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THE CHILDREN AND YOUNG PEOPLE'S HEALTH EQUITY COLLABORATIVE (CHEC)

What good child health equity data looks like and how the voluntary, community and social enterprise sector can contribute

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Cheshire and
Merseyside
Health and Care Partnership

South Yorkshire and Bassetlaw
Integrated Care System

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INTRODUCTION

This report seeks to provide an overview of what constitutes good data on child health equity and why having good data matters. It recognises the wealth of both quantitative and qualitative data held by statutory organisations (e.g. healthcare, local authority) as well as voluntary, community and social enterprise (VCSE) sector organisations, but for a number of reasons, which are explored in this paper, there are barriers to fully integrating this data to create a holistic picture of child health equity.

This paper draws on learning from the Children and Young People's Health Equity Collaborative (CHEC) - acollaboration between Barnardo's, the UCL Institute of Health Equity (IHE) and NHS Birmingham and Solihull, NHS Cheshire and Merseyside and NHS South Yorkshire Integrated Care Systems (ICSs) - in particular, from the Data Working Group which collectively explored solutions, including the use of local data, to challenges such as a lack of data availability, disaggregation and cross-organisational data sharing.

This report should be read alongside the complementary paper on the Child Health Equity Monitoring Framework. The Monitoring Framework provides a common set of indicators and a shared language for understanding child health inequalities, supporting collaboration across organisations and sectors. It encourages a more joined-up approach to child health equity, ensuring that work is better coordinated and more effective.

This resource is primarily intended for local health and care systems (ICBs, local authorities, hospital trusts etc.) and VCSE sector organisations. 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 on child health equity.

What is child health equity and why does it matter?

Child health equity is about all children having a "fair and just opportunity to be as healthy as possible"[1] and, as a result, experience a long and healthy life. We know that for far too many children this is not the case and that they face significant health inequities, which are avoidable, unjust and caused by social and economic determinants. These determinants, known as the social determinants of health, are structural and hierarchical and include household income, education, housing and a healthy environment[2]. These are the main drivers of health and have a greater impact than access to healthcare services, whose primary role is to address ill health.

Alarmingly, as set out in a 2024 report by the Academy of Medical Sciences, child health in the UK has declined considerably in recent years. Infant mortality rose between 2014 and 2017, plateauing in recent years, and other indicators of child health and wellbeing are heading in the wrong direction[3]. Rates of overweight and obesity have increased, as has demand for mental health services. Compared with similar high-income countries, the UK has some of the lowest rates of breastfeeding. In most cases, childhood vaccination rates have fallen below the levels recommended by the World Health Organization (WHO) and dental extractions because of preventable tooth decay are the most common reason for children being admitted to hospital for dental general anaesthetics. Children living in the most deprived areas have experienced the most significant decline in their health. They are more likely than those in areas of lower deprivation to be exposed to key social determinants of health such as poor-quality housing and higher rates of poverty. This has reinforced existing inequalities. The impact of the social determinants on health and wellbeing is seen most starkly in the rise in infant mortality between 2014 and 2017, a third of which was attributed to the increase in child poverty. In the UK, life expectancy is lower for those who live in areas of higher deprivation compared with those in less deprived areas[4],[5].

To improve child health equity, the importance of creating the right environment for children cannot be underestimated. Health inequities can start as early as conception and impact all the way into adulthood. In fact, the first 1,001 days, from pregnancy to age 2, set the foundations for an individual's cognitive, emotional and physical development[6]. Furthermore, they can be passed down generations, which risks creating an ongoing cycle of inequity[6]. Consequently, this period presents the ideal opportunity to arrest the evidenced decline in child health[3].

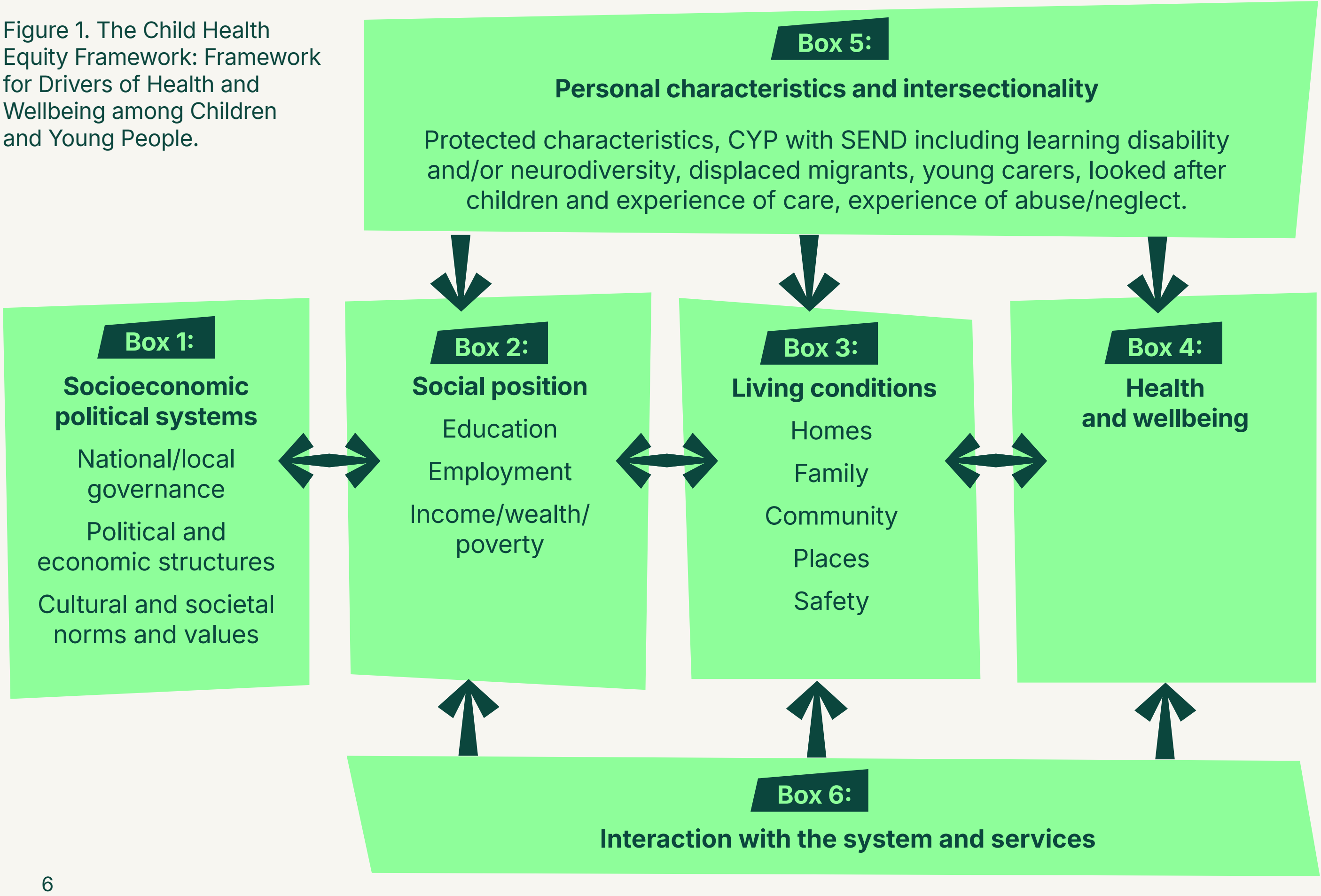
The Children and Young People's Health Equity Collaborative and the Child Health Equity Framework

The CHEC recognises that action on the social determinants of health is essential to improve health outcomes among children and young people and reduce health inequalities; and that these are not adequately addressed in policies, services and interventions that aim to improve health in this group. The programme facilitates new and innovative ways of working across the voluntary sector, academic partners, and healthcare systems. The programme worked with three Integrated Care Systems (ICS) - NHS Birmingham and Solihull, NHS Cheshire and Merseyside and NHS South Yorkshire - who were directly involved in shaping the programme both overall and at a local level.

Underpinning the work of the CHEC is the Child Health Equity Framework, which is a conceptual framework designed to underpin our theoretical understanding of the social factors that can impact on the health of children and young people, and lead to inequitable health and wellbeing outcomes[7]. It sets out the key drivers of health and wellbeing for children and young people and is designed to guide the analysis of data and development of indicators to assess and monitor inequalities in children and young people.

The Child Health Equity Framework was informed by an engagement exercise with over 300 children and young people, in partnership with local voluntary and community sector organisations in each of the three ICS regions. Home, community and education were identified as key components of good health. These insights were used to shape the framework which identified key factors important to children and young people that were not identified in the data.

Figure 1. The Child Health Equity Framework: Framework for Drivers of Health and Wellbeing among Children and Young People.



Box 5:
Personal characteristics and intersectionality

Protected characteristics, CYP with SEND including learning disability and/or neurodiversity, displaced migrants, young carers, looked after children and experience of care, experience of abuse/neglect.

Box 1:
Socioeconomic political systems
National/local governance
Political and economic structures
Cultural and societal norms and values

Box 2:
Social position
Education
Employment
Income/wealth/poverty

Box 3:
Living conditions
Homes
Family
Community
Places
Safety

Box 4:
Health and wellbeing

Box 6:
Interaction with the system and services

The Child Health Equity Framework is accompanied by a list of priority indicators (table 1), which map to the different domains of the framework and are intended to be used by local areas to monitor child health. These priority indicators were shared with Barnardo's staff in a survey to understand the type of child health equity data collected within the charity, as an example of how VCSE sector organisations can contribute to improving child health equity. Further details of the survey findings can be found in Appendix 1.

A standard operating procedure was developed to quality assess the indicators. The mapping process identified important gaps in the national data, in relation to the Child Health Equity Framework, which are focussed primarily around 'Living conditions – Homes, Family, Community, Places and Safety'. In addition, detailed data on children's mental health needs and concepts, such as belonging and feeling loved or safe, were found to be poorly measured at a local level. Where data was identified to address some of these gaps, following a further review of the indicators, it was determined that surveys that collect this data can be sporadic, or the data can be hard to generalise or breakdown to allow for conclusions about local populations to be drawn. Sources for these indicators include the NHS, national government bodies and local authorities. Further details can be found in the complementary paper, "The Children and Young People's Health Equity Collaborative (CHEC): A Monitoring Framework for the Drivers of Health Inequalities". The Child Health Equity Framework underpins the selection of indicators in the Monitoring Framework, which was developed to address the fact that child health indicators usually sit in separate data sets and are not integrated.

Table 1. List of priority indicators accompanying the Child Health Equity Framework

Category	Priority indicators
Child Development, Health and Wellbeing	• Indicators on mental wellbeing - e.g. WEMWBS • Percentage of children receiving the 2-2.5 year developmental check • Rate of teenage mothers (conceptions to females aged under 18 years) • Child overweight (including obesity) rates (reception and year 6) • Hospital admissions for asthma (under 19 years) • Low birth weight • Percentage of physically active children and young people
Education and School Performance	• School readiness: percentage of children achieving a good level of development at the end of Reception (Early Years Foundation Stage Profile) • Persistent absentees - Primary school & Secondary school • Widening participation in higher education • Key stage 2 pupils meeting the expected standard in reading, writing and maths • 5 GCSEs including English and maths
Health Service Quality	• MMR vaccine coverage
Income and Living Conditions	• Proportion of children living in poverty • Children living in long-term workless households • Percentage of families with dependents aged under 16 years living in overcrowded accommodation • Proportion of occupied dwellings with damp problems • Quality of housing
Vulnerable and at-risk CYP	• Child in Need / Child Protection Plans • Proportion of children with special educational needs (SEN) • Youth crime and antisocial behaviour • Children entering the Youth Justice System (10-17)

Why does data quality matter for child health equity and what does good data look like?

Good data enables the tracking of trends in child health, the identification of disparities and areas for intervention, improvements in care, shaping of local and national policies and evidence-based decision making, all of which are essential to achieving health equity.

For data to truly help us to understand need, it must be of sufficiently high quality. While the definition of good quality data can vary, the following six criteria are considered by the government as good measures and recommended for use[8]:

- **Accuracy** – when data reflects reality.
- **Completeness** – when all data that is essential for a particular use is present and available for use.
- **Uniqueness** – when data appears only once in a data set and therefore has not been duplicated.
- **Consistency** – when data values do not conflict with other values within a record or across different data sets. Having data consistency supports better linkage of data from different sources, thus increasing how useful the data is. It should be noted, however, that while this is important for data linkage, it is not sufficient.
- **Timeliness** – broadly refers to data that is available when expected and needed. Where data is time-sensitive, this is a key characteristic, and having up-to-date data is crucial.
- **Validity** – refers to the extent to which data align with the format, type and range in which it is required to be of use.

Further criteria that are not included on the list, but are key to ensuring the usefulness of data in its ability to address health inequities, are:

- **Appropriate disaggregation** – when the data is available at the appropriate level to be useful.
- **Inclusiveness**[1] – when data is collected for all groups. This recognises that data on disability status, ethnicity, gender, sex, sexual orientation, age and geographic status is essential to obtain a true picture of health.

Another characteristic of good data is its relevance to the subjects of that data. This was evident in the work on the Child Health Equity Framework which highlighted that the data we collect on child health does not always align with what children and young people consider important to them. This is crucial to consider in the context of the government’s aspiration to achieve the ‘healthiest generation of children ever’ and challenges us to think outside of our traditional definition of health. Qualitative insights can support this by broadening what is collected beyond health outcomes and creating a narrative through which quantitative data can be interpreted.

An additional factor to consider is the ability to share data between organisations, as this enables the creation of a more holistic picture of child health and wellbeing.

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[1] The above is not an exhaustive list and, according to the Health Equity Assessment Tool [30], there are a number of dimensions that should be considered in relation to health equity. These include protected characteristics as stated in the Equality Act 2010, including socioeconomic status, geographic deprivation (e.g. rural, coastal or urban settings) and inclusion health groups (e.g. young people leaving care).

Limitations of child health equity data

As with all data, that which we traditionally collect to enable us to understand and address child health equity has limitations, which has implications at both a local and national level. These data sets are often quantitative and are not always accessible to the VCSE sector, particularly for smaller organisations commissioned at place-level on small, short-term contracts. This results in gaps in our understanding of child health equity from a quantitative perspective.

The data limitations can be categorised as follows:

Technical challenges

- Disaggregation of national data by key equity factors, such as geography, deprivation, free school meal eligibility, ethnicity and gender, is not always possible due to the form in which it is provided. This creates a barrier to local systems being able to use the data to understand and act on child health inequalities[9].
- There is variation in the age bands that are used to record and report health data, meaning that it cannot be disaggregated or compared. This reduces the overall usefulness of the data[10].
- Some categories of data are reported in multiple settings, and in such cases may be collected and published in different ways, resulting in data sets that are not comparable. This is the case for data related to children with neurodevelopmental disorders such as autism and attention deficit hyperactivity disorder, as assessments are carried out in both community and mental health services[11].
- Linkage between medical and non-medical data sets does not necessarily occur, making it difficult to get a well-rounded picture of child health equity. For example, data sets from primary care, employment, education and housing do not necessarily link, creating a barrier to genuine understanding of how these social determinants impact on children and young people's health outcomes at a local level[12].

Policy and practice

- Disparities in health data, described as the systematic differences in the quantity and/or quality of health data representing different individuals, groups or populations, can arise as an unintended consequence of policy decisions about what data is collected. This leads to certain groups being underrepresented and their needs poorly understood, with resulting inequities that are largely unavoidable[13]. For example, as of February 2024, community paediatrics is no longer included in the 'Referral to Treatment' statistics, leaving us with an incomplete picture of need in the community[14].
- Children and young people are not always prioritised in national policy. For example, Core20PLUS5 was launched by NHS England in 2021 to support Integrated Care Systems to reduce health inequalities[15]. This approach initially focussed solely on adults and a version for children and young people was not launched until the following year, having been adapted from the adult framework[16].
- The data disparity in primary care is important to consider, particularly in light of the government's shift towards neighbourhood health (i.e. the delivery of integrated and localised care). With the exception of access to dental services by age, there is no national government-provided data on children and young people's use of primary care or how use differs between sub-populations (e.g. children and young people living in areas of high deprivation)[17]. The fact that some groups face additional barriers to accessing primary care means that, by definition, GP practices will not hold data on those who do not access their services. These are often the groups most in need of care. There is evidence that children and young people from areas of high deprivation in England may have lower levels of GP consultations compared to those in the general population[17]. Older teenagers have also been shown to be less likely to use primary care[17].
- In the 'National Framework for NHS – action on inclusion health', NHS England highlighted that inclusion health groups, identified as those who are socially excluded and generally experience multiple interacting risk factors for poor health, are not consistently recorded in electronic health data sets when they interact with services[18].
- The Royal College of Paediatrics and Child Health (RCPCH) highlights the association between children's health, education and social outcomes, but that data on each of these areas is not routinely shared between the different agencies that collect it[19]. The reasons for this are numerous and are usually not due to an unwillingness of the agencies involved. They include a lack of legislation and guidance on what can be shared between organisations, how it can be shared and when[19]. The RCPCH has reported that paediatricians have fed back difficulties in exchanging information, which may be due to poor interprofessional communication and/or a lack of interoperability between information systems, preventing effective information sharing[19].

Purpose of data collection

- Organisations involved in the delivery of health and care services collect data for different purposes, resulting in the potential for different requirements for granularity of data[20].
- Data from secondary care and community health services (e.g. Hospital Episode Statistics, Emergency Care Data Set and Community Services Data Set) are collected primarily to support payment and activity monitoring[21]. The emphasis on data to demonstrate performance and that targets are being met introduces bias into what data is considered valuable and can result in an inconsistent picture of health.
- By nature, routine health data do not capture information about health in between interactions with healthcare services. This results in gaps in our understanding of the social determinants of health which could support early intervention and a more preventative approach to care[21]. It should be noted that this is also the case for non-healthcare services.
- Data captured beyond the NHS which focusses on the social determinants of health, such as housing data held by local authorities, would be enormously beneficial alongside health data[21]. With the social determinants being the key drivers of health, such data is invaluable in relation to understanding and addressing child health inequalities and inequities.
- Engagement with children and young people as part of the CHEC identified that the data collected at local and national levels does not always align with what children and young people consider important in relation to their health[22]. You can read more about this in the Children and Young People's Insight Report.

Social factors

- Ethnicity data is key to understanding health inequalities and inequities. However, such data is often challenging to collect and of poor quality[23]. A report by the Race Equality Foundation on "Improving the recording of ethnicity in health data sets: Exploring the views of community respondents and the healthcare workforce", explored how people from Black, Asian and minority ethnic communities are asked about their ethnicity and how it is subsequently recorded. The reported reasons for the challenges in collecting this data include[23]:
    - Different understandings of ethnicity among individuals
    - A lack of explanation as to why ethnicity data is collected, leading to suspicion and sometimes a refusal to answer
    - A limited understanding of the association between ethnicity and health conditions and outcomes
    - Some patients not fitting into the ethnicity categories, resulting in them feeling undervalued, underrepresented and unsure of where to place themselves, partly because categories are not consistent
    - Fear of racial discrimination
- Routine healthcare data does not include those who do not access health services[21]. It is well documented that certain population groups (e.g. ethnic minorities) face barriers to accessing healthcare services. Hence, their representation in healthcare data sets may be disproportionately low in relation to their level of need. Barriers to accessing healthcare services in the UK include language and communication barriers, low health literacy, digital exclusion, lack of culturally appropriate services, geographical inaccessibility, lack of service availability and financial constraints (e.g. travel costs, time off from work)[24].

Despite these limitations, there are examples in the NHS of excellent work being done to improve the quality of child health equity data. This is illustrated by the work of the ICS data leads who have collaborated with local partners to review the priority data indicators to determine local use, identify gaps and source local data to address these gaps. In NHS South Yorkshire and NHS Birmingham and Solihull ICSs, data dashboards which bring together existing health data on child health equity have been created. The data can be analysed by ethnicity, deprivation and geography, and the dashboards will facilitate a deeper understanding of local child health equity in each of the ICSs. All three of the ICSs have aimed to integrate local authority data into their dashboard, and although this was met with some challenges, at the time of publication this had been achieved in Birmingham and Solihull. In Birmingham and Solihull they are also developing a template that will allow other ICSs to replicate their model. Cheshire and Merseyside had an existing dashboard which they are working to update to increase alignment with the CHEC. They have worked with their Beyond Board to secure a commitment to system-wide engagement to collaborate with public health and other local authority partners to bridge gaps in data insights; and improve access to and sharing of data across health and social care, specific to the priority indicators. This is with the aim of adopting wider data sharing across system partners through an agreed local process.

Although this section focusses predominantly on healthcare data, this does not mean that data from the VCSE sector is without limitations. A survey conducted with Barnardo's children's services practitioners outlines some of the challenges faced by VCSE sector organisations in relation to the collection and use of data. These are summarised as follows and can be found in more detail in Appendix 1.

- Unwillingness to share data or a lack of consistent recording
- Limited access to complete data sets due to a lack of parental consent
- Reliance on external agencies for referrals to services
- Limited data collection (e.g. due to inaccurate or missing data on admission, data collected only on those accessing services)
- System and resource issues (e.g. lack of integrated data systems, limited staff time and capacity to collect and record data, internal inconsistencies in data capture)
- Difficulties aligning data across multiple external systems
- Inconsistencies in how data is defined and measured
- External data that is incomplete or out of date
- Internal data that is incomplete (e.g. a high number of 'unknowns' in demographic data)

Both statutory and VCSE organisations hold rich qualitative data that is used to inform service delivery and local outcomes. However, there is a lack of standardised data systems to report these and this data does not routinely inform the collective understanding of child health equity and the wider determinants of health at a local or regional level.

How can the voluntary, community and social enterprise sector contribute to child health equity data?

Despite its limitations, the VCSE sector provides a unique lens through which to view child health equity and the data and intelligence it holds can complement that provided by statutory services. A 2021 report by the members of the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance, 'Making better use of voluntary sector data and intelligence in health service planning', explored how to increase the use of data and intelligence in the VSCE sector in health and social care planning[25]. The report argues that making use of data and insights from the VCSE sector will:

- Improve the health and wellbeing of communities
- Improve services
- Improve partnership working to tackle health inequalities and prevent avoidable ill health

As previously mentioned, VCSE organisations often hold a broad range of quantitative and qualitative data and intelligence on the health and wellbeing of the communities they serve. This may include[25]:

- Facts and figures on individuals (e.g. data on ethnicity, age, sex)
- The impact on individuals of different interventions (e.g. disease prevalence, health and wellbeing outcomes)
- Wider intelligence about populations (geographical, themes and communities of interest), including those who are frequently excluded from routine data sets
- The impact of the wider environment and/or policy decisions on people and communities, for example factors such as poverty, housing and education
- Knowledge about people's access to, use of, and issues with, statutory services, how changes to local service offers may affect local communities and how individuals can be best supported within communities

Qualitative data can be seen as being less rigorous than quantitative data, at significant risk of bias and not generalisable (although this overlooks the fact that such data is not designed to be generalisable)[26],[27]. However, qualitative data focusses on 'how' and 'why', collecting data on people's experiences, behaviours and perceptions and bringing alive lived experience[26],[27]. This can provide a rich context to quantitative data, supporting its interpretation and giving us a deeper understanding of health inequalities. A survey conducted for the 'Making better use of voluntary sector data and intelligence in health service planning' report identified the following additional barriers to using voluntary sector data[25]:

- It is not yet common practice for health-related VCSE data and insight to be shared
- There is a lack of universal understanding of the benefits of sharing VCSE data and insight, particularly in relation to the VCSE's knowledge of statutory services
- There is a lack of processes to enable cross-organisational data sharing which has been highlighted by the challenges experienced as part of the CHEC in relation to data sharing between Integrated Care Boards and local authorities
- Engagement with VCSE organisations does not happen early enough for VCSE insights to influence service design or development
- There are barriers to data sharing, even within formal partnerships and collaborations

Conclusion

This report recognises that for us to improve child health equity, we need a comprehensive understanding of the challenges we are facing. That requires us to have good data and be able to share that data appropriately between relevant organisations. Statutory services hold a wealth of quantitative and qualitative data, as do VCSE sector organisations. Integrating this data would provide us with a much more holistic picture of child health equity than what is currently available to us. However, these data sets have limitations and there are challenges to harnessing the data across local systems to inform collective understanding of child health equity.

Recommendations

Key recommendations for local Integrated Care Systems

- Gaps in cross-organisational data sharing should be identified to determine where action is required. This will help to improve local understanding of and collaborative working on child health inequalities and inequities. Organisations should work together to improve openness and transparency, establish data sharing agreements and, where possible and relevant, joint commissioning outcomes. There is much to be learned from the COVID-19 pandemic during which there was an increased ability to share information “quickly, efficiently and ethically” [28]. It is crucial that this includes VCSE sector organisations to ensure that their data can be used alongside that from statutory services.

Key recommendations for national data producers and the government[2]

- National data producers (e.g. Office for National Statistics, Public Health Scotland) should work to increase the availability of high-quality, timely and reliable child health equity data that is disaggregated by key characteristics such as income, gender, age, race and ethnicity, disability, geographical location, and other context-specific factors. Where local data can add value to national data sets, providing more up to date or more granular insights, it should be used. It is important that they are harmonised to ensure that they measure the same things in the same way, so that comparisons remain valid and that data can still link back to national indicators.
- The government should consider commissioning an equity-focussed review of national healthcare data sets to inform work to improve the quality and inclusivity of child health equity data.
- The 10 Year Health Plan for England references plans to roll out a single unique identifier (SUI) to help overcome some of the barriers to data sharing between agencies[29]. The SUI, known as the unique child identifier, should be piloted and rolled out as soon as possible, and used across the VCSE, education and healthcare.
- The government should establish a national data set on the use of non-dental primary care services by babies, children and young people which can be disaggregated by key characteristics including income, gender, age, race and ethnicity, disability and geographical location.
- The government should develop a set of metrics to support its ambition to create the healthiest ever generation of children. This would help to establish a clear definition and enable progress to be assessed. The included indicators should be able to be disaggregated by key demographic characteristics to enable the monitoring of health inequalities and inequities.

Acknowledgements

The Children and Young People’s Health Equity Collaborative was a Barnardo’s-sponsored collaboration with the Institute of Health Equity and three Integrated Care Systems – NHS Birmingham and Solihull, NHS Cheshire and Merseyside and NHS South Yorkshire. We would like to acknowledge and thank all of the partners, especially our Health Equity Champions, who have generously given their time and expertise to this programme.

Thank you in particular to the Data Working Group, ICS leads and IHE for their support in the development of this report.

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[2] 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.

Appendix 1

Children and Young People's Health Equity Insights

This appendix provides an overview of data collected by Barnardo's to illustrate the potential contribution of the VCSE sector to addressing child health equity. It draws on data from Barnardo's Child Poverty Fund and Practitioner Survey, and a survey of practitioners across frontline services to determine whether data on the set of priority indicators that underpin the CHEC Framework were collected. For further information on the priority indicators, please see the complementary paper on the Child Health Equity Monitoring Framework.

Background to Barnardo's

Barnardo's provides vital support, running 760 specialist services across the UK, contributing to improving wider determinants of health such as child development, health and wellbeing, education and school performance, health service quality, income and living conditions, and supporting underserved and at-risk children and young people.

In 2023/24, Barnardo's services and partnerships reached 356,200 children, young people, parents and carers, including 241,000 children and young people, 19,000 with a disability, 3,000 care leavers and 8,000 looked after children.

Barnardo's delivers many services directly; in these cases, it is possible to determine what data is captured. However, most services are delivered in partnership and use external systems, which means being reliant on what data is captured by those systems.

In 2023/24, Barnardo's worked across 27 external recording systems. Data for around 113,000 service users was recorded on external systems, 127,000 through Essex Child and Family Wellbeing Centres, and 70,000 captured on spreadsheets or external forms. This complexity reflects the diversity of the charity's service delivery but presents challenges when building a full picture of the needs and outcomes of the children and families supported.

Child Poverty Fund

Barnardo's invested in a three-year Child Poverty Fund, intended to meet immediate crisis needs which could not be met elsewhere, by offering financial assistance to families. The Child Poverty Fund provided direct support to 15,592 people in 2023-24, compared with 13,211 the previous year. In 2023-24, 38% of the fund was used to prevent hunger.

Category	2022–2023	2023–2024	Indicator Domain
Preventing hunger	35%	38%	Child Development, Health and Wellbeing
Suitable clothing	24%	24%	Income and Living Conditions
Access to warm spaces	21%	14%	Income and Living Conditions
Access to safe and working appliances	9%	11%	Income and Living Conditions
Helping children stay safe	9%	10%	Child Development, Health and Wellbeing
Access to health-related appointments	1%	2%	Child Development, Health and Wellbeing
Access to employment	1%	1%	Income and Living Conditions

Table 2: The reasons for which support was provided by the Child Poverty Fund

Practitioner Survey

Twice a year, data is collected through the Barnardo's Practitioner Survey. The survey captures insights from practitioners to understand more about the challenges children, young people and families are facing. To supplement the survey, focus groups are run to capture deeper insights from practitioners.

Education and School Performance

Practitioners mentioned that mental health issues are contributing to school avoidance and poor attendance. Practitioners felt that the education system is not meeting the needs of children with special educational needs and disabilities. There are significant delays in support for students, long waiting times for assessments, and a lack of alternative school placements.

- 74% of practitioners reported that they have supported children who have struggled to attend school over the last 12 months.
- 60% responded that mental health and wellbeing is one of the biggest barriers to attendance.
- 30% said unmet needs and lack of support, including unsuitable learning environments and limited access to mental health services, are major factors.

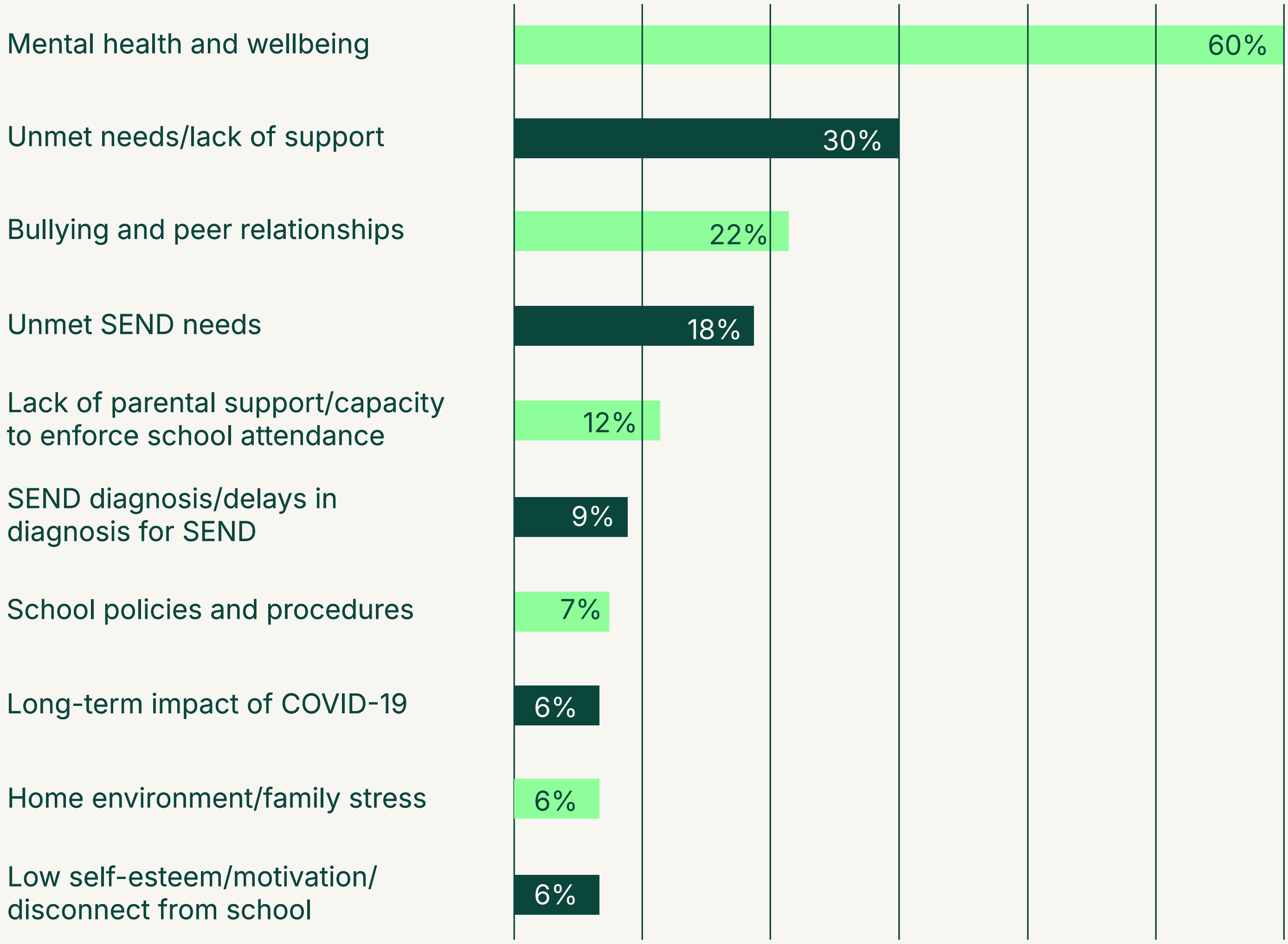


Figure 2: Main reasons children are struggling to attend school (top 10)

Income and Living Conditions

Practitioners reported that families are facing challenges due to the rising cost of living, impacting their ability to afford basic essentials. This is taking a toll on mental health and wellbeing and limiting opportunities for children and young people. The high cost of childcare is making it harder for parents/carers to work and provide adequate support for their children.

- 65% of practitioners surveyed are currently supporting a child, young person, or family experiencing poverty.
- 43% of practitioners surveyed are supporting children or young people who do not have sufficient food to eat because they cannot afford it.
- 31% are supporting children or young people who are not able to stay warm because they can't afford adequate heating.
- 19% are supporting families with harmful levels of mould in their home.

Child Development, Health and Wellbeing

- 72% of practitioners reported that there has been an increase in the number of children and young people they support experiencing mental health and wellbeing issues in the last 12 months.
- Rising anxiety, depression, self-harm, and suicidal thoughts are exacerbated by long wait times for mental health assessments and support.

Data Collection and Indicators

Barnardo's gathers a range of data to better understand needs, build a clear picture of the children, young people and families it supports, and shape its services so they are the right fit for each community.

Child health equity indicators Barnardo's collects data on

As referenced on pages 6-7 of this report, the Child Health Equity Framework is accompanied by a list of priority indicators (table 1), which map to the different domains of the framework and are intended to be used by local areas to monitor child health. To better understand Barnardo's data collection in relation to these priority indicators, a survey was circulated to practitioners.

Category	Priority indicators
Child Development, Health and Wellbeing	• Indicators on mental wellbeing - e.g. WEMWBS • Percentage of children receiving the 2-2.5 year developmental check • Rate of teenage mothers (conceptions to females aged under 18 years) • Child overweight (including obesity) rates (reception and year 6) • Hospital admissions for asthma (under 19 years) • Low birth weight • Percentage of physically active children and young people
Education and School Performance	• School readiness: percentage of children achieving a good level of development at the end of Reception (Early Years Foundation Stage Profile) • Persistent absentees - Primary school & Secondary school • Widening participation in higher education • Key stage 2 pupils meeting the expected standard in reading, writing and maths • 5 GCSEs including English and maths
Health Service Quality	• MMR vaccine coverage
Income and Living Conditions	• Proportion of children living in poverty • Children living in long-term workless households • Percentage of families with dependents aged under 16 years living in overcrowded accommodation • Proportion of occupied dwellings with damp problems • Quality of housing
Vulnerable and at-risk CYP	• Child in Need / Child Protection Plans • Proportion of children with special educational needs (SEN) • Youth crime and antisocial behaviour • Children entering the Youth Justice System (10-17)

Examples of data collected

Throughout the time Barnardo's supports a child, young person, parent or carer, data is collected to help understand their needs, track their progress, and measure outcomes. Here are some examples of the information gathered:

Outcomes data for young people in **leaving care services**, covering support provided around budgeting and money management, education/employment, and housing.

In **mental health services**, session-by-session monitoring of mental wellbeing is carried out.

Qualitative data are collected around the circumstances leading to referral to **Gender Space**, which supports children and young people who identify as trans, non-binary, or are gender questioning, as well as their families.

Data is gathered on the asylum process and outcomes from the Barnardo's **trafficking service and services for unaccompanied young people.**

Within Barnardo's **nursery provisions**, data is collected on children's developmental progress.

In **intensive family support services**, detailed data are held on families, including information on housing, crime, and worklessness.

Foster carers and foster care services record top line information about education engagement and achievements of fostered children. This data provide evidence for quality reports to inspectorates, internal reports and evidence during inspections.

As part of Barnardo's **16-19-year-old Study Programme** delivery in England, its **Employment, Training and Skills service** delivers maths and English. The service collects information on the education history and carries out an initial assessment of these subjects. If a young person hasn't achieved a GCSE in them, they are required to sit them. Success from this is measured and reported in the data. Data is also collected on barriers to learning and success and achievement of their learning aims. As part of the 16-19 Study Programme, young people are supported on to a positive destination, which includes further education and, in some cases, higher education. This information is also recorded. The service benefits children and young people with SEND or an Education, Health and Care plan, those who are young carers, young people who are looked after/care experienced and those experiencing abuse, neglect or mental ill health.

Barnardo's **attendance mentoring service** captures information on school attendance at the point of referral and throughout the intervention, as well as free school meal eligibility, and outcomes related to:

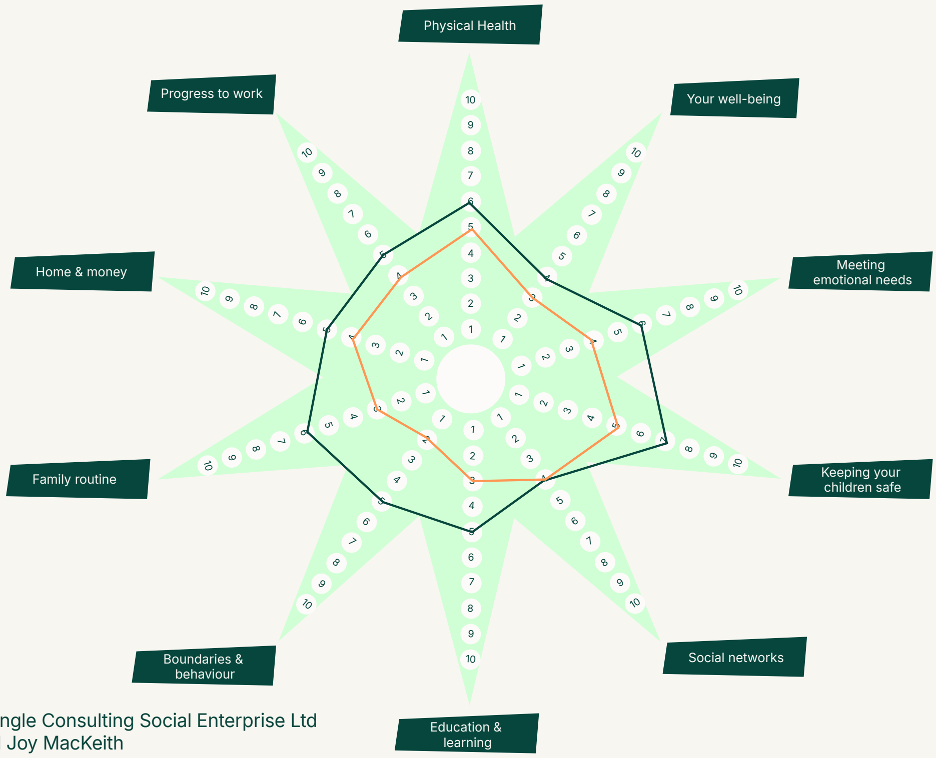
- Mental health
- Routines and boundaries
- Activities outside of school
- Voice of the child

Barnardo's **family support services** monitor outcomes such as:

- Access to necessary healthcare
- Engagement with support services
- Improved physical health and wellbeing
- Increased parental confidence, resilience, and health
- Cessation of parental smoking
- Improved family routines
- Access to appropriate educational placements

In Barnardo's **services for young carers**, information is recorded about the primary and secondary care needs of the parent or sibling being cared for, as well as the number of children given a voice in their child protection or children in care meetings. This provides an understanding of how many children with caring roles may need further support and can compare the number of children represented with the number of meetings held.

Evidence-based approaches are used to measure **wellbeing and support behaviour change** among children, young people, parents and carers to make positive change. Tools like the Outcome Star or Barnardo's Outcome Framework support the charity to understand each individual's journey, track their progress, tailor support, and capture outcomes that are directly relevant to their needs, such as feeling less isolated, adjusting to the impact of chronic illness, or accessing information on housing. These measures not only help services respond to individual needs, they also help to identify patterns across services, highlighting issues and growing complexity in the lives of the children, young people and families.



Family Star Plus™ © Triangle Consulting Social Enterprise Ltd
Authors: Sara Burns and Joy MacKeith
www.outcomesstar.org.uk

Figure 3: Family star plus

A review of the data demonstrates good alignment between what Barnardo's collects and the priority indicators underpinning the Child Health Equity Framework. Data from the Child Poverty Fund and Practitioner Survey map particularly to social factors in box 2 of the framework. However, the survey did not provide evidence that the charity captures data on the following indicators:

Child Development, Health and Wellbeing	• Percentage of physically active children and young people
Income and Living Conditions	• Quality of Housing (Energy Performance Certificate) • Proportion of occupied dwellings with damp problems • Percentage of families with dependents aged under 16 years living in overcrowded accommodation

Engagement with housing and homelessness services delivered by Barnardo's, and across Barnardo's services more widely, did not identify data related to the 'income and living conditions' indicators being collected. Evidence of data on the percentage of physically active children and young people being collected also was not found. Use of an external recording system was identified as a barrier to this.

Benefits of Collecting Data

The data Barnardo's collects enables services to be shaped in a way that means it can respond to local needs, identify emerging challenges, and demonstrate impact, reaching and improving outcomes for those most in need and building a stronger case for sustainable support.

Informs service design and delivery: Data provide clear insight into the challenges faced by children, young people and families, enabling services to be tailored to meet local needs effectively.

Identifies trends and emerging needs: Enables monitoring of indicators and highlights changes over time.

Supports funding and sustainability: Evidence of need and impact strengthens the case for continued or additional funding and supports long-term planning.

Improves outcomes and engagement: Understanding who is accessing services and the outcomes achieved helps identify engagement barriers, improve access, and adapt support.

Enables targeted support for specific groups: For example, tracking autism assessment waiting lists, identifying needs of trans young people, or understanding the child protection history of individuals, to inform interventions.

Enhances service accountability and effectiveness: Demonstrates the impact of service delivery and ensures we are reaching and supporting the most vulnerable.

Supports strategic decision-making: Helps model services based on needs.

Strengthens early years provision: Enables staff to tailor nursery support based on children's developmental needs.

Demonstrates the performance and value of the service to commissioners/funders.

Challenges in Capturing and Using Data

Engagement barriers: Families may be unwilling to share information, and colleagues may not consistently ask for or record key data. Together, these challenges can lead to gaps in the data, reducing its completeness and limiting the potential for meaningful analysis and insight. Young people may also lack the confidence to share information.

Gaps in referral and consent: Reliance on external agencies for referrals and the need for parental consent limits access to complete data sets.

Data collection limitations:

- Inaccurate or missing data at the time of admission
- Young people not completing data returns after leaving services
- Reliance on social workers or external professionals to update records
- Only collecting data on those who access services, which limits understanding of reach and unmet need
- Not all staff and carers record it

System and resource issues:

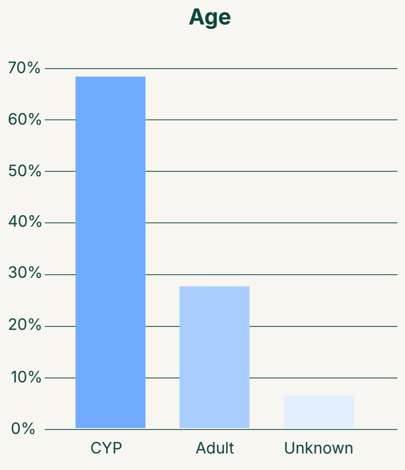
- Lack of integrated data systems, leading to reliance on manual spreadsheets
- Limited staff time and capacity for consistent data collection and entry
- Challenges in capturing data accurately when staff are working in the community
- Internal inconsistencies in how data are captured across teams

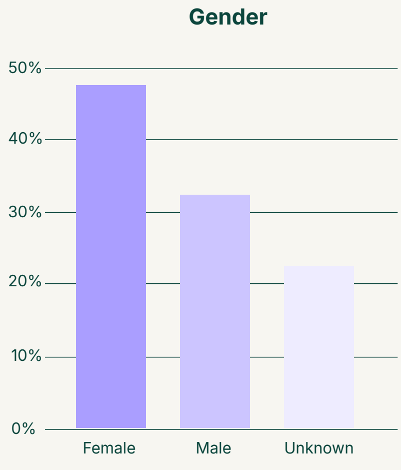
Data sharing and alignment:

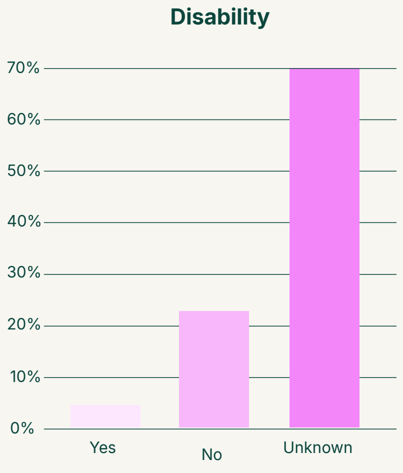
- Difficulties aligning data across multiple external systems due to time, resource, and data protection constraints
- Inconsistencies in how data is defined and measured, making comparisons unreliable

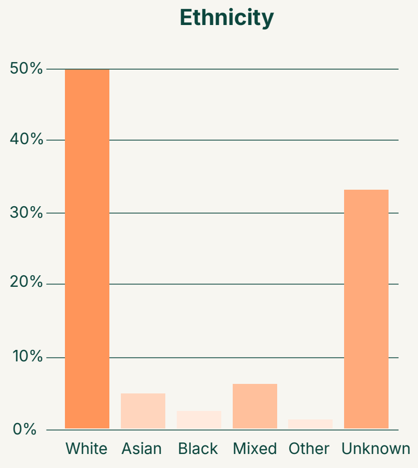
Outdated or incomplete external data: Some external sources, such as census data or ICB-held information (e.g. on obesity or low birth weight), may be outdated, inaccessible, or lack the completeness needed for effective analysis.

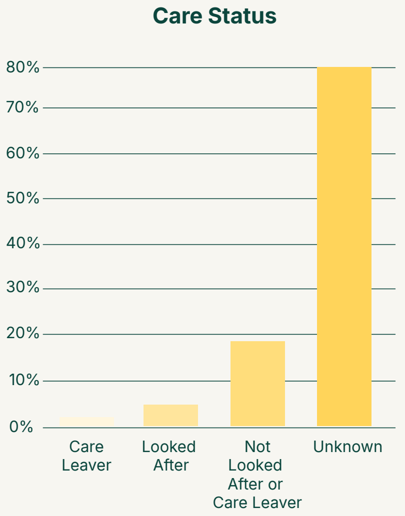
Incomplete internal data: Internally, a large amount of data is categorised as ‘unknown’ which results in an incomplete picture of the children, young people and families being supported. This is well illustrated by the 2023/24 demographic data from 356,220 service users below:

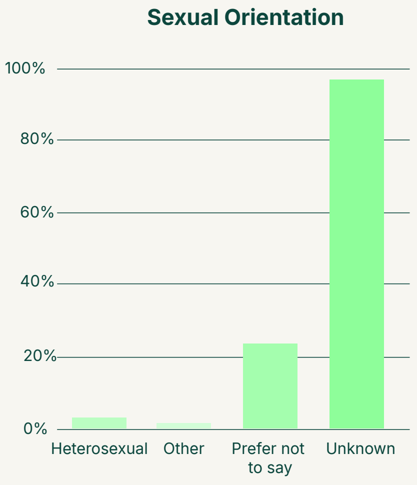

Age


Gender


Disability


Ethnicity


Care Status


Sexual Orientation

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