute and relative low-income families.	https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics
	Priority indicator: Children living in long-term work-less households	Annual UK estimates of the number of children living in households where all adults have not worked for at least 12 months.	https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/childrenlivinginlongtermworklesshouseholdsintheuk/2023#cite-this-statistical-bulletin
	Secondary indicator: Children in temporary accommodation	Households with children, and number of children in temporary accommodation	https://www.gov.uk/government/collections/homelessness-statistics
	Secondary indicator: Employment rate	Percentage of people aged 16 to 64 in employment	https://www.ons.gov.uk/explore-local-statistics/indicators/employment-rate

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 3: Living Conditions **Homes** Aligned to Marmot Principles: 1, 5, 7. **Living condition indicators should be disaggregated by key equity dimensions - including ethnicity, disability, household type, and locality.**	Priority indicator: Children living in overcrowded housing.	Percentage of families with dependents aged under 16 years living in overcrowded accommodation.	https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/overcrowdingandunderoccupancybyhouseholdcharacteristicsenglandandwales/census2021
	Priority indicator: Children living in housing with damp problems.	Percentage of households with dependent children living in homes with damp or condensation.	English Housing Survey: https://beta.ukdataservice.ac.uk/datacatalogue/series/series?id=200010#!/access-data
	Priority indicator: Energy efficiency (warmth) of housing.	Households with an adequate EPC rating (A-C)	Department for Levelling Up, Housing and Communities (DLUHC) Nomis - Query Tool - Energy Efficiency of Housing: https://www.nomisweb.co.uk/query/construct/summary.asp?reset=yes&mode=construct&dataset=2401&version=0&anal=1

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 3: Living Conditions **Family / Community / Place / Safety** Aligned to Marmot Principles: 1 - 8. **Indicators of family, community, place and safety should be disaggregated by key equity dimensions - including ethnicity, disability, household type, and locality.**	Primary indicator: Number of close friends a child or young person can talk to if in trouble.	Measures the perceived availability of close friends whom the child or young person feels they can confide in or seek support from when experiencing difficulties. Includes the number of friends or the degree of social support available.	Local health and care systems to determine which of the below recommended school surveys is most relevant to their local areas. OxWell Student Survey: "How many close friends do you have — friends you could talk to if you were in some kind of trouble?". Link: https://oxwell.org/ BeeWell Survey: Questions on feelings of social connectedness and loneliness, assessing support from peers. Link: https://beewellprogramme.org/research/survey/
	Primary indicator: Frequency of talking to a parent about things that matter.	Measures the frequency with which a child or young person communicates with a parent or guardian about important personal matters, capturing a key dimension of familial support and connectedness. For monitoring, responses indicating communication more than once per week can be highlighted.	Local health and care systems to determine which of the below recommended school surveys is most relevant to their local areas. OxWell Student Survey: "How often do you talk to a parent or guardian about things that matter to you?". Link: https://oxwell.org/ BeeWell Survey: Questions on family relationships and quality of communication with parents. Link: https://beewellprogramme.org/research/survey/
	Secondary indicator: Parental mental health.	Percentage of children living with one or both parents reporting symptoms of emotional distress, by family type and work status.	https://www.gov.uk/government/statistics/children-living-with-parents-in-emotional-distress-march-2022-update
	Secondary indicator: Frequency of quarrels with a parent or guardian	Measures how often a child or young person experiences disagreements or conflicts with a parent or guardian.	OxWell Student Survey: The survey includes questions assessing experiences of conflict with parents or guardians. Link: https://oxwell.org/

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 3: Living Conditions **Family / Community / Place / Safety** Aligned to Marmot Principles: 1 - 8. **Indicators of family, community, place and safety should be disaggregated by key equity dimensions - including ethnicity, disability, household type, and locality.**	Secondary indicator: Quality of relationship with a parent or guardian	Assesses the perceived quality of the relationship between a child or young person and their parent or guardian.	OxWell Student Survey: The survey includes questions evaluating the quality of relationships with parents or guardians. Link: https://oxwell.org/
	Secondary indicator: Air quality (exposure to air pollution) in areas where children live, learn and play	Annual mean ambient air pollution exposure ($PM_{2.5}$ and NO_2) for children. Measures the average annual exposure of children to key air pollutants: fine particulate matter ($PM_{2.5}$) and nitrogen dioxide (NO_2), expressed in micrograms per cubic metre ($\mu g/m^3$).	Defra Pollution Climate Mapping (PCM): https://uk-air.defra.gov.uk/research/air-quality-modelling?view=-modelling
	Secondary indicator: Proportion of children living within accessible distance of green and natural spaces.	Measures the percentage of children who can easily walk to green and natural spaces from their home. These spaces include parks, playing fields, playgrounds, gardens, woods, forests, rivers, lakes, and canals. Accessibility is defined as being within a reasonable walking distance, typically 300–500 meters.	The Children's People and Nature Survey for England: https://www.gov.uk/government/statistics/the-childrens-people-and-nature-survey-for-england-2024-update/the-childrens-people-and-nature-survey-for-england-2024-update
	Secondary indicator: Proportion of households with dependent children experiencing food deprivation.	Measures the percentage of households with children under 18 years old that report experiencing food deprivation, defined as the inability to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, or a meal with a protein-rich food every second day.	We recommend that local health and care systems borrow the validated food insecurity questions from the EU-SILC (e.g. "ability to afford a meal with meat/fish/veg every other day") for their own local surveys. Local areas should draw on relevant questions from: EU-SILC (European Union Statistics on Income and Living Conditions). Or from the Department for Work and Pensions, Family Resources Survey (household food security and food bank usage): https://www.gov.uk/government/collections/family-resources-survey--2
	Secondary indicator: Access to affordable nutritious food	Proportion of households reporting that they cannot afford, or do not have reasonable access to, a healthy and nutritious diet (e.g. fruit, vegetables, and other core food groups).	Local health and care systems are advised to borrow validated tracker questions used in the Food Foundation's Broken Plate indicators to monitor this at local level. For example: "In the last 12 months, was there a time when you or anyone in your household could not afford to eat balanced meals, including fruit and vegetables?". Link: https://foodfoundation.org.uk/initiatives/broken-plate

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 4: **Children and Young People's Health and Wellbeing** Aligned with Marmot Principles: 1, 2, 5, 6 and 7. **Health and wellbeing indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation, and locality.**	Priority indicator: Child mental wellbeing.	Local health and care systems should ensure that validated measures of child mental wellbeing are included in their surveys. This can be done by using established scales such as WEMWBS or ONS personal wellbeing questions, or by adopting/borrowing questions from existing school surveys such as BeeWell, OxWell, or from the School Health Education Unit, depending on local context.	BeeWell Survey : https://beewellprogramme.org/research/survey/ OxWell Student Survey: https://oxwell.org/ School Health Education Unit (SHEU): https://sheu.org.uk/ WEMWBS: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/ ONS four personal well-being questions: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/surveysusingthe4officefornationalstatisticspersonalwellbeingquestions
	Priority indicator: Rate of teenage mothers (conceptions to females aged under 18)	The number of live births to females aged under 18 per 1,000 females aged 15–17 resident in the local area.	Office for Health Improvement and Disparities Fingertips – Sexual and Reproductive Health Profiles: http://fingertips.phe.org.uk/profile/sexualhealth
	Priority indicator: Low birth weight (<2,500 g) among term babies	Proportion of live births at term (≥37 weeks gestation) in which the baby weighs less than 2,500 grams.	Office for Health Improvement and Disparities (OHID) Fingertips: OHID Fingertips – Child Health Profiles: https://fingertips.phe.org.uk/profile/child-health-profiles
	Priority indicator: Percentage of physically active children and young people	Proportion of children and young people meeting the recommended physical activity guidelines (at least 60 minutes of moderate-to-vigorous physical activity per day for ages 5–18).	Active Lives Children and Young People Survey – Sport England: https://activelives.sportengland.org/
	Priority indicator: Child overweight and obesity rates (Reception and Year 6)	Proportion of children classified as overweight or obese based on BMI percentiles according to the UK90 reference population. Data are collected for children in Reception (ages 4–5) and Year 6 (ages 10–11), capturing early and late primary school stages.	National Child Measurement Programme (NCMP) – NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme
	Secondary indicator: Child development outcomes at age 2–2.5 years	Proportion of children achieving age-appropriate developmental milestones in domains including communication, language, physical development, social-emotional skills, and cognitive abilities at around 2–2.5 years.	Office for Health Improvement and Disparities: https://www.gov.uk/government/collections/child-and-maternal-health-statistics#child-development-outcomes-at-2-to-2-and-a-half-years Local health visiting services or the 0–5 Healthy Child Programme data may provide insights at local authority level.

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 4: **Children and Young People's Health and Wellbeing** Aligned with Marmot Principles: 1, 2, 5, 6 and 7. **Health and wellbeing indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation, and locality.**	Secondary indicator: Child development outcomes at age 2–2.5 years	Proportion of children achieving age-appropriate developmental milestones in domains including communication, language, physical development, social-emotional skills, and cognitive abilities at around 2–2.5 years.	Office for Health Improvement and Disparities: https://www.gov.uk/government/collections/child-and-maternal-health-statistics#child-development-outcomes-at-2-to-2-and-a-half-years Local health visiting services or the 0–5 Healthy Child Programme data may provide insights at local authority level.
	Secondary indicator: Children and young people with symptoms of mental ill health	The percentage of children and young people who show signs of mental health difficulties, based on the Strengths and Difficulties Questionnaire (SDQ).	Mental Health of Children and Young People in England Survey (MHCYP), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england Local areas can also collect SDQ data through schools or local surveys, following appropriate consent and safeguarding procedures.
	Secondary indicator: Children and young people's sense of mattering	The percentage of children and young people who feel that they are valued by others and that they contribute positively to their family, school, or community.	OxWell Survey, BeeWell Survey, School Health Education Unit (SHEU), or Understanding Society Youth Questionnaire. Local areas can also use adapted validated questions in school or local surveys.
	Secondary indicator: Children and young people experiencing bullying, abusive behaviour, or threats	The percentage of children and young people who report being bullied, threatened, or subjected to abusive behaviour at school, online, or in their community.	OxWell Survey, BeeWell Survey, Understanding Society Youth Questionnaire, and the School Health Education Unit (SHEU) surveys. Local areas can borrow validated survey questions for inclusion in school or local wellbeing surveys.
	Secondary indicator: Children and young people experiencing social media harms and online safety issues	The percentage of children and young people who report negative experiences online, including exposure to harmful content, cyberbullying, or unsafe interactions on social media platforms.	OxWell Survey, BeeWell Survey, Understanding Society Youth Questionnaire, and the School Health Education Unit (SHEU) surveys. Local authorities can borrow validated questions from these sources for inclusion in school or community-based surveys.
	Secondary indicator: Children and young people feeling safe	The percentage of children and young people who report feeling safe at home, at school, in their community, and online.	OxWell Survey, BeeWell Survey, Understanding Society Youth Questionnaire, and the School Health Education Unit (SHEU) surveys. Local areas can borrow validated survey questions for school or community-based assessments of perceived safety.

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 4: **Children and Young People's Health and Wellbeing** Aligned with Marmot Principles: 1, 2, 5, 6 and 7. **Health and wellbeing indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation, and locality.**	Secondary indicator: Age-standardised avoidable, treatable and preventable mortality rates in CYP (0-19 years)	The rate of deaths among children and young people aged 0–19 years that are considered avoidable, treatable, or preventable per 100,000 population, standardised for age. Avoidable deaths are those that could be prevented through public health interventions or healthcare provision. Treatable deaths are those that could be avoided through timely and effective healthcare. Preventable deaths are those that could be avoided through primary prevention or public health measures.	Office for National Statistics (ONS) – Avoidable Mortality in Children and Young People: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath
	Secondary indicator: Breastfeeding at 6-8 weeks after birth	The percentage of infants who are receiving any breast milk at 6 to 8 weeks of age. Breastfeeding is linked to improved infant health, reduced risk of infections, and long-term benefits for both child and maternal health.	Public Health England / OHID Fingertips – Child Health Profiles: Infant Feeding: https://fingertips.phe.org.uk/profile/child-health-profiles.
	Secondary indicator: Smoking at time of delivery	The percentage of mothers who report smoking at the time of giving birth.	OHID Fingertips – Child Health Profiles: Maternal Smoking: https://fingertips.phe.org.uk/profile/child-health-profiles

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Box 5: **Personal Characteristics and Intersectionality (see also Box 6)** Aligned to Marmot Principles: 1-8 **Data on personal characteristics should be disaggregated by key equity dimensions - including ethnicity, gender, deprivation, and locality**	Priority indicator: Proportion of children with SEN	The percentage of children identified as having special educational needs (SEN), including those with an education, health, and care (EHC) plan or receiving SEN support.	Department for Education – School Census: Pupils with Special Educational Needs: https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
	Priority indicator: Children, registered with a GP, with a learning disability	The percentage of children and young people registered with a general practice who have a recorded learning disability.	Local primary care data extracts from GP records.

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 6: **Interaction with the system and services** Aligned with Marmot Principles: 1, 2, 5, 6 and 7 **System and service interaction indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation and locality.**	Priority indicator: Percentage of children receiving the 2–2.5 year developmental check	The proportion of children aged 2–2.5 years who have received a health review using the Ages and Stages Questionnaire 3 (ASQ-3) as part of the Healthy Child Programme.	Office for Health Improvement and Disparities (OHID) – Child development outcomes at 2 to 2 and a half years: http://www.gov.uk/government/collections/child-and-maternal-health-statistics
	Priority indicator: MMR vaccine coverage	The percentage of children who have received the first dose of the measles, mumps, and rubella (MMR) vaccine by specific ages.	UK Health Security Agency (UKHSA) – COVER Programme Quarterly Vaccination Statistics: https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2024-to-2025-quarterly-data/quarterly-vaccination-coverage-statistics-for-children-aged-up-to-5-years-in-the-uk-cover-programme-october-to-december-2024#data
	Priority indicator: Hospital admissions for children and young people with asthma	The rate of emergency hospital admissions for children and young people (aged 0–18) with a primary diagnosis of asthma.	NHS Digital – Hospital Episode Statistics (HES), including the NHS Outcomes Framework Indicator 2.3.ii: Unplanned hospitalisation for asthma in under-19s: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.ii-unplanned-hospitalisation-for-asthma-diabetes-and-epilepsy-in-under-19s
	Priority indicator: Children entering the youth justice system (10-17)	The number of children aged 10 to 17 who enter the youth justice system for the first time, measured by the number receiving their first caution or sentence.	Youth Justice Board – Youth Justice Statistics: https://www.gov.uk/government/collections/youth-justice-statistics
	Priority indicator: Children in need and child protection plans	The number and proportion of children who are identified as in need or subject to a child protection plan under the Children Act 1989. This includes children who require additional support from social services due to vulnerability, neglect, abuse, or other safeguarding concerns.	Department for Education – Children in Need Census and Child Protection Statistics: https://www.gov.uk/government/collections/statistics-children-in-need

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 6: **Interaction with the system and services** Aligned with Marmot Principles: 1, 2, 5, 6 and 7 **System and service interaction indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation and locality.**	Secondary indicator: Percentage of children on speech and language therapy waiting lists	The proportion of children aged 0–18 who are waiting for speech and language therapy services.	Primary: NHS England – Community Health Services Waiting Times and Activity Statistics: https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists/ Supplementary: Royal College of Speech and Language Therapists (RCSLT) workforce and waiting times reports: https://www.rcslt.org/speech-and-language-therapy/workforce/retention-and-waiting-times/
	Secondary indicator: Percentage of children on CAMHs waiting lists	The proportion of children and young people aged 0–18 who are on waiting lists for Children and Young People's Mental Health Services (CYPMHS), also known as CAMHS.	NHS Digital – Waiting Times for Children and Young People's Mental Health Services: https://digital.nhs.uk/supplementary-information/2025/waiting-times-for-children-and-young-peoples-mental-health-services-2023-24
	Secondary indicator: Number of admissions of children and young people under 18 to tier 4 CYPMHS wards	Secondary indicator: The total number of admissions of children and young people aged under 18 to children and young people's mental health services (CYPMHS) tier 4 inpatient wards. Tier 4 services provide highly specialist inpatient care for those with severe, complex, or high-risk mental health needs that cannot be managed in the community.	NHS England – Mental Health Services Monthly Statistics (MHSDS): https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics
	Secondary indicators: Custody rates and broader offending among children and young people	The proportion of children and young people aged 10–17 who receive custodial sentences or are recorded for broader offending activity.	Youth Justice Board – Youth Justice Statistics: https://www.gov.uk/government/collections/youth-justice-statistics
	Secondary indicator: Access to children's allied health and support services (e.g. social prescribing, occupational therapy, physiotherapy)	The proportion of children and young people referred to allied health or wider support services who access assessment and/or treatment within recommended waiting time standards.	Local NHS provider waiting list and referral data (e.g. community paediatrics, CAMHS-linked social prescribing). Data is usually collected via local electronic patient record systems or community services data sets.

Domain of the Child Health Equity Framework	Indicators	Definitions	Indicator source
Box 6: **Interaction with the system and services** Aligned with Marmot Principles: 1, 2, 5, 6 and 7 **System and service interaction indicators should be disaggregated by key equity dimensions - including ethnicity, gender, disability, deprivation and locality.**	Secondary indicator: Access to and take-up of early years provision	The proportion of eligible children aged 2, 3 and 4 years accessing funded early education entitlements (15 or 30 hours).	Department for Education (DfE), Education provision: children under 5 years of age: https://explore-education-statistics.service.gov.uk/find-statistics/funded-early-education-and-childcare/2025
	Secondary indicator: Provision and reach of parenting support programmes.	The availability and uptake of evidence-based parenting programmes and family support services in the local area, measured as the proportion of eligible families engaged with these services.	As there is no consistent national dataset, local health and care systems should ensure that provision and reach of parenting support is monitored locally. This may involve collecting data on referrals, enrolment, attendance, and outcomes. Insights from families themselves (e.g., surveys or focus groups) can supplement quantitative data to understand barriers to access and effectiveness.
	Secondary indicator: Quality of early years provision	The proportion of early years providers (including nurseries, pre-schools, and maintained nursery schools) judged to meet high quality standards under the emerging Ofsted report card system.	Ofsted inspection data, transitioning from single-word effectiveness grades to more detailed report cards covering areas like quality of education and personal development.
	Secondary indicator: Early years workforce quality	The proportion of early years settings employing staff with Early Years Teacher Status (EYTS) or equivalent professional qualifications.	Government data on early years workforce qualifications, including EYTS status. This is often available through the Department for Education or local authority workforce surveys.
	Secondary indicator: Quality of education settings	The proportion of schools (primary, secondary, and special schools) meeting high-quality standards as assessed by Ofsted.	Ofsted inspection data – including the new report card system that replaces single-word effectiveness grades with more detailed evaluations of quality of education, behaviour and attitudes, and leadership and management.

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All images are posed by models.
Names have been changed to protect identities.

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