The Child of the North: Building a fairer future after COVID-19
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Foreword

The Child of the North is not one child but many and each of their experiences is unique. They are brought up in different places, educated in many different ways and go on to live very different lives.

There is no one experience which speaks to every child across the region, but there is an overall picture painted by this report of inequality between children in the North and the rest of the country.

Childhood is life defining and shaped by factors from before birth through to adulthood. A child’s mother’s health, the care they get, through family or the care system, what house they live in, what food they eat, how often they get to run around, their education, their opportunities. All of these things have a big impact and, as this report shows, the average Child of the North is disadvantaged from the start across all of these measures.

It shows decades of under-funding in children’s services has had a devastating impact. That children in the region are more likely to grow up in poverty, in disordered families, more likely to be less active and eat worse food. And that poverty continues to grow meaning a child growing up in the North is facing enormous challenges their contemporaries in other areas of the country do not have to tackle.

What is also crystal clear is that the pandemic has worsened these already poor outcomes further.

Children in the North of England spent more time in lockdown than those elsewhere – which meant their education and very often their mental health suffered. Their parents were also more isolated.

The report speaks of the ‘toxic stress’ of poor parental mental health, exposure to violence, substance misuse, and abuse and or neglect that negatively influence a person’s health and wellbeing across the life-course. It is our society’s responsibility to collectively come together to get rid of that toxicity.

To care for a child, we need to care about their choices, their future, their equality. Childhood should not be something that happens to children but something they have a say in and have control over. We must put children’s rights at the heart of our society.

Inequality has been shown to be one of the most damaging things to society. This report is a call to government, to educators, to all of us who are participants in this society, of our duty to gift our children equality, no matter where they are born.

Lemn Sissay OBE,
Poet, Author and Chancellor of the University of Manchester
Children in the North missed more schooling in lockdown than their peers in the rest of England. Only 14% received four or more pieces of offline schoolwork per day, compared with 20% country-wide.

The loss of learning children in the North experienced over the course of the pandemic will cost an estimated £24.6bn.

In primary maths, by the second half of the autumn 2020 term, pupils in the North East and Yorkshire and Humber experienced 4.0 and 5.3 months learning loss respectively, compared to less than a month in the South West and London.

Prior to the pandemic, the North saw much larger cuts to spending on Sure Start children’s centres. On average, spending was cut by £412 per eligible child in the North, compared to only £283 in the rest of England.

The mental health conditions that children in the North developed during the pandemic will cost an estimated £13.2bn.

During the pandemic, children in the North were lonelier than children in the rest of England. 23% of parents in the North reported their child was ‘often’ lonely compared to 15% of parents in the rest of the country.

Their parents and carers were also more likely to have often been lonely during the first lockdown: 23% in the North compared to 13% in the rest of England.

More than one in five children in the North are from an ethnic minority. These children are more likely to live in a deprived area than children from an ethnic minority in the rest of England.

In lost wages over their lifetime earnings.

£24.6bn
Child Poverty, Inequality and Deprivation

Child poverty is a huge problem in the North of England. As we start to emerge from the pandemic, the problem is accelerating, and the gap between the North and South of the country is widening.

From a high in the late 1990s, child poverty rates in the North declined, falling faster than in the rest of the country. By 2008, the North East and Yorkshire and Humber had rates close to or below the UK average. But from 2014 child poverty in the North began to rise again, and much faster in all the Northern regions than the UK as a whole.

Now, in the North, nearly a third of children live in poverty. Nearly 60% of local authorities in the Northern regions have above average levels of children in low-income families.

Austerity measures hit children in the North disproportionately, with deeper cuts to children’s services in the North than the rest of the country.

The impact of Northern deprivation is vital large in the statistics. Children under the age of one die at a higher rate in the North than in the rest of England.

Child poverty has long-term effects on children’s development, health and wellbeing and the anticipated pandemic-related increase in child poverty is deeply worrying.

Detailed findings

- When the pandemic hit, 27% of children across the three Northern regions were living in poverty before housing costs and 33% after housing costs, compared to just 20% before housing costs and 30% after housing costs in the UK as a whole.

- Before housing costs, the North East has the highest child poverty rate at 30% and Yorkshire and Humberside the third highest, after the West Midlands. After housing costs, the North East has the second highest rate at 37%, after Inner London. This gap between measures of child poverty before and after housing costs illustrates the importance of housing costs for families’ livelihoods.

- In the North of England 58% of local authorities have above average levels of children in low-income families compared to 19% in the rest of the country.

- Infant mortality is higher in the North of England than in the rest of England, with 4.23 deaths per 1,000 live births compared to 3.95 per 1,000 live births in England as a whole, in the 2017-19 period.

- Between 2010 and 2018, 4.0 and 5.3 months learning loss were experienced in the North East and Yorkshire and Humber respectively, compared to less than a month in the South West and London.

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Regional inequalities in infant and child health were pervasive before the pandemic, with children living in the North experiencing worse outcomes on a range of measures than those living elsewhere in England.

The Government’s lockdown response to COVID-19, aimed at reducing the number of infections, hospital admissions and deaths, had un- intended consequences, exacerbating health inequalities across the UK. Studies have shown that financial and food insecurity and poor mental health increased during this period, with one third of families saying that they were worse off during the first lockdown.

During the pandemic, take-up of early education programmes fell significantly across the country. Because these programmes are particularly beneficial to more deprived children, inequalities in development will increase, disproportionately affecting children in the North of England.

The longer-term impacts of the COVID-19 pandemic and policy response on material and child health and wellbeing need to be closely monitored. Investment in the early years must be prioritised as we exit the pandemic, with additional investment in priority areas and services.

Detailed findings

- Educational inequalities start early. Young children in the North of England are less ready for school than children in the rest of England. Analysis shows that in 2018/19, at the end of reception, 75% of children in the North achieved a good level of development, compared to 73% of children in the South of England.

- Families in the North are more likely to take up the two-year-old early entitlement offer, available to 40% of the most disadvantaged two-year-olds. 74% of families are taking up the offer compared to 67% in the South of England.

- Over the course of the pandemic, take-up of the early entitlement offer declined significantly. By 2021, uptake had declined across England, with only 68% of two-year-olds in the North of England, and 58% in the South of England, accessing early education.

- Since the pandemic, early education uptake has also fallen among three to four-year-olds. By 2021, uptake of early education in the North of England stood at 53% (a decrease of three percentage points from 2020) and 88% in the South of England (a decrease of four percentage points).

- During the first lockdown, only 7% of children who had previously attended formal early education and childcare services continued to do so. Access to early education has a range of benefits for children’s educational, cognitive, and socio-emotional development.

- Evidence suggests that enrolment of all low-income children in high quality early education programmes could close the gap in educational outcomes by as much as 20-50%.

- Mothers and their children growing up in the North – where inequalities are already substantial and where there are already many vulnerable households – are amongst those who have experienced the most negative consequences of the pandemic response.
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Physical activity, obesity and food insecurity

Childhood obesity is more prevalent in the North of England and the children of the North are less likely to be physically active. Regular physical activity during childhood and adolescence is an important foundation for a happy, healthy and longer life. Physically active play, sport and travel have considerable health, psychological and wellbeing benefits to both individuals and health care systems, preventing chronic disease such as obesity, heart disease, stroke, cancer; chronic respiratory disease and diabetes.

According to the Everyday Activity, Every Day governmental report, physical inactivity costs the UK an estimated £74 billion each year.

Children from the most deprived areas of England are more than twice as likely to be living with obesity as those from the least deprived areas. A high BMI in girls appears to be more closely related to low household income than in boys. This relationship between low household income and obesity may be contributing to the higher prevalence of childhood obesity in the North compared to the South of England.

Detailed findings

- Data show that children in the North of England were disproportionately affected by the consequences of the pandemic, experiencing more mental health difficulties compared to children in the rest of England. In particular, the evidence suggests that the mental health of boys aged 5-10 years in all areas of the North, and girls aged 5-10 years in Yorkshire and Humberside, were significantly and negatively affected by the COVID-19 pandemic and the associated lockdowns.
- Loneliness is directly linked to worse mental health among youth. 23% of parents in the North reported that their child was ‘often’ lonely compared to 15% of parents in the rest of England.
- Parents/carers themselves were also more likely to have often been lonely during the first lockdown, 23% in the North compared to 13% in the South.
- In the North, 55% of parents of school-aged children felt that lockdown had caused them and their child to feel significantly more depressed, compared to 44% in South. For school closures, the figures were 45% in the North, compared to 33% in the South.
- Parents in low-income families experienced higher levels of stress and depression during the pandemic. In the Born in Bradford study, clinically significant depression among mothers increased from 11% pre-pandemic to 19% during first lockdown; clinically significant anxiety levels increased from 10% to 16%.
- Referrals to urgent and emergency mental health care rose by 80% between April and June 2021 compared to the same period in 2019; contact with children and young people’s mental health services at the end of June 2021 was up 51% on June 2019.
- Referrals to urgent and emergency mental health care rose by 80% between April and June 2021 compared to the same period in 2019; contact with children and young people’s mental health services at the end of June 2021 was up 51% on June 2019. Among the 10-19 year old group, referrals were up 98% in the North, compared to 59% in the rest of the country.
- The proportion of children in England eligible for Free School Meals has increased during the COVID-19 pandemic, from 15.4% in January 2019 to 20.8% in January 2021. Children living in the North East are most likely to be eligible for Free School Meals (27.5%) and rates are lowest in the South East (6%).
- Tooth decay amongst five-year-old children varies regionally and is highest in the North West (37.7%) and lowest in the South East (17%). As a likely indicator of child poverty, half of five-year-olds (50.9%) in Hastings, East Sussex.
- Food insecurity is higher in households with children compared to the wider population – and it is higher in the North of England compared to the rest of England. Pre-pandemic, government data showed that the prevalence of low and very low household food security was nearly 30% in the North West of England, compared to 6% in the South East and 8% in England as a whole. When marginal food security is considered, the prevalence rises to 18% and 7% for the North East and South West respectively, compared to 11% in the South East, and 34% for England as a whole.

Schools and education

Schools in the North of England have disproportionate numbers of vulnerable and disadvantaged children. This lies at the heart of North-South educational inequalities. The evidence suggests that regional differences in learning loss during the pandemic were driven by disadvantaged pupils consistently falling behind.

From attendance data, it is clear that urban schools and colleges serving the most deprived communities had the most interrupted n-school learning time, and the most limited resources for delivering in-school and online teaching during the pandemic.

Consequently, schools in the most deprived areas of the UK, particularly in the North of England, have borne a disproportionate share of the burden in supporting children and young people through the pandemic. They now face a steeper uphill battle in working to mitigate the negative consequences of the lockdown period.

The pandemic has also highlighted the critical role increasingly played by schools in supporting the health and wellbeing needs of children and young people, especially in our most disadvantaged areas. These problems, school’s efforts, and the accumulating evidence, demand a policy response.

Detailed findings

- During the UK’s first lockdown, across primary and secondary schools, only 14% of children in schools in the Northern regions were receiving four or more pieces of offline schoolwork per day, compared with a country-wide average of 20%.
- There were also regional differences in parental home-schooling support related to regional deprivation. Specifically, the Northern regions of England saw lower levels of parental engagement in the South (52%) in Yorkshire and the Humber (61%) in the South East and East of England, excluding London.
- Children who experience persistent disadvantage leave school on average 22 months behind their peers. A child has an 80% chance of passing maths and English at GCSE if they neither live in poverty nor require the support of a social worker. This figure drops to 65% where a child lives in poverty or needs a social worker.
- By the second half of the 2020 autumn term, primary pupils in the North East were experiencing the greatest loss in reading in the country, of 2.0 and 1.9 months respectively.
- By the second half of the autumn 2020 term, regional differences in learning loss for primary-level maths were even larger. The North East and Yorkshire and Humberside experienced 4.0 and 3.9 months’ learning loss respectively, compared to less than a month of learning loss in the South West and London.
- In a survey conducted across all Bradford schools, teachers expressed concern over the disproportionate effect of COVID-19 on vulnerable children and children with Special Educational Needs and Disabilities. Key issues included the lack of access to specialist services such as children’s social services, Speech and Language Therapy, and counselling. Education psychologists across the North West described similar concerns.

Children in care

The North of England records the highest rates of children in care. It also provides the largest share of children’s home places in England, for children with the most complex needs.

Despite the best efforts of frontline practitioners and the resilience of carers, the outlook for the North is bleak given increasing family adversity, increasing numbers on preventative services, and the continued remote or hybrid delivery of professional help. Added to this is the ongoing crisis in the family courts, insufficiency of out-of-home placements, and the critical shortfall in mental health provision.

The COVID-19 pandemic has heightened the challenges experienced by children, particularly those living in families facing ill-health, insecure incomes, and other adversities. The evidence from the Association of Directors of Children’s Services shows that the pandemic has tipped an increasing number of families into breakdown, resulting in a larger population of children now requiring statutory intervention.

There is a need for an overarching, long-term, equitable plan for children in the North, to address their disproportionate pre-pandemic and ongoing heightened exposure to health damaging poverty and adversities, and to address the disproportionate underfunding and fragility in the health, social care and criminal justice systems that have a duty of care for these children. This plan must tackle the growing North-South divide, and ensure a sustainable financial plan to ‘level up’ opportunities for vulnerable children in the North.
The children of the North of England are increasingly ethnically diverse. All Northern regions include local authorities where ethnic minority children make up a high proportion of the local population, including Bradford (58%), Manchester (64%) and Newcastle upon Tyne (34%).

Persistent interpersonal, cultural and structural racism shapes the lives of ethnic minority children and young people in the North, as in the rest of the UK. While material deprivation is a key driver of poor health for these groups, this is itself rooted in systemic racism. Furthermore, socioeconomic disadvantage is not the whole picture, and the needs and experiences of ethnic minority children and young people cannot be understood and addressed without attention to racism in its many forms.

A large and growing body of evidence demonstrates that the COVID-19 pandemic has exacerbated pre-existing ethnic inequalities. However, there is a concern that the push for quick pandemic recovery solutions will result in the further dilution of attention to ethnic diversity, disadvantage and discrimination. We need policy attuned to worsening ethnic inequalities.

Detailed findings

- In an average local authority in the North of England, 21.4% of school aged pupils now identify as being from an ethnic minority background – this figure ranges from 6.2% to 66.4%.
- 68% of the most deprived third of neighbourhoods for housing and income are also in the most ethnically diverse third of neighbourhoods in Northern authorities. Neighbourhood socioeconomic disadvantage is more strongly correlated with ethnic diversity in the North of England than it is in the rest of the country.
- There are 14 times more low-weight births per 100 (8.4%) in the most ethnically diverse, high deprivation third of neighbourhoods in the rest of England compared to 5.8% in the least ethnically diverse (7.5%). This pattern was approximately the same across the North and the South.
- In the North, body mass index (BMI) was the highest in the rest of England (9.6). Even in similarly deprived neighbourhoods, low-weight births were around 12% higher in the most ethnically diverse third of neighbourhoods (8.4%) compared to the least ethnically diverse (5.8%). This pattern was even stronger across the North and the South.
- In the North, body mass index (BMI) was the highest in the rest of England (9.6). Even in similarly deprived neighbourhoods, low-weight births were around 12% higher in the most ethnically diverse third of neighbourhoods (8.4%) compared to the least ethnically diverse (5.8%). This pattern was approximately the same across the North and the South.
- Research including South Asian parents in the North found considerable energy being devoted to both monitoring children’s health outcomes in primary schools, and supporting their ability to weather the impact of interpersonal racism within schools and neighbourhoods.

The economic impacts of child health

The economic performance of the North of England consistently lags behind that of the rest of the country.

- There is a £4 per-person per-hour productivity gap between the North and the rest of England. Closing this gap would generate an extra £44 billion per-year to the UK economy. 30% of this gap, £13.2 billion per-year, is directly attributable to worse health outcomes in the North.
- The pandemic has had an unequal economic effect on the country, exacerbating existing inequalities and further widening the economic gap between the North and the rest of England.

Children’s rights-based approaches to the development of regional policy and governance

- The evidence presented in this report highlights how the multiple public health, social and economic effects of COVID-19 impact on children in profound and enduring ways.

Children’s key recommendations

1. Increase Government investment in welfare, health and social care systems that support children’s health, particularly in deprived areas and areas most affected by the COVID-19 pandemic.

2. Tackle the negative impacts of the pandemic in the North through rapid, focussed investment in early years services, such as the Health Improvement Fund. This should include health visiting, family hubs and children’s centres - as supported in the Leadsom review - but with investment proportional to need and area-level deprivation adequately accounted for.

3. Commissioners of maternity and early years services must consider the impact of pandemic-related changes in inequalities in families and children’s experiences and outcomes. This must shape service delivery during the recovery.

4. Take immediate measures to tackle child poverty, increase child benefit by £10 per child per week. Increase the child element in Universal Credit and increase child tax credits.

5. We must feed our children. Introduce universal free school meals, make the Holiday Activities and Food Programme scheme permanent, and extend to support all low-income families. Promote the provision of Healthy Start vouchers to all children under five and make current government food standards mandatory in all early years settings.

6. Government should prioritise support to deprived localities by increasing the spending available to schools serving the most disadvantaged pupils in England. This requires a reversal of the current approach to resource allocation: the new national funding formula will deliver 3–4 percentage points less funding to schools in poorer areas relative to those in more affluent areas.

7. Support educational settings to initiate earlier interventions. Teachers and early years professionals see many of the first indicators of children’s risk and vulnerabilities. Prioritising strong pupil and staff relationships and collaboration with parents/carers will ensure a firm foundation for meeting children’s needs, and for a return to learning.
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INTRODUCTION

Social inequalities in child health and the North-South divide in children’s life chances

Authors: David Taylor-Robinson, Davara Bennett, Kate Mason, Hannah Davies, Stephen Parkinson, Kate Pickett

Health inequalities, particularly those affecting children, are a litmus test of society. The data presented in our Child of the North report paint a troubling picture of our society’s soul, and of the deliberate policy choices that have affected children in the North of England. The report shows how the longstanding North-South divide in child health, which largely explains the North-South divide in adult health and economic productivity, was increasing before the COVID-19 pandemic. And it shows how, as a result of the pandemic, the divide has been made much worse.

Before COVID-19 took centre stage, a crisis was already unfolding. Latest pre-pandemic data on trends in inequalities in life expectancy at birth are shocking, revealing a 20-year gap in life expectancy for girls growing up in areas with the lowest life expectancies in the South and areas with the lowest life expectancies in the North. A neighbourhood of Camden had a female life expectancy of 95.4 years, compared to 74.7 years in a community in Leeds. For boys, the gap was greater still, at 27 years – a life expectancy of 95.3 years in Kensington and Chelsea, compared to 68.3 years in Blackpool. The neighbourhoods where children have the lowest life expectancy were in urban areas in the major cities of the North, including Leeds, Newcastle, Manchester, Liverpool and Blackpool.

Children growing up in affluent areas of London and the surrounding home counties have the highest life expectancies. These huge inequalities in life expectancy were increasing pre-pandemic, with life expectancy actually falling for girls growing up in disadvantaged Northern communities, and in areas with pre-existing high levels of poverty and low life expectancy.

We can say a number of things about these inequalities. There is nothing natural about them. They are a consequence of how we organise society. And they are profoundly unjust, the more so because they are preventable – we can do something to address social inequalities in health by organising our society differently. We know what causes them. By and large, across the country, from North to South, the causes of health inequalities are the same. At the heart of the North-South divide are differences in exposure to poverty and the resources needed for health, differences in exposure to health-damaging environments; and differences in opportunities to enjoy protective conditions that help promote and maintain good health – especially the conditions that give children the best possible start in life.

Greater exposure to child poverty is a major cause of the North-South divide in children’s life chances. The 10.5 million children living in poverty in the North of England are, by virtue of their experiences of poverty, less likely to grow up to be healthy and productive adults. On average, levels of child poverty are higher in the North, and there is a greater density of areas with very high levels of child poverty. In many of our large Northern cities, the proportion of neighbourhoods among the most deprived 10% nationally exceeds 30%, reaching 42% in Liverpool (see Chapter 2). Figure 11 shows the main pathways linking family socioecnomic conditions and poverty to poor child health outcomes. It is the accumulation of multiple risks caused by poverty, rather than singular exposures, that makes poverty so toxic for child health. We know a lot about how poverty gets ‘under the skin’. It can lead to persistent disruptions to child development, particularly brain architecture, stress responses, and metabolic balance over the life course, affecting the risk of many adult chronic diseases. Material factors are important. The homes of children living in poverty are...
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The COVID-19 pandemic hit in the middle of this pre-existing, slow-burning crisis for child health in the North of England. An additional systemic shock to the main influences on child health living conditions, family income, employment, education, and access to health and social care services.

The pandemic has clearly exposed and amplified health and social inequalities, but perhaps the most devastating costs are yet to be uncovered. These longer term costs are likely to fall on today’s children as they grow and develop. Our report shows that children in the North spent more time in lockdown, in more difficult circumstances, affecting their own mental health and that of their parents.

The pandemic has exacerbated problems for families in the North, increasing poverty and family stress at a time of restricted access to protective environments such as school and supportive services. Across the UK, both parental mental ill health and child poverty are rising, and we are seeing these rise disproportionately in the North; we know from the evidence outlined above how damaging these risk factors will be for child health.

Already, rising family hardship during lockdown, interacting with increasing levels of parental ill health, has fuelled a large increase in children’s mental ill health. Latest estimates for 2020 show that one in six children (6%) in the UK have a mental health problem, an increase of 13% from 2018. This is in line with the wider impact of the reflection of the impact of the pandemic. The rise in child mental health problems has been greater in the North compared to the South (see Chapter 4).

In policies and practices that improve child health and wellbeing is paramount to ensuring healthy, productive and fulfilling lives for future generations. The inevitable consequences of continued under-investment in children in the Northern regions will be a levelling down of skills, stilted health inequalities and reduced societal productivity in the long term. Although there is no quick fix, we already know what is required to improve child health and reduce inequalities. The necessary measures have been outlined in successive health inequalities reports.15,16

Overwhelming evidence supports the need for a ‘life-course’ approach to tackling social inequalities and improving the health and wealth of the next generation. Health inequalities strategies should be developed with input from children and young people, and aligned to the UN Convention on the Rights of the Child. A proactive and concerted policy focus on children at a national and regional level is required to ensure that they are not further overlooked in the pandemic recovery phase. To ‘level up’, we must prioritise the physical and mental health of families with children. This requires a focus on reducing inequalities in the main upstream influences on health.

First, reducing poverty is a pre-requisite. Child poverty is an easily mitifiable risk factor. Immediate policy options include reversing changes to the welfare system that have led to rising child poverty. It is extremely worrying that recent decisions to remove the £20 per week Universal Credit uplift are estimated to have pushed a further 290,000 children into poverty; many of whom live in the North. Policy makers must guard against a new round of austerity measures and consider an additional one-off income payment immediately on families with children who are worst off, and leading to further cuts to services and welfare support for families with children.

Second, to mitigate the consequences of poverty, we need a fresh commitment to the 1979 Children’s Commissioner for England report on child poverty universalism (services for everyone, with a scale and intensity that is appropriate to the level of need), with a shift in investment towards the early years wherever possible. It is critical that we avoid in support services and children’s preventive services, such as Children’s Centres, and improve access to mental health services for families.

Third, we need to develop an integrated health inequalities strategy, with a focus on children at its heart. This would have an emphasis on ‘health in all policies’, including evaluation of the impact of major policy changes that are likely to influence child health.

These key investments will lead to better overall population health and a reduction in health inequalities, with clear economic benefits. We can pay now, or we will pay more later for society’s failure to promote the health of children.

The message is clear: The North-South divide stems from historically poor policies affecting generations of children. We must not make these same mistakes again.

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North of England and the UK, focusing on 8 percentage points from 2018. The information presented in this chapter will be used as the basis for the wider impact of the reflection of the impact of the pandemic. The rise in child mental health problems has been greater in the North compared to the South (see Chapter 4).

Investing in policies and practices that improve child health and wellbeing is paramount to ensuring healthy, productive and fulfilling lives for future generations. The inevitable consequences of continued under-investment in children in the Northern regions will be a levelling down of skills, stilted health inequalities and reduced societal productivity in the long term. Although there is no quick fix, we already know what is required to improve child health and reduce inequalities. The necessary measures have been outlined in successive health inequalities reports.15,16

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and material deprivation (unable to afford key goods or services) as an alternative, and more direct, measure capturing low income after all unavoidable household costs. Figure 2.4 therefore also shows a formula that has little basis in science, and not taking into account the adverse outcomes critics have levelled at it. 

Chapter 8 of this report outlines the deep health inequalities impact of interpersonal, cultural and structural racism. Figure 2.8 illustrates regional patterns of child poverty by ethnicity. Living in the North is significantly associated with child poverty. But belonging to a minority ethnic group is also powerfully associated with child poverty. There is an urgent need to consider the intersections of child poverty and ethnicity, as well as other aspects of identity such as gender, disability, and age.

Impact of child poverty

There is strong evidence for a causal effect of growing up in poverty on many adverse outcomes, spanning education, employment, lifetime earnings, crime, and both physical and mental health. These adverse outcomes affect children’s life chances and continue to have an impact on adult health and wellbeing outcomes.

Taking three key health outcomes – infant mortality, mental health and obesity – we show the detrimental effect of child poverty in England and the UK:

1. Infant mortality, the death of a child before their first birthday, is a sensitive indicator of the health of any society. Infant mortality was higher in the North than the rest of England in 2017-19, with 4.23 deaths per 1,000 live births in the North compared to 3.95 in the whole of England. Infant mortality had been falling steadily across all of England throughout this century, but in 2013 that trend started to change. Infant mortality began rising in income-deprived parts of the country – though not in more affluent areas. Between 2014 and 2017, an estimated 172 infant deaths (95% CI 74 to 266) were attributable to increases in relative child poverty.

This accounted for almost a third of the overall rise in infant mortality over that period, indicating that child poverty was making a significant contribution to rising infant mortality in deprived areas. A recent analysis at small area level also shows rising infant mortality and stalling life expectancy in England between 2014 and 2019, particularly in Northern urban areas with high levels of poverty. Another recent report using data on deprivation (from the Index of Multiple Deprivation 2019) and child mortality (up to age 17) showed that, between April 2019 and March 2020, there were significantly more deaths in the more deprived areas of the UK than in the least deprived, with most deaths occurring in the first year of life. More than a fifth of all child deaths might have been avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This is equivalent to 700 fewer children dying every year.

2. Mental health was deteriorating for children and young people prior to the COVID-19 pandemic. Using data from the Millennium Cohort Study, a recent study found that 56% of young people aged 17 reported high levels of psychological distress. 24% reported having self-harmed and 7% reported having self-harmed with suicidal intent. Young people from more disadvantaged families, in the lowest 40% of the income distribution, were twice as likely to report having

In England, the other main source of child poverty data is the English Indices of Deprivation. These include child poverty data at local authority level and below, down to Lower Layer Super Output Areas, each of which represents about 1,000 households (there are 32,844 of these areas in England). The Indices of Deprivation are a uniquely valuable source of data on the spatial distribution of child poverty as well as employment, education, housing, health, crime, the environment and access to services. However, they are only published every four or five years and the last edition was in 2019.

In the North East region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.

In the North West, Knowsley has the second highest nationally (45%) after Liverpool. Wirral (40.3%) and South Tyneside (40%) complete the top three. In the South West, Devon (26.9%) is the highest, in the South East, Kent (22.9%) leads, while further north, the highest is South Tyneside (44.1%).

Source: Family Resources Survey.

Figure 2.3. Percentage of children in relative low-income households (<60% median household income), before housing costs, by local authority, 2019/20.

Figure 2.4. Percentage of children in low-income households (<60% median household income) before and after housing costs, and in low-income and deprived households, by region, 2017/20.

Figure 2.5. For each local authority in the North East region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.

Figure 2.6. For each local authority in the North West region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.

Figure 2.7. For each local authority in the Yorkshire and Humber region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.
attempted suicide than their more advantaged counterparts. The proportion experiencing psychological distress was also higher among those from lower income families. Child poverty has a lasting impact on child and adolescent mental health. A single transition into poverty has been linked to child psychological distress, independent of parental employment status.

After accounting for other factors that might influence mental health, research using data from the Millennium Cohort Study found that the odds of poor mental health and wellbeing in children were significantly increased if they transitioned into poverty during their childhood.

Another recent study using trajectory modeling found that persistent poverty and/or persistent parental mental ill health affects over four in ten UK children. The combination of both affects one in ten children, increasing the odds of child mental health problems more than sixfold, compared to children with low exposure to poverty and parental mental ill health. In isolation, poverty and parental mental ill health each doubled the odds of child mental health problems.

Childhood obesity is twice as common in the most deprived areas of England than the least deprived areas, and the prevalence of severe obesity in children in the most deprived 10% of the country is four times as high as in the least deprived 10%. These inequalities have been widening in recent years, and the impacts of the pandemic lockdowns are likely to have exacerbated this (see Chapter 5). A recent study using data from the Millennium Cohort Study reported that when compared with children who had never experienced poverty, those who experienced poverty during childhood – whether transiently or persistently – were more likely to be living with obesity and severe obesity in children in the most deprived 10% of the country is four times as high as in the least deprived 10%.

Austerity measures have also meant cuts to local authority budgets, leading to substantially reduced public expenditure on services for children, particularly early years expenditure, with the greatest cuts in the most deprived areas with the greatest need (see Chapter 3). Between 2010 and 2018, local authority spending on Sure Start children’s centres, per eligible child, was cut by 67% in the North, compared to 63% in the rest of England.

Starting from a higher level of spending in the North due to higher need, this equates to much larger cuts in absolute terms in the North: on average, spending was cut by £332 per eligible child in the North, compared to only £283 in the rest of England (or £347 per child across England as a whole). A recent study investigated the impact of cuts to Sure Start children’s centres on child obesity between 2010 and 2017. Sure Start children’s centres provide universal services for families with pre-school children, including for child and family health, parenting, money, employment and early learning. Spending on these centres decreased by 53% over the study period, with deeper cuts in more deprived local authorities.

Each 10% cut in spending was associated with an increase in obesity prevalence the following year. This equates to an additional 4,575 obese children (95% CI 1,751 to 7,399), with the number rising to 9,174 if overweight children are included (95% CI 2,689 to 15,660) compared to the counterfactual scenario where spending on Sure Start children’s centres had been maintained. Combined, rapid changes to the welfare system and cuts to local authority spending have had directly affected child poverty and subsequent negative health and wellbeing outcomes for children and young people.

COVID-19 and child poverty and inequalities

While there are no official national child poverty indicators covering the period of the COVID-19 pandemic, projections suggest that the impact will be substantial. Both relative and absolute poverty are expected to rise sharply in 2020/21. Illness due to COVID-19 and long COVID and job loss are the primary causes of this projected increase.

Many households have sought support from a welfare system that has been transformed by the cuts resulting from austerity policies. During the pandemic, by May 2020, the number of households claiming Universal Credit jumped by more than 1 million to 4.2 million. By December 2020, nearly 6 million people were claiming EWP, 2021 – twice the pandemic figure.

Temporary mitigating policies introduced to support people during the pandemic have provided additional income, for example the £20-a-week increase to Universal Credit and the working tax credit, which ended in October 2021, but this was not extended to other welfare benefits and may lead to inequalities in poverty between recipients of different benefit types during this period.

The Resolution Foundation suggests that rising unemployment and the removal of the £20 uplift on 6th October 2021 will lead to a further 1.2 million people, including 500,000 children, falling into relative poverty – the biggest year-on-year rise in poverty since the mid-1990s. In the course of this pandemic, there has been growing evidence of increasing deprivation, child hunger, family indebtedness, use of food banks, and general distress.

Recommendations

We have presented evidence that, in the decade that preceded the pandemic, child poverty and deprivation were already rising, with rapid increases in areas across the North of England. As child poverty has long-term effects on children’s development, health and wellbeing, the anticipated pandemic-related increase in child poverty is deeply worrying.

In order to reduce the lifelong consequences of child poverty, we need a commitment to universal services and a focus on proportionate universalism: services provided to everyone, but with a scale and intensity that is proportionate to the level of need. Offering this support to all children, particularly in the early years, is a critical and cost-effective investment. Early years services should be protected.

Central Government

- Maintain and steadily improve the real value of the National Living Wage. This is the only policy on this list of recommendations to Central Government to which they have already committed.
- Protect investment in early years services.
- Increase child benefit by £10 per child per week. Child benefit has lost a quarter of its value since 2010.
- Introduce universal free school meals.
- Increase the child element in Universal Credit and child tax credits.
- Abolish the benefit cap.
- Abolish the two-child limit for benefits eligibility.
- Abolish the bedroom tax and lift the local rent limit for people in receipt of housing benefits.

Local authorities, local services and the NHS

There are strategies at a local level that local authorities, local services and the NHS can implement to support and mitigate the effects of poverty. Collective action between local government, the voluntary sector and local business can go some way towards mitigating the impact of child poverty.

- Local authorities can use their advice services (e.g. welfare rights advice) to support benefits uptake and help claimants negotiate the complexities of the benefit system.
- Local authorities may also use discretionary payments to support families in poverty. They also have the power to use their discretion to vary council tax benefit for families with children.
- Schools and other educational providers can limit costs during school holidays and government funds, the introduction of Universal Credit (in 2013), the benefit freeze (in 2015) and more recently, the introduction of the two-child policy (in 2017). Whilst all have different targets, their intended function has been the same: to reduce welfare spending and move people into work as a route out of poverty. Figure 2.2 shows that prior to 2013 the child poverty rate was falling. However, after the introduction of many of these austerity policies, child poverty started to rise, leading many to infer a causal relationship.

Moreover, work has not provided a sure route out of poverty for children. More than 75% of children living in poverty are actually in households where someone is in part-time employment, and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment.

Austerity measures have also meant cuts to local authority budgets, leading to substantially reduced public expenditure on services for children, particularly early years expenditure, with the greatest cuts in the most deprived areas with the greatest need (see Chapter 3). Between 2010 and 2018, local authority spending on Sure Start children’s centres, per eligible child, was cut by 67% in the North, compared to 63% in the rest of England.

Starting from a higher level of spending in the North due to higher need, this equates to much larger cuts in absolute terms in the North: on average, spending was cut by £332 per eligible child in the North, compared to only £283 in the rest of England (or £347 per child across England as a whole). A recent study investigated the impact of cuts to Sure Start children’s centres on child obesity between 2010 and 2017.

Sure Start children’s centres provide universal services for families with pre-school children, including for child and family health, parenting, money, employment and early learning. Spending on these centres decreased by 53% over the study period, with deeper cuts in more deprived local authorities.

Each 10% cut in spending was associated with an increase in obesity prevalence the following year. This equates to an additional 4,575 obese children (95% CI 1,751 to 7,399), with the number rising to 9,174 if overweight children are included (95% CI 2,689 to 15,660) compared to the counterfactual scenario where spending on Sure Start children’s centres had been maintained. Combined, rapid changes to the welfare system and cuts to local authority spending have had directly affected child poverty and subsequent negative health and wellbeing outcomes for children and young people.
While a recent study modelled substantial impacts of the COVID-19 pandemic on maternal and child undernutrition and child mortality in low- and middle-income countries, there is a clear need to explore the pandemic on maternal and child undernutrition and child mortality in Pakistan by their mother (7.3 per 1000 live births), followed by Black African (10), Black Caribbean (5.8), Bangladesh (5.6), Indian (4.7), the ‘all other’ group, which includes Chinese (4.3), and then White British (3.2) and White Other (2.6). Causes of infant death vary between groups.

Congenital anomalies have consistently been found to be more prevalent among the Pakistani group than other ethnic groups, as well as a failure to respond appropriately to prematurity and low birth weight also contribute importantly to higher death rates among babies in the South Asian and Black groups.

Figure 3.3 shows the average percentage of low birth weight among babies born in areas with different combinations of socioeconomic deprivation and ethnic minority density. There were around 14 times more low-weight births per 100 (6.4%) in the most ethnically diverse, high deprivation third of neighbourhoods than there were in the least deprived, least ethnically diverse third of neighbourhoods (5.8%). Even in similarly deprived neighbourhoods, low birth weights were around 12% higher in the most ethnically diverse neighbourhoods (8.4%) compared to the least ethnically diverse (5.5%).

This pattern was approximately the same across the North and the South. Over and above socioeconomic deprivation, some migrant women are exposed to particular stress during pregnancy and childbirth as immigration rules can enforce family separation, leaving women alone. This lack of social support is likely to increase risk of poor birth outcomes47, and family separation has a detrimental impact on children48.

The quality of care that ethnic minority women receive during pregnancy, labour and birth has been called into question repeatedly over the past decades49. A series of studies document dissatisfaction with care, poor communication, and discriminatory treatment50–52, as well as a failure to respond appropriately to the needs of women who are exposed to particular stress during pregnancy and childbirth53. The quality of care that ethnic minority women receive during pregnancy, labour and birth has been called into question repeatedly over the past decades. A series of studies document dissatisfaction with care, poor communication, and discriminatory treatment, as well as a failure to respond appropriately to the needs of women who are exposed to particular stress during pregnancy and childbirth.

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**Promising practice: BL3 Maternity Hub, Bolton**

BL3 Maternity Hub opened in June 2021. The hub is a partnership between Bolton NHS Foundation Trust and Bolton Council of Mosques, and is led by a Specialist Cultural Liaison Midwife, Banash Nazmeen. The hub provides a base for maternity services, bringing care closer to home for those who may have previously faced barriers when accessing maternity care. The hub includes a clinic but most importantly also offers an open drop-in for women, staffed by a multilingual member of staff. Learning sessions have been co-produced with local women, covering the topics that they feel are most important, and held at times and in ways that meet their needs. Sessions are interactive and are provided with interpreters. The hub hosts listening events and open discussions around issues such as informed choice and advocacy during pregnancy and delivery.

**Participants in co-production workshops:**

“What was interesting to see was the insight from the session that I haven’t thought before. Opportunities for communities to interact and communicate.”

“Stories, food, worries – everything can be shared amongst the women [here]”

**More information:** [https://www.boltonft.nhs.uk/2021/06/bl-3-maternity-hub](https://www.boltonft.nhs.uk/2021/06/bl-3-maternity-hub)

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**Widening health inequalities during the COVID-19 pandemic**

The Government’s ‘lockdown’ response to COVID-19, aimed at reducing the numbers of infections, hospital admissions and deaths, had unintended effects, exacerbating health inequalities across the UK. Studies have shown rates of financial and food insecurity and poor mental health rising during this period (see Chapters 2 and 5). One-third of families reported being financially worse off during the first lockdown (March – June 2020), which will have increased already existing ethnic and socioeconomic inequalities (see Chapters 2 and 8).

Many families lived in very challenging circumstances during lockdown, including food and housing insecurity, which will have implications for their long-term financial security, health, and wellbeing. Evidence shows that already vulnerable families were amongst those who experienced the most negative social and financial consequences of the Government’s pandemic response. In this chapter, we focus on the impact of the COVID-19 associated restrictions on mothers’ mental health, health visiting services, and school readiness.

Impact of COVID-19 on women having babies during the pandemic

Research and understanding of the impact of the Government and healthcare responses to COVID-19 on women in the perinatal period (from pregnancy to one-year post-birth) is accumulating. Services for pregnancy changed significantly during the pandemic: risk of COVID-19 to pregnant women was unknown, and so stringent restrictions on their activities were imposed to minimise infection prevention.

Examples include: a switch to remote-consultation for midwife and health visiting appointments; women being required to attend separate appointments alone; and partners being extremely restricted in time allowed in hospital before and after the birth of their baby. Limited contact with carers and support will have impacted on women during their pregnancy and postnatally. Given what we know about the importance of this period for the mother and her child’s future development, and the increased health inequalities for vulnerable families, it is critical to understand women’s experiences.

Researchers in Bradford have found that there was a powerful underlying pattern in women feeling fearful, anxious, or lonely; or suffering from depression during their pregnancy, and at critical points in their routine care such as scan appointments. A significant proportion of new mothers in the UK (c. 54%) reported being isolated; 35% said they felt lonely, and 32% said they felt worried (7%) during the COVID-19 pandemic and initial lockdown whereas considerably more than the 20% of new and expectant mothers who were affected by poor mental health pre-pandemic. Figures are likely to be worse in the North, which spent a month and a half longer in lockdown than the rest of England. New mothers with babies under one year of age expressed feelings of “being robbed of the joys of motherhood.”

Women described a worsening of their mental health during the pandemic. Reports of clinically significant depression increased in mothers from 11% before COVID-19 to 15% during the first lockdown, and clinically important anxiety increased from 10% to 16%. Mothers who were most likely to become depressed or anxious were those who were lonely or financially insecure. Key factors associated with becoming depressed or anxious during the pandemic were loneliness, and financial, food and housing insecurities. Due to changes in service provision during the pandemic, some women were not able to access specialist mental health services.

Emerging evidence suggests that the move to online care by midwives and health visitors during the pandemic impacted disproportionately on ethnic minority women as interpretation services were often not integrated into the new ways of working and poor access to digital technologies and overcrowded housing conditions and consultations. Importantly, the hostile environment for migrants intensified during this period, with an increase of over 50% to the immigration Health Surcharge, and heightened political rhetoric around the ‘migrant crisis’. Coupled with worsened socioeconomic conditions, these trends raise concerns about increased prenatal stress and the associated increased risks of miscarriage and prematurity - relationships that have been found in other cohorts.

The cost of perinatal mental health is estimated to be £8 billion for each year’s birth cohort. There is a lack of national data on perinatal mental health so it is not possible to comment on regional differences or the impact that COVID-19 has had; good quality data are needed as a matter of priority. Given the short- and long-term consequences of mental illness on the physical and psychological wellbeing of mother and baby, there is an urgent need during the COVID-19 recovery for action to provide support to mothers who have been affected.

The longer-term impact of the COVID-19 restrictions on pregnant women and their new parents is also of concern. Increased stress and anxiety, poor mental health, and a lack of opportunity for partners to be involved in and bond with their unborn baby, could all have consequences for parents’ relationships with each other and with their baby, which will subsequently have an impact on the child’s health, wellbeing, and educational attainment.

In the Working for Babies report 2021, 98% of service providers reported that parental anxiety, stress or depression had impacted babies and their organisation worked with, and that this was affecting bonding and responsive care.

However, for some families, the opportunity to spend more time at home was experienced positively, with more emotional and physical support from partners being at home, less stress, more opportunity for responsive breastfeeding, and more contact time with their baby.

**Health visiting and early years’ services during COVID-19**

Health visitors play a key role in ensuring all children get the best possible start in life. Before the COVID-19 pandemic, the distribution of health visiting services was uneven across England with service provision not matched to need within the population served. There was also a 19% decrease in numbers of health visitors in post before COVID-19 recovery for action to provide support to mothers who have been affected.

In the UK, in response to the first wave of the COVID-19 pandemic, up to 63% of health visitors were redeployed. Whilst high levels of redeployment were not seen universally across the North, the area has increased vulnerabilities with known worse outcomes for infants with special healthcare needs.

Despite these changes, health visitors went ‘above and beyond’ to support vulnerable families. As we move into recovery, there is a need to align staffing and capacity to areas of greatest need for early years support from health visitors. Further funding is needed to reduce the heightened risks and vulnerabilities in families who had a baby during the pandemic.

In the pre-COVID-19 decade, local Authority expenditure on Sure Start and early years’ services per child aged 0-4 years, in the North and the rest of England, 2010/11 - 2018/19 (2018/19 prices).

**Figure 3.3. Percentage of low weight births by deprivation-minority ethnicity intersection.**

*Source: Author’s analysis of Public Health England Local Health Indicators."

**Figure 3.4. Local Authority expenditure on Sure Start and early years’ services per child aged 0-4 years, in the North and the rest of England, 2010/11 - 2018/19 (2018/19 prices).**

**Figure 3.5. School readiness: % of children achieving a good level of development at age 5, by deprivation-minority ethnicity intersection.**

**Figure 3.6. Percentage of children not reaching ‘good’ levels of development at age 5, by deprivation-minority ethnicity intersection.**

**Note:** Data is from the Labour Force Survey (LFS)20 and the Labour Force Survey (LFS)21 as well as administrative data from the Department of Education (DoE), the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government (MHCLG) and the Office for National Statistics (ONS). The data includes children aged 0-4 years, in the North and the rest of England, from 2010/11 to 2018/19. Figures are age standardised using the 2011 population by ethnicity and deprivation.

**Figure 3.7. School readiness: % of children achieving a good level of development at age 5, by deprivation-minority ethnicity intersection.**

**Note:** Data is from the Labour Force Survey (LFS)20 and the Labour Force Survey (LFS)21 as well as administrative data from the Department of Education (DoE), the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government (MHCLG) and the Office for National Statistics (ONS). The data includes children aged 0-4 years, in the North and the rest of England, from 2010/11 to 2018/19. Figures are age standardised using the 2011 population by ethnicity and deprivation.

**Figure 3.8. Percentage of children not reaching ‘good’ levels of development at age 5, by deprivation-minority ethnicity intersection.**

**Note:** Data is from the Labour Force Survey (LFS)20 and the Labour Force Survey (LFS)21 as well as administrative data from the Department of Education (DoE), the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government (MHCLG) and the Office for National Statistics (ONS). The data includes children aged 0-4 years, in the North and the rest of England, from 2010/11 to 2018/19. Figures are age standardised using the 2011 population by ethnicity and deprivation.

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**Quote from a mother in the ‘Born in Bradford’ cohort.**

> “I was very teary, very, very teary. I had panic attacks. I’d never had a panic attack before. I think it was the restrictions placed on us. I felt out of control and I felt panicked about what was going to happen. I felt like we’re going into the complete unknown with this baby compared to the other babies and I didn’t know how my maternity leave was going to go, I didn’t know how life was going to be, but just the waiting to hear on the news what I was allowed and not allowed to do, I think that had a bigger impact than I imagined it would do.”

*Source: Brawner et al 2021*
A four times greater decrease in spending in the most deprived quintile of Local Authorities compared to the least deprived quintile left the North particularly hard hit (Figure 3.4, and see Chapter 2). The cuts to investment in Sure Start centres are likely to have affected

progress in school readiness77 and have been linked to increased obesity prevalence by the time a child starts school78.

School readiness and COVID-19

The pandemic has seen an interruption to schooling and interrupting periods of remote learning with issues around digital access and literacy. Children’s level of school readiness differs across England. Nationally, 72% of children achieved a good level of development in 2018/1979.

Across the South of England, 73% of children achieved a good level of development, compared to 70% of children in the North. The North East, North West and Yorkshire and Humberside have the lowest levels of school readiness (Figure 3.5). Children experiencing multiple forms of adversity are least likely to achieve good levels of development. Figure 3.6 shows that, even before the pandemic, ethnically diverse neighbourhoods had higher rates of children not achieving good levels of development, even when they had similar levels of socioeconomic deprivation.

The highest proportion of children not reaching good levels of development at age five were in neighbourhoods with combined high levels of non-white ethnic density and deprivation. This proportion was higher in the North than in the South of England (51.4% compared to 46.2%). These early childhood experiences impact on educational attainment and employment. The impact of the pandemic on children’s learning and development has exacerbated these inequalities.

On average, across England, pre-COVID-19, uptake of early education or childcare services for children aged 2-4 years was 77%75, with uptake in the North higher than that of the South of England. In 2020, uptake of the 2 year old early entitlement offer, available to 40% of the most disadvantaged 2-year olds, stood at 74% in the North of England and 67% in the South of England (Figure 3.7). By 2021, uptake had declined across England, with 68% of 2-year olds in the North of England and 58% in the South of England accessing early education.

Since the pandemic, early education uptake has also fallen among 3-4-year-olds, albeit at a lower rate. By 2021, uptake of early education in the North of England stood at 93% (a decrease of 3 percentage points from 2020) and 88% in the South of England (a decrease of 4 percentage points).

During the first lockdown period, only 7% of children who had previously attended formal early education and childcare services continued to do so. Access to early education has a range of benefits for children’s educational, cognitive, and socio-emotional development76. Because attendance is particularly beneficial to more deprived children, inequalities in development will increase, disproportionally affecting children in the North of England. Evidence on the investment of low-income children in high quality early education programmes could close the gap in educational outcomes by as much as 20.50%

Already, research has highlighted the negative impacts on children who did not attend early years settings compared with children of critical workers or vulnerable children who continued to attend. For example, parents reported negative impacts on social and emotional development77, and service providers have noted consequences for the physical development of children in deprived homes in particular.

In 2020, a national Ofsted survey of 208 providers found that 53% of providers surveyed believed children had fallen behind in personal, social and emotional development, whilst 29% believed that children had fallen behind in the area of communication and language78. Of particular concern among providers were children living in poverty, children with English as an additional language and those with special educational needs and disabilities. The pandemic will have further widened the learning gap for many of these children, and will have an onward impact throughout their lives.

The impact of children’s missed learning has significant cost implications in the long term. data from the OECD shows that a loss of one-third of a school year’s worth of learning reduces the subsequent earned income of the pupils concerned by approximately 3%

A loss skilled workforce will likely also reduce the national economic growth79. Key to mitigating these economic impacts is early investment, which can help to reduce inequalities and prevent achievement gaps more cost-effectively than tackling them in later life80.

Since data have been mostly produced at a national level, there are still gaps of understanding available to 40% of the from the pandemic from a regional perspective. As more data become available, the full impact of the pandemic on children in the North will be better understood.

Conclusion

We document that mothers and their children growing up in disadvantaged regions and in already vulnerable households, particularly in the North, are amongst those who have experienced the most negative consequences of the pandemic response. The long-term impacts of the COVID-19 pandemic on maternal and child health and wellbeing need to be closely monitored.

A focused investment in the early years must be prioritised as we are committed to the provision of additional investment in priority areas and services through serious investment can start to reduce health inequalities and break the intergenerational cycle of inequality seen across the North. There is a clear need to frankly take a lifecourse approach to tackling inequalities, ensuring every child has a good start in life, reducing early years adversity and leading to improvements in health for all.

Recommendations

Government to develop a monitoring system for understanding long-term impacts of the pandemic on maternal and child health and wellbeing

Government to provide rapid, focussed investment through the early years to ameliorate negative impacts of the pandemic

Government to recognise specific challenges of intergenerational inequality across the North and to list its ever evolving opportunity for all

Commissioners of maternity and early years services to consider the impact on inequalities of service changes during the pandemic to determine the shape of services during recovery.

Acknowledgments

NIHR North East North Cumbria Applied Research Collaboration.

Context

Unstable mental health disorders in children and adolescents are linked to poor academic outcomes and poor health, including drug abuse, self-harm, and suicidal behaviour. They often persist into adulthood, contributing to economic and social consequences for the individual and society81. The mental health of children and adolescents was deteriorating prior to COVID-19, but there was significant rise during the pandemic, particularly in the North of England82.

Referrals to urgent and emergency crisis care have risen by 80% between April and June 2021 compared to the same period in 20209. Contact with children and young people’s mental health services at the end of June 2021 was up 51% on June 2019. This is an urgent need to ensure that schools and services can provide immediate intervention and continued support to young people, so that mental health problems do not result in unfortunate consequences, with negative impacts on educational attainment, labour market outcomes, and adult health.

Widening health inequalities during the COVID-19 pandemic

Pre-pandemic, child mental health was already in crisis10, with evidence of rising prevalence of mental health problems for UK children11, increasing inequalities12, and unsustainable pressures on services. The pandemic has exacerbated problems, increasing family stress, removing protective environments such as schools, and decreasing physical access to services13.

Research has shown huge variation in how children experienced lockdowns in the UK14, but more young people experienced a probable mental health disorder in July 2020 and March 2021 compared to 2019. For example, in 2019, one in nine children aged 5-10 years had a probable mental health disorder in 2019, compared to one in nine in 20209.20.21 Our analyses of data from July 2020, when regional information was last available, reveal pronounced regional variations: Boys aged 5-10 years in the North, and girls aged 5-10 years in Yorkshire and Humberside, appear to have been significantly affected by the COVID-19 pandemic and associated lockdowns, experiencing large increases in poor mental health (Figures 4.1 and 4.2).

Other available data, covering changes in overall mental health over the course of the pandemic (March 2020-May 2021) for children aged 5-16, show that children in the North of England were disproportionately affected, experiencing more mental health difficulties compared to children in the rest of England. Local lockdowns had a crucial influence (Figure 4.3).9

Trends in the determinants of child mental health

Before COVID-19, determinants of child mental health, including family socioeconomic conditions, parental mental health, family stress levels, loneliness, and sleep quality, were the same for children in the North of England, and for children in the rest of England.8 The pandemic exposed greater mental health difficulties among children in the North, particularly in the post-COVID-19 pandemic period.6-9,20-25

Children in the North of England spent more time in lockdown and were more exposed to severe financial and digital vulnerabilities during the pandemic compared to the rest of the UK (see Chapter 6). Parents in low-income families have experienced higher levels of depression and stress during the pandemic4.26 Determination in mental health was worse for working parents and was strongly related to increased financial insecurity and time spent on childcare and home schooling85,86,87.

Evidence suggests that children and adolescents living in households experiencing financial insecurity, and/or where a parent experiences a mental health disorder, are more likely to have a probable mental health condition78, so there is an obvious need to monitor both parent and child mental health. Given that restricted access to technology during COVID-19 has been a barrier to learning (see Chapter 6), thereby increasing the attainment gap26, the COVID-19 pandemic has magnified health, educational, and social inequalities.

Parents with young children (0-5 years of age) at home during the first lockdown in England were significantly more likely to experience deteriorating mental health, with increases in stress as they tried to balance workplace and childcare commitments88. Among parents with school-aged children, 44% and 33% felt that the lockdown and school closures respectively had caused them and their child to feel significantly

Figure 3.7. 2-year-old early entitlement take up, 2019-2021.

Source: Department for Education (2020).
Importantly, ethnic minority children and young people face some problems around sleep, which over a quarter of 6-10 year olds and over a third of 11-16 year olds were worried to sleep during lockdown.

Sleep is also important for mental health, but was significantly worse during first lockdown; clinically significant anxiety increased from 10% pre-COVID-19 to 27% towards the end of first lockdown, compared to 10% pre-COVID-19. Figure 4.4 shows that there were differences in loneliness between the North and the rest of England, with 23% of parents in the North reporting that their child was 'often' lonely compared to 16% of parents in the rest of England. Parents/caregivers themselves were more likely to have often been lonely during the first lockdown in the North compared to the rest of England.

Loneliness is directly linked to worse mental health among youth. There was an increase in the prevalence of loneliness during the pandemic, with 43% of children and adolescents in England saying they were 'often' or 'always' lonely during the first lockdown compared to 10% pre-COVID-19. Figure 4.4 shows that there were differences in loneliness between the North and the rest of England, with 23% of parents in the North reporting that their child was 'often' lonely compared to 16% of parents in the rest of England. Parents/caregivers themselves were more likely to have often been lonely during the first lockdown in the North compared to the rest of England.

Mental health among ethnic minority children and young people

The national survey data available both pre- and post-COVID-19 suggest that ethnic minority children have similar or better mental health than their White British counterparts, though patterns are varied across indicators. For example, the NSH Digital survey of over 3,000 children reports that rates of ‘probable mental disorder’ were lower among the broad ‘Black and minority ethnic’ group than the White group: 8% compared to 11% in July 2020, and 4% compared to 5% in 2017.

However, assessing ethnic differences in the prevalence of mental illness is controversial and complex since data are often not collected systematically and within all groups of ethnic minority samples.

The COVID-19 pandemic appears to have created some particular risks for poor mental health among ethnic minority children, including disproportionately high rates of COVID-19 illness and mortality among ethnic minority communities, contributing to an increase in patients of Black and ethnic minority background accessing hospital services in a given month, for the North and for the rest of England.

Positive effects of the COVID-19 pandemic on mental health and wellbeing

Many children and young people experienced positive aspects of lockdown during the spring and summer, which continue to impact positively on the health and wellbeing of young ethnic minority people, require support for scale-up, evaluation and sharing of lessons learnt.

I feel that because I was meant to be doing A-levels this year and I’m being given calculated grades, there will be bias from employers in the future because it seems like we’ve ‘earned it’.

(18 year old, Manchester)

I have felt incredibly lonely despite having what is honestly a great support system and being in the same household as one of my best friends, my sister.

(16 year old)

I ‘do not look forward to anything during the day (other than meals), including talking to friends, consuming media, reading, doing exercise, university work, and experience sleep related anxiety towards the end of the day’.

(18 year old)

I have a lot of friends from my year group and having the classes online has made it hard to access new help/therapies.

(16 year old)

I feel that it has not helped much. It is very different and takes away from all the fun that is usually had in school.

(16 year old)

“I’ve been struggling with the fact that I cannot physically see my counsellor and I’m finding it hard to access new help/therapies.”

(16 year old)

“I already had a history of mental health issues, being shoved into a house in the middle of nowhere with none of my friends, and having quite a lot of anxiety, but this year turned out even worse.”

(18 year old)

All in all, there is no sign that they are doing any better than before.

(17 year old)

“My moods have been all over the place, dealing with depression and an eating disorder getting even worse.”

(17 year old)

Source: Demko published at the end of 2020.
Effect on mental health and wellbeing

The pandemic has brought this objective into focus. Achieving it will require a public mental health approach that includes a focus on prevention early in the lifecycle and highlights the importance of early detection and prompt access to professional treatment.

Recommendations

- Monitor longer-term mental health impacts of COVID-19 pandemic for children and parents. Parental mental health difficulties predict emotional disorders in children and increase the risk of poor physical health. Given that parental ill-health has risen during the pandemic, particularly for those experiencing increased financial insecurity, there is a need for parental mental health moving forward and provide supported to families where needed.

- Improve NHS Specialist Services for Children and Adolescent Mental Health. Access to children’s mental health services has improved in recent years, but remains inadequate. NHS England needs to increase the pace at which services expand to meet the commitments in the NHS Long Term Plan, which include the expansion of NHS Services for children and adolescents. As part of this aim, we must:
  - Make sure that all young people and parents/carers know how to find support and how to find children’s mental health services. There must be rapid access to evidence-based services for those who need it. Children and adolescents, and their caregivers, must know where to find support. But they must also be seen quickly, and receive effective support.
  - Develop more inclusive policies and resource allocation that: target inequalities and discrimination; enhance accessibility and appropriateness of services; and improve outcomes.
  - Make wellbeing a priority in school catch-up planning. Improving NS-5 specialist services and support will also need a broader systems response to children’s mental health, incorporating schools and the voluntary sector. Schools are key sites for children’s wellbeing and mental health, with some key changes before and the pandemic for young people related to school and feeling under pressure. This situation is particularly evident in children and young people. This is why we have included a focus on mental health provision for children and adolescents: it is unlikely that we will have capacity to deal with the unprecedented surge following the pandemic. Central to the Green Paper on Children’s Mental Health was the implementation of Mental Health Support Teams to facilitate joint working between schools and the NHS, with graduated levels of support available across schools and specialist services.

In May 2021, NHS England announced the creation of around 400 Mental Health Support Teams across England. This objective was championed by the Children’s Commissioner. Even before the pandemic, NHS services were unable to meet the level of need for mental health provision for children and adolescents. It is unlikely that they will have capacity to deal with the unprecedented surge following the pandemic. The implementation of Mental Health Support Teams to facilitate joint working between schools and the NHS, with graduated levels of support available across schools and specialist services.

These measures have the potential to build an inherently more flexible system that can respond to the changing needs of children. However, progress should be regularly examined and regional accessibility monitored to ensure that services are available where they are needed most.

Physical activity, obesity, and food insecurity

This chapter examines physical activity levels, food intake, and levels of food insecurity, and the prevalence of obesity in children living in schools re-opened in September 2020. It also includes the results of an extensive survey of physical activity levels, food insecurity, and obesity for children.

While the legacy of those changes is yet to play out, there is real risk of short-term impacts translating to longer-term effects on health, and widening inequalities. There is some good news from initiatives tackling physical activity and food insecurity, helping to ‘level up’ children in the North, but there is little confidence in the sustainability of these efforts. If no child is to be left behind, plans must be upscaled and sustained.

Physical activity

Regular physical activity during childhood and adolescence is an important foundation of a healthy, longer life. Physically active play, sport and travel have considerable health, psychological and social benefits in children and adolescents (preventing chronic disease such as obesity, heart disease, stroke, cancer, chronic respiratory disease and diabetes) (42). According to the Every Child a Thriving Boy and Girl national report, physical inactivity costs the UK an estimated £7.4 billion each year (43).

Prior to COVID-19, children’s self-reported physical activity levels in England in 2018/19 showed that the majority of children were not meeting the recommended guidance of a daily average of at least 60 minutes of moderate-to-vigorous physical activity. This was more pronounced in the North, where only 45.6% of children were meeting the physical activity guidelines, compared to 47.3% in the rest of England. Perhaps not surprisingly, these sub-optimal levels dropped further during the COVID-19 pandemic, with a reported 2% decrease across England in 2019/20 (44). The existing gap between the children in the North and elsewhere persisted, with figures falling to 43.7% and 45.3%, respectively.

The ‘systems’ that children lived in changed drastically, usually: everyday inequalities and discrimination; physical activity levels fell in schools, playgrounds, Physical Education, after-school activities, play in parks and playgrounds, playing with friends, and organised sport and recreational activities fell even more. Physical activity behaviors are known to track from childhood into adolescence, then into adulthood, and although the legacy of the impact on physical activity remains uncertain, it is imperative that we act now to minimise the risks of ill health through inactivity, with a particular focus on addressing inequalities.

Children living in some areas of England have been disproportionately affected, as have some ethnic minority groups. Figure 5.1 shows that more children living in the South met physical activity guidelines both before and during the pandemic, compared with all other regions of England. The South also experienced a smaller reduction in the proportion of children meeting guidelines during the pandemic than the rest of the country (45).

Drawing on data from the Active Lives Children and Young People Survey, Figure 5.2 illustrates that significantly fewer children from Black, Asian and other ethnic minority backgrounds met physical activity guidelines prior to and during the COVID-19 pandemic. The reduction in children meeting guidelines was smaller for White children than for children from Black, Asian and other ethnic minority groups. This further indicates the specific role of ethnicity in the impact on physical activity during the COVID-19 pandemic.
The new Kashmir Park in Bradford, which opened in June 2021, is a haven for local children and families. It has quickly become a destination for children and families in the Bradford district.

Councillor Sarah Fernby, Bradford Council’s Executive Member for Healthy People, places, said: “This is a fantastic initiative that has taken many years of painstaking planning by the community, ward councillors, partners and agencies and our own landscape and design team. The children and families who have already been using the park will enjoy the physical and mental health benefits of it for many years to come.”

Councillor Aneela Hussain, local ward councillor, said: “This park has quickly become a haven for local children and families to play and connect.”

Marcus Rashford (#EndChildFoodPoverty137)

Food insecurity occurs when people lack both physical and economic access to sufficient, safe, and nutritious food. Many issues can compound food insecurity beyond poverty, including physical and environmental factors, family and social support, and social exclusion. However, food insecurity is typically more defined as the lack of financial resources required to ensure reliable access to food to meet dietary, nutritional, and social needs.

Food insecurity is higher in households with children compared to the wider population (Figure 5.4), and it is higher in the northern regions relative to the UK (Figure 5.5). Pre-COVID-19, government data showed that the scale of very low and low household food security was 11% in the North West and 10% in the North West of England, compared to 6% in the South East and 8% for England as a whole. When marginal food security is included, these figures rise to 18% and 17% for the North East and North West respectively, compared to 11% in the South East and 14% for England as a whole.

The map in Figure 5.6 shows the geographical distribution of a composite index of risk of food insecurity developed by researchers at the University of Southampton, based on a combination of area-level data on benefits claimants, household income, mental health, and educational attainment. The index reveals a higher risk of food insecurity in the North compared to the South. Of all the areas in England at risk of food insecurity, a third were in the North West and 96% of those were urban areas. Food insecurity is associated with rates of childhood obesity rates, income deprivation and Free School Meal eligibility in an area, highlighting the disproportionate exposure of children in the North to a range of health-related risks.

People with lower incomes are also more likely to live in areas with limited access to affordable food, known as food deserts. A 2018 report found that six of the ten most deprived food deserts in England are in the North (3 in and Liverpool), and the most deprived food desert is in England is in Hull.

The collective evidence is that the COVID-19 pandemic has exacerbated the issue of food insecurity across the UK. In January 2021, over a fifth of people reported having less income than they did before the pandemic, and 2% reported losing all their income as a result of the lockdown. A 2020 survey reported that 14% of adults living with children had experienced moderate or severe food insecurity in the first six months of the pandemic — up from 11.5% pre-pandemic. In the first two

**Figures and Tables**

**Figure 5.4. Percentage of households with children experiencing food insecurity compared to households without children, between March 2020 and January 2021.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Households with Children Experiencing Food Insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2020</td>
<td>11%</td>
</tr>
<tr>
<td>May 2020</td>
<td>10.8%</td>
</tr>
<tr>
<td>June 2020</td>
<td>10.6%</td>
</tr>
<tr>
<td>July 2020</td>
<td>10.4%</td>
</tr>
<tr>
<td>August 2020</td>
<td>10.2%</td>
</tr>
<tr>
<td>September 2020</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

**Figure 5.5. Creating Active Schools Framework.**

**#CreatingActiveSchools**

**Promising practice: Kashmir Park, Bradford.**

The new Kashmir Park in Bradford, which opened in June 2021, is the result of a transformation of unused wasteland at the centre of a densely populated residential area into a thriving green space. The emphasis in Kashmir Park is on ‘natural play’ and providing a safe place for families to meet outside together.

Landscaping and work planting wildflowers and trees have resulted in natural elements, including rocks and boulders that children can climb. This is integrated with new footpaths and a walled area to explore.

The park incorporates natural paths to help link local residents to schools, shops, and other community facilities, creating opportunities to walk through the specially designed natural environment, allowing for safer and easier ways to connect local community areas.

As the project develops, more work is planned to further improve the connectivity of surrounding streets, support people to access the park, and encourage sustainable transport to and from local areas. Over 2,000 children and local residents were involved in the design of the park. Bradford Council’s Landscape, Design and Conservation team developed the site, working closely with the Sport England-funded programme, JU:MP; local families; local councillors; and the wider communities of the Bradford district.

Councillor Sarah Fernby, Bradford Council’s Executive Member for Healthy People, Physical Activities, said: “This is a fantastic initiative that has taken many years of painstaking planning by the community, ward councillors, partners and agencies and our own landscape and design team. The children and families who have already been using the park will enjoy the physical and mental health benefits of it for many years to come.”

Councillor Aneela Hussain, local ward councillor, said: “This park has quickly become a haven for local children and families to play and connect.”

Chris Tolson, Headteacher, St James Academy, Bradford
The Child of the North: Building a fairer future after COVID-19

**Tracking food insecurity through the pandemic in Bradford.**

Families participating in the Born in Bradford study reported an increase in food insecurity from 14% pre-COVID-19 to 20% in the first wave (April - June 2020)\(^1\).

This remained high well into the pandemic (October - December 2020), with 17% of families reporting that food did not last and that they had no money to buy more\(^2\).

In addition to the likely impact on physical health, there was a clear relationship between food insecurity and mental health, with children of families more than three times as likely to have depression or anxiety if they were food insecure\(^3\).

As in many areas, emergency food aid provision was increased at this time: 59 new services were set up across the region within the first few months of the pandemic\(^4\).

Educational institutions played a key role in this and 42% of the meals served were school-based. Services reported increased demand for culturally sensitive food and meals worth $3.7bn\(^5\).

We analysed neighbourhood rates of childhood obesity, examining data from the National Child Measurement Programme. However, data collection was paused during the pandemic. At the start of the pandemic, children in the North were more likely to be living with obesity at reception age – 10.7% compared to 9.6% of children in the rest of England. By year age 10/11, this has grown to 22.6% for a child in the North compared to 20.5% in the rest of England (Figure 5.7). Figure 5.8 shows the regional patterning of obesity at age 17, using data from the millennium cohort study, indicating a further widening of the gap between North and South.

Inequalities in childhood obesity: deprivation, and ethnicity

Childhood obesity at the start of the pandemic, 35% of children in England in their last year at primary school were living with overweight or obesity. Children living with obesity are at increased risk of psychological and physical health problems that can persist into adulthood.

This may result in longer periods of poor health and a shorter life expectancy compared with those of a healthy weight. In 2019, this gap was 10.7% compared to 9.6% of children in the rest of England. By year age 10/11, this has grown to 22.6% for a child in the North compared to 20.5% in the rest of England (Figure 5.7).

A high body mass index in girls appears to be more closely related to low household income than in boys. Given that there are relatively more families living in areas of high deprivation in the North compared with the South of England (with the exception of some parts of London), it is not surprising that the prevalence of childhood obesity is greater in the North.

We analysed neighbourhood rates of childhood obesity, examining the interaction of deprivation and ethnicity. A neighbourhood deprivation quintile represents between 5,000 and 15,000 people. This analysis reveals that the highest childhood obesity rates (26%) are found in neighbourhoods in the North of England that are among the most deprived and nationally for housing and income, and have relatively large ethnic minority populations. In all but low deprivation areas, obesity in girls is more closely related to low income than in boys.

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**Footnotes:**


2. Source: Born in Bradford Study, 2020

3. Source: quote reproduced from the Food Foundation, 2022

4. Source: quote reproduced from the Food Foundation, 2022


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**Promising practice:**

**The Bread and Butter Thing.**

The Bread and Butter Thing (TBBT) operates in deprived communities, acting as a catalyst for change and providing routes out of poverty. TBBT coordinates a safe and effective system for collecting donations of surplus food from businesses such as supermarkets, then redistributes the food surplus to its network of members via affordable food hubs.

The weekly affordable food hubs create events where local people meet, volunteer, engage with each other and access support.

The model is based on a streamlined way of working that maximises resources and minimises waste, creating an affordable food service that is simple and cost-effective. As a result, TBBT helps to make people’s lives more affordable while encouraging them to eat better. But they also support families to maximise their resources.

TBBT partner with existing community venues, working to identify and engage the bespoke support each community belief would be valuable. This could be debt and housing advice or employment and mental health support. The solutions vary but TBBT’s role is to provide coordinate and facilitate.

This mixture of grassroots support and community-based events has proved to be high-impact and sustainable. 83% of members say that using TBBT enables them to feed their families and 57% say it is good for their community.

‘Never in a million years did I think I would be in a situation where I had to choose between food or bills because money was so tight. I am 53 years old, have worked since I was 14, and have never had to deal with food poverty due to COVID. We managed to stay afloat from March 2020 without work or income but then things become too much. A neighbour’s daughter told us about TBBT and it has been a life saver. Not just the food but the knowing that there is always someone coming every week. The crew at the hub do an amazing job. I was a bit unsure about going to TBBT because I thought it was going to be a demeaning experience but I was so wrong. I feel nothing like that when I go. The crew actually make it feel like you’re doing them a favour by taking in the food I can’t think of you all enough!’ Paule, Manchester

More information: https://www.breadandbutterthing.org/
neighbourhoods in the North, we see higher rates of childhood obesity where the relative size of the ethnic minority population is higher (Figure 5.9).

In the North, BMI was the highest in the third of neighbourhoods that were the most ethnically diverse and the most deprived, with BMI being on average 3 points higher (26.2) in the most ethnically diverse third of neighbourhoods than it was in the least ethnically diverse third of neighbourhoods with equivalent deprivation (23.2). In the rest of the country, the difference was 2.4 points.

However, there were fewer inequalities between ethnically diverse and homogeneously white neighbourhoods in less deprived areas in the North than there were in less deprived neighbourhoods in the rest of the country (Figure 5.8).

The National Child Measurement Programme was paused during the COVID-19 pandemic due to school closures. As such, there are no data yet available to assess whether the pandemic has affected child health, although it is widely accepted that childhood obesity is a key health issue. In this context, the impact of COVID-19 on childhood obesity is significant. Although this is an area of research, it is important to highlight the need for continued monitoring of childhood obesity trends and the development of effective strategies to address this issue.

The elephant in the room is what this would cost. In the challenges that must ensure access to health services according to need, with an whole system approach, with a broader set of initiatives targeting, in childhood obesity across England. Beyond this, we need a policy response and the need for whole system actions.

The research suggests that reducing child poverty is a pre-requisite for tackling inequalities in over- and under-weight among children. However, they rely on an individual's ability and will to make healthier lifestyle choices – including what food and drink they buy and consume – and on their access to appropriate health services in their local area. A recent study sampling local authority obesity programmes found that the overwhelming focus on changing individual behaviours rather than changing the environments in which people live. Alone, therefore, the Obesity Plan is likely to have limited impact.

The research suggests that reducing child poverty is a pre-requisite for reversing and reducing the overall prevalence of, and inequalities in, childhood obesity across England. Beyond this, we need a whole system approach, with a broader set of initiatives targeting, in childhood obesity across England. Beyond this, we need a whole system action.

Educational settings

From September 2020, health education became statutory in all English state-funded schools. The curriculum includes content on the importance of exercise, good nutrition and the risks associated with an inactive lifestyle, including obesity. The School Fruit and Activity Action Plan aims to improve the delivery of Physical Education, with schemes to improve active learning (teaching that incorporates movement) and access to extra-curricular sports facilities. In addition, a voluntary Healthy Schools Rating Scheme in England surveys school food and children’s physical activity levels. While this support has stakeholder support, its impact is unclear and has attracted criticism for placing additional burden on schools.

Free School Meals are an important upstream policy option, as highlighted above in the section on food insecurity. School food standards have been in place in England since 2006, but do not apply in early years settings. In settings for under-5s (nurseries), studies have found low adherence to voluntary government food and physical activity standards.

Extending mandatory food standards to nurseries and monitoring all settings may encourage healthier behaviours. Food prepared in-school can be more nutritionally balanced than food brought from home; one study found only 1% of packed lunches met school food standards between 2006 and 2016. A study examining the impact of universal infant-free School Meals found that they are linked to a reduction in children’s body mass index throughout the first year of school.

Town planning

The most deprived is one of the main factors driving childhood obesity. Environmental inequalities reflect childhood obesity trends; socioeconomically deprived and ethnically diverse areas have fewer green spaces for exercise perceived to be safe or accessible. Since 2010, there has been no ministerial responsibility for children’s play or a national policy strategy in England. Local government is central to so much of what makes places good places to live.

Councils are the biggest investors in sport, leisure, parks, and green spaces, spending £1.1 billion per year in England. Providing opportunities for physical activity, affordable to all, is crucial to reduce weight-related health inequalities. Local authority sport, leisure and cultural facilities play an essential role in giving children the best start in life, with 72% of schools relying on public swimming pools to teach children how to swim. Our previous research has shown that by reducing the cost of using facilities local authorities can have a major impact on levels of physical activity – and, importantly, increase the physical activity of more disadvantaged groups who have previously been the most inactive.

However, local authority budget cuts over the last 10 years have impacted planning services, and more so in disadvantaged areas. There is a need to re-invest in those functions if we want healthier environments to be part of our COVID-19 recovery plan.

Urban green spaces, such as parks, playgrounds, and residential gardens that local governments develop and maintain can promote mental and physical health, and reduce morbidity and mortality. Local council libraries, community centres, and cultural facilities can also improve social cohesion. They also provide educational opportunities, develop digital skills, assist with job applications, and increase empathy and anxiety reduction. Physical and psychological services provided by local government also play a vital role in public health.

These services help manage environmental health hazards, such as air and noise pollution, infectious diseases. They also regulate industries to promote public health. Furthermore, local government’s planning and developmental services are responsible for community and economic development plans that influence local jobs, transport and living environments, all of which have important implications for physical, mental, and cultural health.

Education and cultural, environmental, and planning services are responsible for community and economic development plans that influence local jobs, transport and living environments, all of which have important implications for physical, mental, and cultural health.

The wider environment is one of the main factors driving childhood obesity. Environmental inequalities reflect childhood obesity trends; socioeconomically deprived and ethnically diverse areas have fewer green spaces for exercise perceived to be safe or accessible. Since 2010, there has been no ministerial responsibility for children’s play or a national policy strategy in England. Local government is central to so much of what makes places good places to live.

Despite evidence of links between the built environment and obesity, the 2020 Planning White Paper does not refer to the role that planning can play. The Town and Country Planning Association Policy Alliance and others argue that incentives to build healthy environments are weak, as standards for minimum space, green space access and walkability are all optional.

Industry

The 2018 Soft Drink Industry Levy taxes some drinks containing 5g of sugar or more per 100 ml. Since the introduction of the levy, sugar in products subject to it has been reduced by 44% on average. In 2017, Public Health England set a voluntary target for industry to reduce sugar content by 20% in foods that contribute the most sugar to children's diet, including cereals, yogurts, and confectionery. In 2018, the UK Government challenged industry to achieve a 20% reduction in the calorie content of products that are significant contributors to children's energy intake, including ready meals, and products, by 2024. Data on progress towards this goal will be published in late 2021.

The food industry is concerned about additional mandatory regulation, as sugar reduction in food is technically complex and consumer awareness of reformulated products may be hindered by advertising restrictions. However, advertising restrictions are also crucial. A significant body of research has found that food and drink advertising affects children’s preferences.

The 2018 Soft Drink Industry Levy taxes some drinks containing 5g of sugar or more per 100 ml. Since the introduction of the levy, sugar in products subject to it has been reduced by 44% on average. In 2017, Public Health England set a voluntary target for industry to reduce sugar content by 20% in foods that contribute the most sugar to children's diet, including cereal, yogurts, and confectionery. This has led to an average sugar content reduction of 3% in selected products. In 2018, the UK Government challenged industry to achieve a 20% reduction in the calorie content of products that are significant contributors to children's energy intake, including ready meals and products. Data on progress towards this goal will be published in late 2021.

The food industry is concerned about additional mandatory regulation, as sugar reduction in food is technically complex and consumer awareness of reformulated products may be hindered by advertising restrictions. However, advertising restrictions are also crucial. A significant body of research has found that food and drink advertising affects children’s preferences.

Research indicates that advertising restrictions could contribute...
However, the framing of these letters has been found to contribute to an avoidance of weight management services. The demand for weight management services is assessed by individual health service commissioners based on expert advice, national guidelines and local data. There is no central mechanism to assess whether the provision of services for children is adequate to meet need.

In 2018/19, local authorities in England spent £262m on childhood obesity services, a real term decrease of 1% since 2016/17. However, the UK Government has announced a £500m funding commitment to weight management services for parents, adults and children between 2021 and 2022. This includes £70 million for NHS and local authority weight management services, and £30 million in incentives to motivate people to maintain a healthy weight, including a free NHS 12-week weight loss plan app and upselling for healthcare professionals.

Obesity specialists argue that the tiered system is blocking patients’ access to treatments. Researchers have estimated that only 23% of 283,000 children eligible for weight management services are likely to attend. Barriers to accessing services are uncertain but may include a lack of available information and perceptions of weight stigma. A child must attend weight management services (Tier 3) for 6 months before being considered for surgery (Tier 4), which the National Institute for Health and Care Excellence recommends only in exceptional circumstances. Obesity specialists argue that access to treatments should be addressed in the Future of Health and Care White Paper187. Surveying and evaluating weight management services might allow the Government to address gaps in provision and learn which interventions work best.

There is consensus that the most effective interventions involve coordination between different service providers, robust monitoring, and work to reduce inequity.

RECOMMENDATIONS

Physical Activity

- Consider and involve children and child health in planning and regeneration decisions.
- Pilot initiatives to increase green space use which tackle structural quality issues, address fears about safety, encourage communities to reclaim their local green spaces, and champion local authorities to put park and green space improvements at the heart of place making.
- Build on the School Physical Education and Sports Premium to implement whole school physical activity programmes.

Food insecurity

- Introduce a Fair School Meals scheme and holiday food programme support all low-income families, including all children living in households receiving benefits in the North of England.
- Introduce a National Food System Strategy to make the Fair School Meals scheme permanent and extend the holiday food programme for a minimum of three years in the aftermath of the pandemic to promote the provision of nutritionally balanced meals to support children’s health and development.
- Restore the £20 benefits uplift, in order to ensure that all those in work and / or accessing benefits in the North of England have sufficient income to afford a nutritionally balanced diet.
- Further increase the value of Healthy Start vouchers.
- Expand the Healthy Start School Scheme and improve in receipt of benefits.
- Promote the provision of Healthy start vouchers to all children under 5, to bridge the current gap in food support for vulnerable young children in the pre-school period before Free School Meals can be accessed.
- Invest in early years provision to support preschool children, including support with nutrition.
- Establish a central ministerial post responsible for food insecurity within the Levelling Up agenda.
- Increase benefits to a level sufficient to ensure that everyone can afford essential food, ensuring that charitable efforts do not become a substitute for fixing the problem of inadequate social security.
- Use food-related community projects to build community resilience and support other basic health and wellbeing needs, have been criticised188, on the grounds that they detract from a public education food strategy.

These criticisms neglect the glaring reality that children suffering hunger or mental health problems will not learn effectively. At the same time, critics fail to recognise that inequities are bad for everyone: if schools are forced to take responsibility for feeding their most disadvantaged children, then this leads directly to less resource for supporting the education of other children.

The pandemic has highlighted the unacceptable levels of disadvantage suffered by children in our most deprived areas, and shown the necessity of helping schools to support their children’s needs – so that all children and young people can learn effectively, and so that we can break the inequality cycle.

Inequities within the educational system

The COVID-19 pandemic revealed the critically important role played by educational systems in supporting the needs of all children and young people and, specifically, the most vulnerable within our society. But the pandemic also showed that schools inadvertently reflected – and amplified – the inequity parts of our country.

Children in the North of England are at greater risk of being born into unhealthy environments189.

Schools in the North of England have a disproportionate number of children in poverty, children with low levels of development entering school (see Chapter 3), vulnerable children, children who have suffered from neglect and abuse, and children in local authority care (see Chapter 7). There is evidence that disadvantage can dent aspirations190. Thus, many schools struggle with educational attainment and supporting social mobility because of the myriad issues that affect children and young people on the other side of the school gate.

There is overwhelming evidence that the pandemic hit our most deprived areas hardest – the well-documented pre-existing divide between North and South meant that children and young people in the North of England were disproportionately affected by the pandemic.

Past Northern Health Science Alliance reports have highlighted persistent or deepening inequities, with statistics detailing the 17% higher mortality rate in the North, the average of 41 additional days in lockdown – a greater figure than anywhere else in the country, higher unemployment rates, and decreased parental and child mental

Children’s experiences of lockdown (from a primary school in Lancashire)

“I found it quite lonely because (…) my dog passed away, so the house was empty. It was boring, my brother was doing homework, my parents were on their computer, there was nothing to do.”

“It was quite hard because we only had two laptops, I didn’t get as much help. I am used to getting help.”

“I didn’t really like home schooling (…) because I find it sometimes hard to work when I don’t have a friend around.”

“Home schooling is hard because it is hard to work from home.”

Schools and education

Children in the North of England are at greater risk of being born into unhealthy environments189.
The Child of the North: Building a fairer future after COVID-19

wellbeing (see Chapter 4 and earlier NHSA COVID-19 report). These factors affect children and young people’s education, increasing the probability that they have experienced bereavement, and creating serious challenges in the home learning environment. From attendance data, it is clear that urban schools and colleges serving the most deprived communities had the most interrupted in-school learning time, and the most limited resources for delivering in-school and online teaching during the pandemic. Consequently, schools in the most deprived areas within the UK, many of which are in the North of England, have borne a larger share of the burden in supporting children and young people through the pandemic. They face a steeper uphill battle in working to mitigate the negative consequences of the lockdown period.

The digital divide

The broader inequalities affecting schools were well illustrated by the digital inequity exposed throughout the pandemic. Schools in our most deprived areas were less likely to have the necessary digital technology for remote teaching, and their teachers were less likely to be trained in the use of online platforms. The Teacher Tapp survey reported that teachers, especially those in deprived schools, were ill-prepared for distance teaching. A recent survey showed that around two thirds of teachers had little or no previous experience with online teaching, and only 44% reported being well-supported with adequate resources. Only three percent of teachers in the poorest schools hosted an online class, and only four percent had audio/video calls with a student.

While 60% of private schools in the most affluent areas already had an online presence, the figure was 23% for the most deprived schools. These structural inequalities translated into fewer online lessons for children in the North than in the South of England (Figure 6.6).

The unequal implications of the shift to remote education were also revealed in data from the ‘Bare in Bradford’ birth cohort study, collected throughout the pandemic. Children of South Asian heritage were more likely to have had access to computer equipment ‘only some of the time’ compared to children from White British (62%) and other ethnic groups (20%). This pattern was also reflected in access to books (17% of children of South Asian heritage had access to books compared with 47% White British children). Notably, a number of schools made the decision to avoid online resources for all children because many were unable to access digital technologies. This illustrates the point that inequalities are bad for everyone – with the less disadvantaged children directly affected by their classmates’ lack of access to digital resources.

There were also marked regional differences in the amount of offline schoolwork provided to students (Figure 6.2), with only 40% of children in schools within the Northern regions receiving four or more pieces of offline schoolwork per day, compared with the country-wide average of 20% during the UK’s first lockdown across primary and secondary schools.

The disproportionate impact of the COVID-19 pandemic on children with Special Educational Needs and Disabilities

The disproportionate impact of the COVID-19 pandemic on children with Special Educational Needs and Disabilities Schools were less able to provide support related to regional deprivation and groups particularly. In a survey conducted across all Bradford schools, teachers expressed concern over the disproportionate effect of COVID-19 on vulnerable children and children with Special Educational Needs and Disabilities (SEND). Key issues included the lack of access to specialist services such as children’s social services, Speech and Language Therapy, and counselling. Education Psychology services also experienced reduced access to psychologists across the North West described similar concerns (see Case study on next page).

These children and their parents experienced loss, worry, and changes in mood and behaviour as a result of the rapid social changes imposed during the pandemic. Some parents reported feeling overwhelmed, and normal routines they had been counting on were disrupted. Children with SEND often benefited particularly from routine and regular interactions with their teachers and teaching assistants.

The interactions and intersections between SEND and other vulnerabilities associated with deprivation added to the disproportionate impact of COVID-19 on vulnerable children and families living in the most disadvantaged communities. Case study: school in Cheshire.

In early spring 2020, Olivia* became head teacher of a small school in Cheshire. Although the school is located in a mostly affluent area, more than 50% of the children on Free School Meal premium and more than 10% with education health and care plans. Overall, this is a school where, in Olivia’s words, the level of unmet need was “ferociously high.”

Three weeks into her headship, the country went into its first lockdown. In Oliva’s words, the pandemic required a coordinated and inclusive response for both parents and children. Olivia reported that many of the parents were “frustrated” of the virus, the pandemic and the lockdown. Olivia wrote a training manual for all teachers and teaching assistants about COVID-19, how it is transmitted, and how to protect against it.

Throughout the lockdown, teachers and teaching assistants delivered, on foot or driving around the local area, daily knocks on the doors of all children in receipt of Free School Meals. Each family received a phone call at least once a week, and many were called every day. Every week they put together a set of home learning activities, available on the school’s website.

It soon became clear that many families didn’t have the internet, keyboards, pens and paper to make use of these materials. Subsequently, every Monday, full packs of materials, including everything from worksheets to pencils, were made available to every family that needed them. These were either collected from the school or, for many, delivered to their homes. All this had to be paid from the school budget.

* Name changed to protect confidentiality

The home learning environment

During the lockdown period, children’s experiences of learning were much affected by differences in access to resources (such as laptops) and parents’ ability to help with schoolwork. For children receiving Free School Meals, a proxy measure of disadvantage, parents were less likely to be working during the lockdown.

However, these parents found it more difficult to help their children: they reported not feeling confident about home schooling, that they were less likely to understand their children’s learning tasks. Some disadvantaged children had little learning experience during lockdowns because the child with SEND also face more stressors, which are likely to have an adverse effect on the quality of their relationship with their teachers. Thus, family resource inequality extends both to the amount of time spent learning, and to the resources available to assist learning.

There were also regional differences in parental home-schooling support related to regional deprivation. Specifically, the Northern regions of England saw lower levels of parental engagement than the South (Yorkshire and the Humber, 50% parental engagement; South East and East of England excluding London, 59%, Figure 6.3). Lack of parental support and limited access to technology were an issue for many families.

Again, lack of broadband and Wi-Fi were major issues. While local initiatives in some places sought to improve access specifically for children in deprived areas (one example is the ‘Connecting Kids’ initiative), learning was curtailed for many. Schools across all regions, but particularly in deprived areas, are now facing the challenge of supporting their children to catch up on lost curriculum content.

Case study: local authority in Greater Manchester.

Since schools re-opened, Sarah*, a trained Educational Psychologist working for a local authority in Greater Manchester, noted a common pattern whereby children with SEND had gaps in their learning.

Many children with SEND have been unable to access online learning. Even those with access have struggled to participate.

For some nursery children there has been a regression in social and communication skills and interaction development. For example, Sarah has been working with a 5-year-old girl with Down’s syndrome who developed several imaginary friends during lockdown and is now requiring a high level of adult support to re-establish her friendships in school.

More positively, Sarah’s team have adapted their resources to work online, using creative ways of gathering pupils’ voices; playing games, setting up classroom observations with teachers via a tablet, and carrying out alternative assessments using online tools. Sarah noted the benefits of school staff remaining with the child or young person during assessments, providing a new opportunity to build relationships that may not have developed in previous face-to-face consultations.

Notes: * Name changed to protect confidentiality

Figure 6.2. Percentage of pupils receiving offline schoolwork, at different frequencies of lessons*, by region.

Figure 6.3. Parental engagement in learning during the COVID-19 pandemic (%).

A widening attainment gap

Children growing up in disadvantaged communities have lower levels of educational achievement. Children who experience disadvantage leave school on average 22 months behind their peers. A child has an 80% chance of passing maths and English at GCSE if they neither live in poverty nor require the support of a social worker. This figure drops to 65% where a child lives in poverty or needs a social worker. It plummeted yet further to 13% where a child experiencing disadvantage also has Special Educational Needs.

The Child of the North programme, which shows the large regional differences and South-North divide in educational qualifications for young people, based on analysis of the nationally representative UK Millennium Cohort Study.

These pre-pandemic attainment gaps were already a source of intense concern, leading the Department for Education to create the Opportunity Area programme. This programme sought to address disparities in attainment and social mobility within twelve areas that performed particularly poorly on key metrics.

A disproportionate number of these areas are located in the North of England, and Bradford is among them (see Case study on next page). Children in Bradford were likely to show less progress in their schooling than the national average. Half of the children in Bradford were leaving school without a low ‘C’ grade in English or maths (see Figure 6.5).

The Opportunity Area programme adopted a ‘place-based’ approach, targeting areas of greatest disadvantage, and it succeeded in addressing some educational inequalities. For example, in Bradford, the programme targeted school improvement: 39 schools that girls rated as ‘Requires Improvement’ or ‘Inadequate’ in 2016 were rated as ‘Good’ in 2017, and 2018.

Notes: * Lessons such as worksheets, assignments, watching videos Source: Green (2020).
Case study: Bradford Opportunity Area.

The Bradford Opportunity Area has the dual goal of creating a community of practice across the 208 schools in Bradford (supported by the Chief Executive Officers of the Academy Trusts and the Head teachers of the schools). The partnership has been formalised through the creation of a Centre for Applied Education Research, which brings together all stakeholders who wish to improve outcomes for children and young people using evidence-based approaches. The network includes the local authority, the NHS Care Trust, the Bradford Hospital Trust and the regional university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit. The Bradford District have appointed a Senior Responsible Officer with responsibility for multi-agency working, and designated a senior representative from each organisation to facilitate genuine multi-agency work to support children and young people through the education system. The partnership has started to describe, test and refine the processes, tools and skills needed to link services such as health and social care with educational systems – a route to engage with children and families, and offer support at the earliest opportunity, without taking vulnerable children into clinical or social care systems. In short, we must place the education system at the heart of recovery plans. Educational establishments can play a role here through the effective ‘levelling up’ of the COVID-19 inequality legacy – a route to engage with children and families, and offer support at the earliest opportunity, without taking vulnerable children into clinical or social care systems.

Recommendations

There is a clear case for making educational settings the catalysts, enablers, and beneficiaries of multi-agency efforts to tackle structural inequalities. Systems must change so that education settings can act as hubs where children’s holistic needs are met. Across educational settings, all must respond to deliver universal services at a scale and intensity proportionate to the degree of need.

1. Use educational settings as a means of connecting with families and localities.

Educational establishments present visible, physical spaces in the heart of every child’s community. They are connected to and trusted by the overwhelming majority of children and families, every day. They offer places – in partnership with professionals from other services – to engage with children and families, and offer support at the earliest opportunity, without taking vulnerable children into clinical or social care systems. In short, we must place the education system at the heart of recovery plans. Educational establishments can draw on first-hand experience of what learning was lost – and the emotional and social needs of their children – to provide a platform to address the identified problems of inequality.

The support provided by educational establishments needs to be integrated with other services offering help to children and their families, and structured so as to promote equity of access and effectiveness. There are already demonstrated impact in and beyond the classroom on a national stage.

by one Oftsed grade by 2019, exceeding the 25-school target. This equation to approximately 12,000 pupils now attending a ‘Good’ or ‘Outstanding’ school.

The Opportunity Area allowed the design and delivery of the innovative ‘glasses in classes’ and ‘early identification of autism’ projects, and attracted £3.75 million of external funding, which allowed 180 schools to engage with educational research activity. The work of the Bradford Opportunity Area partnership board also resulted in the opening of a new PricewaterhouseCoopers office in Bradford, with recruitment policies deliberately designed to attract young people from disadvantaged backgrounds. PricewaterhouseCoopers Bradford office added 225 professional, high-quality jobs in the heart of Bradford, with more planned.

In the North Yorkshire Coast Opportunity Area, in 2016, the percentage of pupils reaching the expected standard in mathematics at Key Stages 1 and 2 was 64% and 64.4% respectively. By 2019, these figures had risen to 83.8% and 70.5%. Disadvantaged pupils experienced the greatest gains, with increases at Key Stages 1 and 2 of 11.5 percentage points and 14.3 percentage points, respectively. The North Yorkshire Coast Opportunity Area also ensured that schools had access to a consistent supply of high-quality teachers.

Teacher recruitment and retention interventions filled 225 vacancies over 45 schools, reducing reliance on supply cover. The programme managed to decrease permanent and fixed term exclusions by 82% and 15% respectively.

The Opportunity Area also fostered a holistic approach to the health and education of children. Over 6,000 primary-age pupils were screened for speech and language disorders. Over 700 pupils were subsequently discharged from therapist services due to no longer needing speech and language support. It is now clear that targeting educational inequalities in our most disadvantaged areas can achieve many successes. Unfortunately, there is growing evidence to suggest that the pandemic has wiped out these hard-won gains.

The pandemic has undoubtedly exacerbated the attainment gap. It is difficult to accurately measure how far the gap has widened within a region or nationally because the assessment process across the school system has been so disrupted. However, estimates for autumn 2020 put the gap between the most and least disadvantaged Year 6 pupils at seven months, an increase of two months from previous estimates. The gap for Year 1 pupils is also around seven months for both reading and maths, and the gap for Year 2 pupils widened.

There are also regional disparities in the degree of learning loss as a result of the pandemic. By the second half of the 2020 term, primary pupils in the North East and North West experienced the greatest loss in reading within the country, of 2.0 and 1.9 months respectively. In maths, at primary level, differences by region were even larger, with the North East and Yorkshire and Humberside experiencing 4.0 and 3.9 months’ learning loss respectively – compared to less than a month of learning loss experienced in the South West and London.

There is evidence that differential impacts by region are driven by disadvantaged school children disproportionately and consistently falling behind expectations. In Leeds for example, during the first lockdown, children in Reception class were less likely to have made progress against important Early Learning goals. Progress was slower for children from deprived communities, whose first language is not English, children who needed additional classroom support. This has major implications for children and young people in the most deprived regions, given the number of electoral wards in England.

Impact on adolescents

Young people’s experiences of schools and disadvantage under lockdown were captured in the Youth Under Lockdown Survey. Young people’s experiences of lockdown were shaped by what they missed – family and friends, physical exercise, much reduced during lockdowns (see Chapter 5), social skills, independence skills and mental health (see Chapter 4). Support must go beyond adding more curriculum content. It should include activities, for example excursions, sports days, clubs, and investment in school libraries. These activities require resources. If this support is provided, the inequalities highlighted and increased by the pandemic will track through to adulthood, following children as they apply for university places and enter the workforce (see Chapter 5).

Educational establishments need to be partners in the recovery work and efforts to address inequalities. They are ideally placed to capture the voice of the children, young people and their wider communities. Schools and teachers need to be at the heart of local and national efforts to address children’s education, development and wellbeing, with local knowledge given due respect and teachers’ expertise heard and recognised.

Our communities deserve opportunities for growth as well as remedies for the ‘Big Bet’ failures and opportunities for culture and leisure are shown to protect against vulnerabilities. Educational establishments need to be connected to and supported by businesses and social businesses to engage and understand places and their people, and help our businesses and enterprise initiatives target investment more effectively, and thereby drive social mobility. This economic and social development cannot take place without investment in the infrastructure that surrounds educational settings, including better and faster transport.

The support provided by educational establishments needs to be integrated with other services offering help to children and their families, and structured so as to promote equity of access and effectiveness. There are already demonstrated impact in and beyond the classroom on a national stage.

A role for the education system in mitigating the COVID-19 inequality legacy

The findings outlined in this chapter illustrate the need for government to partner with educational establishments in the fight against the most deprived areas. This is key to the effective ‘levelling up’ of these areas. Educational systems have an important role to play in addressing wider developmental, social, and emotional challenges and setbacks caused by the pandemic, for example in physical exercise, much reduced during lockdowns (see Chapter 5), social skills, independence skills and mental health (see Chapter 4).

Support must go beyond adding more curriculum content. It should include activities, for example excursions, sports days, clubs, and investment in school libraries. These activities require resources. If this support is provided, the inequalities highlighted and increased by the pandemic will track through to adulthood, following children as they apply for university places and enter the workforce (see Chapter 5).

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The support provided by educational establishments needs to be integrated with other services offering help to children and their families, and structured so as to promote equity of access and effectiveness. There are already demonstrated impact in and beyond the classroom on a national stage.

Educational establishments can ensure that the voices of children and young people, their families, and their communities are heard. Those voices must drive forward effective change (see Chapter 5).

Reflections from teachers in the North of England.

“We were worried about language – many of our pupils are not speaking English at home and parents do not speak English…”

“We’ve had to work with parents and social care teams to build the confidence so [vulnerable and SEND] children are attended every day.”

“My children face a range of special needs from low income families. The post Covid support for tech software has been appallingly slow and lax. This has meant middle class kids have, in general, had far higher levels of engagement than working class kids.”

“I work with students with a range of special needs from low income families. The post Covid support for tech software has been appallingly slow and lax. This has meant middle class kids have, in general, had far higher levels of engagement than working class kids.”

“Very uncertain about the ‘safeguarding’ of myself and my students using free software. Conflicting advice from schools, government and unions.”

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The Child of the North: Building a fairer future after COVID-19

The UN has warned of a looming mental health crisis and urged support they provided to vulnerable children during the lockdown. This requires a reversal of the current approach to resource whereby the new national funding formula will deliver 3–4 percentage points less funding to schools in poorer areas than to those in more affluent areas189.

Prioritise deprived localities. There is a need to prioritise and direct resources to the localities, communities, and individuals who have suffered most from the pandemic – those in the most deprived areas. There needs to be an increase in the spending available to schools serving the most disadvantaged pupils in England. This requires a reversal of the current approach to resource whereby the new national funding formula will deliver 3–4 percentage points less funding to schools in poorer areas than to those in more affluent areas189.

The provision of support to our most disadvantaged areas has already yielded dividends through the Department for Education’s Opportunity Area initiative. There is robust evidence showing the initiative’s profound impact on children and young people in those areas. Policies must reflect the evidence building schools or improving school leadership in deprived areas per se will not tackle the wicked problems that underpin educational inequalities. A whole system approach across government departments, including directed resources, is required to reverse the tide of inequality, and genuinely level up opportunities for children and young people in the UK.

3. Make a reality of multi-agency working. Professionals on the frontline need to have the freedom and support to connect and act together. This must involve removing ‘artificial’, non-legal barriers to information sharing that work against children’s best interests, and enabling the pooling of budgets, targeting of criteria, and alignment of operational processes. We need to develop information sharing tools and build effective education-centred partnerships at the local level, engaging professionals and the community. This will make a reality of effective multi-agency working.

4. Establish clear accountability and authority, enabled by a single point of leadership. An approach to recovery based in educational settings requires dedicated resources and a mandate to challenge and influence delivery of support across services. A Senior Responsible Officer for tackling inequality within an area needs to drive change across a range of systems, liaise with multiple stakeholders and, where necessary, influence the deployment of resources and people behind a strategic plan.

There is a need to establish a single, clear, and short management chain, enabling good oversight of issues, accelerated decision making, and clarity of communication. A ‘whole system’ leadership team must draw resources from across all agencies, including health, social care, and policing. These resources must drive a truly multi-agency response within educational settings.

5. Use educational settings to initiate earlier interventions. Teachers and early years professionals see many of the first indicators of risk and vulnerabilities, before those issues cross the desk of clinicians, social workers, and other professionals. The post-lockdown problems of risk and vulnerability are likely to be felt particularly in the North due to economic reasons, but many pupils were unable to consistently attend school during the summer of 2021.

Prioritising strong pupil and staff relationships and collaboration with parents/carers will ensure a firm foundation for meeting children’s needs and a return to learning. For example, schools are well positioned to offer a practical evidence-informed response to the ongoing psychological impacts of the pandemic, from bereavement and loss through to social isolation, using resources such as the Recovery Curriculum190 (see Chapter 6).

6. Support staff in educational settings. There is a need to consider, post-lockdown, how education staff can be supported and better prepared for possible challenges that lie ahead. In particular, teachers must be supported to maintain the level of support they provided to vulnerable children during the lockdown. The wellbeing and mental health of education staff needs to be protected if they are to be effective in helping children and young people.

The UN has warned of a looming mental health crisis and urgent governments to redress the historic underinvestment in psychological services. There is a need to create mechanisms to build resilience in education staff, limit burnout, and protect jobs. Teachers need to be offered Continuing Professional Development to build digital communication skills.

7. Put ‘Research & Development’ at the heart of strategy and delivery. The breadth of academic expertise and capacity within universities is matched by the enthusiasm of researchers to engage with real challenges. Stakeholders need to be prepared to learn together, not just when implementing interventions, but on an ongoing basis.

A shared culture, and a virtuous cycle of learning through evidence and practice has the potential to inform effective integrated practice. Academics play an important role in describing patterns of vulnerability and the effect of vulnerability on education outcomes and resources. All stakeholders – including schools, nurseries, local authorities, health service providers and others – can benefit from cutting-edge knowledge generation, including powerful data science tools and information systems.

Figure 6.4. Attainment scores for children in Bradford compared to the National average, 2016.

<p>| Percentage of pupils reaching the expected standard in reading at the end of key stage 1 (2016) |
|---------------------------------|----------------|-----------------|----------------|-----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>Bradford</th>
<th>All pupils</th>
<th>FPM pupils</th>
<th></th>
<th>Bradford</th>
<th>All pupils</th>
<th>FPM pupils</th>
<th></th>
<th>Bradford</th>
<th>All pupils</th>
<th>FPM pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%</td>
<td>74%</td>
<td>78%</td>
<td>70%</td>
<td>74%</td>
<td>81%</td>
<td>82%</td>
<td>70%</td>
<td>74%</td>
<td>81%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Context

This chapter focuses on children in public care in the North, and captures the challenges that services were facing prior to, and throughout the COVID-19 pandemic. The North of England records the highest rates of children in care and provides the largest share of children’s home places in England, for children with the most complex needs.

Despite the best efforts of frontline practitioners and the resilience of the care system, the outcome for the North is bleak. Increasing family adversity, pressures on preventative services and the continued remote hybrid delivery of professional help, mean that pressures in social care are not likely to let up. Further stacked challenges arise from the ongoing crisis in the family courts, insufficiency of our home placements and critical shortages in mental health provision.

In this chapter, we present new data from one North West NHS Trust. The data capture escalating rates of detention, by the police, of children in acute mental distress, including children in care. We set out key policy recommendations that will help avert further harms to children in the North, whilst levelling up life chances. These recommendations require urgent attention.

Children in care in England

Of the 12 million children in England, 400,000 (3%) are in the social care system at any one time191. Over 80,000 children – an all-time high – were in care in England during the year ending 31st of March 2020200.

The State has corporate responsibility for ensuring the best possible outcomes for children who require out of home care. However, demand is outstripping supply for key services, affecting the courts’ ability to make robust and timely decisions for children, and local authorities’ ability to provide high-quality placements suited to children’s needs, including placements in residential and secure children’s homes. A growing population of older children requiring out of home care adds to the difficulties that Children’s Services face191.

Pre-pandemic challenges in the Northern regions

Prior to the pandemic, given limited available resources, public services in the North of England were struggling to meet the needs of an escalating number of children in need or in care201. Unprecedented cuts to Children’s Services since 2008/9 have forced local authorities to reshape and restrict services against a backdrop of greater need202. Between 2015/16 and 2017/18, the number of children in need increased by 7%, in line with population growth, there was a sharp 77% increase in child protection assessments201, reflecting a shift in the balance of activity away from prevention, and resulting in escalating rates of children in care201. The steepest increases of rates of children in care since 2008/9 have been in the most deprived local authorities201. A disproportionate number of these most deprived local authorities are in Northern regions.

Regional and local authority differences in the current rates of children in care are considerable (Figure 7). In the year ending

Figure 7. Looked after children per 10,000 children, by local authority in England, 31 March 2020

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Rate per 10,000 children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackpool</td>
<td>223</td>
</tr>
<tr>
<td>Bradford</td>
<td>222</td>
</tr>
<tr>
<td>Bury St Edmunds</td>
<td>158</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>189</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>223</td>
</tr>
<tr>
<td>North East</td>
<td>977</td>
</tr>
<tr>
<td>North West</td>
<td>100</td>
</tr>
</tbody>
</table>

31st March 2020, on average 67 children per 10,000 were in care in England. Of the local authorities with more than 100 children per 10,000 in care, 21 of 26 are in the North. At the end of March 2020, the prevalence of children in care per 10,000 of the Child population was 974 in the North, compared to 818 in the rest of England200. The North records a number of extreme outliers with very high rates of children in care:

- In Blackpool, 223 per 10,000 children are in care
- In Middlesbrough, 189 per 10,000 children are in care
- In Hartlepool, 158 per 10,000 children are in care
- The North East is the region with the highest persistent overall rates of children in care

Out-of-home care for children is the costliest statutory service for local authorities. It also results in multiple costs beyond children’s needs, including placements in residential and secure children’s homes. A growing population of older children requiring out of home care adds to the difficulties that Children’s Services face191.

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Prior to the pandemic, given limited available resources, public services in the North of England were struggling to meet the needs of an escalating number of children in need or in care201. Unprecedented cuts to Children’s Services since 2008/9 have forced local authorities to reshape and restrict services against a backdrop of greater need202. Between 2015/16 and 2017/18, the number of children in need increased by 7%, in line with population growth, there was a sharp 77% increase in child protection assessments201, reflecting a shift in the balance of activity away from prevention, and resulting in escalating rates of children in care201. The steepest increases of rates of children in care since 2008/9 have been in the most deprived local authorities201. A disproportionate number of these most deprived local authorities are in Northern regions.

Regional and local authority differences in the current rates of children in care are considerable (Figure 7). In the year ending
A North-South divide in the provision of children’s homes has marked concentrations of children’s homes in the North of England adds to the already intense pressure on services in the North. Approximately 1 in every 10 children live in a children’s home. These homes accommodate children and young people with the most complex difficulties. Relative to other children in care, these children are more likely to:

- Have experienced multiple moves in care
- Have poorer mental health
- Have a statement of Special Educational Needs
- Have more behaviour difficulties
- Live further away from their birth families

In England, there are currently 12,175 registered children’s homes (not North) (Table 7.1).

The 2016 Narey Review drew attention to the concentration of residential care facilities in the North West, with around 25 children waiting for a secure children’s home placement on any given day. The lack of appropriate secure homes is considered a key factor in the increasing detention of children by the police under the Mental Health Act 1983.

Accounting for high rates of children in care: family adversity in the North

Children may require statutory intervention for multiple reasons. However, what children in the poorest areas of England are disproportionately at risk of entering care is well established. Chapter 2 of this report describes the deteriorating living standards and family adversity that children in the North of England experience. Poverty is implicated in parental mental health problems and addiction, couple conflict and other causes of childhood adversity and trauma associated with the involvement in Children’s Services and care.

It is therefore no surprise that regions of the North record the highest rates of domestic abuse, and high prevalence of both child and adult mental ill health (see Chapter 4). In the year prior to March 2020 lockdown, all three regions of the North recorded the highest rates of domestic abuse-crimes in England.

Prevention and early identification are key to reducing family adversity and childhood trauma and to preventing children from requiring formal statutory intervention. However key services, including health visiting, mental health, substance abuse and domestic violence services, are increasingly overwhelmed and underfunded.

In a nutshell, there is unequivocal evidence that Children’s Services and partner agencies were considerably overstretched, due to family adversity, prior to the introduction of social restrictions in March 2020.

In the current pandemic, with an already high prevalence of childhood adversity and family breakdown, coupled with significant restrictions on family contact due to social distancing requirements, including with parents, siblings and grandparents.

This has placed considerable strain on foster placements, with the Association of Directors of Children’s Services reporting increased placement disruption. Foster carers themselves have experienced difficulties in reducing contact and respite provision due to the pandemic.

Children involved in family court proceedings since March 2020, have encountered barriers to access to justice and delays in the determination of their care proceedings (Figure 7.3). In the first quarter of 2021, the average public law (child protection) case took 41 weeks to complete. This is a marked increase in duration from the same period in 2020, when the average was 34 weeks.

The family courts make critical decisions for children, including whether children in care should be returned to families, remain with alternative carers or be adopted. Many children’s lives have been left in limbo due to family court decisions.

Again, inevitably, these backlogs have a greater impact on regions in the North, where, prior to the pandemic, numbers of family court cases were already disproportionately high. The prospect of systems recovery is likely, given that the family justice system went into the pandemic crisis in ratio due to funding cuts.

During the last decade:

- Government funding for the family justice system fell by 21%
- Legal aid budgets fell by 40%
- Court buildings closed
- Judge sitting days reduced

There are worrying signs that the care experience of children with the most complex needs may have been compromised during the pandemic. Complaints to Ofsted about providers of residential care have risen by 18% during the year 2020. At the same time, there has been growing concern over the placement of children in unsuitable residential homes because of a mismatch between need and the availability of foster carers or approved children’s home placements during the pandemic.

Family adversity: what is the outlook for the North?

The COVID-19 pandemic has highlighted the challenges experienced by children, particularly those living in families facing ill-health, insecure incomes, and other adversities. The evidence from the Association of Directors of Children’s Services is that the pandemic has tipped an increasing number of families into breakdown, resulting in a larger population of children now requiring statutory intervention.

There has been a sharp increase in adults reporting depression during the pandemic compared to pre-pandemic. In early 2021, 27% adults experienced depression – more than double the pre-pandemic rate. People living in the most deprived fifth of areas were five times more likely to experience depression during the pandemic (28% of people) compared to the least deprived (6% of people). Police data have also shown an increase in domestic abuse offences during the pandemic.

Children and young people have themselves highlighted the wide-ranging impacts of the pandemic on children experiencing family adversity during lockdowns:

- Of all these children who have been causing fights have been stuck at home with nowhere to go, they may have witnessed their parents fighting, their parents might have lost their jobs; for these reasons the young people are very unhappy with the ongoingıp of restrictions.

Young person engaged with a community group in Bradford

Moreover, during the pandemic many encounters between services and children and families that would previously have occurred face-to-face shifted online. For example, health visiting face-to-face visits were suspended for most families (see Chapter 3). This constrained opportunities for early identification of family adversities, including
mental ill health and domestic abuse, and provision of treatment and support. Taken together, the evidence on adverse trends in family adversities and increasingly overwhelmed services does not suggest that the numbers of children in care are likely to fall in the North in the near future. In particular, local authorities in the North will struggle to refocus services on prevention, because they cannot avoid the huge costs associated with children who are already in their care.

Recommendations

There is an urgent need to address the greater risk for children in the North of becoming involved with statutory Children’s Services and the care system. A range of prevention strategies can be deployed to reduce this risk, focussed on strengthening economic support for families; promoting social norms that protect against violence and adversity; identifying family adversity and providing appropriate support and treatment; and making sure that children get the best possible start in life. The Independent Review of Children’s Social Care seeks to align services far more closely to family need, and is very welcome. However, as short-term crisis funding to public services is withdrawn, public services face a cliff edge, at a time when need is at an all-time high.

Priorities include:

- Implementing policies to reduce child poverty, including improvements in the real value of the National Living Wage, and increases in child benefit, the child element of Universal Credit, and child tax credits (see Chapter 2).
- Improving the mode of delivery must not compromise the support and treatment; and making sure that children get the best possible start in life. The Independent Review of Children’s Social Care seeks to align services far more closely to family need, and is very welcome. However, as short-term crisis funding to public services is withdrawn, public services face a cliff edge, at a time when need is at an all-time high.**

Priorities include:

- Implementing policies to reduce child poverty, including improvements in the real value of the National Living Wage, and increases in child benefit, the child element of Universal Credit, and child tax credits (see Chapter 2).
- Increasing funding for preventative services (health visiting, children’s centres, family hubs, early help) – proportional to need, and
- Improving the real value of the National Living Wage, and
- Improvements in the mode of delivery must not compromise the support and treatment; and making sure that children get the best possible start in life. The Independent Review of Children’s Social Care seeks to align services far more closely to family need, and is very welcome. However, as short-term crisis funding to public services is withdrawn, public services face a cliff edge, at a time when need is at an all-time high.

What do the data tell us? Section 136 detentions in one North West NHS Trust.

- Numbers of section 136 detentions have been increasing since 2017 in the case study area.
- Since the start of social restrictions in March 2020, a steeper, statistically significant increase, is evident.
- Children in care feature disproportionately in the statistics. 17% (52 of 305) detentions were children in care. Yet children in care constitute only 3% of all children in the general population.
- Girls were more likely than boys to be detained (63% of all detentions, and 69% of the children in care detained).
- The reason why children are detained is most often harm to self (95%).
- The age of children detained ranged from 9 to 18 years.
- 53% of detentions were repeat detentions; some children had been detained more than 10 times.
- Most detentions took place outside of working hours or at the weekend.
- Most children were detained in hospital Accident and Emergency or paediatric wards, pending assessment within working hours.
- The length of time for which children were detained by a police officer frequently breached regulation (24 hours maximum) owing to assessment waiting times or bail availability.

The police officers interviewed were deeply concerned about the increasing number of detentions during the pandemic. They were worried about the lack of suitable places of safety and considered detention of a child in either Accident and Emergency or general paediatric wards to be highly inappropriate and distressing for all. Police officers were required to remain with the child due to the lack of appropriate provision for these children, but felt that they did not have the specialist expertise to care for a child in acute distress. One police officer, describing a child curled up and sleeping on the floor of an Accident and Emergency department: “wholly, wholly inappropriate”.

Regarding detentions in a paediatric ward, a police officer stated: “More often than not they are ... kicking off. You have poorly children who are then being disturbed and frightened by the behaviour of another child. ... Detaining, restraining, head guards, limb restraints, handcuffs. On and off all night. All night. It wasn’t good for the other children, and the child you have detained, this is horrific.”

The police officers referred to the frequency with which they detained children from children’s homes. They were particularly concerned about children placed in care from out of the area, for whom information was not available quickly to inform police actions. This meant that police were unable to use information to ascertain risk to self and try to avoid detention as far as possible.

“for looked-after children placed away from their home location – there is no local information”
There is a concern that the push for quick pandemic recovery overlooks ethnic make-up, and national surveys, including the UK Household Longitudinal Study (HLS)209,210, do not support analyses by ethnic group and region due to inadequate sample size. It is very rare to find data disaggregated by ethnicity and geography — yet we know that experiences and opportunities among ethnic minority children vary geographically.

The Race Disparity Audit is a useful initiative, but draws on primary sources that often employ very broad ethnic categories222. At the local level, Joint Strategic Needs Assessments lack health-related information on ethnic minority children and young people, and pay no attention to racism as a determinant of poor health223.

This absence of data and analysis hinders local patterns, renders some groups completely invisible, and precludes investigation of the key drivers of health disadvantage. Promising work that goes greater attention to understanding the needs of ethnic minority children — such as work conducted in Leeds (see textbox on this page) — should be emulated.

Understand and address socioeconomic deprivation

Pre-COVID-19, important ethnic inequalities in socioeconomic adversity were well documented at a national level. Unemployment236, precarious employment and low paid work237 are all more common among ethnic minority people than the majority White. Furthermore, welfare benefit changes over the last decade have reduced the safety net for low earning households209,210, with ethnic minority families faring disadvantaged by obstacles to benefits uptake238 and especially the benefit cap239 and two-child limit on Universal Credit240.

These disadvantageous conditions are consistently reflected in higher rates of poverty, particularly among Pakistani and Bangladeshi groups239. Table 8.1 shows the most recent data from the Department for Work and Pensions on child poverty by ethnic group.

An analysis of the UK Household Longitudinal Study that in the two years to March 2019, 9% of White households were in fuel poverty, compared with 18% of households in the aggregated ‘all other ethnicities’ group240. Gipsy, Traveller and Roma populations remain unenumerated in many national datasets, but available evidence suggests they experience extreme socioeconomic deprivation241.

Chapter 2 presents data from the Family Resources Survey for 2017-20 combined to illustrate regional patterns of child poverty by ethnicity. While both living in the North and belonging to a minority ethnic group are significantly associated with child poverty, minority ethnicity has the greater effect. Drawing on aggregated data, Figure 8.2 presents the intersection (or coincidence) of socioeconomic deprivation (a combined measure of low income and poor housing) and minority ethnicity. Each neighbourhood, representing between 5,000 and 10,000 people, is colour-coded according to both deprivation and ethnic density.

The nine colours represent the range from low deprivation/low minority ethnicity (light grey) through to high deprivation/high minority ethnicity (dark green). The light grey areas, with more White children and less socioeconomic deprivation, are often found on the peripheries of sub-regions. Clusters of high deprivation and relatively high minority ethnicity (dark grey) are present in most Northern sub-regions.

Figure 8.3 shows the proportion of neighbourhoods that fall into each intersection in the North and South. 68% of the most deprived third of neighbourhoods for housing and income are also in the most ethnically diverse third of neighbourhoods in Northern authorities. 14% of all neighbourhoods in the North are in the most deprived third of all neighbourhoods nationally for income and housing compared to 11% in the South (see the top panels of Figure 8.3). In both North and South, there is a strong association between ethnic minority density and neighbourhood socioeconomic disadvantage — but there is a stronger association in the North of England than in the rest of the


<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Child poverty rate (%)</th>
<th>(After Housing Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Mixed/Multiple Ethnic Groups</td>
<td>34.7</td>
<td>29.1</td>
</tr>
<tr>
<td>Indian</td>
<td>24.1</td>
<td>19.9</td>
</tr>
<tr>
<td>Pakistani</td>
<td>50.4</td>
<td>46.3</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>59.2</td>
<td>56.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>31.2</td>
<td>27.4</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>41.8</td>
<td>37.2</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>41.8</td>
<td>37.2</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>42.8</td>
<td>39.2</td>
</tr>
<tr>
<td>All</td>
<td>22.1</td>
<td>18.9</td>
</tr>
</tbody>
</table>

country. In the North, ‘low’ deprivation neighbourhoods are twice as likely to have relatively high White, than relatively high non-White, child populations (22% versus 9%)..

Children from ethnic minority populations are far more likely to be living in particularly adverse socioeconomic conditions at this neighbourhood level. Further, this breakdown suggests that the scale of the inequality is greater in the North of England than it is in the rest of the country.

Post-pandemic, we can expect these ethnic inequalities to be further exacerbated. Recessions affect ethnic groups differentially, with unemployment rising more sharply among ethnic minority groups than majority White groups. Employment disadvantage will impact both younger children via diminished household income, and those aged 16 and over who need to enter the labour market. Indeed, ethnic minority young adults face the intersection of racial and age-related labour market disadvantages. Preliminary data from the Department of Work and Pensions plotted in Figure 8.4 show a concerning rise in unemployment among the non-White population.

Pakistanis and Bangladeshi workers were particularly heavily concentrated in shut-down sectors. Government job retention and creation initiatives have paid scant attention to ethnic dimensions. Though loss of working hours was similar across ethnicity, 15% fewer workers from the ethnic minority group were furloughed and 13% more became unemployed than the White group. Employment disadvantage will impact both younger children via diminished household income, and those aged 16 and over who need to enter the labour market. Indeed, ethnic minority young adults face the intersection of racial and age-related labour market disadvantages. Preliminary data from the Department of Work and Pensions plotted in Figure 8.4 show a concerning rise in unemployment among the non-White population.

Local and national policy makers must recognise and tackle the roots of ethnic minority labour market disadvantage and socioeconomic deprivation. For instance, pay differences between White and ethnic minority workers are not explained by the jobs they do or the regions they work in, comparable Black employees have been found to earn 11% less than their White counterparts. Racism and discrimination are the driving forces behind these inequalities, and there has been little to no improvement over recent decades. Beyond the individual and societal effects of racism and ethnic inequalities in the labour market, there is also a huge productivity cost; it has been estimated that full utilisation of ethnic minority talent would deliver a £24 billion per year boost to the UK economy.

Tackling racism at interpersonal, cultural and structural levels

Racism is best understood as an organised social system that operates at different levels, and manifests in both overt and covert ways. The health and wellbeing of ethnic minority children and young people is undermined by interpersonal, cultural and structural racism.

Evidence suggests that racism is not only emotionally damaging but that its effects accumulate over the lifespan, leading to activation of stress responses, harmful hormonal adaptations and adverse impacts on both mental and physical health. The pervasive nature of racism and its impact on ethnic minority health has been consistently highlighted in the UK. While racism based in religious, as well as ethnic, identity is also a serious cause for concern, interpersonal racism is the most readily recognised form of racism; manifested as verbal abuse and physical attack but also often as brief and commonplace slights, indignities, incivilities or oversights.

Ethnic minority children and young people in Britain consistently report experiences of interpersonal racism in educational, health and social settings. In one study, 95% of young Black people reported having witnessed the use of racist language at school. In another, a Scottish Muslim pupil recalled the lasting impact of...
The Child of the North: Building a fairer future after COVID-19

The Child of the North: Building a fairer future after COVID-19

The Child of the North: Building a fairer future after COVID-19

Figure 8.3. North-South comparison of the proportion of neighbourhoods in each category of the deprivation / ethnic minority density grid. Compared to the South of England, the North contains a higher proportion of neighbourhoods in the deepest green/blue category of the grid, with highest levels of both low income and housing deprivation and ethnic minority density.

<table>
<thead>
<tr>
<th>North (%)</th>
<th>South (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>1.5</td>
<td>1.3</td>
</tr>
<tr>
<td>1.1</td>
<td>1.0</td>
</tr>
<tr>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>0.9</td>
<td>0.8</td>
</tr>
<tr>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>0.1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Omar, Age 14-16

Research including South Asian parents in the North found considerable energy being devoted to both monitoring children’s exposure to, and supporting their ability to weather the impact of, interpersonal racism within schools and neighbourhoods. Consultation exercises with young people in Northern cities have highlighted racism and discrimination as a deep concern and priority for action to improve wellbeing.

“Know that we suffer the effects of racism in the City we love. Help us to eradicate racism in Bradford.”

(Bradford Schools Pandemic Recovery Summit)

In large-scale consultation exercises aimed at understanding the impact of COVID-19 on ethnic minority groups, exacerbation of historic discrimination and stigma and an increase in racist attacks, particularly among Chinese communities, were highlighted.

“Currently we have a Chinese mother with children. She’s suffered domestic violence and moved out of the home, but because of the racist comments due to COVID-19, people shouting at her, she’s so scared so she moved back to her husband! This happens a lot, we suffer a lot of racist comments in the Chinese community due to COVID-19.”

Stakeholder

Racist and prejudiced views have often been found to develop childhood. This may therefore be an opportune time to take action. However, the evidence base on effective interventions to reduce interpersonal racism is weak. An evidence review for the Scottish Government on what works to reduce prejudice and discrimination concluded that there was a need for sustained activity within the context of broader institutional change.

Interventions informed by social-psychological theory and that facilitate positive intergroup contact, perspective-taking or empathy were also considered effective. In educational settings, peer engagement and cooperative learning are also promising. However, there is also evidence that intergroup activity can have unanticipated negative effects and does not necessarily lead to broader shifts towards inclusive attitudes and behaviours, underscoring the need for sustained action at systemic levels.

Specifically acknowledging and naming racism has been reported as important to ensure that initiatives aimed at young people from minority ethnic backgrounds are effective. There is also a need for clear and accessible routes for ethnic minority children and young people to report interpersonal racism, and for action to be taken.

Chapter 10 of this report makes the powerful case for foregrounding children’s rights.

Ethnic minority children must be empowered to know and claim their rights. Strong within-group ties are important for developing wider social capital and resistance to racism within ethnically diverse communities. Several reports have highlighted the need for more community “safe spaces” that can buffer the impact of interpersonal racism for ethnic minority children and young people. Persistent under-funding of community projects in general, and a reluctance to fund ethnically specific initiatives in particular, were repeatedly highlighted as key issues by stakeholders consulted for this report.

Cultural racism refers to “the instillation of the ideology of inferiority in the values, language, imagery, symbols, and unstated assumptions of the larger society. It creates a larger ideological environment wherein the system of racism can flourish and can undergird both institutional- and individual-level discrimination.”

UK policy and societal attention directed towards ethnic minority young people is overwhelmingly negative, focusing on individual and community deficits rather than structural disadvantage. For example, popular perceptions, and media and policy portrayals, depict Black and Muslim young men as dangerous and deviant. These negative stereotypes legitimise their harsher treatment, and dismiss their caring roles, affective ties and community cohesion.

Cultural racism also pervades the Islamophobia to which young people in many Northern towns are commonly subjected and frequently remark unacknowledged in work to address ethnic inequalities, reflecting the international experience of children and young people from Muslim minorities. Muslim girls and young women are overwhelmingly portrayed as down-trodden and backward.

Cultural racism is also perpetuated via schools. African-Caribbean young women constructed as ‘inadequate learners and devalued femininities’. Such narratives perpetuate inequalities and legitimise inter-personal racism and differential treatment.

South Asian parents in the North have been found to express fears regarding their children’s developing identity and sense of belonging in the face of such negative narratives. Runnymede Trust’s “Reframing race project”, launched in 2019, seeks to reframe the public perception around British Asian and young people from minority ethnic backgrounds, race, racism and racial justice, challenging negatives and foregrounding the assets and successes of ethnic minority communities.

Activities that nurture a sense of belonging and pride in ethnic identity and heritage are important for developing community resilience and resistance. Recognition of the role of faith communities in engaging with communities and acting as a trusted source of information, leadership and engagement is needed to promote social cohesion.

Contact between children and young people from different ethnic groups is another important factor in increasing social cohesion, promoting good community relations and reducing cultural racism – though how to achieve and sustain this effectively remains underdocumented.

Sport is one mode of drawing children and young people from different ethnic backgrounds together and promoting health. There are several positive Northern initiatives, such as the Unity Gym Project in Sheffield and Rotherham United Community Sports Trust.

Structural (or institutional) racism refers to the processes of racism that are embedded in laws, policies, and practices of institutions that provide advantages to White ethnic groups and differentially oppress, disadvantage, or neglect the needs of ethnic minority groups.

Recognising structural racism means acknowledging that racism persists within institutions even when individuals themselves are not explicitly prejudiced.

Structural racism has multiple dimensions and leads to disadvantage in areas such as employment, education, housing, health, criminal justice, and social cohesion. This can exacerbate the effects of racism that individuals experience and can perpetuate social disadvantage.

Race inequalities are often perpetuated by societal structures that uphold power dynamics and reproduce racial hierarchies. These systems can be difficult to challenge, and may require systemic change to address.

The disproportionate rates of exclusions experienced by some ethnic minority pupils, particularly Black Caribbean (4.0% for temporary exclusion in 2018/19), Mixed White/Black Caribbean (0.7%), Irish Traveler (0.6%) and Gypsy/Roma (0.2%) compared to White British (0.6%) are a huge cause for concern given the variety of negative outcomes that ensue. This persistent inequality demands attention to the systemic racism that is embedded in society and that must be addressed through policy and practice.

There is extreme concern among pupils, parents and teachers regarding the resilience of police-school partnerships, which has
Dental health issues for ethnic minority children and young adults.

Tooth decay and its effects pose significant health and well-being challenges for British children. Children from ethnic minority communities are more likely to experience tooth decay, with Gypsy/Romani traveller children most affected (5.9%)289.

Dental extractions are the leading cause of hospital admissions amongst UK children aged 5-9 years, with children from deprived communities four times more likely to have tooth extraction283. The prevalence of tooth decay amongst 5-year-old children varies regionally and is highest in the North West (37%) and lowest in the South East (27%) at a local authority level. Over half of 5-year-olds (59.6%) in Blackburn and Darwen experience tooth decay when compared with 11% in Hastings, East Sussex.

Ethnic minority children experience greater levels of decay on front present teeth compared to White children; and ethnic minority children are more likely to experience tooth decay, with Gypsy/Romani traveller children most affected (5.9%)289.

Policy and practice have not responded well to the dental health needs of ethnic minority children. Dentistry’s prevention approaches have been shown to target working-class and ethnic minority mothers by assuming a knowledge and skills deficit296,297. Little attention is paid to how intra-household dynamics, poverty, and racism, may compound child dental health needs. National public health policy has recognized the complex inter-relationships between dental health, underweight and nutritional needs.

Due to additional COVID-19 control measures, and social distancing guidelines, access to dental care at the high-street dentist and hospitals declined by around 50-75%, leaving vulnerable children waiting in pain longer. An estimated nine million children missed out on dental care285,286.

That said, the evidence available paints a worrying picture of persistent socioeconomic disadvantage underpinned by systemic racism and life-long structural and curated inequalities, particularly for some ethnic minority groups. Evidence also points to a worsening situation during the COVID-19 pandemic and recovery phase, and a continued lack of policy attention to ethnic injustices.

Recommendations

Know your population

Over-arching

- Develop and sustain adequately resourced and evidence-based approaches to child and young person-led policymaking, with representation of roles with power (93.4%) of ethnic minority groups, including representation in leadership roles, at national, regional and local level.

National

- Retain and more widely promote the Race Disparity Audit. Expand it to include a greater focus on children and disaggregated data by region.

- Ensure a focus on children’s health within the NHS Race and Health Improvement Plan with particular attention to interactions between ethnic and regional disadvantage, and between ethnic and religious discrimination.

- Develop systems to include ethnicity in all national public health data collection systems, including Child and Maternal Health datasets and products. Inclusion of Gypsy, Traveller and Roma populations within such systems is important, given the high levels of inequity that existing data demonstrate.

Local

- Improve Joint Strategic Needs Assessments and their impact.

- Make better use of existing data on ethnicity.

- Ensure commissioning and service responsiveness to ethnic inequalities, with effective monitoring, incentives and penalties.

- Develop new systems to routinely collect and report ethnicity data.

- Demand data broken down by ethnicity from all partners and link this to service level agreements.

- Routinely collect and report data on race. Link this to mechanisms for promoting anti-racist practice in public and community services.

- Co-create safe spaces for active listening and meaningful involvement of children and young people from ethnic minority backgrounds, so they have an opportunity to share their lived experience and be heard, and whose health and wellbeing are informed by their insights and experiences.

- Develop the infrastructure and partnerships required to improve the collection of data on health and healthcare use and outcomes for ethnic minority populations.

Community groups and voluntary organisations have challenged injustices and led the way on providing information and resources to those whose exclusions has intensified during the pandemic. Pressure to address injustice came from the voluntary sector, professional groups and academics. Publication of a well-researched report, commissioned by Public Health England, was initially suppressed by the government and only released after considerable pressure.

These pandemic events demonstrate the persistent lack of attention to racism and disadvantage amongst pregnancy care across pregnancy and early years (see Chapter 3), child mental wellbeing (see Chapter 10 for further discussion of meaningful participation of children and young people) and oral health.

Address socioeconomic deprivation

Over-arching

- Embed Equity ImpactAssessments into all COVID-19 recovery and future policy processes relating to socioeconomic deprivation at national, regional and local levels to identify, understand and address differential impacts by ethnicity.

National

- Address evidence on the needs of ethnic minorities within all COVID-19 recovery programmes.

- Reinvest the Universal Credit uplift.

- Recognise the child benefit uplift.

- Since the Health and Social Care Bill was announced, the McGregor-Smith report has been commissioned to tackle labour market discrimination, particularly in publicly funded institutions.

- Implement a real Living Wage and improve workers’ rights across all sectors.

Local

- Provide sustained funding and support to initiatives that are grounded in local communities with meaningful involvement of ethnic minority children and young people; evaluate and share learning.

- Embed local systems and processes of decision-making to give effect to ethnic minority children, young people and families a living, rather than a marginal, role.

- Ensure all publicly funded services including schools have strong anti-racist policies that set out clear actions and commitments to anti-racism across all partner organisations.

Embed ethnic equality into public services

Over-arching

- Increase representation of ethnic minority staff within public services and in decision-making processes, particularly in leadership positions; to reflect the populations served e.g. national and regional strategic boards and local Health and Wellbeing Boards.

- Develop and support workforce allocations that target inequalities and discrimination; enhance accessibility and responsiveness of services; and improve outcomes298.

- Explicitly acknowledge racism as a determinant of health and healthcare outcomes and embed action on ethnic inequality across the commissioning cycle.

- Embed high quality Equity Impact Assessments and Health Equity Audits into all national and local health and social care strategies and initiatives to shape design, delivery and ongoing evaluation and improvement.

- Ensure that race equality is part-and-parcel of all health inequalities policy and practice.

Local

- Invest in capacity building and collaboration with communities. Seek out community-led responses to chronic and acute public health crises that too often go unrecognised and un(der) funded.

- Use the move towards Integrated Care Systems outlined in the NHS Long Term Plan and Health and Care Bill 202122 as an opportunity to cross-sector working including local authorities, NHS services and community organisations to tackle ethnic health inequalities and racism.
Regional differences in economic performance pre-COVID-19

There is a well-known ‘productivity gap’ between the North and the rest of England. It has been estimated that productivity within the Northern regions is £4 per person-per-hour lower than in the rest of the country[1]. This productivity gap costs the UK economy around £44bn a year. Figure 9.1 plots the average productivity – measured by Gross Value Added – for the North and the rest of England from 2010 to 2018, with linear prediction up to 2025.

Productivity in the North is consistently well below the rest of England, and this ‘productivity gap’ is predicted to grow, rather than shrink. In this chapter we outline how the productivity gap has its origins in the relatively poor health of children in the North. Socioeconomic conditions for families have a profound impact on child health and development, impacting children’s ability to grow up to be healthy, productive adults in the future.

In 2018 ‘Heath for Wealth’ report, the Northern Health Science Alliance found that improving health in the Northern regions would reduce the regional gap in productivity by 30%, or £20 per person per hour, generating an additional £13.2 billion in UK Gross Domestic Product. In this chapter we outline the relationship between the health of children and economic productivity in adulthood[10].

Regional differences in economic performance during COVID-19

Two more recent reports by the Northern Health Science Alliance showed that these regional inequalities grew during the pandemic, with the North experiencing higher unemployment rates (Figure 9.2) and a reduction in wages (Figure 9.3)[16,62].

Previous chapters in this report have demonstrated the relationship between family socioeconomic circumstances and various aspects of child health (see Chapter 2), and how rising unemployment and family poverty are damaging to child health, particularly mental health (see Chapter 4).

Figure 9.4 shows the percentage change in gross weekly pay between 2019 and 2020. Throughout large areas of the North, pay reduced considerably. Table 9.1 displays the percentage change in gross weekly pay at regional level. Males living in the North of England saw a slight increase in pay between 2019 and 2020 – an average pay of males fell by 2.4%. Females living in all three Northern regions and the rest of England.

This too is likely to have resulted from a disruption in the education and training pathways of children and adolescents due to the pandemic. However, it is also important to note that, in the absence of urgent intervention, later in the chapter we show that worsening child mental health over the pandemic could have long-term negative impacts on labour market outcomes. We estimate a wage reduction of 0.5%-0.7% for males and 1.9%-2.3% for females, in the North of England. In comparison, we estimate a wage reduction of 0.4%-0.5% for males and 0.7%-0.8% for females, in the rest of England.

Chapter 6 highlights how the interruption to in-school learning during the pandemic has led to a widening of the attainment gap between advantaged and disadvantaged pupils, and, given the concentration of deprivation in the Northern regions, between the North and the rest of England.

Increased prevalence of mental health problems, in part driven by rising child poverty, is likely to have a lasting negative impact on important life outcomes[316-320]. We model these expected long-term effects, in the absence of urgent intervention, later in the chapter.

We show that worsening child mental health over the pandemic could have long-term negative impacts on labour market outcomes. We estimate a wage reduction of 0.5%-0.7% for males and 1.9%-2.3% for females, in the North of England. In comparison, we estimate a wage reduction of 0.4%-0.5% for males and 0.7%-0.8% for females, in the rest of England.

Regional differences in health and economic productivity increase during COVID-19

Productive adults have long-term positive impacts on labour market outcomes. Higher educational attainment, training and work experience and youth unemployment 321-325.

Policies to control the spread of COVID-19, such as social distancing and school closures, have acted as a negative shock to cognitive ability, non-cognitive skills and health all three capabilities. In particular, the growing isolation and uncertainty caused by the COVID-19 pandemic has led to an increase in mental health problems among children and adolescents (see Chapter 4). In the short term, such negative health impacts are likely to hinder the development of both cognitive and non-cognitive ability. In the long term, this increased prevalence of mental health problems, in part driven by rising child poverty, is likely to have a lasting negative impact on important life outcomes[316-320]. We model these expected long-term effects, in the absence of urgent intervention, later in the chapter.

We show that worsening child mental health over the pandemic could have long-term negative impacts on labour market outcomes. We estimate a wage reduction of 0.5%-0.7% for males and 1.9%-2.3% for females, in the North of England. In comparison, we estimate a wage reduction of 0.4%-0.5% for males and 0.7%-0.8% for females, in the rest of England.

This too is likely to have resulted from a disruption in the development of both cognitive and non-cognitive skills[1]; with, once again, potential lasting negative impacts on labour market outcomes.

There is ample evidence that child cognitive ability is an important predictor of labour market outcomes, including earnings, occupation, work experience and youth unemployment 321-325. We also know that individuals with better non-cognitive skills in childhood and adolescence are rewarded in the labour market in adulthood 321,322,324,326-330. We model the expected long-term labour market effects of an increase in the attainment gap resulting from the pandemic. We show that, in the absence of intervention, the learning loss in the North of England is likely to lead to a 17.2% reduction in wages for males, and a 22.7% reduction in wages for females. This is comparatively higher than the potential wage reduction in the rest of England (10.1% for males and 13.1% for females) due to a wider attainment gap in the North of England.

The negative shock to all three key capabilities resulting from the pandemic is likely to have a disproportionate impact on the most vulnerable children (see Chapter 7). Children in care or those in an unstable living environment are likely to be worst affected 331. We also know that adverse childhood experiences can have a significant obstetric impact on key capabilities 332-334. Children exposed to abuse and neglect as a result of the lockdown are also likely to face disproportionate long-term impacts on their life outcomes.
The association between child health and economic performance at local authority level

Healthy children are much more likely to go on to live longer, happier, healthy, and fulfilled lives. Healthy children have been shown to be more likely to obtain good grades, be in employment, and earn higher salaries[334].

Having outlined the evidence on how children’s health and cognitive and non-cognitive skills in early life affect labour market outcomes over the lifecycle, we now demonstrate that measures of child health are contemporaneously associated with economic performance at upper-tier local authority-level within England.

We measure the economic performance of local authorities using Gross Value Added. This is a sub-national measure of productivity and is reported at local authority level by the Office for National Statistics[335]. We use data from 2018, and we use population counts to calculate Gross Value Added per-head. We consider three measures of child health or performance, each from a different stage of childhood.

First, we consider the rate of premature births (less than 37 weeks gestation, expressed as a rate per 1,000 of all births)[336]. In longitudinal studies shorter gestational duration even within the term range is associated with poorer socioeconomic outcomes in adulthood, including education, income and likelihood of claiming welfare or disability benefits[337]. Figure 9.5 shows that there is a strong negative association between premature birth and Gross Value Added per-head, indicating that local authorities with a higher rate of premature births typically experience lower economic productivity. A 10 percentage point reduction in the rate of premature births of 10 per 1,000 births is associated with an increase in Gross Value Added per-head of £2,727 (95% CI £760 to £4,690).

Second, we consider the percentage of reception-aged children (4-5 years of age) who are overweight or obese[152]. Figure 9.6 shows that there is a strong negative association between this and Gross Value Added per-head, indicating that local authorities with a higher prevalence of overweight and obese young children typically experience lower economic productivity. A 10 percentage point reduction in the percentage of reception-aged children who are overweight or obese is associated with an increase in Gross Value Added per-head of £10,786 (95% CI £5,139 to £16,432).

Third, we consider the percentage of children who achieve five or more GCSEs at grade A*-C (including English and Maths)[338]. Figure 9.7 shows that there is a strong positive association between this and Gross Value Added per-head, indicating that local authorities with a higher percentage of children doing well in their GCSEs typically experience higher economic productivity. A 10 percentage point increase in the percentage of children who achieve five or more GCSEs at grade A*-C (including English and Maths) is associated with an increase in Gross Value Added per-head of £4,241 (95% CI £1,342 to £7,141).

The charts show that there are important associations between child health and the overall economic performance of local authorities. Poor health in childhood may impact adult life chances through multiple pathways, including through impacts on early development, and through ill health, leading to school absence, family stress and social isolation, with subsequent impacts on attainment and labour market transition.

The learning loss in reading was 1.9 months in the North of England and 1 month in the rest of England.

The learning loss in Maths was 3.8 months in the North of England and 2.4 months in the rest of England. Taking an average over the reading and Maths learning losses, we estimate that the overall learning loss was 2.9 months in the North of England and 1.7 months in the rest of England. Evidence suggests that an extra year of education results in a 7%-9% labour market return for males and 9%-11% labour market return for females[334].

We estimate that in the absence of urgent intervention, the widening of the attainment gap will result in a 1.7%-2.2% reduction in wages for males in the North of England and a 1.0%-1.3% reduction in wages for males in the rest of England. This increases to a 2.2%-2.7% reduction in wages for females in the North of England and a 1.3%-1.6% reduction in wages for females in the rest of England.

There are large regional inequalities in the degree of learning loss, with the North East and Yorkshire and Humber suffering the greatest learning loss. We estimate that in the absence of intervention, the widening of the attainment gap will result in a wage reduction of 2.6% for males in the North East of 1.8%-2.3% for males and 2.3%-2.8% for females. In Yorkshire and the Humber, we estimate that the widening of the attainment gap will result in a wage reduction of 2.0%-2.6% for males and 2.6%-3.2% for females.

The most up-to-date estimates of average future lifetime earnings reported by the Office for National Statistics are from 2018[339]. The estimated reductions in earnings will be much larger in reality. However, the relative difference between the North and the rest of England is likely to stay the same in the absence of urgent intervention. From Figure 9.8, as children move into adulthood, males in the North will lose 70% more in lifetime earnings than males living in the rest of England (£12,534 compared to £7,392). Females living in the North will lose 69% more than females living in the rest of England (£9,314 compared to £5,513).

The Child of the North: Building a fairer future after COVID-19

Gestational duration, expressed as a rate per 1,000 of all births

Figure 9.5. The association between the rate of premature births per 1,000 births and Gross Value Added (GVA) per-head.

Figure 9.6. The association between the percentage of children aged 4-5 years (in reception) who are classified as being overweight or obese, and Gross Value Added per-head.

Figure 9.7. The association between the percentage of children who achieve five or more GCSEs at grade A*-C (including English and Maths), and Gross Value Added per-head.
Given population estimates of children aged 5 to 16, this is equivalent to £24.6 billion in lost wages in the North (£14.4 billion for males and £10.2 billion for females).

Preliminary figures on the attainment gap for the whole of England for the spring term suggest a further widening of the attainment gap resulting from the 2021 lockdown. This suggests that the above figures may be an underestimate of the true impact of the COVID-19 pandemic on future labour market outcomes.

**Mental health**

There is strong evidence that poor child and adolescent mental health in particular is linked with poorer subsequent academic and labour market outcomes\(^{343}\). Chapter 4 outlines the inequalities in children’s mental health outcomes between the North and the rest of England, as well as the considerable and unequal rise in mental ill health as a consequence of the COVID-19 pandemic.

Given the evidence presented in that chapter and other evidence indicating that a 10% increase in depressive symptoms is associated with a 2.4 fewer months of education\(^{344}\), we estimate that the worsening of mental health during the pandemic will result in an average of 0.9 fewer months of education for boys in the North of England and 0.6 fewer months of education for boys in the rest of the England.

For girls, we estimate that in the absence of intervention, those in the North will complete on average 2.5 fewer months of education, compared to 0.9 months in the rest of England. This equates to a wage decrease of 0.5%-0.7% for males in the North of England and 0.4%-0.5% for males in the rest of the England. This increases to 1.9%- 2.3% for females in the North of England and 0.7%-0.8% for females in the rest of the England.

We can apply the same methods outlined above to calculate a conservative estimate of the potential loss of lifetime earnings (Figure 9.9). As children grow into adulthood, males in the North will lose 180% more than females living in the rest of England (£7,996 compared to £2,856). Given population estimates of children aged 5 to 16, this is equivalent to £33.2 billion in lost wages in the North (£4.4 billion for males and £8.8 billion for females).

Chapter 4 presents trends in the present chapter and other evidence indicating that a 10% increase in depressive symptoms is associated with a 2.4 fewer months of education\(^{344}\), we estimate that the worsening of mental health during the pandemic will result in an average of 0.9 fewer months of education for boys in the North of England and 0.6 fewer months of education for boys in the rest of the England.

A Strengths and Difficulties Questionnaire score, commonly used measure of children’s mental health and wellbeing, indicates a mental health problem\(^{342}\). Chapter 4 outlines the inequalities in children’s mental health outcomes between the North and the rest of England, as well as the considerable and unequal rise in mental ill health as a consequence of the COVID-19 pandemic.

The estimates in this chapter suggest that wages in the North will fall further behind those in the rest of the county, for both males and females. Urgent intervention is needed to prevent these regional inequalities widening any further.

### Policy recommendations

To mitigate the negative impacts of the COVID-19 pandemic on economic productivity, and address the wide and growing inequalities between the North and the rest of England, we have the following policy recommendations:

- **Increase investment in the systems that support the health of children, particularly those living in deprived areas and those most affected by the COVID-19 pandemic across welfare systems, health and education.**
- **Offer greater support for children’s educational development in the post-pandemic years to “make-up” for lost development of cognitive and non-cognitive skills via enhanced funding to early years services, children’s centres and schools in most deprived areas.**
- **Invest in intensive multi-component employment interventions to an average lifetime income of £31,840 for those in the North of England and an average lifetime loss of £9,460 for those in the rest of England.**

**Implications for regional inequalities**

Given that economic performance and wages in the North are already lower than in the rest of the county, the findings outlined in this chapter are worrying. Yet again, it appears that the North of England will take the largest financial hit, both now and well into the future. The estimates in this chapter suggest that wages in the North will fall further behind those in the rest of the county, for both males and females. Urgent intervention is needed to prevent these regional inequalities widening any further.

### Public heath

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**Implications for regional inequalities**

Given that economic performance and wages in the North are already lower than in the rest of the county, the findings outlined in this chapter are worrying. Yet again, it appears that the North of England****
The Child Friendly Cities Programme.

A good example of how the UNCRC is used as a framework to effect regional change is the UNICEF Child Friendly Cities Programme. This programme, which was launched in 1996 in Scotland, is now being applied by over 100 cities worldwide, supports local governments and organisations in realising the rights of children at a regional level.

The principles guiding the development of a child friendly city mirror the overarching principles of the UNCRC: children’s rights should be upheld without discrimination (Article 2); the best interests of the child should be a primary consideration (Article 3); local governments should be committed to ensuring children’s rights to life, survival and healthy development (Article 6); children have the right to voice and have their opinions taken into account in decisions that affect them (Article 12).

Building a child friendly city also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It demands a consultation with children and young people who are likely to be affected by the proposed measures.

The panel ‘The Child friendly Cities Programme’ above illustrates how notwithstanding any legal incorporation of the UNCRC into English law, there are case studies and successful programmes for grounding localised planning in global children’s rights standards.

2. Assessing the impact of legal and policy changes on children COVID-19 has demanded urgent changes to law and policy — not least in the field of education and social care — which have radically altered the way that children were being delivered. A children’s rights-based approach demands that any legal and policy changes, even in times of emergency, should be scrutinised in advance to ensure they will respond to children’s needs appropriately, or at least not adversely affect children.

A key mechanism for achieving this is through routine Children’s Rights Impact Assessments (CRIA)364. Children’s Rights Impact Assessments is a key mechanism for achieving this is through routine Children’s Rights Impact Assessments, and, most notably by the Court of Appeal in the case of Children’s Rights Impact Assessments, therefore, was that the Scottish Government should further develop the National Performance Framework to create a more cohesive and systematic approach to data collection and evaluation that is based on agreed indicators related to all rights guaranteed to children. It also recommended that these be developed with the active involvement of children and young people.

A key recommendation arising from the Children’s Rights Impact Assessments, therefore, was that the Scottish Government should further develop the National Performance Framework to create a more cohesive and systematic approach to data collection and evaluation that is based on agreed indicators related to all rights guaranteed to children. It also recommended that these be developed with the active involvement of children and young people.

3. Routine and meaningful participation of children and young people in decision making

Any COVID-19 recovery plan, if it is to respond effectively to the interests and needs of children, needs to be directly informed by children’s views and experiences. The importance of the right of the child to be consulted in all matters affecting them, as recognised in Article 12 of the UNCRC, extends beyond individual decisions to those with a collective impact, many of which are taken at local government level.

A recent study, on the impact of the pandemic on children’s lives, captured the views of 26,258 children across 137 countries (see Chapter 9). The study emphasises that engaging directly with children’s voices, to advocate connecting to children and their families by making use of education settings as a starting point, has the potential to be a powerful tool for understanding the perspectives of ethnic minority children, whose views are routinely overlooked, to the detriment of policy.

Engaging directly with children also requires us to present the issues and frame the debates in ways that are accessible to them, in accordance with Article 12 of the UNCRC. There are good examples of how local agencies have included the voices of children in decision making across the North during the course of the pandemic, including the responses of education settings in Bradford that were brought together for a ‘Pandemic Recovery Summit’ in early 2021.

Efforts must be made, for example, to produce legal and policy information of direct relevance to children in a format and medium that is accessible. Children need to understand not only what their rights are in the abstract, but how they are and could be realised in practice.

COVID-19 impact assessments in Scotland.

A much more meaningful model of Children’s Rights Impact Assessment (CRIA) in Scotland, which was launched in 1996, is that the exercises brought together for a ‘Pandemic Recovery Summit’ in early 2021.

For example, the decision to enable 12–15-year-olds across the UK to self-consent to COVID-19 vaccination will only be effective and meaningful if accompanied by child-focused information on children’s legal rights to consent to their own health treatment and on the human rights and benefits associated with vaccination357.

4. Public budgeting grounded in children’s rights

A particularly important feature of a children’s rights-based approach is the need to consider children’s rights in all budgetary decisions. This goes beyond simply ear-marking money for child-specific areas such as education and child protection.

Rather, it demands a routine consideration of all budgetary decisions affecting children, requiring that spending on children be made explicit in all budgets, and that children be consulted in budgetary decision-making.

The UN Committee on the Rights of the Child underscores the importance of children’s rights budgeting in the following statement: “The Committee reiterates that prioritizing children’s rights in budgets, at both national and subnational levels, as required by the Convention, contributes not only to realizing those rights, but also to long-lasting positive impacts on future economic growth, sustainable and inclusive development, and social cohesion”.

Sophisticated conceptual and methodological frameworks around children’s rights budgeting and resource allocation have been developed, including practical tools for involving young people in economic policy369. Importantly, serious insurges have been made at a regional level to apply children’s rights budgeting methods.

Conclusion

The impact of the COVID-19 pandemic on children will be felt for years to come. Engaging with children’s voices in pandemic recovery planning, and embedding a children’s rights-based recovery planning, will ensure that children’s voices are heard not just in the recovery plan, but for the next generation.

The growth of understanding around the importance of involving children in decision-making, around ensuring children’s rights are considered, systematically and holistically, and around cultivating a solid evidence base for the impact of local policy on children, has stimulated a range of conceptual and methodological frameworks to support this aim.

While fidelity to children’s rights in local strategic planning requires that resources be devoted to young people at a time when budgets are strained, there is also a growing body of evidence that this economic outlook early on in a child’s life is a sound investment that yields benefits for society more generally (see Chapter 9).
The COVID-19 pandemic has changed the lives of children across the world. Some of the short-term impacts, including the exacerbation of pre-existing inequalities, are documented in this report. The long-term effects, some of them unpredictable at this time, will unfold well into the future.

Children and young people have experienced profound changes in their daily routines and education, many of them in families that have experienced destabilising losses – of work, income and loved ones.

They are growing up in a world hampered by other crises and upheavals: the climate emergency, massive biodiversity loss, other pandemics, including pandemics of mental illness, obesity and disease caused by air pollution; and the rapidly evolving influence of automation and technology on traditional careers and employment expectations.

Throughout the preceding chapters, we have focused, as a collaboration of Northern academics and experts in child wellbeing, on the impact of the pandemic on the North of England. But all of the lessons of the report, and all of the recommendations we make to reduce inequalities and improve the lives of children and young people, can be applied across the regions and constituent countries of the UK and beyond.

If we are serious about ‘levelling up’ the life chances of all children and young people held back by inequalities, then this report can be a beacon for change beyond the North of England. Similarly, although time and space constraints prevent us from devoting chapters to all groups of children and young people who might have special or additional needs, our policy recommendations are broad and deep enough that, if enacted in timely fashion and at scale, they could profoundly improve the health, wellbeing and life chances of all children.

The world we once knew, that was filled with colour and light, abruptly turned colourless and dull.

Children are the living messages we send to a time we will not see.

John F. Kennedy

CONCLUSIONS

Authors: Kate Pickett, Davara Bennett, Kate Mason, Hannah Davies, Stephen Parkinson, David Taylor-Robinson

Schools Pandemic Recovery Summit 2021: Our Manifesto

1. Listen to our voice before you form policy because we know what effect that policy will have.
2. Make mental health support for young people a priority in schools and in the community too. Explain how we access it and act quickly.
3. Don't lose the benefits of technology and learning at home that we have gained through the pandemic.
4. Make clear your plans to help us make up for lost learning.
5. Listen to us before you decide how to help us with the uncertainty surrounding exams and assessments this year and next.
6. Hear us when we say it’s not all about lost learning, we’ve lost social, cultural and sporting opportunities too. We must make up for this too.
7. We are not all the same but we all want the same chances. Help us to eradicate the effects of disadvantage and poverty. This begins with simple stuff: making sure everyone has food, security, heat, the best uniform, school supplies, and technology.
8. Know that we suffer the effects of racism and help us to eradicate it.
9. Always tell us what you are doing for us and why. And remember to do this forever.
10. Make this the beginning of a brighter future for us all, one filled with colour and light.

Source: https://www.bardoottrust.org/schools-pandemic-recovery-summit/
It is deeply troubling that children in the North have been more vulnerable to the impact of the pandemic. Just as it is troubling that, even before COVID-19, children in the UK were less resilient, and had worse health, wellbeing and educational attainment than children living in other rich developed countries – they should have been.

The COVID-19 crisis has brought into sharp relief the pre-existing vulnerability of too many Northern children to the policies, politics and practices that perpetuate inequality. 'Levelling up' for the North must be as much about building resilience and opportunities for these future children and generations as it is about building roads, railways and bridges.


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