South Gloucestershire Council

Delivering for you

Annual Director of Public Health Report

Giving every child the best start in life

Recognising and taking action to reduce inequalities in children and young people in South Gloucestershire

2023

CONTENTS

FOREWORD

Welcome to the **Annual Director of Public Health Annual Report for South Gloucestershire 2023.** This is my first annual report following my appointment as Director of Public Health in October 2022.

Directors of Public Health have a statutory requirement to report on the health of their local communities and highlight areas of concern. In this report, I have chosen to focus on the health and wellbeing of children and young people in South Gloucestershire who have been at the centre of my work, and the work of the Public Health and Wellbeing Division, over the last year.

Children and young people are our future, and in South Gloucestershire we are determined to give them the very best start in life.

As a Public Health and Wellbeing Division, we have committed to prioritising action to promote and protect physical and mental health and wellbeing from conception throughout childhood to ensure that this strong foundation will carry on through the life-course. Using evidence-based approaches, we aim to support children, young people, and families to help themselves while working with health and education professionals and other partners to ensure access to appropriate services for those who need support.

The local data and insights presented in this report show that despite the progress we have made towards making South Gloucestershire a healthier and better place for children and young people to live in, not all children are doing as well as they should.

There are significant and persistent inequalities in outcomes for our children and young people. The effects of the Covid-19 pandemic are clearly still being felt and for many these have been exacerbated by the cost-of-living crisis. We see this reflected in children's living conditions, development outcomes, physical health, educational attainment, and beyond. The impacts of these events on the lives and outcomes for children and young people are likely to be long lasting and we know that, whilst they touch on the whole of society, they will be felt most acutely by people who have the least.

The health and wellbeing of children and young people is important for all of us. The report sets out a series of actions we can take together to tackle causes of deprivation and other inequalities and reduce differences in outcomes for children and young people in South Gloucestershire and ensure that all have the opportunity to reach their potential.

I would like to acknowledge and thank those in the Public Health and Wellbeing Division who have been involved in preparing this report, and colleagues across the Council, NHS, and VCSE sector working each day to improve health and wellbeing of children and young people in South Gloucestershire.

Sarah Weld
Director of Public Health

EXECUTIVE SUMMARY

Inequalities in outcomes for children and young people in South Gloucestershire

Health, wellbeing, and development outcomes for children and young people are generally better in South Gloucestershire than nationally. However, there are inequalities in outcomes between different groups. These are persistent and have been worsened by the recent Covid-19 pandemic and the rising cost-of-living.

This report builds on existing evidence to tell the story of outcomes for children and young people in South Gloucestershire. The report aims to summarise the current state of inequalities using selected outcomes, with specific focus on key phases in the life course of a child.

Inequalities are present at the time of pregnancy and birth

Children from the most deprived areas of South Gloucestershire are more likely to be born to mothers who smoke during pregnancy, to have low birth weight, and not be breastfed at birth. The age and ethnicity of mothers are two other factors associated with inequalities in children at birth.

Children experience significant inequalities in their early years

Fewer children from our most deprived communities reach expected levels of communication and language skills and development compared with those from the least deprived settings. They are also less likely to be ready for school by age five years.

Physical health is poorer among children from the most deprived areas

Consistently higher rates of overweight and obese children are found among those living in the most deprived areas and in children from black communities. Poor oral health is also more common among children from the most deprived settings.

Socio-economic, ethnic, and gender inequalities exist in educational outcomes

Children from mixed ethnicities, from the most deprived settings, requiring support for special educational needs, and eligible for free school meals have relatively poorer primary and secondary school attendance and attainment. Young males and children from less affluent backgrounds are more likely to be classified as not in education, employment, or training.

Inequalities undermine children's mental health and wellbeing

Overall mental health and wellbeing has worsened since the Covid-19 pandemic. Mental and emotional wellbeing is worse among children who identify as females or other sex, of mixed ethnicity, eligible for free school meals, and/or have special education needs.

Poverty is a key driver of inequalities among children and young people

Insufficient household income, chronic illness in the family, high living costs, and lone parenting all increase the risk of child poverty. Children from households with high levels of poverty and unemployment experience increased levels of childhood abuse and neglect. Children from black or mixed ethnicities are significantly more likely to be eligible for free school meals which is associated with worse developmental and educational outcomes.

Tackling inequalities in children and young people is crucial for future outcomes

Inequalities are apparent in children and young people in South Gloucestershire right from the point of conception and pregnancy through to adolescence and will persist beyond this into adult life, and indeed, into future generations. For the many children experiencing multiple disadvantages, the impacts on their health, wellbeing, and development are likely to be

significant. There is a lot that can be done to tackle inequalities including rebalancing the system and moving funding from crisis support into early help and prevention built around families.

Inequalities are entrenched but not inevitable and there is a lot that can be done to tackle them

There is clear evidence and rationale for the need to do things differently. We need to design systems that prioritise prevention and early help around children and young people and work directly with families and communities to do this in ways that meet their needs and make sense to them.

Call to action

The report sets out key cross-system opportunities for protecting and improving the health and wellbeing of children and young people in South Gloucestershire:

1. Strongly prioritise early prevention and target children and young people at risk of multiple vulnerabilities.

2. Rebalance the system towards earlier, whole family help.

3. Address family poverty and financial insecurity.

4. Strengthen data systems to improve collection of individual-level and population-level data on inequalities in the outcomes of children and young people.

5. Strengthen parental and broader community involvement in the development of initiatives to tackle inequalities.

Inequalities in the outcomes of children and young people in South Gloucestershire

PREGNANCY AND MATERNITY

Mothers who smoke in pregnancy[1]

- **2.8x** more — mothers from the **most deprived** areas smoke.*
- **5.6x** more — mothers aged **20 years or younger** smoke.†

Initiation of breastfeeding in babies[1]

- Less than **50%** — of mothers aged **20 years or younger** breastfeed.†
- **10%** fewer — mothers from the **most deprived** areas breastfeed.*

EARLY YEARS[1‡]

- **6%** fewer — 2-2.5-year olds from the **most deprived** areas achieve expected levels in communication.
- **10%** fewer — children from the **most deprived** settings achieve a good level of development.
- **2.8x** less — children with **SEN** are likely to achieve a good level of development.
- **27%** fewer — children eligible for **FSM** achieve a good level of development by end of reception.

EDUCATION

Progress between end of primary school and end of key stage 4 is:[2]

- **63%** lower — among pupils requiring **SEN** support.
- **34%** lower — among pupils eligible for **FSM**.
- **32%** lower — among pupils from a **disadvantaged** background.

The average attainment 8 score of children eligible for FSM is **16 points** lower than that achieved by all other children.[1]

PHYSICAL HEALTH

Obesity

- **18% more** Year 6 children and **8% more** reception-age children from black communities are overweight or obese.[1]
- **9% more** Year 6 and **6% more** reception-age children from the most deprived areas are overweight or obese.[1]

Oral health

- **229% more** 0-5-year-olds and **123% more** 6–10-year-olds from the most deprived backgrounds have hospital admissions for dental extractions due to dental caries.[3]

MENTAL HEALTH

Proportion of school-age pupils that are unhappy most of the time is:[4 ¶]

- **211%** more — among those who identify as being of **'other'** sex.
- **116%** lower — among pupils requiring **SEN** support.
- **73%** lower — among pupils eligible for **FSM**.
- **30%** more — among school pupils of **mixed ethnicity**.
- **7%** more — among **female** school pupils.

SEN: Special education needs; FSM: Free school meals

* Compared with those from the least deprived settings;
† Compared with mothers aged 40+ years;
‡ Based on extrapolations from national level data on inequalities;
¶ Compared with the South Gloucestershire average

1 OHID Fingertips. Public Health Profiles. Fingertips.phe.org.uk
2 Local Government Association. LG Inform: Improving services through information. https://lginform.local.gov.uk
3 NHS Digital. Hospital Episodes Statistics, "Analysis of Admitted patient care," 2022.
4 South Gloucestershire Council / Foster & Brown research, "Online Pupils Survey," 2023.

INTRODUCTION

Children and young people (CYP) represent almost one-quarter of the population of South Gloucestershire. The 2021 census reported that there were just over 62,000 children aged 0-18 living in South Gloucestershire, The CYP population has grown over the last decade and is set to continue to increase with as many as 14,000 more children by 2043 (1).

Children of today will become tomorrow's adults and their health and wellbeing will determine their capacity to play their part in the development of their local communities and the nation at large.

Our recently published Children and Young People's Needs Assessment shows that, on the whole, health, wellbeing, and development outcomes for children and young people are generally better in South Gloucestershire than nationally. However, the effects of the Covid-19 pandemic are clearly still being felt and for many these have been exacerbated by the rising cost of living.

When we explore data and insights from a sub-South Gloucestershire level, looking at inequalities in outcomes by geography, deprivation, equality group, or specific vulnerabilities, we see that outcomes are not good for all children. In fact, there are persistent and sometimes growing inequalities in outcomes between particular groups of children within the community. Some of these outcomes are consistently poor and are worsening (1).

Indicators of relative deprivation such as the proportion of children eligible for free school meals (FSM) suggests an increase in deprivation (a concept that refers to the lack of sufficient resources required for living well). While there have been some improvements in measures such as child vaccination rates and mortality rates, inequalities are growing in the rates of children with obesity and poor oral health and other measures of health and wellbeing.

The conditions in which a child lives and grows (including their housing, nutrition, family life, local community, air pollution, education system and access to health and care) have lifelong and intergenerational impacts on their health and wellbeing (2). Experiences during a child's early years have huge impacts on their development outcomes and well-being (2) throughout their childhood and into adulthood. Conception, pregnancy, and the first few years of life are critical periods of development. Later childhood and adolescence are also critical periods of development, and a window of opportunity. Positive experiences during these periods will have a long-lasting impact and are associated with better school performance, better social and emotional development, improved health and life expectancy, and a potential for higher income later in life (3). The opposite is also true with negative experiences.

The aim of this report is to try to tell the story of children and young people's health, wellbeing, and inequality in South Gloucestershire using a few key outcomes. That is not to say that other outcomes or indicators are not relevant or important, but the aim is to present a clear narrative about children's outcomes and life chances, using indicators that are perhaps greater than the sum of their parts, containing information about the outcome itself but also reflecting wider impacts on children's lives.

The report summarises outcomes and inequalities throughout the life-course of a child from infancy through to adolescence, drawing attention to emerging differences between groups of CYP as they relate to socioeconomic disadvantage, ethnicity, gender, and other circumstances.

There is a well-established and growing body of evidence showing both improved outcomes and more cost-effective services[1] for children and young people if risk factors or needs are identified early and families are supported to thrive. Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work.

There are many examples of good practice in this area locally, but they are not all being implemented systematically. The report goes on to set out cross-system opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence to optimise the outcomes and reduce inequalities for all children and young people in South Gloucestershire.

[1] Early Intervention Foundation. The cost of late intervention: EIF analysis 2016.

CHILDREN AND YOUNG PEOPLE IN SOUTH GLOUCESTERSHIRE – AT A GLANCE

WHAT DO WE MEAN BY INEQUALITIES

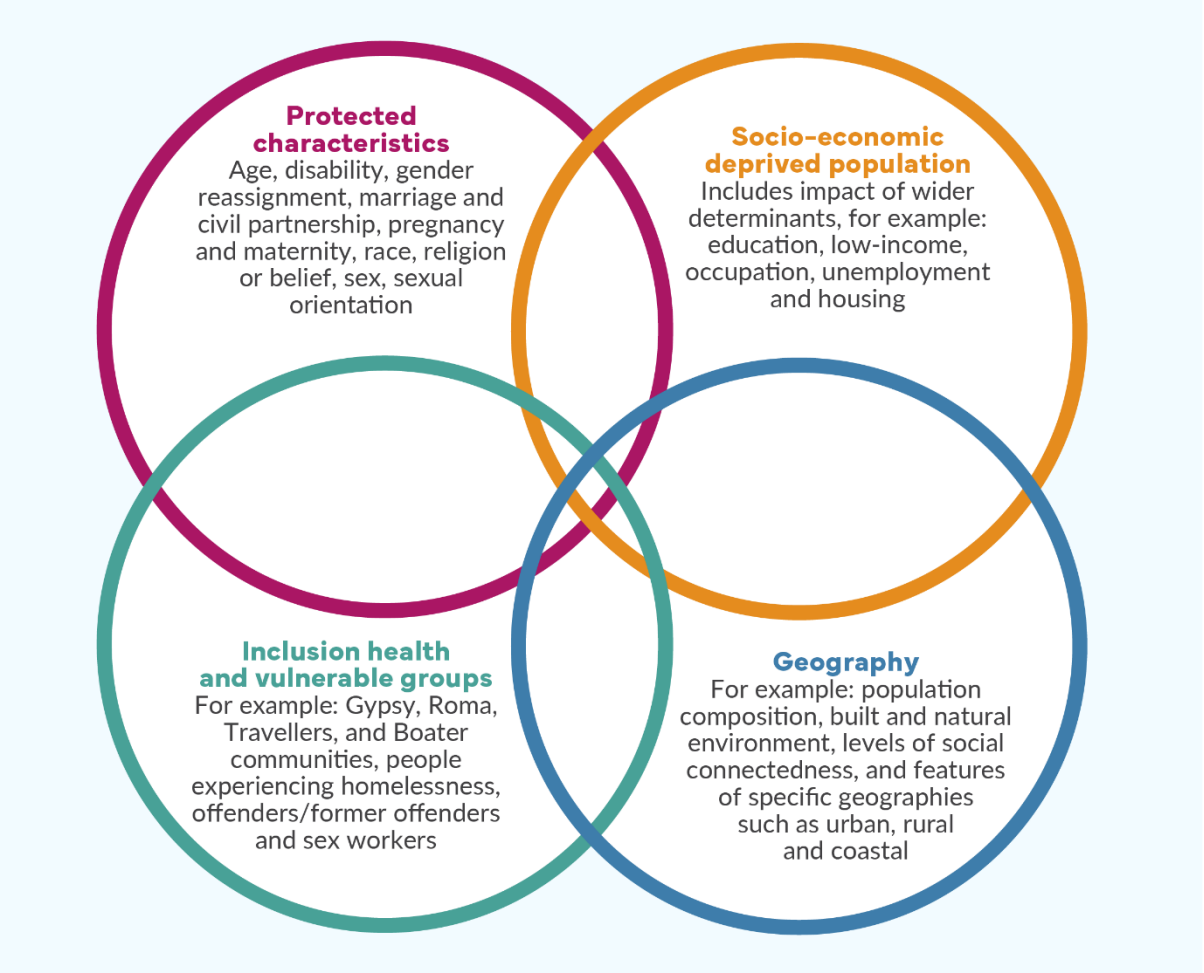
Inequalities are “unfair and avoidable differences in health [and other outcomes] across the population, and between different groups within society” (4). There have always been inequalities in outcomes between different parts of society, but the events of the last three years as we lived through the Covid-19 pandemic and the rising cost of living have increased these inequalities within the South Gloucestershire community. There is a clear and ethical need to look closer at where and why they exist locally and develop strategies to tackle them.

Health is influenced by individual factors such as diet, exercise, smoking, alcohol, and genetics. But beyond these, housing, education, employment, income, environment, and access to services are wider determinants that also influence health, both directly and via influence on the individual risk factors listed above (5). Variations in living conditions such as financial stability, or housing result in differences or inequalities in health, wellbeing, and development outcomes between different groups. For example, a child whose parents cannot afford healthy meals because of low household income is at risk of undernutrition and poor health compared with another child from a more affluent background.

Socioeconomic disadvantage is a key driver of inequalities. Children from less affluent backgrounds are more likely to be worse off than their counterparts from more affluent settings. A recent survey reported what children across the UK think about the effect of poverty on their ability to feel ‘healthy, happy, and well’ (6). They noted that not having enough money for healthy food leads to malnutrition, disease, sleeping difficulties, and poor mental health. According to them, if you *‘can’t afford good housing, [you] could be homeless. You would be lacking basic things like electricity, or hot, clean water – leading to poor hygiene (dirty clothes, hair etc)* (6).’ It is clear from this survey that children recognise the impact of poverty on their health and wellbeing.

Other factors linked with inequalities in outcomes include being a member of vulnerable groups, sharing certain protected characteristics, or living in certain environments. These factors often overlap and when people have two or more of these, they are likely to experience more severe inequality (Fig. 1; adapted from Health inequalities: place-based approaches to health inequalities). This is because the impacts of inequalities add up among those who have more than one type of disadvantage (7). Also, considering that the causes of inequalities are not equally spread throughout the population, some groups are more likely to experience it at a greater magnitude than others. There is an unlevel playing field where groups at one end face multiple inequalities leading to bigger negative health outcomes than those at the other end. Furthermore, the outcomes of less affluent people living in affluent areas tend to be worse for several reasons including feelings of exclusion and lack of self-esteem (3).

Figure 1. Domains of health inequality (adapted from Health inequalities: place-based approaches to health inequalities)



The South Gloucestershire Children and Young People's Needs Assessment identified significant cross over and intersectionality between vulnerable groups. For example, it reported that half of children who meet the criteria to be considered 'in need' are also eligible for free school meals, nearly a third have an Education Health and Care Plan (EHCP), and a quarter require Special Educational Needs (SEN) support (1). If we know that outcomes are worse for children with each of these individual vulnerabilities, then we can only imagine the impact for children who experience these multiple levels of disadvantage.

Method

This report builds on the insights generated from the South Gloucestershire Children and Young People's Needs Assessment. To tell the story of inequalities among children and young people in South Gloucestershire, we have selected a number of key outcomes that reflect the course of life of every child from conception till they reach 18 years of age. These are outcomes that present a clear narrative about children's outcomes and life chances, using indicators that are perhaps greater than the sum of their parts.

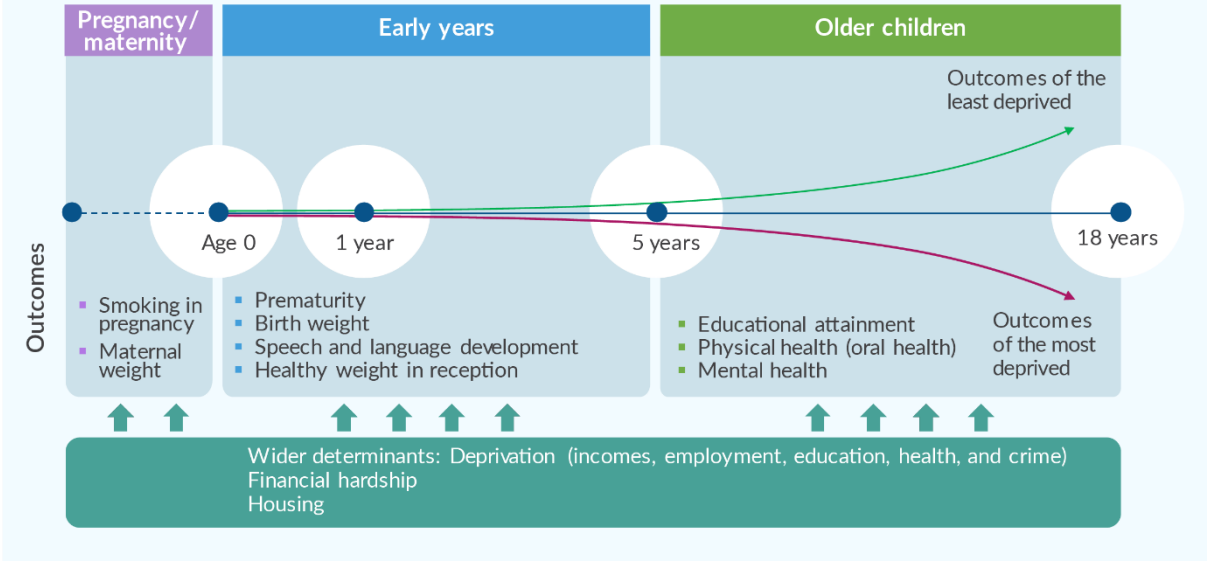
The choice of outcomes was also guided by availability of data. We noted that local data on inequalities by socioeconomic deprivation, equality groups, vulnerability, and geography were limited in terms of availability and completeness. As a result, we selected indicators that provided some visibility into existing disparities across different groups of children and young people in South Gloucestershire. Continuing to improve recording and analysis of inequalities

data is therefore critical to being able to better understand local inequalities and analyse the effect of any interventions.

The report takes a life course approach to examine inequalities in the outcomes of children and young people. Based on available evidence, what happens during the early life of a child determines future prospects in health, education, work, and life in general. Using the life course approach, we can show the significant impact of inequalities in early life on later outcomes of children and young people.

As illustrated in Fig. 2, we examine inequalities through the developmental journey of a child and split this into three key phases: (i) the period of pregnancy and birth, (ii) the early years between ages 0 and 5 years, and (iii) school age between ages 6 and 18 years, and highlight local action we have taken as a Public Health and Wellbeing Division, often in support of or in partnership with communities and other teams and organisations across South Gloucestershire. We have also identified opportunities for further action from a review of evidence and national policy.

Figure 2. Framework for using the life course approach to inequalities in children and young people in South Gloucestershire



PREGNANCY AND BIRTH

A mother's health before conception and during pregnancy influences her child's future physical, emotional, and cognitive development (8). Many factors will influence a mother's health and wellbeing and the health of her growing baby during pregnancy. These include whether she is financially secure, her ability to provide good nutrition for herself, her body mass index (BMI), her engagement with services, and whether or not she smokes cigarettes.

Systematic differences in the experiences of women during pregnancy lead to differences in outcomes for babies, meaning that an inequalities gap is present even before a child is born. Addressing inequalities during this period is therefore crucial to addressing inequalities in the later outcomes for children and young people.

This report has used birthweight as a proxy outcome for the health of the baby at birth. In addition to this, key modifiable factors that impact on the health of babies are included: smoking during pregnancy and breastfeeding.

Smoking in pregnancy and after childbirth

Why this is important

- Reducing exposure to tobacco smoke among pregnant (and postpartum) women and newborns is one of the best ways to ensure a healthy start to a child's life.

- Exposure to tobacco smoke during pregnancy is associated with adverse birth outcomes such as premature births, low birthweight, and babies with physical abnormalities (9). Children whose mothers smoked during pregnancy are also at greater risk of respiratory conditions such as asthma and pneumonia, behavioural problems such as attention deficit hyperactivity disorder (ADHD), and poor school performance (10).

- Children who live with a smoking parent are more likely to become smokers themselves, especially if they live in deprived areas, near shops that sell cigarettes, or have friends that smoke (11).

- Smoking during pregnancy is associated with deprivation and has adverse effects on the health of babies, making maternal smoking both a cause and a result of inequalities.

Situation in South Gloucestershire

- About 9 in every 100 pregnant women (8.6%) smoked at the time of delivery in 2021/22 (12). This proportion has slightly reduced from 10.1% in 2018/19.

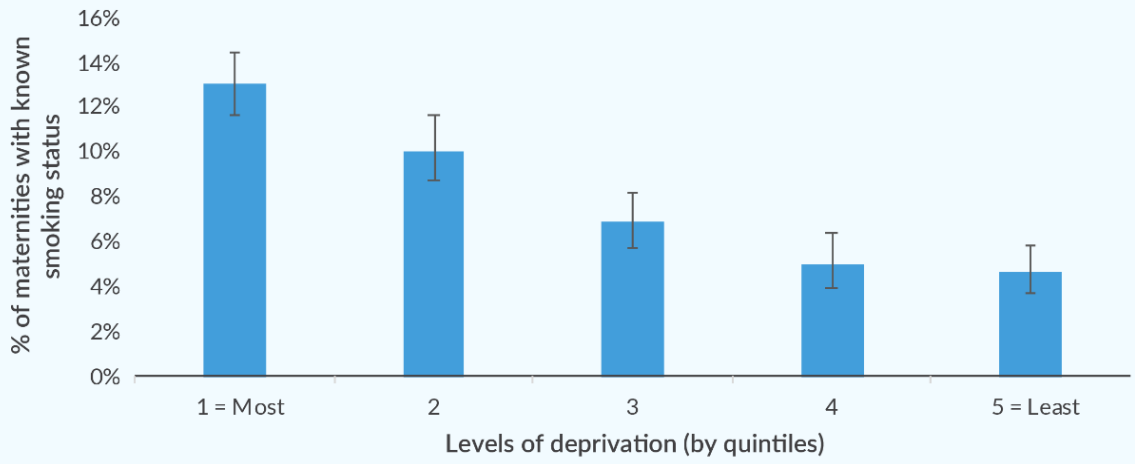
- Compared with neighbouring areas, the proportion of pregnant women who smoked at time of delivery in South Gloucestershire is similar to Bristol (8.8%), and lower than the South West regional average of 9.9% (12).

Inequalities in smoking during pregnancy

- Mothers who live in the most deprived areas are significantly more likely to smoke at delivery compared with those who are from the least deprived areas (Fig. 3).

- Mother's age is strongly associated with smoking behaviour. The proportion of mothers aged 20 years or less who smoked at delivery (28%) is significantly higher than the 5% of mothers aged 40+ who smoked at time of delivery (1).

Figure 3. Inequalities in smoking at time of delivery in South Gloucestershire by deprivation quintiles



(Source: Children & Young People's Needs Assessment 2023)

(South Gloucestershire, pooled data from 2019–21; (1))

Drivers of inequalities in smoking during pregnancy

- Mothers with a lower socioeconomic status often have more psychological and emotional difficulties, less social support, fewer financial resources, and less residential stability. Additionally, motherhood can bring about added stress and smoking is often incorrectly perceived as a stress reducer (13).

- Social support also plays a role in the use of tobacco as smoking rates are highest among single mothers, many of whom are also within the younger age brackets (13).

- Smoking is strongly associated with alcohol and substance misuse and national level data shows a strong relationship between their use and ethnicity (mixed ethnicity – drug misuse, white ethnicity – alcohol) and area deprivation (1).

Local action

In South Gloucestershire we have:

- Piloted a Stop-Smoking intervention aimed at reducing the proportion of women smoking at time of delivery to less than 6% (which is the national target). Through this innovative approach, we enhanced the support offer available to pregnant smokers and encouraged uptake and ongoing engagement with local stop smoking services. With a focus on vulnerable and disadvantaged groups, all 80 spaces available were filled and feedback received was positive.

- Developed an evidenced-based Bristol, North Somerset, and South Gloucestershire (BNSSG) standard smoking cessation pathway and a BNSSG Maternity Trust 'smoking in pregnancy' clinical guideline; and delivered multiple educational events to midwifery staff and the wider health community who come in to contact with pregnant women.

- Co-funded carbon monoxide monitors for use by midwives and other midwifery staff through the local authority and local maternity neonatal services boards; and ensured availability of nicotine replacement therapy on hospital formulary for pregnant women

admitted as inpatients and on postnatal wards, ensuring that supply is offered on discharge.

- Improved referral feedback and communication loops between the stop smoking services and maternity services; and conducted an in-depth qualitative research study to explore the contextual and psychosocial barriers and enablers to smoking cessation in pregnancy.

Low birth weight

Why this is important

- The weight of a baby at birth is a key indicator of its immediate health and a determinant of future health. Low birth weight babies – whose weight at birth is less than 2,500 grams – are at increased risk of illness and more likely to die in infancy.

- Longer-term effects of low birth weight include poor cognitive development and increased risk of developing chronic illnesses such as diabetes and cardiovascular disease in later life (14). Children born with very low birthweight are especially at high risk of developmental difficulties, poor cognitive and motor skills (15).

- Factors responsible for low birthweight include extremes of maternal age (younger than 16 or older than 40), multiple pregnancies, obstetric complications, chronic maternal conditions such as hypertensive disorders of pregnancy, poor nutrition, exposure to indoor air pollution, tobacco, and drug use (16); many of which are modifiable risks.

Situation in South Gloucestershire

- Overall, 4.8% of all babies born in South Gloucestershire in 2021 had low birth weight, reducing from 5.4% in 2020 but changing very minimally over the past decade (12).

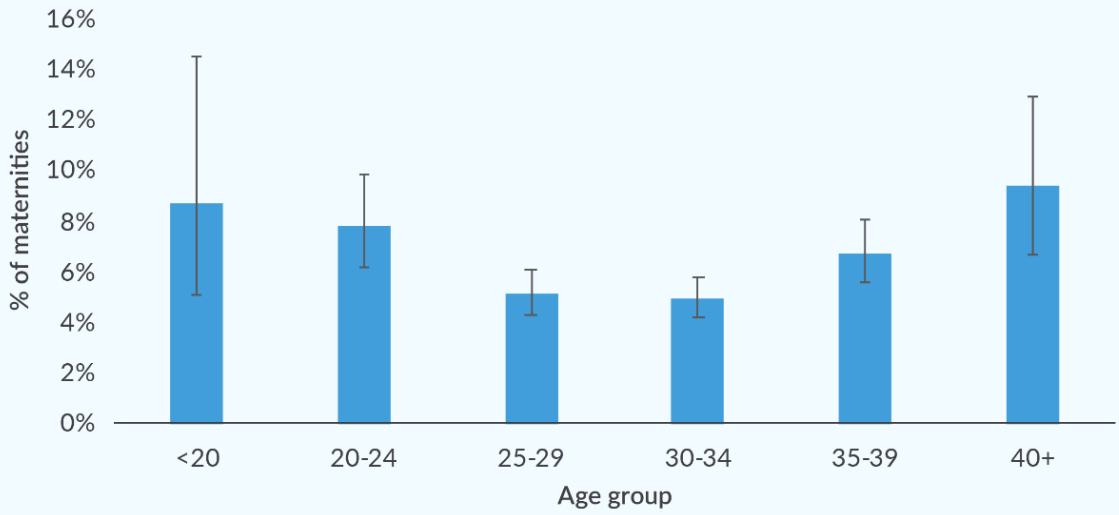
- South Gloucestershire ranks better than the South West regional average of 5.5% and England's national average of 6.8%.

Inequalities in low birth weight

- Disparities exist in the proportion of all babies born with low birth weight by the age of the mother (Fig. 4), ethnicity, and deprivation in South Gloucestershire.

- Mothers younger than 20 years or older than 40 years, from Asian or black ethnicities, and living in more deprived areas have the highest rates of low birthweight babies, although not significantly different from the South Gloucestershire average.

Figure 4. Age inequalities in low birth weight



(Source: Children & Young People's Needs Assessment 2023)

(South Gloucestershire, pooled data from 2019–21; (1))

Drivers of inequalities in low birth weight

- The relationship between deprivation and low birth weight is complex. Mothers from the most deprived settings are more likely to smoke and drink during pregnancy, live in poverty, have limited access to adequate nutrition, and suffer from increased stress – all of which can lead to low birth weight (17).

- Advanced maternal age and teenage pregnancies are known factors that are linked with adverse birth outcomes on account of multiple biological and social mechanisms (18) (19).

- Low birthweight is closely associated with preterm birth as almost 3 in 4 low birthweight babies are born pre-term and more than half of preterm babies are of low birthweight (20). Data on preterm births in South Gloucestershire reflect a similar pattern to low birthweight in terms of the proportion of premature (< 37 weeks gestation) births and inequalities by age, ethnicity, and deprivation (12).

Local action

In South Gloucestershire:

- The Healthy Start scheme offers eligible women a card with money on it to purchase milk, fruits, vegetables, and pulses and access Healthy Start vitamins. This supports them during pregnancy and breastfeeding with adequate nutrition.

Breastfeeding initiation

Why this is important

- Breastfeeding is associated with improved health outcomes of both babies and mothers (21). The World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) recommend the initiation of breastfeeding within the first hour following birth, and exclusive breastfeeding (that is, no other liquids or food) throughout the first six months of life (22).

- While evidence supports breastfeeding as an investment in better outcomes for children and young people, we understand that the subject of breastfeeding is still an emotive one. Some mothers some choose not to breastfeed their infants and some are not able to despite their best efforts, although evidence shows that with support, most mothers can (23).

Situation in South Gloucestershire

- About 8 in 10 women (79.8%) breastfed their babies at birth in South Gloucestershire in 2020/21 (12). This rate has been increasing over time (24) and is higher than the regional and national averages of 75.4% and 71.6% respectively.

- Breastfeeding rates reduce substantially between birth and 6-8 weeks. Data from 2021/22 indicates that about 6 in 10 (59%) women continue to breastfeed through week 6-8, a significant drop from the 8 in 10 that had started at the birth of their child (12).

Inequalities in breastfeeding

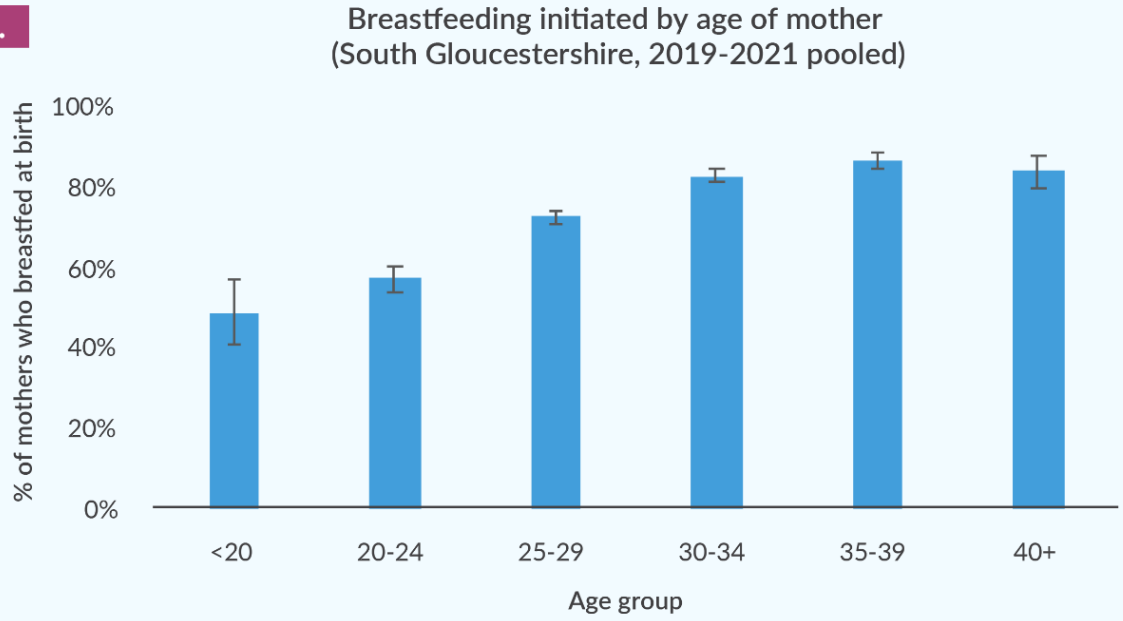
- Less than half of mothers younger than 20 years breastfeed their children at birth, which is significantly lower than the overall South Gloucestershire rate (Fig. 5a).

- The rate of breastfeeding at birth by women with white ethnicity is significantly lower than the rates among women from other ethnicities (Fig. 5b).

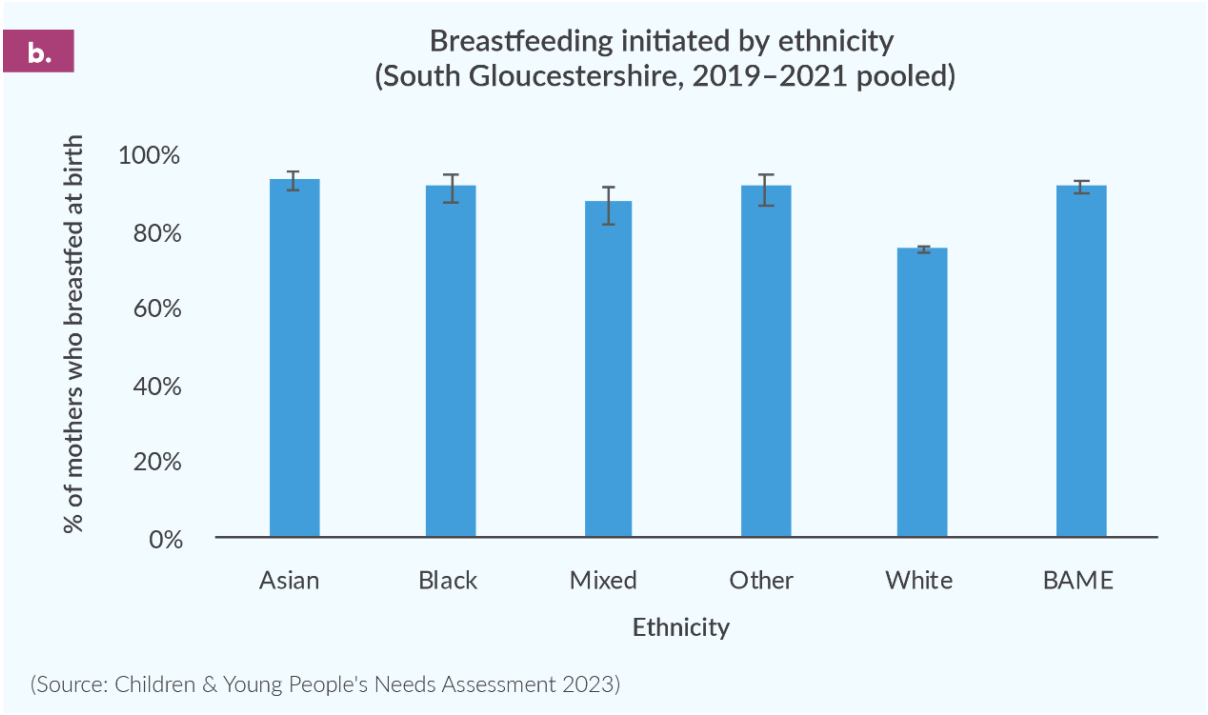
- Mothers from the most deprived settings have significantly lower rates of breastfeeding initiation compared with those who live in the least deprived settings.

Figure 5. Inequalities in breastfeeding initiation by age of mother (a) and ethnicity (b)

a.



(Source: Children & Young People's Needs Assessment 2023)



(Source: Children & Young People's Needs Assessment 2023)

Drivers of inequalities in breastfeeding

- Younger mothers are more likely to have limited understanding of breastfeeding, see themselves as unable to breastfeed, and consider the demands of breastfeeding as conflicting with their youth and social standing (25).

- Mothers from the most deprived environments are more likely to have insufficient understanding of the health benefits of breastfeeding and less access to professional breastfeeding support. These factors, working singly or in combination, put babies at a disadvantage both during the first few months and later on in life.

Local action

In South Gloucestershire we have:

- Implemented the Specialist Breastfeeding Support Service which is delivered by the Health Visiting Service. Through this service, parents can access needs-led, face to face support for breastfeeding/infant feeding in their own home, or at community venues from the team of Infant Feeding Specialists.

- Established infant feeding specialist clinics which are managed by teams of specialist midwives. Each team of community midwives offers antenatal classes for mothers, including a session on infant feeding and caring for a new baby.

- Commissioned an accessible, community-based peer-support group service for mothers who are seeking additional support to breastfeed. This service complements the universal provision of infant feeding support and aims to build and develop community capacity and mother to mother support whilst enabling and empowering parents to make informed decisions.

- Introduced the Breastfeeding Friendly Scheme across South Gloucestershire which aims to welcome and encourage mums and families to breastfeed whilst out and about in South Gloucestershire.

- Commissioned the South Gloucestershire Breastfeeding Support Service for a further year to provide accessible community-based peer-support groups for mothers who are seeking additional support to breastfeed. The service complements the universal provision of infant feeding support and is delivered alongside Barnardo's Infant Feeding Pilot, an online support project, currently running in South Gloucestershire. The service aims to build and develop community capacity and mother-to-mother support whilst enabling and empowering parents to make informed decisions.

CASE STUDY: Baby Friendly Initiatives – Maternal Early Childhood Sustained Home-Visiting

The Maternal Early Childhood Sustained Home-visiting (MECSH) is an evidence-based program we provide in South Gloucestershire to improve maternal and child health outcomes. Originally developed in Australia and adapted to a UK model, MECSH is based on core health visiting principles and provides an opportunity to offer additional, early support to the family of any child who is at greater risk of experiencing poor outcomes due to one or more factors in their lives.

Health visitors share information about the MECSH programme with families at the universal antenatal visit which takes place in the home from 28 weeks gestation. Families can enrol onto the MECSH programme at any time from the antenatal visit up to 8 weeks after the baby has been born. The programme includes an additional 20 contacts over 2 years, many of which are at home and with the same health visitor where possible. This means families have an opportunity to build a relationship with their health visitor and to talk about parenting issues that are important to them within a structured framework of support and consistent, evidenced resources.

Through MESCH, health visitors continue to work towards improving the transition to parenthood. The programme supports parents to think about their own physical and emotional health and be the best parents they can be whatever their circumstances. Families are encouraged and supported to engage with resources in their local community, such as children's centres.

Families enrolled on the MECSH programme have shared how valuable they have found the additional time and support from the health visiting team. They indicated that the home visits have been informative. Parents also report that they feel more confident as parents in understanding their babies and engaging and accessing with wider community support and groups.

In South Gloucestershire, we have recorded improved child communication and symbolic behaviour, reduced hostile parenting, longer breastfeeding period, improved parenting confidence and self-efficacy, and improved home environment. These outcomes ultimately translate to good health and development for the child, as well as their family and community.

Opportunities for further action

With the understanding that the period between conception and age two years sets the foundations for a child's lifelong physical, cognitive, and emotional development, there are six action areas that can guide the establishment of the best start for life during the first 1,001 days of a child (The Best Start for Life Report).

These include:

- Seamless support for families: a coherent joined-up Start for Life offer available to all families.
- A welcoming hub for families: family hubs as a place for families to access 'Start for Life' services.
- The information families need when they need it: designing digital, virtual and telephone offers around the needs of the family.
- An empowered 'Start for Life' workforce: developing a modern skilled workforce to meet the changing needs of families.
- Continually improving the 'Start for Life' offer: improving data, evaluation, and outcomes to ensure they are meeting the needs of families.
- Leadership for change: ensuring local and national accountability and building the economic case.

Additional opportunities to reduce inequalities in maternal smoking, low birth weight, and breastfeeding are highlighted in the table below.

Smoking in pregnancy
▪ Implement the new Office for Health Improvement and Disparities (OHID) South West 'Guidance for Delivering Smoke Free Homes – Maternity/Health Visitor Pathway' towards reducing tobacco dependence in the postnatal period and limiting infant exposure to smoke-related harms. ▪ Work closely with partners, including mothers and families, to monitor uptake and outcomes of 'stop smoking' support service and ensure it is achieving aims, including reaching mothers that are most likely to smoke. ▪ Increase awareness of the dangers of smoking in pregnancy and the support available. Ensure that awareness campaigns are reaching women who are most likely to smoke during pregnancy and that practitioners who are in contact with pregnant women can make every contact count by promoting stopping smoking as a way to support the health of their babies and their own health. ▪ Work with partners to develop a support offer for wider family post-birth, to increase proportion of children living in a smokefree home. ▪ Support targeted implementation of evidence-based financial incentives locally to support mothers who smoke (during and after pregnancy) to quit in line with the new "smokefree generation" policy. ▪ Continue implementation of the South West Guidance for the Delivering Smoke-Free Homes maternity smoking pathway so that tobacco dependence in the post-natal period and infant exposure to smoke-related harms can be reduced further.
Low birth weight
▪ Work with communities and maternity trusts to reduce late booking for antenatal care as early booking enables health promotion to commence at the earliest possible

opportunity, including swift detection of factors that may have an adverse outcome on pregnancy including low birth weight.

- Interface with communities to engage and empower groups through knowledge and sharing information to help women understand the purpose for early antenatal booking. Enable health providers and commissioners to identify any barriers to accessing early ante-natal care.

- Promote awareness and uptake of the Healthy Start scheme and increase the consumption of healthier, varied, and more sustainable diet (including fruits and vegetables) and the intake of supplements during pregnancy.

Breastfeeding initiation

- Encourage and support families to breastfeed. Explain the evidence that proves breastfeeding gives mothers and babies significant health benefits well beyond the breastfeeding period itself.

- Support women to respond to their babies' needs for food and offer ongoing, one to one, practical and skilled help to get breastfeeding off to a good start. Provide women who breastfeed with information and support to enable them to maximise the amount of breastmilk their baby receives.

- Ensure all women have access to ongoing, evidence-based infant feeding support, including referrals to specialist support in their local community and in a variety of formats, that services are monitored, evaluated, and adequately resourced to meet need local need.

EARLY YEARS

The early years of a child's life from birth to 5 years are critical to overall health and development. During this phase, children acquire and refine physical/movement, language and communication, social and emotional, and cognitive skills which they build on throughout later life. This is also one of the periods during which inequalities once set, can be difficult to change in terms of later outcomes in adulthood. Working together with parents and carers to tackle disadvantage early can make a big difference in a child's future health and development outcomes.

This report focuses on two indicators that provide a measure of development during the early years: (i) communication and language skills at ages 2 to 2.5 years, collected as part of the Healthy Child Programme development review which is delivered to all children around their second birthday as part of the universal health visitor service; and (ii) school readiness, a measure of children's development at the end of the academic year in which a child turns 5. Assessment of other areas of development during the early years is limited by availability of data.

Communication and language skills

Why this is important

- Communication and language are building blocks of learning and development (26). Any delays in a child's acquisition of the appropriate level of language and communication for age may slow down overall development and negatively affect educational achievements.

- As children build their ability to speak and listen, they develop the foundations for reading, writing, and making sense of symbols. While many children have no problems in acquiring the expected level of development in communication and language, some may struggle. Early identification of need and appropriate support is important to reduce the inequality gap.

Situation in South Gloucestershire

- Approximately 9 in 10 (89.7%) children in 2021/22 reached the expected level in communication skills at ages 2 to 2.5 years (12).

- By the end of reception, 83.3% of children locally had reached the expected level in communication and language skills. This proportion is higher than the regional and national averages.

- Assessing the trends in communication and language over the last few years in South Gloucestershire is difficult due to lack of data collection during the pandemic. However, it appears that the rates of children reaching expected levels of development in communication and language skills have reduced nationally since the start of the Covid-19 pandemic (12).

Inequalities in communication and language skills

- Local data on inequalities during the early years is limited, which makes it difficult to assess the extent to which groups within South Gloucestershire have reached expected levels of communication and language skills between ages 0 and 5 years.

- National level data shows a 6.2% gap in the proportion of children achieving expected level in communication skills at ages 2-2.5 years across both ends of the deprivation

spectrum (12). Children from the most deprived settings have the lowest proportions (82.9%) of those who have achieved a good level of communication at 2-2.5 years, compared with those from the least deprived settings (87.8%).

Drivers of inequalities in communication and language skills

- Deprivation can limit the ability of parents and carers to respond to the early language needs of a child and provide a home learning environment that boosts language development during the early years.

- Children from disadvantaged backgrounds often have less opportunities to develop their vocabulary. This often have negative effects on the developmental and educational outcomes of these children, and their potentials later on as adults.

Local action

In South Gloucestershire we:

- Provide opportunities for parents and carers to speak with specialists regarding concerns they may have about their child's speech and language development.

- Supported eight early years settings through a speech and language project. Through this project, speech and language therapists and setting support officers worked alongside practitioners to provide bespoke support and modelled effective practice.

- Provided bespoke support to 105 children with speech, language, and communication needs through Education Inclusion Officers

Readiness for school

Why this is important

- School readiness is a measure of children's development at the end of the early years foundation stage (EYFS), specifically the end of the academic year in which a child turns 5. It assesses how prepared a child is to succeed in school cognitively, socially, and emotionally (27).

- Being school ready has an impact on a child's future educational achievement and life chances. Children that do not achieve expected levels of development by age 5 years and are not school ready are more likely to have poor educational and health outcomes when they grow older.

Situation in South Gloucestershire

- About 7 in 10 children (69.6%) achieved a good level of development at the end of reception in 2021/22.

- 71.8% of children locally reached the expected level of development in communication, language, and literacy skills at the end of reception (12).

Inequalities in readiness for school

- There is currently very limited local data showing trends over time and gaps across different groups within South Gloucestershire.

- National data shows that children who are from black ethnicities, have first language other than English, eligible for free school meals, have special educational needs (SEN) status,

and from the most deprived backgrounds are the least likely to reach expected levels of development by age 5 years (12).

- Nationally, 10% less children from the most deprived settings achieve good level of development compared with those from the least deprived settings. Similarly, fewer children with SEN achieve good level of development relative to those without SEN (with a difference of 47%, (12)). Anecdotal evidence suggests that these gaps at national levels reflect the situation in South Gloucestershire.

Drivers of inequalities in readiness for school

- Parenting is a major determinant of school readiness. Parents and carers from the most deprived settings often lack the resources and opportunities to provide a child with the best learning environment from an early age (28).

- Good quality early years education is a protective factor that can help equip children with the skills needed to be ready to attend school.

Local action

- Support is available for parents and carers through the Access and Response Team (ART) which is the 'front door' of children and young people's services in the council.

- Implemented a transition fund to support settings to help transition pupils into reception when they do not have a needs assessment request in place. Responses from educational settings indicate satisfaction that the funding is helping to meet the needs of children.

Opportunities for further action

Communication and language skills
▪ Support parents and carers by providing information on ways to improve early language acquisition. Enable them to access services appropriately and early with any concerns about their child's hearing through health literacy and self-care. ▪ Ensure early identification of children with signs of speech and language delay and ensure uptake of appropriate early intervention strategies or specialist support and referral through training early years practitioners and other key staff.
Readiness for school
▪ Provide information and guidance to parents and carers on local early years learning provision and support them to prepare their child for the transition to early years education and school, and early identification of any health and wellbeing concerns. ▪ Work in partnership with health visitors, school nurses, and education settings to support children starting school or moving between education settings.

CHILDHOOD (SCHOOL-AGE)

Education

Education is strongly linked with future health and wellbeing outcomes and life chances. School attendance provides opportunities for a child to develop life skills necessary for problem-solving, life-long learning, developing supportive social connections, accessing good work, and feeling empowered (29). Furthermore, there is evidence showing that schooling is associated with a wide range of health benefits including physical activity, improved sleep, better mental health and wellbeing, and longer life expectancy (30).

This report considers two key education indicators: (i) school attendance and (ii) educational attainment.

School attendance

School attendance in this report is assessed using rates of persistent absentees (proportion of children who miss 10% of lessons or more) (31) and the proportion of young people aged 16/17 years classified as not in education, employment, or training (NEET).

Why this is important

- Schools provide structured educational settings where children and young people can learn what they need to reach their potential. Being with children of similar ages and teachers is one of the best ways for children to learn (32).

- School attendance is closely linked to academic achievement, setting children up with the skills and qualifications they will need to thrive in employment and society.

- Being in school keeps children safe and provides opportunities for extracurricular activities. Children who attend school regularly do better than their peers who have higher rates of absence (32).

- Consequences of poor school attendance or not being in education, employment, or training (NEET) is that young people are at greater risk of poor health, depression, crime, or early parenthood.

Situation in South Gloucestershire

- In 2021/22, the rates of persistent absentees in primary and secondary schools were 16.0% and 27.9% respectively (12). These rates were reducing prior to the pandemic but have increased significantly since the height of the pandemic in 2020/21. Similar increases have been observed nationally.

- Seven (6.8%) out of every 100 young people aged 16/17 years were classified as NEET in 2022/23. There has been a gradual increase in this proportion from 4.7% in 2017, and the rates in South Gloucestershire have been consistently higher than national averages since 2019 (12).

Inequalities in school attendance

- Local data on inequalities in the rates of persistent absentees and NEET in South Gloucestershire is not currently available.

- National data shows that children from mixed ethnicities, from the most deprived settings, requiring SEN support, and eligible for FSM have relatively higher rates of persistent absenteeism in both primary and secondary schools (12).

- Significantly more males than females were persistently absent from primary school in 2021/22 based on national data, while significantly more females than males were persistently absent from secondary school during the same period (12).

- Significantly more 16–17-year-olds from white ethnicities, males, and from the most deprived settings are classified as NEET when compared with the national averages (12).

Drivers of inequalities in school attendance

- There is a strong but complex relationship between socioeconomic background and school attendance. Children from less affluent backgrounds face several barriers that affect their developmental outcomes and subsequent educational experiences including school attendance.

- Living in poverty increases the risk of poor physical and mental health, behaviour problems, substance abuse, reduced access to transport, exposure to environmental hazards, and exposure to crime – all of which contribute to school absenteeism (33).

- Since the pandemic, there has been increased recognition and reporting of emotional based school avoidance. There is work underway locally and nationally to understand the impacts of this on school attendance.

Educational attainment

Educational attainment is a measure of the academic standard that pupils achieve. It is measured at the end of key stages (KS) 1–4, with each key stage representing a range of school years. We can also consider the improvements children make between different key stages.

Why this is important?

- Academic success is strongly linked with a child's feeling of satisfaction and wellbeing (34).

- Higher levels of wellbeing are also associated with positive engagement in school activities which enhances the child's ability to do well in school. Improving educational outcomes can improve health and wellbeing, which in turn further improves educational outcomes in a positive circle.

- The education and qualifications that children achieve during their schooling are key factors that determine their future employment and earnings. Being in employment and not living in poverty are both strongly correlated with good health and wellbeing outcomes. Educational attainment is therefore both a result of and cause of inequalities.

Situation in South Gloucestershire2

- The "Attainment 8: average score" measures the average performance of pupils across eight qualifications at the end of KS4, at 15-16yrs old (12). Data from 2021/22 shows that

[2] It is difficult to look at the trends over time in South Gloucestershire because changes in the way GCSE grades were awarded during the Covid-19 pandemic makes comparisons of the current rates with the rates before 2020 inaccurate.

the current average score in South Gloucestershire is 49.5 which is slightly better than the regional (48.7) and national (48.7) averages.

- Progress 8 scores are a measure of the progress children make between the end of primary school (KS2) and General Certificate of Secondary Education (GCSE) stage (KS4). Whilst progress 8 scores have been historically low in South Gloucestershire, there have been improvements in recent years (increasing from -0.30 in 2016/2017 to 0.02 in 2022/2023), and now comparable with neighbouring local authorities (35).

Inequalities in educational attainment

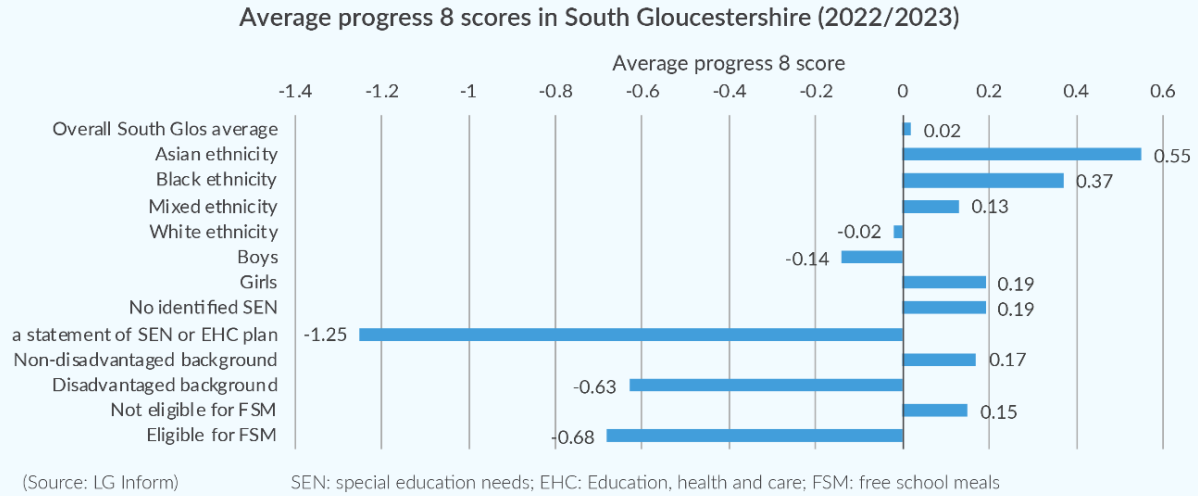
- Pupils requiring SEN support (-1.25), eligible for FSM (-0.68), or from a disadvantaged background (-0.63) have substantially lower average progress 8 scores than their colleagues. This gap is bigger in South Gloucestershire than it is nationally (Fig. 6).

- Children eligible for free school meals (FSM) have made significantly less progress (as measured by progress 8 scores) than non-FSM eligible pupils. The gap between these two groups is now larger than pre-pandemic levels and larger than other comparable area averages (1).

- There is a strong relationship between progress 8 scores and deprivation, both locally and nationally, with children living in more deprived areas achieving lower scores on average. In children from the most deprived groups in South Gloucestershire, these scores are worse than for the most deprived groups of children nationally.

- Whilst black, white, and mixed ethnicity children all had lower progress 8 scores than children from Chinese and Asian ethnic groups, for most ethnic groups, the results in South Gloucestershire broadly reflected the results for England.

Figure 6. Inequalities in average progress 8 scores



Drivers of inequalities in educational attainment

- There is a clear link between deprivation and educational attainment. From an early age, children from less affluent circumstances often lack positive home learning environments and opportunities which set them up for better educational performance later (36).

- The gaps between those from less affluent and more affluent backgrounds continue to widen through primary and secondary school and by the time young people take their GCSEs, the gap is potentially irreversible (36).

- Children from less affluent circumstances tend to have poorer school attendance which in turn affects performance.

- Poverty is linked to inadequate nutrition, disturbed sleep, and poor physical and mental health, which makes it a lot more difficult for children to perform at their best within educational settings (37) (38).

- Low aspirations amongst parents and children from deprived backgrounds also have a negative influence on children's outcomes (38).

Local action

In South Gloucestershire we have:

- Produced the Local Authority School Attendance Strategy that sets out the expected school and local authority support for children and families.

  This includes:
  - Plan to deliver a tiered support service to schools and families in relation to improving school attendance. The aim is to provide early intervention and support to families in order to help children return to school and to reduce the number of prosecutions in relation to school attendance.

- Produced an Emotional Based School Avoidance (EBSA) toolkit for schools which guides early years settings and schools in the education and development of children and young people with special educational needs and disabilities.

- Drafted a Staged Approach Document for school-based support and recruited eight Family Link Workers to work with families towards improving school attendance.

- Carry out termly targeted support meetings for all schools to support improved whole school attendance.

Physical health

The health of a child can be looked at from various perspectives, one of which is physical health. Physical health is broader than an absence of infirmity or disease. Health is a resource for living and includes an individual's ability to be able to engage well with the world around them.

We have selected obesity and oral health as key indicators of inequality in physical health outcomes in children and young people.

Obesity

Obesity and overweight simply mean an accumulation of excess body fat (39) (40). This often occurs as a result of an imbalance between energy consumed (from eating and drinking) and energy expended through physical activity and bodily functions (41). Unlike in adults, defining whether a child is overweight or obese is more complex (National Child Measurement Programme - NHS Digital). This is because children of different ages and sexes grow and develop at different rates. The National Child Measurement Programme, also implemented in South Gloucestershire, measures the height and weight of children in schools in reception and year 6 to assess levels of overweight and obesity in the population.

Why this is important

- The rising numbers of children and young people that are either overweight or obese is a source of concern because of the potential health and wellbeing impacts in childhood and adulthood.
- Being overweight or obese can negatively affect school performance in children and is associated with stigmatisation, bullying, and low self-esteem.
- Obesity that persists into adulthood increase the risk of a wide range of chronic illnesses such as diabetes, asthma, and cardiovascular disease; menstrual abnormalities, and depression (40) (42) (43).
- Moderate to severe obesity can reduce life expectancy by 3 to 10 years (44).

Situation in South Gloucestershire

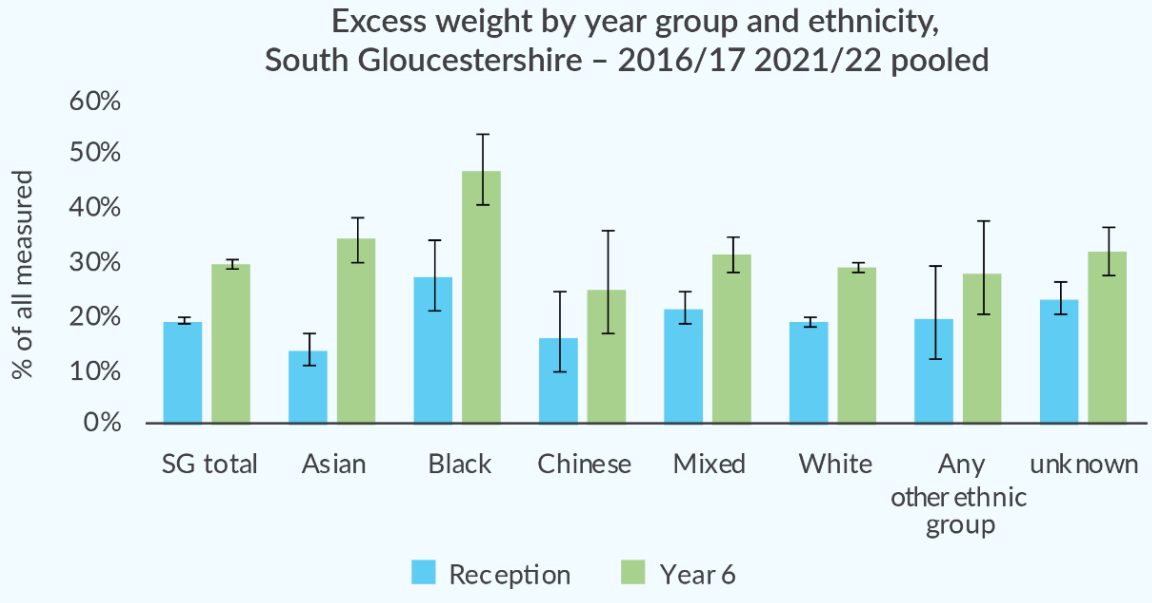
- Less than 2 in 10 reception-age children in South Gloucestershire are overweight, including obesity (%) based on data from 2022/23, with the proportion dropping significantly from the previous year 2021/22 (12).
- The proportion of Year 6 children that are overweight (including obesity) has increased from 28.4% in 2018/19 to 31.9% in 2022/23, with a slight improvement from the previous year (12). This indicates that about 3 out of 10 children in Year 6 are overweight.
- South Gloucestershire appears to have relatively lower prevalence of obesity compared with neighbours (Bristol and Gloucestershire) (12).

Inequalities in childhood obesity

- Significantly higher rates of overweight/obese children are found among those living in the most deprived areas and this has been consistent over time (1).

  Children from black ethnicities (relative to white and Asian pupils) have significantly higher rates of overweight and obesity (Fig. 7; (1)).

Figure 7. Ethnic inequalities in childhood excess weight



(Source: Children & Young People's Needs Assessment 2023)

Drivers of inequalities in childhood obesity

- Unhealthy foods such as sugar-sweetened beverages, low nutrient and energy-dense foods are major causes of obesity. They tend to be less expensive than healthy foods. Children from deprived backgrounds have difficulties accessing affordable healthy food which contributes to their increased risk of obesity (45).

- Access to green spaces is less likely for children and young people in more deprived urban areas, which reduces opportunities for engaging in regular exercise and physical activity (46).

- The influence of ethnicity on obesity cannot be easily separated from that of deprivation as people from ethnic minority groups are more likely to live in more deprived areas, which are associated with lower rates of physical activity and healthy eating (45).

- Poor nutrition during pregnancy and in early life (which is more common among the most deprived) is associated with an increased risk of obesity in children and young people (47).

Local action

In South Gloucestershire we have:

- Implemented a pilot Extended Brief Intervention (EBI) in 2022/23 which provided support and guidance to eligible families whose reception-age children were identified to be overweight (not including obese) among the approximately 3,100 children in South Gloucestershire assessed for overweight and obesity. Families were offered a detailed conversation on physical activity, healthy eating and diet, and wellbeing.

- Developed a Healthy Weight pilot programme for families in partnership with active lifestyle centres. This is a 12-week programme for families with children aged 5-17 years who are above a healthy weight. Weekly sessions include information on healthy eating and wellbeing as well as access to physical and leisure activities.

- Introduced and evaluated a pilot early-years prevention programme called ‘Healthy me’ which aimed to support families with children aged 2-4 years. It included 6 weekly structured sessions to support physical development, incorporating physical activity and messages on portion sizes, hunger cues, sleep, and screen time.

- Learning from these interventions will be included in future service design and planning.

- Are promoting and supporting local delivery of the Healthy Start scheme which is driving specific actions to support good nutrition and reduce diet related inequality in children. Healthy Start is a national scheme which aims to help young families and those who are pregnant to buy healthy food, milk, infant formula, fruit, and vegetables.

- Delivered training to practitioners working with families to talk about weight sensitively and signposting to local services.

CASE STUDY: National Child Measurement Programme

Every year in England, children in Reception and Year 6 have their height and weight measured at school as part of the National Child Measurement Programme (NCMP). This is a mandatory programme in which height and weight measurements are used to calculate weight status.

The measurements are carried out in school by trained school nursing staff. Height and weight measurements along with supporting resources are shared with parents/carers in a letter shortly afterwards. In South Gloucestershire, all mainstream schools take part in this programme, achieving high participation rates and robust high-quality data.
It is important to have a good understanding of how children are growing, so that the best possible advice and support can be provided for them and their families. Within the context of inequalities, this programme ensures that we have the necessary evidence to identify children who are at a disadvantage and respond with tailored support.

Oral health

In this report, oral health of children is assessed using two measures: (i) the average number of decayed, missing (due to caries), or filled teeth (dmft) per child, and (ii) determining the percentage of children with experience of visually obvious dentinal decay.

Why this is important

- Oral health is recognised as a key indicator of a child's overall health, wellbeing, and development (48). The condition of a child's teeth and gums can be a cause of persistent pain and influences the child's ability to eat, speak, and socialise.

- When a child has poor oral health as evidenced by toothache or need for dental treatment, they may have to be absent from school and parents may also have to take time off work to take their children to the dentist for care (49).

Situation in South Gloucestershire

- As at 2021/22, the average dmft per child in South Gloucestershire was 0.72 (12). This is more than double the mean value of 0.31 recorded in 2018, indicating worsening oral health of children (12).

- 17.4% of 5-year-olds in the local area had experienced visually obvious dental decay in 2021/22, an increase from 14.3% during the previous assessment period (2018/19).

- One major consequence of dental decay is hospital admission for tooth extraction under general anaesthetic. The rates of hospital admission for tooth extraction among children in South Gloucestershire is substantially higher than the national average.

Inequalities in oral health

- Diet, dental hygiene practices, and access to dental services play a key role in poor oral health and these factors are all also associated with deprivation (50). Local data on disparities in dmft and dental decay across groups in South Gloucestershire is lacking.

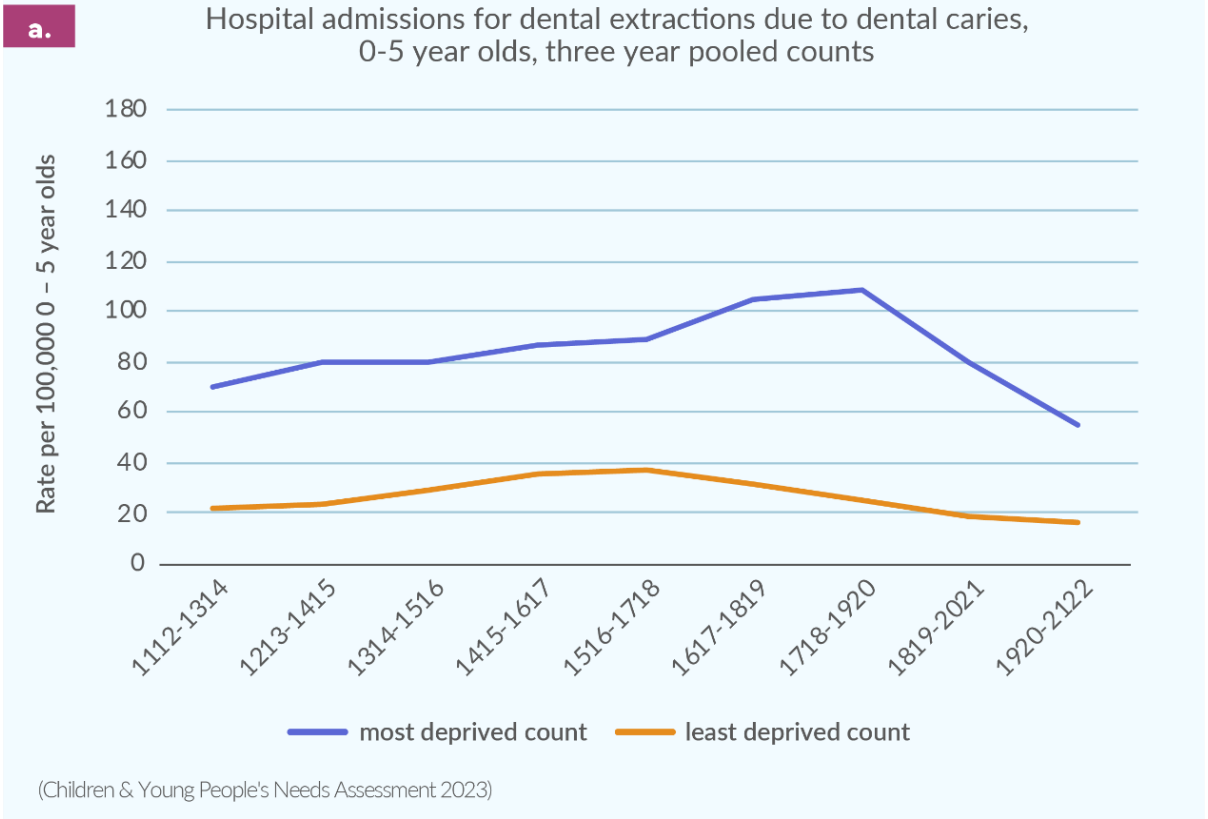
- Evidence on hospital admissions for dental extractions due to dental caries showed that children aged 0-5 and 6-10 years from the most deprived backgrounds had the highest rates of hospital admissions (Fig. 8). The drop in dental extractions in recent years is potentially due to the limited access to primary and secondary dental care due to the Covid pandemic, difficulties accessing NHS dentistry, and the long waiting times for dental procedures.

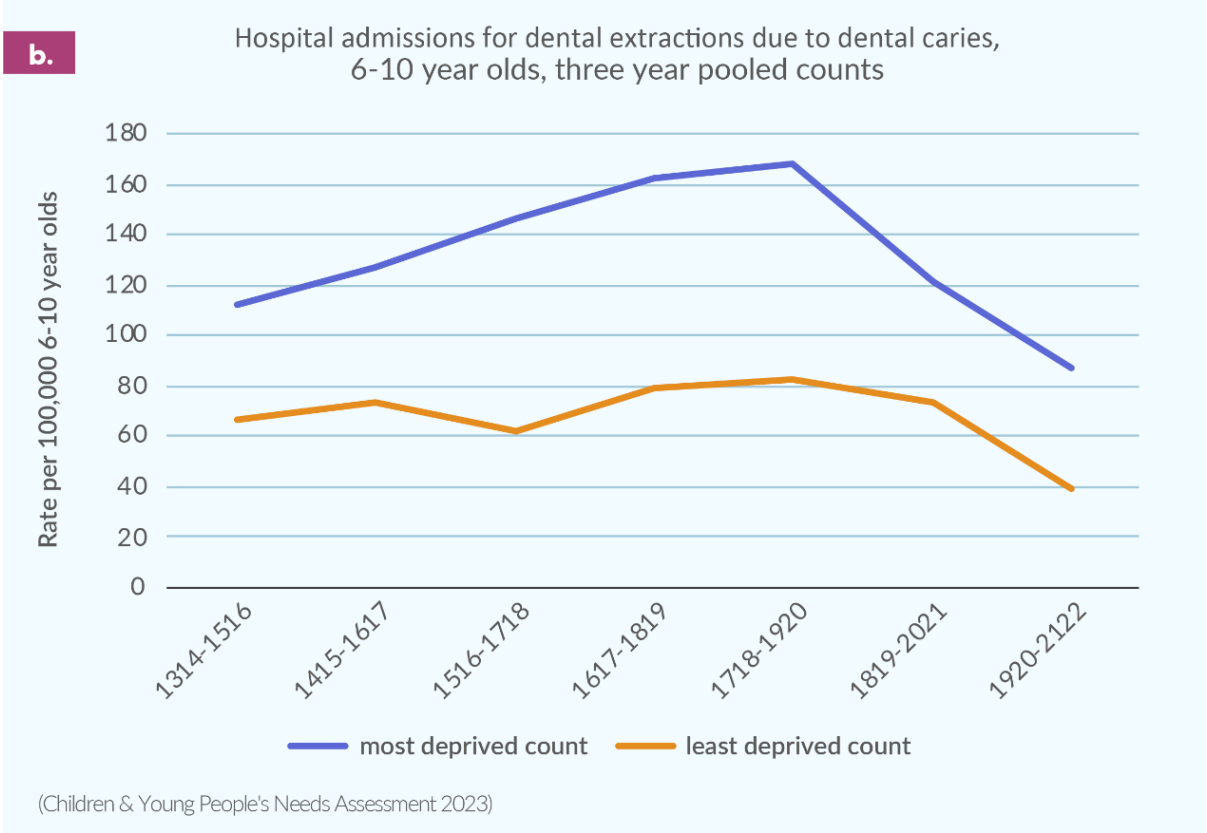
- Rates of hospital admissions are higher among boys than girls. In addition, children with learning disabilities, looked after children, and children from other vulnerable groups are thought to have greater oral health needs (South West Oral Health Needs Assessment).

- Local data on ethnic disparities in the oral health of children and young people in South Gloucestershire is lacking. However, a national survey showed that 70% of Black and 68% of Asian respondents do not visit a dental practice except when they have an urgent issue (compared with 52% of White respondents) (51).

- Regular dental attendance is much lower among those in low socioeconomic groups with negative implications on oral health outcomes (49).

Figure 8. Inequalities in hospital admissions for dental extractions by deprivation in South Gloucestershire





Drivers of inequalities in oral health

- Reduced access and utilisation of dental services among those from the most deprived settings have been suggested as a potential explanation for the worse oral health outcomes among children and young people from these settings.

- Accessing NHS dental appointments is associated with long waiting times, and the alternative of private dental care is too expensive for many families who struggle to pay for NHS dental treatments (52).

- Children from the most deprived settings are less likely to afford hygiene essentials including toothbrushes and toothpastes necessary to maintain good oral health (53).

- Children from low-income households are more likely to consume diets that are high in sugar, which increases the risk of dental decay (54).

Local action

In South Gloucestershire we:

- Participated in the pilot of ‘First Dental Steps’ project. This pilot project provides oral health packs including toothpaste, toothbrush, and a sippy cup for children between the ages of 0-2 years.

- Are working with partners to produce an oral health strategy for the local integrated care board. Including oral health promotion and access to routine and specialist dental care.

Mental health and wellbeing

At its simplest, good mental health is the absence of a mental disorder or mental health problem. Good mental or emotional wellbeing is closely linked to good mental health, but they are not quite the same thing.

Emotional wellbeing describes the ability of an individual to successfully handle stresses and adapt to changing and difficult times (55). Someone who has been diagnosed with a mental health disorder can achieve emotional wellbeing some of the time but is likely to experience lower emotional wellbeing compared to someone without a diagnosed disorder. Likewise, someone who has neither mental nor physical illnesses could still have a poor state of emotional wellbeing.

Why this is important

- Mental health can impact on every aspect of a child's life, including physical health, educational achievements, relationships, and overall wellbeing.

- Mental health problems during childhood may lead to poorer quality of life in adulthood, and worsen life-long inequalities in health, education, employment, and mortality outcomes.

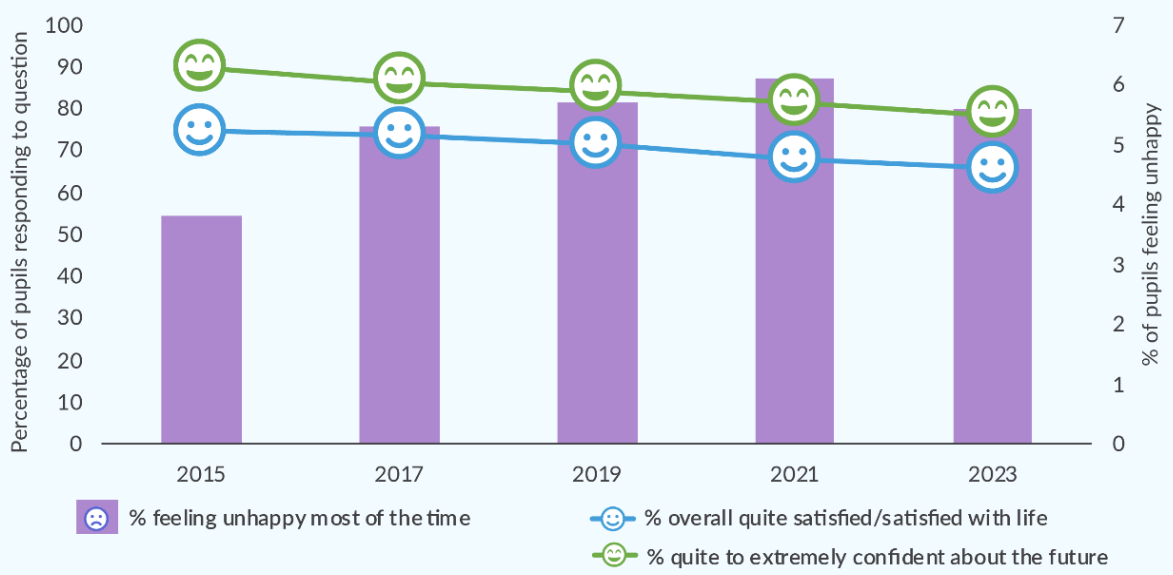
- Emotional wellbeing is particularly important during the period when a child is developing emotional awareness, a sense of self and identity, and resilience to cope with day-to-day challenges. Poor emotional wellbeing has been linked to suicides which is a leading cause of death in children and young people nationally.

Situation in South Gloucestershire

- Local survey data shows that the proportion of children indicating that they felt unhappy most of the time has slowly increased from 3.8% in 2015 to 5.6% in 2023. Also, the proportion of children who described themselves as confident about the future reduced from 89.7% in 2015 to 78.1% in 2023 (Fig. 9).

- The worsening state of mental health in children and young people has been attributed in part to the recent Covid-19 pandemic and associated periods of lockdowns.

Figure 9. Responses to questions on satisfaction and happiness between 2015 and 2023

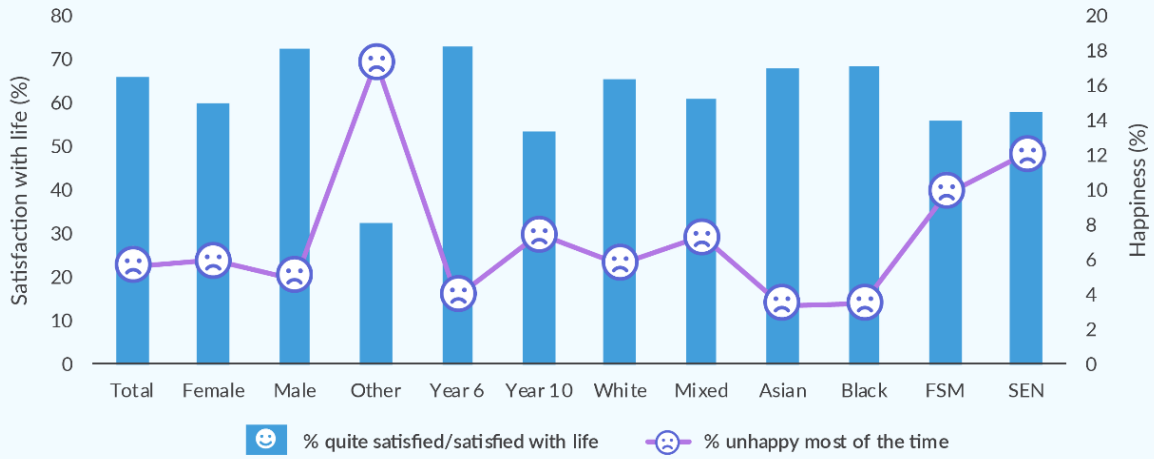


(Source: Online Pupils Surveys 2015, 2017, 2019, 2021, and 2023)

Inequalities in mental health

- Pupils who identified as females, other sex, of mixed ethnicity, eligible for FSM, and/or have special education needs had worse emotional wellbeing than their counterparts (Fig. 10).

Figure 10. Inequalities in emotional wellbeing in pupils aged 8 – 18 years



(Source: OPS 2023)

Drivers of inequalities in mental health

- Children who come from disadvantaged backgrounds are at greater risk of poor mental health than those from the least deprived settings.

- Being eligible for FSM appears to be associated with higher rates of unhappiness and dissatisfaction with life, a relationship that may be explained on the basis of individual

attributes such as low self-esteem and difficulties communicating, and social circumstances in which children live – including poverty, crime, and poor housing (56).

- There is a complex relationship between poor mental health and children with SEN as they can be at higher risk of mental health challenges than those without SEN (57).

- There is a gender gap in emotional wellbeing with females having lower levels of emotional wellbeing. This gap reflects what has been noticed in other studies (58). However, it is not yet clear why the differences between males and females remain wide.

Local action

In South Gloucestershire we have:

- Deployed Mental Health Support Teams (MHST) to two areas of South Gloucestershire, prioritised as they have; high levels of deprivation, levels of children on FSM, exclusions, and Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) scores.

- Established the Mental Health and Wellbeing Award which equips schools to take a whole-school approach to mental health and wellbeing, focusing not just on the pupils but parent/carers and staff as well. As the second round of schools are reviewed for the award in early 2024, we are targeting schools within the areas of highest deprivation who currently do not have access to mental health support teams.

- Set up an action group on special education need and disabilities (SEND) and social, emotional and mental health (SEMH) as part of the council's CYP mental health strategy which integrate mental health work across agencies working within the local area and ensure links with the broader SEND strategy.

- Established a strong CYP Mental Health Partnership, made up of a range of organisations that work together to understand the needs of local children and young people, promote good mental wellbeing and focus on priority areas where partnership working can have the biggest impact.

CASE STUDY: The South Gloucestershire Health and Wellbeing Online Pupil Survey (OPS)

The South Gloucestershire Health and Wellbeing Online Pupil Survey (OPS) is an initiative of the Public Health and Wellbeing Division of South Gloucestershire Council. The aim of the survey is to capture the thoughts and voice of pupils across the local authority. It particularly provides a vital and comprehensive picture of the needs of children and young people across the local authority.

The first edition of the survey was carried out in 2015, and we have continued to conduct it every two years thereafter in 2017, 2019, 2021, and 2023. This time series provides us the opportunity to look at what has been happening over time. The survey is organised into seven sections (demographics, healthy eating, physical activity, substances, citizenship, safety, and relationships) and it targets those in primary (Year 7) and secondary (Years 8-11) schools, and those in further education (Year 12).

The results of the OPS have proven to be an invaluable resource in helping individual schools, the South Gloucestershire Council, and other stakeholders to understand how children and young people in South Gloucestershire behave and what they really think about a range of health-related issues. Data from the OPS have been used in recent needs assessments and have guided the development of strategies and interventions across the local authority. Through the OPS, we can target interventions to those who will most benefit from them and reduce inequalities.

Opportunities for further action

Education
▪ Ensure that from birth, children have the right building blocks to support their development and educational attainment. This includes identifying issues early, investing in quality early years education and building effective universal and targeted support around families. ▪ Develop systems and strategies to support children to attend school regularly, particularly for those children known to be higher risk of poor outcomes. ▪ Support families who are experiencing poverty and financial insecurity to ensure that effects on children's education are minimised. ▪ Support schools to build cultures and practices that support children's wider physical and mental health and wellbeing, enabling them to flourish in education. ▪ Solutions developed must consider addressing socioeconomic disadvantage, optimising home learning environments and parenting skills, and improving the attitudes and behaviours of young people towards increased school attendance and potentially, better performance in school.

Physical health

Obesity

- Explore additional funding to expand free school meals to all children in primary schools so that access to nutritious and healthy meals can become more equal.
- Improve the awareness of parents on the effects of excessive consumption of sugar-sweetened, low nutrient, and energy-dense foods.
- Encourage full participation of children in the National Child Measurement Programme, using the programme as an opportunity to engage with parents of all children measured to promote healthy weight.
- Support education settings to deliver high quality personal, social, health and economic (PSHE) education, activities, and interventions to promote health and wellbeing through the health promotion in education settings programme and the online pupil health and wellbeing survey.
- Monitor uptake of the Healthy Start scheme from an inequalities perspective and provide insights to inform local planning and promotion of the scheme.
- Adopt preventative approaches for promoting a healthier weight. This could be done by producing a local authority healthy weight declaration which includes influencing the planning system to create supportive environments, destigmatising weight, and endorsing a “health at any weight” approach.

Oral health

- Encourage young people, parents and carers to visit the dentist for dental care including preventive care (especially those at high risk of tooth decay) and create an awareness of free NHS dental services where available.
- Provide evidence-based information and guidance to enable parents and children to make informed decisions about oral health and lowering the risk of tooth decay such as avoiding sugary foods and drinks.
- Provide support to parents and carers on supervising toothbrushing to ensure teeth are brushed thoroughly until children can do this independently, and provide age-appropriate guidance on dental care.
- Facilitate the delivery of a regional ‘Supervised Tooth Brushing’ programme. This involves training and supporting workers and practitioners in early years settings to supervise toothbrushing among children aged 3-5 years when attending the setting.
- Implement the ‘First Dental Steps’ programme across South Gloucestershire which, in collaboration with public health nurses, ensure that all families with a child aged 0-2 years will be provided with an oral health pack and education.

Mental health

- Provide parents and carers with evidence-based information about the importance of building resilience including family relationships and how to meet their child’s emotional needs.
- Promote and support the development of a whole-school approach to emotional and mental health and wellbeing, including measures to prevent and stop bullying, enhancing social skills, independence, and self-confidence.
- Offer young people information and guidance about emotional wellbeing and mental health, including keeping well mentally, adopting healthy lifestyles, developing healthy

respectful relationships, recognising bullying, and know how to access support if they are worried.

- Creating new ways of targeting underserved groups as a large number of children experiencing poor mental health are not currently in school (emotion-based school avoidance).
- Continue to develop and offer training to anyone who works with children and young people. The addition of the bitesize training offer expands our scope to reach more people and increase knowledge on the mental health of children and young people, self-care and resilience, the links between drugs, alcohol, and mental health, and trauma awareness.

WIDER DETERMINANTS OF HEALTH

Free school meals

School meals have benefits on childhood nutrition and overall health and development. Children who eat a balanced, healthy diet are more likely to be alert in class and have more energy to enjoy an active lifestyle. The impact has been shown to last well into adulthood, with evidence linking free school meals to improved educational attainment, financial and health benefits.

School food standards in England have improved, with researchers finding that school lunches are on average more nutritious than the packed lunches that children might otherwise bring. All children in the first 3 years of primary school can receive FSM regardless of family income (referred to as Universal Infant FSM (UIFSM)). Only older children from families with household incomes less than £7,400 a year (after tax and not including any benefits) are eligible for FSM (59). However, there is currently a bill in the UK Parliament aimed at introducing a new policy to expand eligibility to all primary school children.

Why this is important

- Financial and food insecurity is linked to poor health and wellbeing in children. The prevalence is rising and has been exacerbated by Covid-19 control measures. Free school meals are a critical tool for mitigating the negative health effects of child poverty among low-income families.

- Eligibility for FSM can be used an indicator of socioeconomic disadvantage (including household income deprivation) in the local area (60). By determining the numbers of children eligible for FSM, we can estimate levels of deprivation and vulnerability, and the effects on the outcomes of children and young people.

- Wider benefits of FSM include improved access to healthy, nutritious meals, promotion of healthy eating, improved social skills at mealtimes, increased variety of food options, and improved behaviour and educational attainment.

- Nevertheless, based on the current criterion of household income less than £7,400 a year, about one third of children living in poverty in the UK do not qualify for free school meals.

Situation in South Gloucestershire

- Over the past five to six years, the proportion of children eligible for FSM in South Gloucestershire has almost doubled from 8.1% in 2017 to 15.1% in 2023 (Fig. 11a, (61)). This suggests an increase in the population of children living in deprivation.

- The proportion of all pupils taking up FSM in South Gloucestershire is 10.7%, which is less than the regional average of 15.1% and the national average of 18.6% (61).

Inequalities associated with free school meals and related outcomes

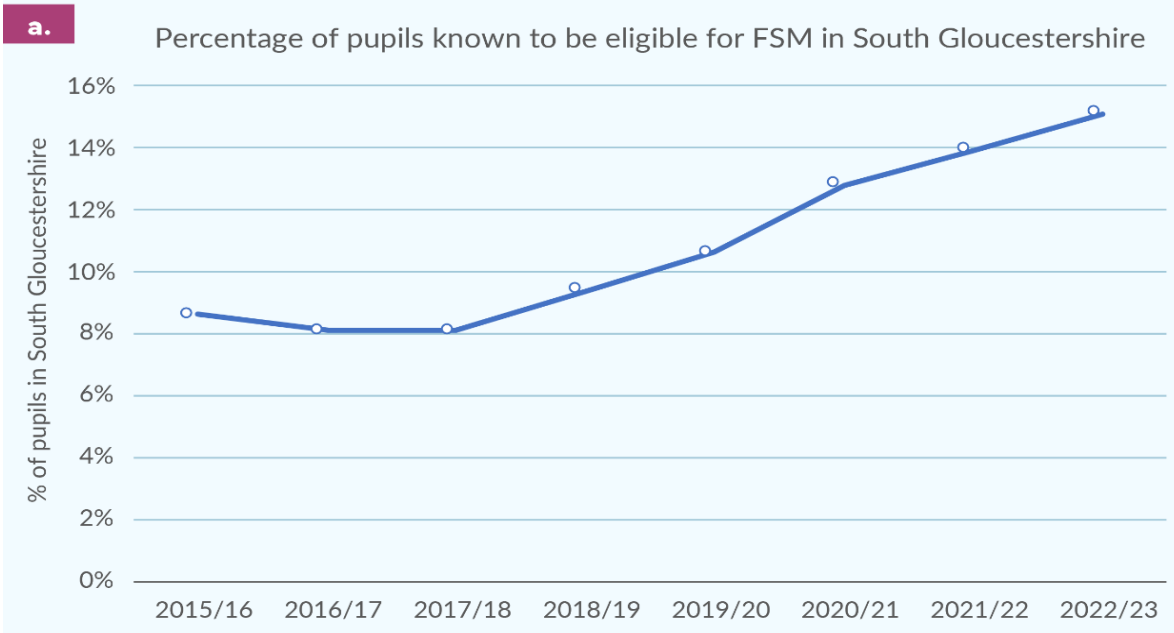
- National level data indicates that children from black or mixed ethnicities are significantly more likely to be eligible for FSM (12).

- Children who are eligible for FSM tend to have worse developmental outcomes. The proportion of children achieving a good level of development by the end of reception is 27.3% lower among those eligible for FSM when compared with the rest of the children of the same age (Fig. 11b, (1)).

- Children on FSM achieved an average attainment 8 score[3] of 36.7 points compared with the average score of 52.4 achieved by all other children; indicating that pupils on FSM are not making as much progress as non-FSM eligible pupils.

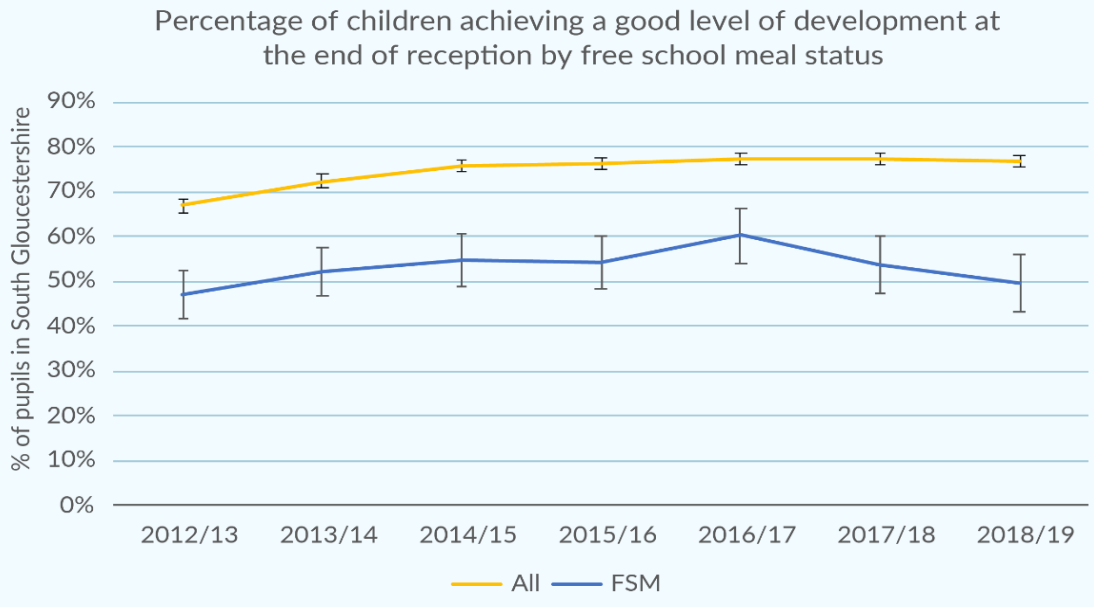
Figure 11. Percentage of pupils eligible for free school meals (a) and percentage of children achieving good level of development at the end of reception (b)

a.



(Source: Department for Education)

b.



(Source: Children & Young People's Needs Assessment 2023)

[3] The average attainment 8 score measures the average performance of pupils across eight qualifications at the end of KS4

Local action

In South Gloucestershire we have:

- Established a working group to improve FSM uptake among eligible children through the Holiday and Activities Programme and the Healthy Start scheme.
- Raised awareness and promoted the benefits and entitlement for FSM, including uptake of Pupil Premium
- Organised dialogues on longer term approaches for increasing the uptake of free school meals, and school food in general.

Child poverty

A child is considered to grow up in poverty if they live in a household where the income is below 60% of the average (median) income for that year (1). However, this does not take into account housing costs, so the number of children living in households that are facing significant financial insecurity is likely to be much higher.

Why this is important

- Growing up in poverty has been shown to have the strongest negative impacts on children's health, cognitive, mental, and social development, and educational attainment (62).
- Children who live in poverty tend to have limited material resources, live less healthy lifestyles, have poorer education, and experience a lot of stress; all of which interact to worsen inequalities in outcomes.
- The impacts of child poverty are significant and tend to follow children and young people through their life and increase the risk of socioeconomic disadvantage in adulthood. Children who grow up in poverty are much more likely to become poor adults, potentially becoming the parents of the next generation of children living in poverty.

Situation in South Gloucestershire

- Child poverty has been on the rise locally and nationally over the last decade (1). In South Gloucestershire, eligibility for FSM (a proxy for relative poverty) has increased as shown earlier in Fig. 10.
- About 1 in 10 children live in relative poverty which increases to as much as one in every five children in some areas in South Gloucestershire if housing costs are factored in (63).
- Although South Gloucestershire as a local area has an income deprivation affecting children index (IDACI) that is lower than the regional average (10.4% vs 17.1%), nine wards in the local area are more affected. As many as 20% of children aged 0-15 years in Charlton & Cribbs live in income deprived families. This is followed by 17.6% in Patchway Coniston and 17.5% in Woodstock.

Inequalities and drivers of child poverty

- There is evidence indicating that children from ethnic minority groups; where parents are unemployed, inactive, in fulltime education; or having a lone parent with dependent children are more likely to live in poverty (63).

- The major drivers of child poverty are insufficient household income and high living costs associated with raising children (64). Households with lone parents (most of whom tend to be mothers) and/or having at least one person with a chronic illness increase the risk of child poverty.

- Families who live in households in poverty may find it difficult to afford healthy foods, manage rising costs of energy, and purchase basic hygiene products – all of which may independently or interactively lead to poor outcomes in children.

Local action

In South Gloucestershire we:

- Worked directly with a group of South Gloucestershire mothers to better understand their needs and build on their ideas for how best to provide financial support to their families.

- Conducted a series of 'Happy Parent, Happy Child' roadshows, engaging directly with over 350 families to raise awareness of the support available linked to cost of living or financial hardship, including on the South Gloucestershire Happy Parent, Happy child website.

- Provide warm packs in winter and cool packs in summer to children's centres, to be distributed to families. The packs include blankets and water bottles, among other items. We also provide additional information on cost-of-living support to children's centres to share with families.

- Provide families with support to help increase financial security. This is through a range of options including increasing income through employment and training and maximising income through benefit advice and guidance. Our Financial Wellbeing Framework is being developed to help Council teams and partner organisations understand where and how they may help families address financial security issues.

Domestic abuse

Why this is important

- Although domestic abuse can only be directly experienced by people aged 16 and over in the UK, domestic abuse in the household[4] undermines a child's basic need for safety and security, causing damaging effects on mental and physical wellbeing.

- From a more long-term perspective, domestic abuse in early life is an adverse childhood experience which can be very stressful for a child. This type of experience increases a child's risk of engaging in health harming behaviours in adolescence and adulthood, which in turn reduces the chance of living a healthy and productive life (65).

- Domestic abuse is particularly associated with drug and alcohol misuse as young people may drink alcohol to cope with the stress of experiencing domestic abuse (66).

[4] Part 1 of the Domestic Abuse Act 2020 provides that a child who sees or hears, or experiences the effects of, domestic abuse and is related to or under parental responsibility of the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse. This means that where the Act imposes a duty in relation to victims of domestic abuse, this will include children. Domestic Abuse is distinct from child abuse. Statutory definition of domestic abuse factsheet - GOV.UK (www.gov.uk)

Situation in South Gloucestershire

- About 1 in 5 (23%) secondary school pupils (year 12) reported that they or a family member had been the victim of domestic abuse or domestic violence (1). For many of them, the abuse or violence was not very frequent. However, this occurred often or on most days among 7% of them, and as much as 16% of the pupils reported the abuse as continuing.

Inequalities in domestic abuse

- The experience of domestic abuse has strong roots in socioeconomic disadvantage. While local data is lacking, there is evidence showing that household poverty is associated with increased levels of domestic abuse and violence (67). National level data shows that children living in the most deprived areas have higher rates of Children in Need due to abuse or neglect (63).

Drivers of inequalities in domestic abuse

- There is strong evidence showing that poverty can be a causal factor in child domestic abuse (67). Poverty is associated with parental substance use, poor parental mental health, and several other factors that increases a child's risk of experiencing domestic abuse.

- The impact of poverty on child domestic abuse appears to be stronger in families with young children (67).

- Children from settings associated with high levels of poverty, unemployment, or unoccupied housing tend to experience more maltreatment.

Local action

In South Gloucestershire we:

- Support children and other members of the South Gloucestershire community who are or have been victims of domestic abuse via Next Link Plus

- Recommissioned our Domestic Abuse Safe Accommodation and Specialist Support Services. In Safe Accommodation, children and young people now receive their own support worker and access to play sessions and play therapy. Through the specialist support services in the community, there is a CYP independent domestic violence adviser (IDVA) and a 16–25-year-old IDVA who can work with young people who are living or have lived in abusive households and those in 'abusive/unhealthy' relationships of their own.

- Our annually reviewed CYP Domestic Abuse service provides 1:1 support and group work to young people referred into the service.

- Commissioned a Multi-Agency Safeguarding Hub (MASH) IDVA who takes part in daily MASH meetings and hold a caseload of families impacted by domestic abuse as well as providing training and advocacy for social workers and other professionals involved in MASH discussions.

- Commissioned a 2-year pilot programme of Iris Advise providing advocacy and screening for domestic abuse and sexual violence in Sexual Health settings. This service is engaging with younger adults (and pregnant women and LGBTQ+ victims) who otherwise have not come through mainstream services.

Opportunities for further action

Free school meals
▪ Addressing reasons for low FSM uptake such as acceptability and raise awareness on the benefits of FSM and entitlement.
Child poverty
▪ Identify children and families at risk of experiencing poverty, such as minority groups, workless and low-income households, and families with at least someone suffering from a long-term illness. ▪ Develop a pilot family hub, including the involvement of financial security related support. ▪ Based on need, provide information about local universal services, for example family hubs or children's centres, where parents and carers can seek additional support and advice, for example budgeting support or peer support networks. ▪ Secure opportunities for a winter clothing grant for families to access if needed. ▪ Develop support sessions delivered in Children's Centres and libraries to help people facing cost of living and other financial pressures to improve their circumstances (e.g., accessing debt advice or home energy savings) ▪ Link in with the ongoing work in early years and the first 1,001 days to help new families who may be facing poverty or financial pressures.
Domestic abuse
▪ Create awareness of specialist support for children across local areas. This ensures that children affected by domestic abuse can access support as quickly and easily as possible. ▪ Embed the use of trauma-informed approaches in assessing need among children and young people including family relationships and dynamics. Support children and young people, parents, and carers, building on their strengths and attributes to address concerns, support self-care, and improve wellbeing.

CALL TO ACTION

It is clear that there are inequalities across health and developmental outcomes of children and young people in South Gloucestershire. These inequalities are apparent from the point of conception and pregnancy through to adolescence and will persist beyond this into adult life, and indeed, into future generations.

There is evidence that the same groups of people are consistently affected, especially children living in poverty, from certain equalities groups, those eligible for free school meals, requiring SEN support and children in the care system among others. We know that these vulnerabilities are likely to be additive and for the many children experiencing multiple disadvantages, the impacts on their health, wellbeing, and development are likely to be more extreme.

Inequalities are entrenched but not inevitable and there is a lot that can be done to tackle them and improve outcomes across all groups of children and young people locally. We need to rebalance the system and move funding from crisis support into early help and prevention built around families.

There is clear evidence and rationale for the need to do things differently; we need to design systems that prioritise prevention and early help around children, young people and work directly with families and communities to do this in ways that make sense to them.
With key services under pressure, it is easy to assume that we cannot afford to deliver a comprehensive prevention agenda. But in terms of both longer-term financial investment and the outcomes for children and families in South Gloucestershire, we cannot afford not to.

The key cross system opportunities for protecting and improving the health and wellbeing of children and young people in South Gloucestershire are to:

1. Strongly prioritise early prevention and target children and young people at risk of multiple vulnerabilities

Inequalities appear from conception through to pregnancy, childbirth, and the early years, and continue to perpetuate into adulthood and future generations.

There is a need to shift towards effective prevention early on in a child's life rather than later response when inequalities are well established. This means re-assessing areas where early intervention can be optimised in CYP services. Considering that the effects of inequalities are additive and multiplicative, we also must focus more on children and young people who face multiple vulnerabilities while making provision for other children who are less at risk.

2. Rebalance the system towards earlier, whole family help

Resources need to be reallocated towards early help for families. As set out in the Early Help System Guide, early help should be understood and seen as everyone's responsibility across the partnership of services working with children, adults and families. By increasing the appetite for change, strengthening partnerships, streamlining access to help, and developing shared systems for collecting data and measuring outcomes at the local level, systems can be reorganised towards early help.

3. Address family poverty and financial insecurity

Evidence shows that poverty and deprivation during childhood negatively influence development and health outcomes. Children from the most deprived settings do worse than those from more affluent settings.

We need to support families to mitigate the impacts of poverty and help families achieve financial security. Also, we need to understand and take account of financial pressures when working with them and identify opportunities to increase financial security. This ensures that our response and support is suitable. Any measure aimed at helping households improve their financial wellbeing will help to address some of the underlying causes of poor health in children and young people.

4. Strengthen data systems to improve collection of individual-level and population-level data on inequalities in the outcomes of children and young people

Local data on inequalities by socioeconomic deprivation, equality groups, vulnerability, and geography are limited in terms of availability and completeness. This limits visibility into existing disparities across different groups of children and young people.

Improving data and collating local insights into the causes and distribution of inequalities in South Gloucestershire will ensure that we can appropriately develop and target our interventions in a way that ensures that we achieve the results we want. Additionally, sharing and making data available to all partners and stakeholders involved in action to reduce inequalities will stimulate collective action and help focus on the most effective solutions.

5. Strengthen parental and broader community involvement in the development of initiatives to tackle inequalities

The voice of children, parents, carers, and other key stakeholders within the community are key in the development of solutions to reduce inequalities. We need stronger community involvement in the co-development of strategies and interventions aimed at reducing inequalities. We also need to engage with and gather insights from children and young people because what they think and feel matters in the work we do. Much can be achieved by working in partnership, ensuring that services and support are centred around the child and family, and are accessible, non-stigmatising, and trauma informed.

REFERENCES

1. **South Gloucestershire Council.** *Children & Young People's Needs Assessment 2023.* Yate : South Gloucestershire Council Public Health & Wellbeing Division, 2023.
2. **Dornan, P and Woodhead, M.** *How Inequalities Develop through Childhood: Life course evidence from the Young Lives cohort study.* Florence : UNICEF Office of Research, 2015. Office of Research Discussion Paper No.2015-01.
3. **Marmot, M, et al.** *Health equity in England: The Marmot review 10 years on.* London : Institute of Health Equity, 2020.
4. **NHS England.** What are healthcare inequalities? [Online] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/.
5. **Public Health England.** Place-based approaches for reducing health inequalities: main report. 2021.
6. **Royal College of Paediatrics and Child Health.** *State of Child Health.* London : RCPCH, 2020.
7. **The King's Fund.** Health inequalities in a nutshell. [Online] 20 August 2021. https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-inequalities.
8. **Gray, R.** *Life stage: Pre-conception and pregnancy.* 2012. Annual Report of the Chief Medical Officer.
9. Cigarette smoking during pregnancy and adverse perinatal outcomes: a cross-sectional study over 10 years. **Tarasi, B, et al.** 2022, BMC Public Health, Vol. 22, p. 2403.
10. **Royal College of Obstetricians & Gynaecologists.** Smoking and pregnancy. [Online] December 2015. https://www.rcog.org.uk/for-the-public/browse-our-patient-information/smoking-and-pregnancy/.
11. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. **Leonardi-Bee, J, Jere, M and Britton, J.** 2011, Thorax, Vol. 66, pp. 847-855.
12. **Office for Health Improvement & Disparities.** Child and Maternal Health Profiles. *Fingertips.* [Online] 2023. https://fingertips.phe.org.uk/profile/child-health-profiles/.
13. Understanding inequalities of maternal smoking—Bridging the gap with adapted intervention strategies. **Boucher, J and Konkle, A.** 3, 2016, Int J Environ Res Public Health, Vol. 13, p. 282.
14. **United Nations Children's Fund and World Health Organization.** *Low birthweight: Country, regional and global estimates.* New York : UNICEF, 2004.
15. *Growth and development in children born very low birthweight.* **Scharf, RJ, et al.** 5, 2016, Arch Dis Child Fetal Neonatal Ed, Vol. 101, pp. F433-8.
16. National, regional, and worldwide estimates of low birthweight in 2015, with trends from 2000: a systematic analysis. **Blencowe, H, et al.** 7, 2019, Lancet Global Health, Vol. 7, pp. e849-e860.
17. Weighting of risk factors for low birth weight: a linked routine data cohort study in Wales, UK. **Bandyopadhyay, A, et al.** 2023, BMJ Open, Vol. 13, p. e063836.
18. Maternal age at first childbirth and risk of low birth weight and preterm delivery in Washington State. **Aldous, M B and Edmonson, M B.** 21, 1993, JAMA, Vol. 270, pp. 2574-7.
19. Advanced maternal age and the risk of low birth weight and preterm delivery: a within-family analysis using Finnish population registers. **Goisis, A, et al.** 11, 2017, American Journal of Epidemiology, Vol. 186.

20. **AIHW (Australian Institute of Health and Welfare).** *Australia's mothers and babies 2017—in brief.* Canberra : AIHW, 2019. Perinatal statistics series no. 35. Cat. no. PER 100.

21. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. **Victora, CG, et al.** 10017, 2016, Lancet, Vol. 387, pp. P475-490.

22. **World Health Organization.** Breastfeeding. [Online] 2023. https://www.who.int/health-topics/breastfeeding#tab=tab_1.

23. **Public Health England.** New survey of mums reveals perceived barriers to breastfeeding. [Online] 27 March 2017. https://www.gov.uk/government/news/new-survey-of-mums-reveals-perceived-barriers-to-breastfeeding.

24. **South Gloucestershire Council.** *Spring School Census 2022.* Yate : s.n., 2022.

25. Trends and inequalities in breastfeeding continuation from 1 to 6 weeks: findings from six population-based British cohorts, 1985–2010. **Simpson, D, et al.** 2022, European Journal of Clinical Nutrition, Vol. 76, pp. 671-679.

26. **Department for Education.** Development matters: Non-statutory curriculum guidance for the early years foundation stage. 2020.

27. **Public Health England.** *Improving school readiness: Creating a better start for London.* London : Public Health England, 2015.

28. **Save The Children.** Mind the gap: Getting our children ready for school. [Online] 7 September 2018. https://www.savethechildren.org.uk/blogs/2018/mind-the-gap-getting-our-children-ready-for-school.

29. **The Health Foundation.** How do our education and skills influence our health. [Online] 30 August 2017. https://www.health.org.uk/infographics/how-do-our-education-and-skills-influence-our-health.

30. **Department of Health & Social Care.** *Education, schooling and health summary.* [Online] 13 September 2021. https://www.gov.uk/government/publications/education-schooling-and-health/education-schooling-and-health-summary.

31. **Department for Education.** Pupil absence statistics: methodology. [Online] 18 May 2023. https://explore-education-statistics.service.gov.uk/methodology/pupil-absence-in-schools-in-england.

32. —. Why is school attendance so important and what are the risks of missing a day? [Online] 18 May 2023. https://educationhub.blog.gov.uk/2023/05/18/school-attendance-important-risks-missing-day/.

33. Mapping inequalities in school attendance: The relationship between dimensions of socioeconomic status and forms of school absence. **Klein, M, Sosu, E M and Dare, S.** 2020, Children and Youth Services Review, p. 105432.

34. **Public Health England.** *The link between pupil health and wellbeing and attainment.* London : Public Health England, 2014.

35. **LG Inform.** Data and reports. [Online] 2023. https://lginform.local.gov.uk/dataAndReports/search?text=progress+8.

36. **Goodman, A and Gregg, P.** Poorer children's educational attainment: how important are attitudes and behaviour? York : Joseph Rowntree Foundation, 2010.

37. **Public Health England.** *School food and attainment: Review of the literature.* London : Public Health England, 2013.

38. **Department for Children, Schools and Families.** Deprivation and education: The evidence on pupils in England, foundation stage to key stage 4. 2009.

39. **NHS.** Obesity. *Health A to Z.* [Online] 15 February 2023. https://www.nhs.uk/conditions/obesity/.

40. *Childhood obesity: causes and consequences.* **Sahoo, K, et al.** 2, 2015, J Family Med Prim Care, Vol. 4, pp. 187–192.

41. **Australian Institute of Health and Welfare.** *A picture of overweight and obesity in Australia 2017.* Canberra : AIHW, 2017. Cat. no.PHE 216.

42. Childhood obesity and its physical and psychological co-morbidities: a systematic review of Australian children and adolescents. **Sanders, R, et al.** 6, 2015, Eur J Pediatr, Vol. 174, pp. 715-46.

43. **NHS Digital.** National Child Measurement Programme, England, 2022/23 School Year. [Online] 19 October 2023. https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2022-23-school-year/introduction.

44. **The Academy of Medical Royal Colleges.** *Securing our healthy future: Prevention is better than cure.* London : The Academy of Medical Royal Colleges, 2023.

45. **Holmes, J.** Tackling obesity: The role of the NHS in a whole-system approach. London : The King's Fund, 2021.

46. **Obesity Health Alliance.** Turning the tide: A 10-year healthy weight strategy. 2021.

47. *The Barker hypothesis.* **Edwards, M.** 2017, Handbook of Famine, Starvation, and Nutrient Deprivation, pp. 1-21.

48. **World Health Organisation.** Oral health. [Online] 2024. https://www.who.int/health-topics/oral-health/#tab=tab_1.

49. **Public Health England.** Health matters: child dental health. [Online] 14 June 2017. https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health.

50. **Local Government Association.** *Tackling poor oral health in children: Local government's public health role.* London : Local Government Association, 2016.

51. **Teeman, D.** Identifying and addressing oral health inequalities in dental care. *General Dental Council.* [Online] 4 February 2021. https://www.gdc-uk.org/news-blogs/blog/detail/blogs/2021/02/04/identifying-and-addressing-oral-health-inequalities-in-dental-care.

52. **Healthwatch.** Twin crisis of access and affordability calls for a radical rethink of NHS dentistry. [Online] 24 May 2021. https://www.healthwatch.co.uk/news/2021-05-24/twin-crisis-access-and-affordability-calls-radical-rethink-nhs-dentistry.

53. **The Hygiene Bank.** The Hygiene Bank: Hygiene poverty 2022 summary report. London : The Hygiene Bank, 2022.

54. **British Dental Association.** Sugar levy and oral health. *Blog.* [Online] 2023. https://bda.org/news-centre/blog/sugar-levy-and-oral-health-a-battle-won-but-the-war-is-not-over.

55. **National Institutes of Health.** Emotional Wellness Toolkit. *Health Information.* [Online] 8 August 2022. https://www.nih.gov/health-information/emotional-wellness-toolkit.

56. **The King's Fund.** Reducing inequalities in children and young people's mental health. [Online] 8 December 2017. https://www.kingsfund.org.uk/blog/2017/12/reducing-inequalities-children-young-people-mental-health.

57. **The Royal Borough of Kensington and Chelsea.** Mental health of children/young people with SEND. [Online] 5 October 2021. https://www.rbkc.gov.uk/kb5/rbkc/fis/advice.page?id=Dhf0zeqwzlU.

58. **Office for Health Improvement and Disparities.** 4. Children and young people. [Online] 12 April 2022. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/7-children-and-young-people.

59. **Department for Education.** Free school meals: Guidance for local authorities, maintained schools, academies and free schools. 2023.
60. **Office for National Statistics.** Education, social mobility and outcomes for students receiving free school meals in England: initial findings on earnings outcomes by demographic and regional factors. [Online] 25 January 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/educationsocialmobilityandoutcomesforstudentsreceivingfreeschoolmealsinengland/initialfindingsonearningsoutcomesbydemographicandregionalfactors.
61. **Department for Education.** Schools, pupils and their characteristics. [Online] 8 June 2023. https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics/2022-23.
62. **NHS Health Scotland.** Child poverty in Scotland: health impact and health inequalities. Edinburgh : NHS Health Scotland, 2018.
63. **Office for Health Improvement and Disparities.** Public health profiles. *Fingertips.* [Online] 2024. https://fingertips.phe.org.uk .
64. **Royal College of Paediatrics and Child Health.** Child health inequalities driven by child poverty in the UK - position statement. [Online] 21 September 2022. https://www.rcpch.ac.uk/resources/child-health-inequalities-position-statement.
65. **Welsh Government.** Review of adverse childhood experiences (ACE) policy: report. 2021.
66. **Alcohol Change UK.** *Alcohol and domestic abuse.* 2021.
67. **Bywaters, P, et al.** The relationship between poverty and child abuse and neglect: new evidence. s.l. : Nuffield Foundation, 2022.
68. **Office for National Statistics.** How the population changed in South Gloucestershire: Census 2021. [Online] 28 June 2022. https://www.ons.gov.uk/visualisations/censuspopulationchange/E06000025/.
69. **South Gloucestershire Council.** South Gloucestershire JSNA Mapping Tool. [Online] 19 October 2023. https://app.powerbi.com/view?r=eyJrIjoiMjdhZTE5YjYtMzBjYi00ZDVjLTkwMDAtMDU0MDg3YjE2YmJjIiwidCI6IjY0YjA5ZTUyLTg3YWQtNDZiZS05N2QyLWQ5NmRkMDZmM2FkNCIsImMiOjh9&pageName=ReportSection.
70. **Marmot, M.** Fair society, healthy lives: the Marmot Review : strategic review of health inequalities in England post-2010. London : The Marmot Review, 2010.
71. **National Institutes of Health.** Emotional wellness toolkit. [Online] 8 August 2022. https://www.nih.gov/health-information/emotional-wellness-toolkit.
72. **South Gloucestershire Council.** Children and Young People's Mental Health and Emotional Wellbeing Needs Assessment 2020/21. Yate : South Gloucestershire Council, 2021.

ACKNOWLEDGEMENTS

Reducing inequalities among children and young people is everyone's business. This DPH report is evidence of that and represents whole team effort in the Public Health and Wellbeing Division at South Gloucestershire Council. Thanks go to everyone who contributed to this report.

Editors:

Paul Okediji and Helen Tapson

Contributors:

Sarah Godsell, Amanda Preddy, Nikki Giles, Nicky Ellis, Kate Grant, Sarah Amos, Lindsay Gee, Rebecca Loaring, Milla Churchill, Jo Briscombe, and Mike Wheeler

Data and analytics:

Samuel Coleborn, Sarah Webb-Phillips, and Olivia Ford

Media, communications, and design:

David Pedley and Kate Batchelor

Reviewers:

Lynn Gibbons, Rosie Closs, and Jacqui Offer

We also appreciate all other colleagues and partners who have continued to invest efforts in tackling inequalities in children and young people in South Gloucestershire.