

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



EXECUTIVE SUMMARY

60 second summary

Children in the North are more likely to live in poverty than those in the rest of England – and increasingly so. Poverty is the lead driver of inequalities between children in the North and their counterparts in the rest of the country, leading to worse physical and mental health outcomes, educational attainment, and lower lifelong economic productivity.

The COVID-19 pandemic has made this situation worse. Although the full impact is not yet known, modelling suggests that, without intervention, the outlook is bleak. To address the North-South productivity gap we must tackle the stark inequalities evidenced in this report, put in place a child-first place-based recovery plan, and enable the children of the North to fulfil their potential.

Who is the Child of the North today?

The Child of the North has a

27%

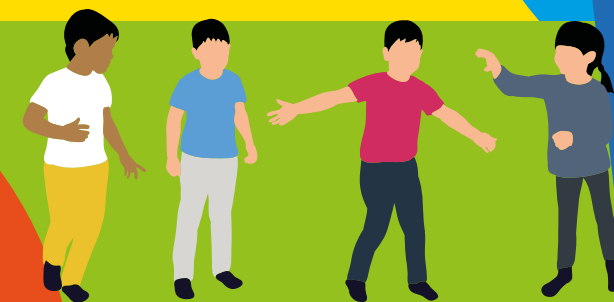
chance of living in poverty compared to **20%** in the rest of England.

They have a

58%

chance of living in a local authority with above average levels of low-income families, compared to **19%** in the rest of England.

Compared to children in England as a whole, they are more likely to die under the age of one.



In the first lockdown there was a massive drop-off in nursery and childcare services for eligible children, with only **7%** continuing to attend. Attendance has a range of benefits for children's health and development, particularly for deprived children. **Because the North is more deprived as a whole,** North-South inequalities in children's development are expected to increase.



The Child of the North is more likely to be living with obesity than a child elsewhere in England.

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 lost wages over their lifetime earnings.

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.**

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.

Children in the North are significantly more likely to be in care than those in the rest of England. **Of the local authorities with more than 100 children per 10,000 in care, 21 of 26 are in the North.**

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.

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

in lost wages over their working lives.

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 writ 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 Humber 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 England.

■ 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, 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 £412 per eligible child in the North, compared to only £283 in the rest of England.

■ Both relative and absolute poverty are expected to rise sharply in the North in 2021/22. Illness due to COVID-19 and long COVID, and job loss, are the primary causes of this projected increase.

■ 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, twice the pre-pandemic figure.

Pregnancy and Early Years

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 unintended 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.

The pandemic had a negative effect on new mothers in the UK. In the Northern City of Bradford, new mothers reported feeling low (56%), lonely (59%), irritable (62%), and worried (71%), during lockdown, 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.

Over the course of 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 maternal 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, 70% 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 93% (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 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 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.

Child mental wellbeing

The rise in mental health issues in the North over the course of the pandemic is of particular concern. Untreated 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 and can have substantial socioeconomic consequences.

The mental health of children and adolescents was deteriorating prior to COVID-19, but there was significant deterioration during the pandemic, particularly in the North of England.

There is an urgent need to ensure that schools and services can provide immediate intervention and continued support to children and 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.

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 Humber, 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 depression and stress 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 increased from 10% to 16%.

■ Referrals to urgent and emergency mental health crisis care have risen 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.

■ The COVID-19 pandemic has created particular risk factors for poor mental health among ethnic minority children, including disproportionately high rates of COVID-19 illness and mortality among ethnic minority communities, the heightened racist rhetoric around the spread of the virus, and family financial stress.

■ Some children and young people experienced positive aspects of lockdown, including spending more time with family, and becoming more independent and responsible. Whether or not children experienced lockdown as negative or positive depended on their family circumstances, their experiences of school, and to some extent their age, gender, and ethnicity.

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 Everybody Active, Every Day governmental report, physical inactivity costs the UK an estimated £7.4 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

■ Children in the North are more likely to be living with obesity at reception age: 10.7% of children in the North compared to 9.6% of children in the rest of England. By year six, or age 11, this has grown to 22.6% in the North compared to 20.5% in the rest of England.

■ In 2018/19, 45.6% of children in the North were reaching physical activity guidelines compared to 47.3% in the rest of England. In 2019/20 the figures fell to 43.7% and 45.3%, respectively.

■ Environmental inequalities reflect childhood obesity trends: socio-economically deprived and ethnically diverse areas have fewer green spaces for exercise that are perceived to be safe or accessible, and they have more takeaway outlets.

■ 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 (16%).

■ Tooth decay amongst five-year-old children varies regionally and is highest in the North West (31.7%) and lowest in the South East (17.6%). At a local authority level, over half of five-year-olds (50.9%) in Blackburn and Darwen experience tooth decay compared with 1.1% 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 11% in the North East and 10% 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 17% for the North East and North West respectively, compared to 11% in the South East, and 14% 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 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 of 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 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, schools’ 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 than the South (50% in Yorkshire and the Humber, 59% in the South 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 and North West experienced 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 Humber experienced 4.0 and 5.3 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, pressures 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 critical shortfalls 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 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 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.

Detailed findings

■ 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 97.4 in the North, compared to 61.8 in the rest of England.

■ 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; in Hartlepool, 158 per 10,000.

■ 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 social care. Children in care require help from health, welfare, education and justice services because they are more likely to have special educational needs, have mental health difficulties, experience school exclusion, be involved with youth justice and have experienced adversity and trauma.

■ The compounding costs are particularly challenging for areas in the North of England, where numbers of looked after children are very high.

■ In England, there are currently 12,175 registered children’s home places for children – but provision falls short of demand and availability is uneven across England. There are far more children’s homes in the North of England. Homes in the North provide placements for children from across the whole of England.

■ There are 952 children’s homes in the North of England, and just 1,426 children’s homes in the whole of the rest of the country. A far greater number of children with the most complex difficulties are placed in the North West in particular, where there is a greater availability of residential beds.

■ Because of the costs already tied to a large population of children in their care, local authorities in the North will struggle to re-direct funds to early family help.

Ethnic minority children and young people: health and wellbeing

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 deprivation is more strongly correlated with ethnic diversity in the North of England than it is in the rest of the country.
- There were around 1.4 times more low-weight births per 100 (8.4%) 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-weight births were around 12% higher in the most ethnically diverse neighbourhoods (8.4%) compared to 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 third of neighbourhoods that were the most ethnically diverse and the most deprived. On average, BMI was 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, in the North, there were fewer inequalities between ethnically diverse and homogenously white neighbourhoods in less deprived areas than there were in less deprived neighbourhoods in the rest of the country.
- 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.

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.

Detailed findings

- During the pandemic, the North experienced higher rates of unemployment than elsewhere, and a fall in median wages.
- Given the clear evidence of the impact of child health and development on employment chances and labour market outcomes at individual level, it is imperative that we improve the health of children at societal level: not only for the long-lasting impact on children’s lives, but also for the effect it is likely to have on the economy.
- There are strong associations between child health and economic performance: areas with better child health have higher 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.
- 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.
- Children in the North have experienced a bigger loss of learning during the pandemic. As a result, when these children move into adulthood, men in the North will lose an estimated 70% more in lifetime earnings than men living in the rest of England (£12,534 compared to £7,393). Women living in the North will lose an estimated 69% more than women living in the rest of England (£9,314 compared to £5,513). 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 men and £10.2 billion for women).
- Children in the North have also experienced a much larger increase in probability of reporting a mental health condition. This will have long-term consequences for their future economic performance. Men in the North will lose 33% more than men living in the rest of England (£3,856 compared to £2,892). Women living in the North will lose 180% more than women 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 £13.2 billion in lost wages in the North, £4.4 billion for men and £8.8 billion for women.

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.

An abundance of research demonstrates that the prioritisation of children’s rights, services and remedies from the very early stages of children’s lives is the best way to achieve positive societal change.

A COVID-19 recovery plan explicitly grounded in the obligations, values and processes associated with children’s rights has much to offer in mitigating the ongoing effects of the pandemic.

- The key features which can be used as a blueprint are:**
- A COVID-19 recovery strategy for the North grounded in children’s rights principles and provisions
 - The impact of legal and policy changes on children must be assessed
 - There should be routine and meaningful participation of children and young people in local recovery planning
 - Public budgeting should be grounded in children’s rights.

Child of the North key recommendations

This set of recommendations should form the basis of an action plan to build a fairer future for children of the North after COVID-19. Detailed recommendations are given at the end of each chapter.

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 service changes on 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.

8

NHS England and NHS Improvement and the Office for Health Improvement and Disparities should adopt a public mental health approach that includes a focus on mental ill health prevention early in the life-course, recognising the importance of early detection and prompt access to professional treatment.

9

Government should invest in and develop a place-based monitoring system for understanding the longer-term mental health impacts of COVID-19 pandemic on children and parents. Targeted support should then flow to families where needed, including outreach services more closely tailored to the needs of vulnerable parents.

10

Area-level measures of children's physical and mental health should be developed to better understand place-based inequalities.

11

More NIHR research should be undertaken into the relationship between child health and economic performance, in particular in understanding the likely causal pathways between these in order to identify entry points for policy.

12

Government should reinvest in services that tackle domestic abuse, recognising the part domestic abuse plays, not only in children entering care, but also in high conflict divorce and separation cases, which also feature disproportionately in the North.

13

Address the uneven geographic distribution of children's residential care, including secure provision, in order to reduce the disproportionate burden on the North. An impact assessment of the disproportionate costs to a range of services in the North due to the number of children with complex care and support needs, is needed and long overdue.

14

Embed Equity Impact Assessments in all COVID-19 recovery and other policy processes relating to socioeconomic deprivation at national, regional and local levels.

15

Use Children's Rights Impact Assessments to anticipate and evaluate the specific impact of COVID-19 recovery strategies on children and young people. Collect, disaggregate and publish relevant data so that the impact of the pandemic on children can be routinely evaluated.

16

Promote and expand the Race Disparity Audit, sharpening the focus on children and drawing on disaggregated data by region. Ethnicity should be included in all national public health data collection systems, including child and maternal health datasets.

17

Increase the representation of ethnic minority staff within public services and in decision-making processes with specific recruitment targets, recruitment campaigns and greater transparency on the percentage of ethnic minority staff. This should be particularly in leadership positions, in order to reflect the populations served.

18

Local COVID-19 recovery strategies must be grounded in internationally recognised human rights-based values and principles, notably those contained in the United Nations Convention on the Rights of the Child 1989.

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

"There can be no keener revelation of a society's soul than the way in which it treats its children."

Nelson Mandela (8 May 1995)

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 highest 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 Leeds¹. 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.

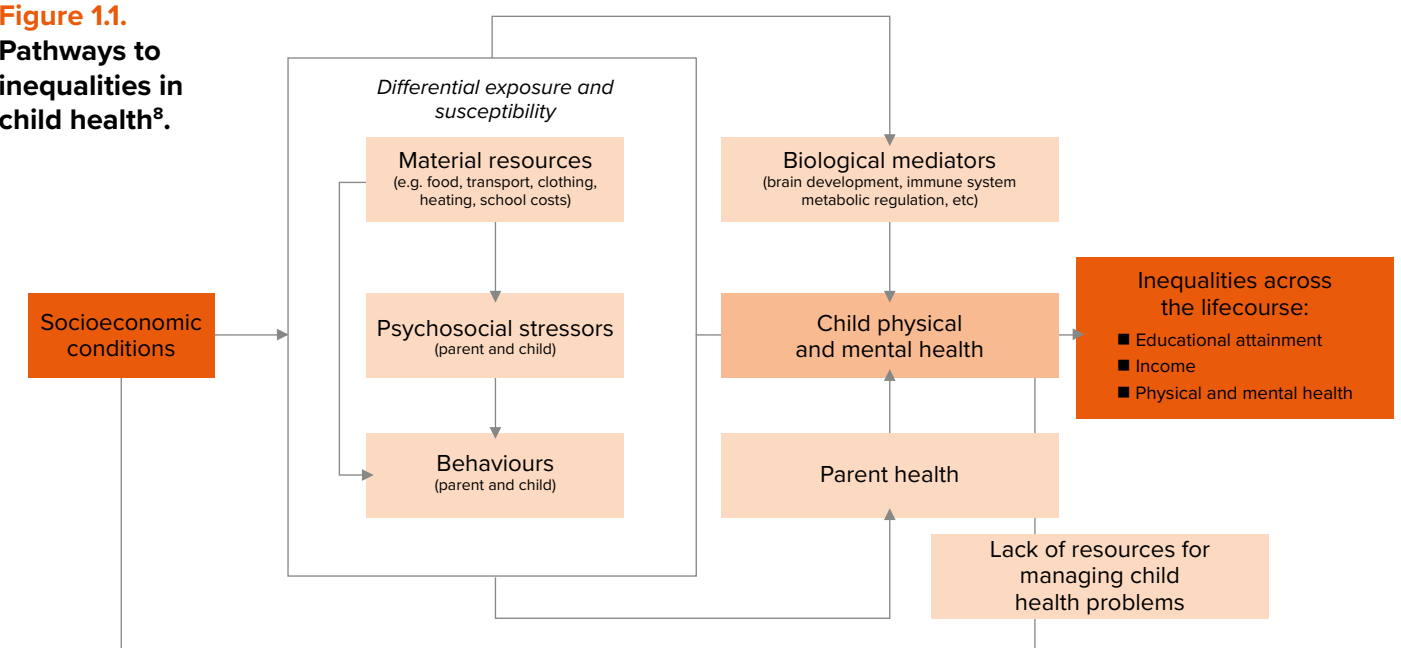
Children growing up in affluent areas of London and the surrounding home counties have the highest life expectancies. These huge inequalities in life expectancy were increasing pre-pandemic, with life expectancy actually falling for girls growing up in disadvantaged Northern communities, and in areas with pre-existing high levels of poverty and low life expectancy².

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 differently³. 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 life⁴.

Greater exposure to child poverty is a major cause of the North-South divide in children's life chances. The 1.05 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 1.1 shows the main pathways linking family socioeconomic 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 health⁵. 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 lifecourse, affecting the risk of many adult chronic diseases⁵⁻⁷. Material factors are important. The homes of children living in poverty are

Figure 1.1.
Pathways to inequalities in child health⁸.



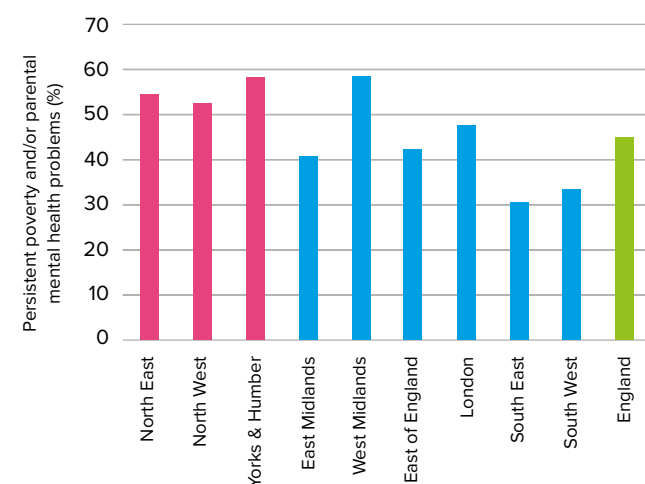
more crowded, noisier, and of lower quality than those of their peers who do not live in poverty.

Their neighbourhoods are more dangerous, the air they breathe more polluted. Children growing up in poverty have worse nutrition, are more likely to be hungry, have a less stimulating learning environment, more restricted access to books, computers, and school trips.

We know that poverty impacts family functioning and parental health and behaviour, which, in turn, affect child health. A recent study, using data from a nationally representative sample of thousands of children born in 2000, assessed the impact on children's health of childhood adversities that cluster with poverty³. The study shows that over 40% of children in the UK experience continuous exposure to either poverty and/or parental mental ill health.

These common exposures lead to large negative impacts on child physical, mental, cognitive and behavioural outcomes, for example increasing the risk of children developing mental health problems six-fold when both exposures are present. Figure 1.2 shows that these harmful exposures are very common, and much more so in Northern regions (55% overall), compared to the Southern regions (32% overall).

Figure 2.4. Persistent poverty and/or parental mental health problems up to age 14, by region.



Source: UK Millennium Cohort Study, analysis by Nicholas Adjei, University of Liverpool

The evidence in this report shows how, in recent times, austerity measures have made the situation worse, with the burden of local authority cuts and welfare reforms falling more heavily on disadvantaged rather than affluent areas, on the North rather than the South, and on more vulnerable population groups such as children (see Chapters 2, 3, 5, 7, 10). Research has shown that rising child poverty has contributed to rising inequalities in infant mortality¹⁰ and children becoming looked after¹¹; and how a reduction in local government spending has deepened inequalities in life expectancy at birth², childhood obesity¹² and adolescents becoming looked after in England. We know that these inequalities in childhood track into adulthood, significantly influencing morbidity and indeed mortality over the lifecourse¹³, driving unsustainable pressures on health and social care systems.

These trajectories of poor health stemming from childhood exposure ultimately explain differences in societal productivity, as outlined in Chapter 9. If we want to address the North-South productivity gap, we need to first address the health gap, which begins in childhood.

The COVID-19 pandemic hit in the middle of this pre-existing, slow-burning disaster for child health in the North, causing 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 develop¹⁴. 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 mental health problems, has fuelled a large increase in children's mental ill health. Latest estimates for 2020 show that one in six children (16%) in the UK have a mental health problem, an increase of six percentage points from 2018. The increase is likely to be, in part, a 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 fulfilled lives for future generations. The inevitable consequence of continued under-investment in children in the Northern regions will be a levelling down of skills, still-widening 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^{3,4,15,16}.

Overwhelming evidence supports the need for a 'lifecourse' 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 modifiable 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 poverty¹⁷, many of whom live in the North. Policy makers must guard against a new round of austerity measures falling disproportionately 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 universal services and a focus on proportionate universalism (services for everyone, but with a scale and intensity that is proportionate to the level of need), with a shift in investment towards the early years wherever possible. It is critical that we re-invest 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 net economic benefits. We can pay now, or we will pay more later for society's failure to promote the healthy development of children in the North.

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.

Child Poverty, Inequality and Deprivation

Authors: Jonathan Bradshaw, Sophie Wickham, Alexandros Alexiou, Calum Webb

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and the rest of England and the UK, focusing on the wide-ranging consequences of child poverty and the impact of changes in social security.

Child poverty in the UK

In 2019/20 there were 4.3 million children living in poverty in the UK after housing costs¹⁸. There are 400,000 more children living in poverty than there were in 2009/10, a significant reversal of a longer-term trend of falling poverty. All four official measures of child poverty show large increases in the proportion of children living in relative poverty (in households below 60% of the median income) and absolute poverty (in households below 60% of the 2010/11 median income, held constant in real terms), before and after housing costs, between 2009/10 and 2019/20 (Figure 2.1). Child poverty costs the UK an estimated £38 billion a year through loss of future earnings and tax receipts, benefits costs, and additional public and general spending¹⁹.

Figure 2.1. Child poverty rates in the UK, 1998/99 – 2019/20.

Source: Institute for Fiscal Studies historical data set on poverty and inequalities.

Child poverty in the North

The main source of government data on child poverty is the national annual Family Resources Survey, but in any single year the regional samples of households are too small to yield reliable estimates. To produce reliable estimates, three years must be combined. The most recent regional data are for the period 2017-2020 – child poverty data covering the pandemic period will not be published until 2022.

Figure 2.2 presents child poverty rates after housing costs over time, comparing the three Northern regions with the UK as a whole. From a high in the late 1990s child poverty rates in the North declined, falling faster than the UK rate. By the time of the global economic crisis, the North East and Yorkshire and Humber had rates close to or below the UK average. But from 2014/15 child poverty in the North began to rise again, and much faster in all the Northern regions than the UK as a whole, widening the gap once again. Between 2011/12-13/14 and 2017/18-19/20 the child poverty rate increased by 11 percentage points in the North East, and 6 percentage points in Yorkshire and Humber, compared to 3 percentage points for the UK as a whole. Based on these data, 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.

Figure 2.3 shows the percentage of children living in relative poverty by local authority in England. Poverty data here are taken from the Department for Work and Pension's Children in Low Income Families database. This provides annual statistics for each financial year on the number and proportion of children living in relative and absolute low income before housing costs by local area across the UK20. The map shows the proportion of children living in relative low-income households in England for the financial year 2019/20. There is a large concentration of children living in poverty in the Northern regions. Compared to the English average of 19%, 58% of local authorities

Figure 2.1. Child poverty rates in the UK, 1998/99 - 2019/20.

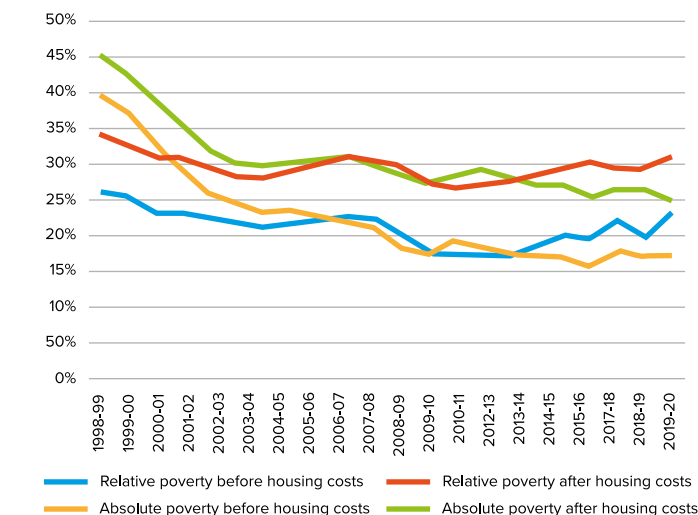
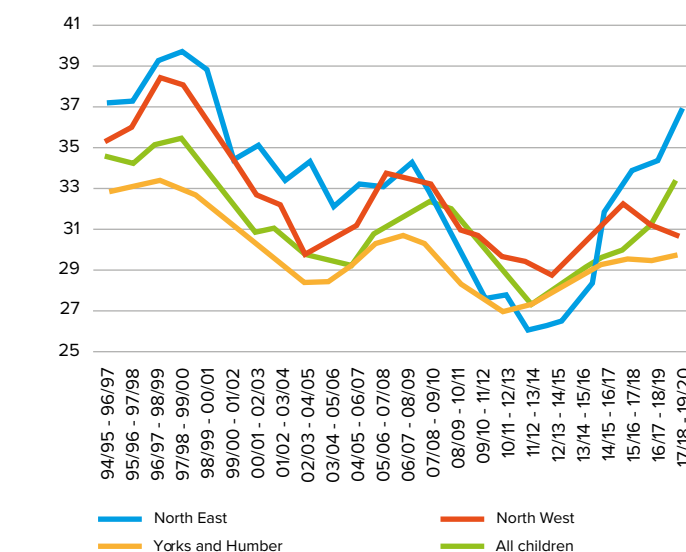


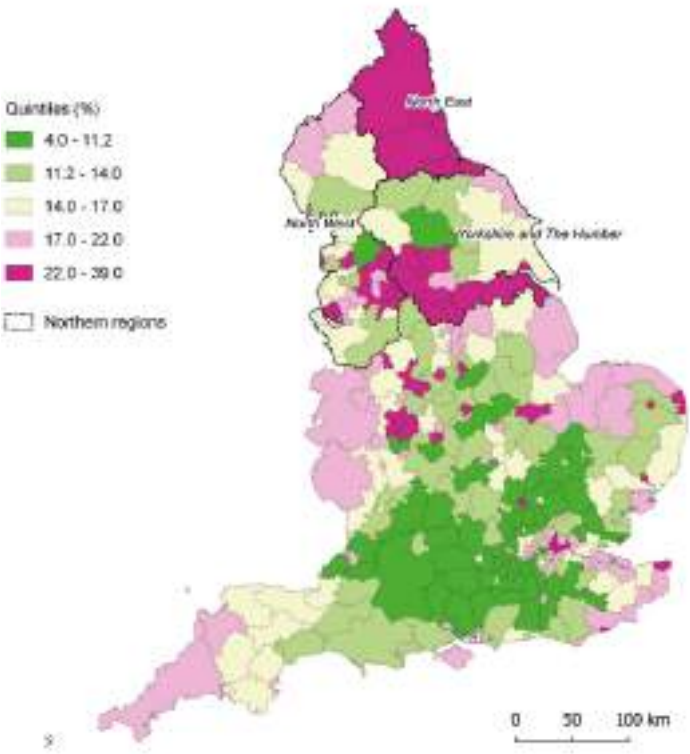
Figure 2.2. Trends in percentage of children in low-income households (<60% median household income) after housing costs.



within the Northern regions had above average levels of children in low-income households.

Figure 2.4 shows the relative child poverty rate by region using the average over the three years prior to the COVID-19 pandemic. The blue bars represent child poverty before housing costs and the orange bars child poverty after housing costs. Before housing costs, the North East has the highest child poverty rate at 30% and Yorkshire and Humber the third highest, after the West Midlands. After housing costs, the North East has the second highest rate at 37%, after Inner

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



London. This gap between measures of child poverty before and after housing costs illustrates the importance of housing costs for families' livelihoods.

The relative poverty measure based on income is sometimes criticised for being based on an arbitrary threshold of an income distribution, adjusted for household size and composition using a formula that has little basis in science, and not taking into account all unavoidable household costs. Figure 2.4 therefore also shows an alternative, and more direct, measure capturing low income and material deprivation (unable to afford key goods or services) by region for the same time period²⁰. Using this low-income and deprivation measure, the North East again has the second highest poverty rates after Inner London, at 17%. Yorkshire and Humber comes third, equal with the West Midlands.

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 2019²¹.

Figures 2.5, 2.6 and 2.7 show, within each upper-tier local authority in the Northern regions, the proportion of Lower Layer Super Output Areas that fall into the bottom 10% of these areas nationally on the Income Deprivation Affecting Children Index (IDACI). If the Northern region were comparable to England as a whole, this proportion should be 10%. Very few local authorities in the Northern regions meet that criterion. Indeed, in the North East, Middlesbrough has the highest proportion of Lower Layer Super Output Areas in the bottom 10% nationally (48%) and Hartlepool the third highest (43%). In the North West, Knowsley has the second highest nationally (45%), Liverpool the fourth highest (42%). In Yorkshire and Humber, Hull has the fifth highest nationally (38%).

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.

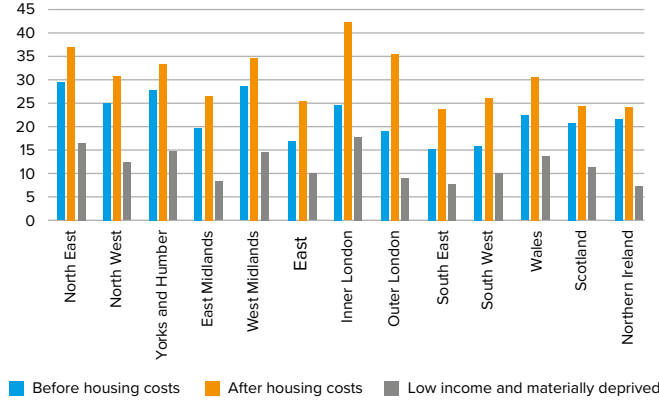


Figure 2.5. For each local authority in the North East region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.

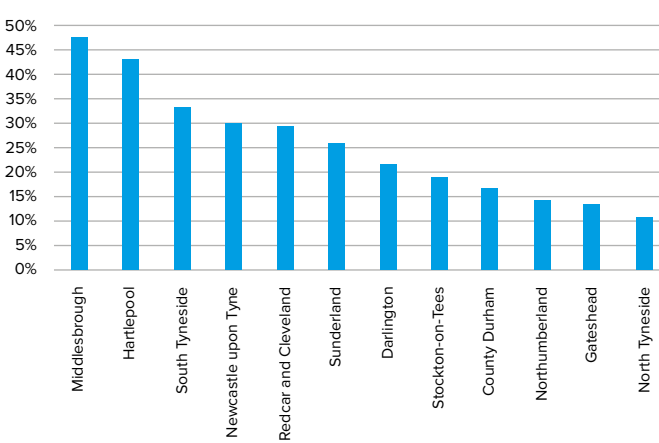
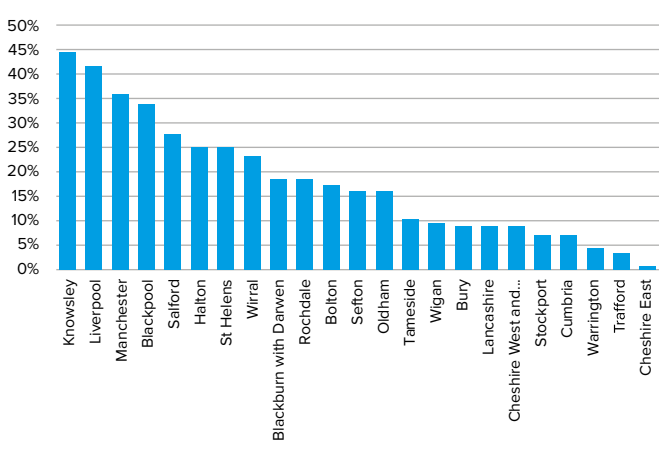


Figure 2.6. For each local authority in the North West region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.



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.

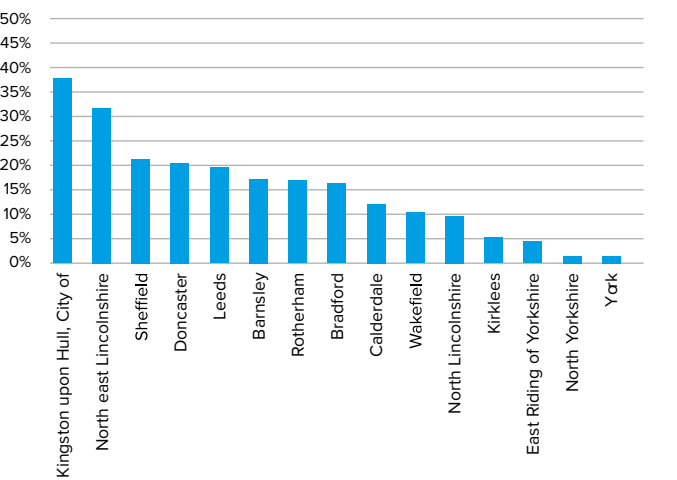
Impact of child poverty
There is strong evidence for a causal effect of growing up in poverty on many adverse outcomes, spanning education, employment, lifetime earnings, crime, and both physical and mental health.²² These adverse outcomes affect children's life chances and continue to have an impact 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 England²³. 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 areas¹⁰. 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 poverty¹. Another recent report using data on deprivation (from the Index of Multiple Deprivation 2019) and child mortality (up to age 17) showed

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.



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 life²⁴. 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 16% 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.²⁵ Young people from more disadvantaged families, in the lowest 40% of the income distribution, were twice as likely to report having

Figure 2.8. Percentage of children living in poverty by ethnic group and geography.

	White			Mixed/Multiple Ethnic Groups			Indian			Pakistani			Bangladeshi			Chinese			Any other Asian background			Black/African/Caribbean/Black British			Other Ethnic Group			Total		
	24.6%	20.9%	21.1%	37.5%	43.7%	44.5%	26.9%	21.6%	30.1%	45.5%	43.3%	57.5%	58.5%	70.5%	64.2%	44.4%	30.6%	23.3%	50%	45.6%	67.6%	56.8%	37.8%	46.1%	40%	59.5%	47.9%	26%	23%	24.8%
	N:1158/713	N:2977/1136	N:1085/6929	N:9/24	N:50/126	N:49/110	N:1452	N:502/232	N:43/143	N:3966	N:186/430	N:299/520	N:38/65	N:31/44	N:81/65	N:9/18	N:15/49	N:7/50	N:18/36	N:31/68	N:25/37	N:25/44	N:102/270	N:101/219	N:20/50	N:88/148	N:57/119	N:1329/5068	N:2939/12743	N:2527/10202
	North East	North West & Merseyside	Yorks & Humber	East Midlands	West Midlands	Eastern	London	South East	South West	Wales	Scotland	Northern Ireland	All																	

Source: Family Resources Survey

N = Number of children in sample living in poverty / Total number of children in sample

attempted suicide than their more advantaged counterparts. The proportion experiencing psychological distress was also higher among those from lower income families²⁵. 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 childhood²⁶.

Another recent study using trajectory modelling 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 problems⁹.

3. 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%²⁷. 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 in adolescence⁶.

The role of social security and cuts to local authority funding

In 2010, the government introduced an austerity programme with the primary aim of reducing the government's deficit and shrinking the welfare state, predominantly by moving people into work. The past decade has seen the introduction of the benefit cap, the under-occupation penalty (bedroom tax), the abolition of discretionary social

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 relationship²⁸.

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 paid employment¹⁸, and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment²⁹.

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 £412 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 numbers that would be expected had funding levels for Sure Start children's centres been maintained³⁰.

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

Whilst there are not yet any 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 2021/22. 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 (DWP, 2021) – twice the pre-pandemic figure³¹.

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 400,000 children, falling into relative poverty – the biggest year-on-year rise in poverty since the 1980s³¹. Over the course of the pandemic, there has been growing evidence of increasing deprivation, child hunger, family indebtedness^{32,33}, use of food banks³⁴, and general distress³⁵.

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 schools and holidays through food provision and free or reduced clothing and educational resources.
- Local businesses can pay staff the Living Wage.
- The NHS can play an important advocacy role in local communities.
- People at risk of and experiencing poverty should be supported to enter the national debate by describing how the rise in poverty has affected them.
- Follow the blueprint laid out in the Greater Manchester Independent Inequalities Commission³⁶. The report lays out clear, achievable recommendations to tackle poverty and deprivation, and improve wellbeing and equality at local level.

However, we note that options at local level are restricted by cuts to local authority and NHS services and provision. Whilst united and connected local strategies to mitigate the effects of child poverty are imperative, a sharp focus on central government is needed. It is the inadequacy of central government's support for children that is driving up child poverty in England.



Pregnancy and Early Years

Authors: Judith Rankin, Sally Bridges, Sunil Bhopal, Pamela Qualter, Josie Dickerson, Anna Sanders, Calum Webb, Sarah Salway, Ghazala Mir

Context

Experiences during pregnancy and the early years are of lifelong and crucial importance to a child's physical and mental health, educational attainment and health and wellbeing into adolescence and adulthood. Accumulating evidence from across the psychosocial and biological sciences makes it clear that exposure to adversity and 'toxic stress' (including poor parental mental health, exposure to violence, substance misuse, and abuse/neglect) has vast potential to negatively influence the trajectory of a person's health and wellbeing across the lifecourse.

The absence of positive experiences including warm, nurturing care from securely attached caregivers puts children at high risk of not meeting their developmental potential and of not being able to thrive³⁷ (Figure 3.1).

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 countries³⁸, there is a clear need to explore how maternal and child physical and mental health and wellbeing within the UK has been affected in different regions, given the

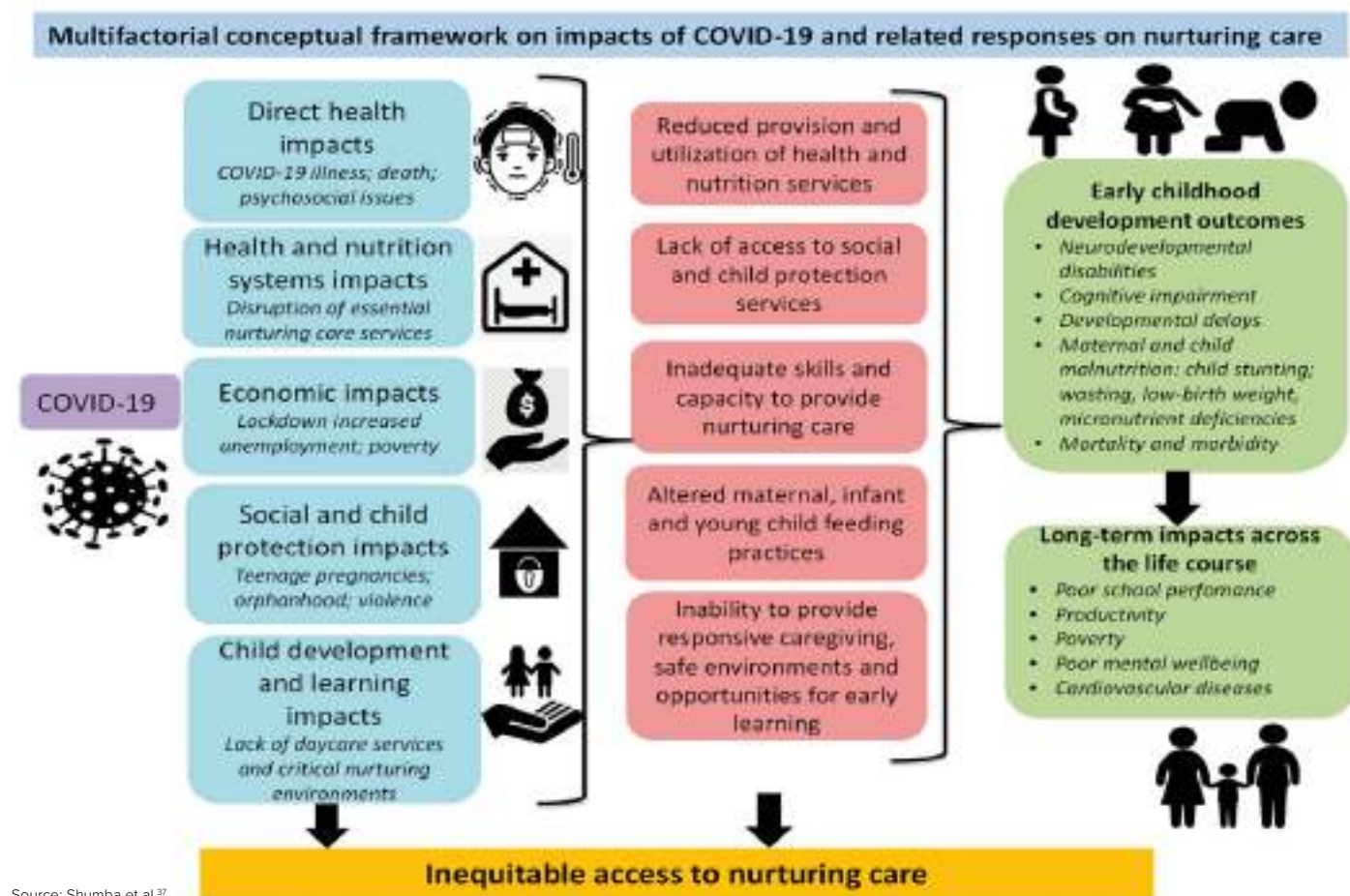
variations in deprivation and affluence across the UK.

Existing health inequalities in pregnancy outcomes pre-COVID-19 pandemic

A recent systematic review of the literature showed persistent inequalities in pregnancy outcomes (stillbirth, neonatal mortality, perinatal mortality, preterm birth and low birth weight) for women from lower levels of occupation/social classes compared to women from the highest levels³⁹.

Regional inequalities in infant/child health were pervasive before the COVID-19 pandemic, with infants and children living in the North having worse outcomes on a range of measures than infants/children living elsewhere in England. For example, the North East and North West had the highest under-18 conception rates; low birth weight in term babies was highest in the West Midlands and North East; and infant mortality rates were highest in the West Midlands and North West (Figure 3.2)⁴⁰. The Due North report published in 2014 showed that worse child health is a key driver of the North-South divide in adult health and life expectancy⁴, with those born in the most deprived areas of the North, on average, living almost 10 years less

Figure 3.1. Infographic summarising impact on babies of poor early-life experiences.



Source: Shumba et al.³⁷

than those born in the least deprived areas in the South⁴⁰.

Addressing the drivers of poor pregnancy and child health outcomes is essential to breaking the cycle of inequality. The arrival of the COVID-19 pandemic highlighted and exacerbated these inequalities.

Perinatal and infant mortality among women from ethnic minority communities

Elevated rates of perinatal and infant mortality in the UK are associated with socioeconomic deprivation and ethnic minority identity^{41,42}. The Office for National Statistics' analysis of 2017 births shows that infant mortality was highest among babies identified as Pakistani by their mother (7.3 per 1,000 live births), followed by Black African (7.0), Black Caribbean (5.8), Bangladeshi (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 groups⁴³. Prematurity and low birth weight also contribute importantly to higher death rates among babies in the South Asian and Black groups⁴⁴. 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 1.4 times more low-weight births per 100 (8.4%) 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 weight births were around 12% higher in the most ethnically diverse neighbourhoods (8.4%) compared to the least ethnically diverse (7.5%).

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 outcomes⁴⁵⁻⁴⁷, 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 decades^{41,49}. A series of studies document dissatisfaction with care, poor communication, and discriminatory treatment⁵⁰⁻⁵², as well as a failure to respond appropriately to particular needs.^{53,54} A shortage of midwives from ethnic minority backgrounds in the North has been identified as a particular concern, as well as the poor experiences of ethnic minority staff^{55,56}.

The ongoing challenge to deliver equity and equality in maternity and neonatal care has been recently reiterated via NHS Maternity Transformation Programme's new guidance to local systems⁵⁷ and the

Figure 3.2. North/South differences in some key pregnancy and child outcomes, 2018 data.

Under 18s conception rate/1,000 2018

Crude rate - per 1000					
Area	Recent trend	Count	Value	95% Lower CI	95% UpperCI
England	▼	14,736	16.7	16.4	17.0
North East	▼	986	24.9	23.4	26.5
North West	▼	2,500	21.7	20.9	22.6
Yorks and Humber	▼	1,698	19.6	18.6	20.5
West Midlands	▼	1,843	19.1	18.2	20.0
East Midlands	▼	1,260	16.8	15.9	17.7
East of England	▼	1,417	14.4	13.7	15.2
London	▼	1,915	13.9	13.3	14.6
South East	▼	1,990	13.5	12.9	14.1
South West	▼	1,127	13.3	12.5	14.1

Low birth rate of term babies 2018

Crude rate - per 1000					
Area	Recent trend	Count	Value	95% Lower CI	95% UpperCI
England	▶	16,224	2.8	2.82	2.91
West Midlands	▶	2,017	3.3	3.17	3.46
North East	▶	787	3.2	3.04	3.49
Yorks and Humber	▶	1,711	3.1	3.00	3.29
London	▶	3,382	3.0	2.97	3.18
North West	▶	2,125	2.9	2.79	3.04
East Midlands	▶	1,219	2.7	2.55	2.85
East of England	▶	1,651	2.6	2.53	2.78
South West	▶	1,241	2.5	2.38	2.66
South East	▶	2,091	2.4	2.30	2.50

Infant mortality rate 2016-18

Crude rate - per 1000					
Area	Recent trend	Count	Value	95% Lower CI	95% UpperCI
England	-	7,608	3.9	3.8	4.0
West Midlands	-	1,206	5.8	5.5	6.1
North West	-	1,161	4.6	4.4	4.9
East Midlands	-	628	4.0	3.7	4.4
Yorks and Humber	-	750	4.0	3.8	4.3
South East	-	1,086	3.6	3.4	3.9
East of England	-	711	3.4	3.1	3.6
North East	-	277	3.3	3.0	3.8
London	-	1,240	3.3	3.1	3.5
South West	-	549	3.3	3.0	3.6

Source: Public Health England <https://fingertips.phe.org.uk/profile/child-health-profiles>

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, Benash 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/bl3-new-maternity-hub/

NHS Race and Health Observatory’s priority work in this area.

Widening health inequalities during the COVID-19 pandemic

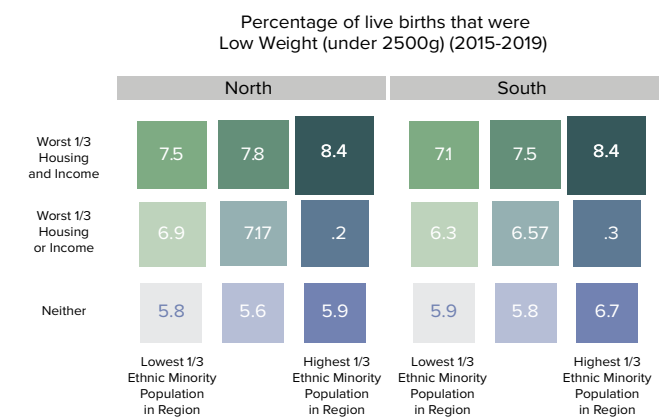
The Government’s ‘lockdown’ response to COVID-19, aimed at reducing the number of infections, hospital admissions and deaths, had unintended effects, exacerbating health inequalities across the UK. Studies have shown rates of financial and food insecurity and poor mental health increasing during this 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 ethnic and socioeconomic inequalities⁵⁸ (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 also 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 response 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: the risk of COVID-19 to pregnant women was unknown, and so stringent restrictions on their activities were imposed to prioritise infection prevention.

Examples include: a switch to remote-consultation for midwife and health visiting appointments; women being required to attend antenatal appointments alone; and partners being extremely restricted in time allowed in hospital before and after the birth of their

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



Note: Size of each square proportional to the outcome
Source: Author’s analysis of Public Health England Local Health Indicators.

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 2021⁵⁹

baby. Limited contact with services 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 narrative of women feeling alone and fearful during their pregnancy, and at critical points in their routine care such as scan appointments⁵⁹. A significant proportion of new mothers in the UK reported feeling low (56%), lonely (59%), irritable (62%), and worried (71%) during the COVID-19 pandemic and initial lockdown⁶⁰, considerably more than the 20% of new and expectant mothers who were affected by poor mental health pre-pandemic⁶¹. Figures are likely to be worse in the North, which spent a month-and-a-half longer in lockdown than the rest of England⁶². New mothers with babies under one year of age expressed feelings of “being robbed of the joys of motherhood”.⁶³

Women described a worsening of their mental health during the pandemic. Reports of clinically important depression increased in mothers from 11% before COVID-19 to 19% 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 insecure⁶⁴. 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 compromised consultations⁵². 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 worsening 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^{65,66}.

The cost of poor perinatal mental health is estimated to be £8.1billion for each year’s birth cohort^{67,68}. 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 new parents is also of concern. Increased stress and anxiety, poor mental health, and a lack of opportunity for partners to be involved 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 their organisation worked with, and that this was affecting bonding and responsive care⁶⁹.

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 baby⁷⁰.

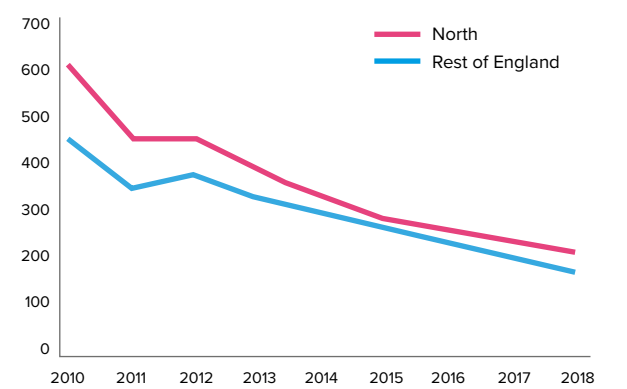
Health visiting and early years’ services during COVID-19

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 the pandemic (September 2015 to June 2019) ⁷¹.

In the UK, in response to the first wave of the COVID-19 pandemic, up to 63% of health visitors were redeployed⁷². Whilst high levels of redeployment were not seen universally across the North, the area has increased vulnerabilities with known worse outcomes for infants on a range of key measures, so any changes to service provision will have had an adverse impact.

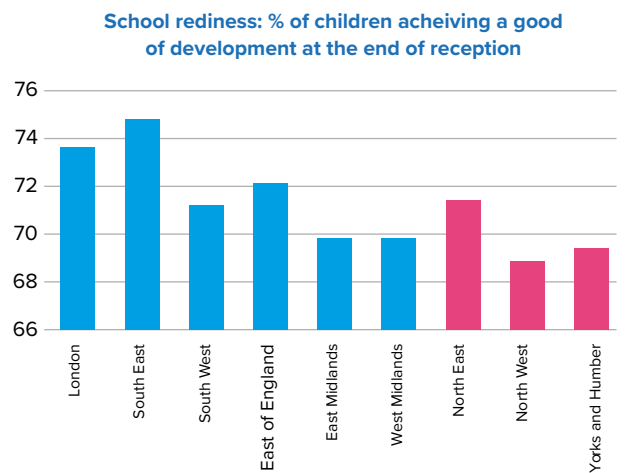
Despite these changes, health visitors went ‘above and beyond’ to support vulnerable families. As we move into recovery, there is a need to align staffing and capacity to areas of greatest need for early years support from health visitors. Further funding is needed to reduce the heightened risks and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

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).



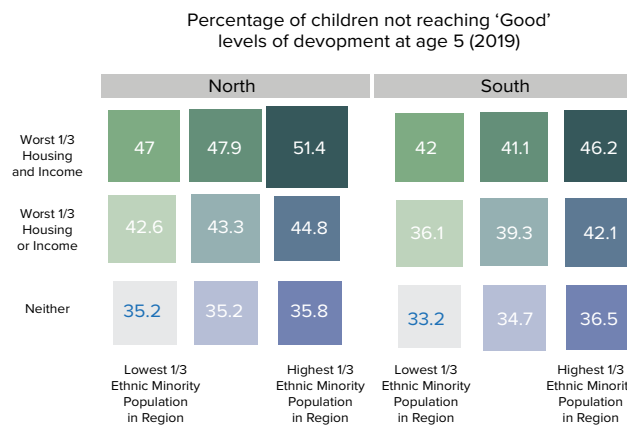
Source: Place-based Longitudinal Data Resource
http://dx.doi.org/10.17638/datacat.liverpool.ac.uk/1340

Figure 3.5. School readiness: % of children acheiving a good level of development at the end of reception.



Source: Bamba et al/NHSA (2020)¹⁵

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



Note: Size of each square proportional to the outcome.
Source: Author’s analysis of Department for Education data and Public Health England Local Health Indicators.

baby during the pandemic.

In the pre-COVID-19 decade, mean Local Authority spending per child on early years’ services, including Sure Start children’s centres, which provide community-based services for children and their parents, had decreased by 53% in real terms between 2010/2011 and 2016/2017⁷².

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 readiness⁷³ and have been linked to increased obesity prevalence by the time a child starts school¹².

School readiness and COVID-19

The pandemic has seen an interruption to schooling and intermittent 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 2018/1974.

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 Humber have the lowest levels of school readiness (Figure 3.5)¹⁵. 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.

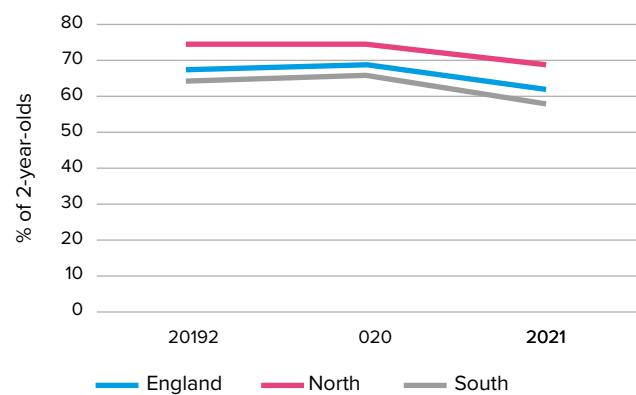
The highest proportion of children not reaching good levels of development at age five were in neighbourhoods with combined high levels of non-white ethnic density and deprivation. This proportion was higher in the North than in the South of England (51.4% compared to 46.2%). These early childhood experiences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

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



Source: Department for Education (2021)⁷⁶

more deprived children, inequalities in development will increase, disproportionately affecting children in the North of England. Evidence suggests that the 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%⁷⁷.

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 development⁷⁸, and service providers have noted consequences for the physical development of children in deprived homes in particular⁷⁹.

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 communication and language⁸⁰. 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 years' worth of learning reduces the subsequent earned income of the pupils concerned by approximately 3%.

A less skilled workforce will likely also lower rates of national economic growth⁸¹. 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 life⁸².

Since data have been mostly produced at a national level, there are still gaps in our understanding of children's development during 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 longer-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 exit the pandemic, with additional investment in priority areas and services. Only through serious investment can we start to reduce health inequalities and break the intergenerational cycle of inequality seen across the North. There is a clear need to 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 & 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 invest to level out 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.

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Child mental wellbeing

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Context

Untreated 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, and can have substantial socioeconomic consequences. 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 England⁸³.

Referrals to urgent and emergency crisis care have risen by 80% between April and June 2021 compared to the same period in 2019⁸⁴; contact with children and young people's mental health services at the end of June 2021 was up 51% on June 2019. There 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 crisis'⁸⁵, with evidence of rising prevalence of mental health problems for UK children⁸⁶, increasing inequalities⁸⁷, and unsustainable pressures on services. The pandemic has exacerbated problems, increasing family stress, removing protective environments such as schools, and decreasing physical access to services⁸⁸.

Research has shown huge variation in how children experienced lockdowns in the UK⁸⁹, but more young people experienced a probable mental health disorder in July 2020 and March 2021 compared to 2017: one in six children aged 6-16 years had a probable mental health disorder in 2021, compared to one in nine in 2017^{83,90}. 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 Humber, 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 years, 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)^{89,91}.

Trends in the determinants of child mental health

Before COVID-19, evidence highlighted important determinants of child mental health, including family socioeconomic conditions, parental mental health, family stress levels, loneliness, and sleep quality. Some of these same determinants posed a greater threat to mental health during the COVID-19 pandemic.

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 UK⁹² (see Chapter 2). Parents in low-income families have experienced higher levels of depression and stress during the pandemic⁸⁹. Deterioration in mental

Figure 4.1. Percentage of girls 5-10 years of age with a probable mental health disorder, in 2017 and 2020.

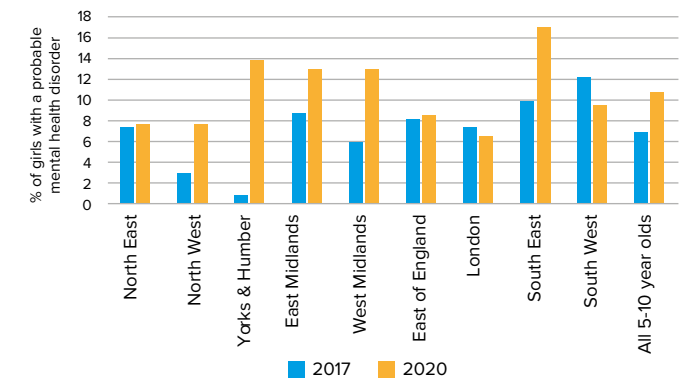
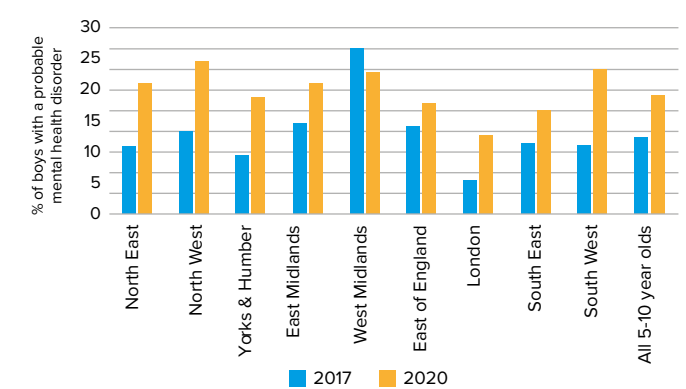


Figure 4.2. Percentage of boys 5-10 years of age with a probable mental health disorder in 2017 and 2020.



Figures 4.1 and 4.2: NHS Digital (2020) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up/data-sets>

health was worse for working parents and was strongly related to increased financial insecurity and time spent on childcare and home schooling^{58,93}.

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 condition⁸³, 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 gap⁹⁴, 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 themselves experienced deteriorating mental health⁹⁵, with increases in stress as they tried to balance work and childcare commitments⁸⁹. 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

more depressed⁹⁶. In the North the figures were substantially higher, at 55% and 45%. In the Born in Bradford study, clinically significant depression among mothers increased from 11% pre-pandemic to 19% during first lockdown; clinically significant anxiety increased from 10% to 16%⁵⁸.

In a qualitative study of mental health among parents, children and young people participating in the Born in Bradford study, both parents and children expressed anxiety about COVID-19⁹⁷. Some children were so anxious that they did not leave the house even for permitted activities, and some experienced a worsening of pre-existing symptoms, such as nervous tics and bedwetting.

As well as worrying about their own risk of becoming ill, children worried about their parents, grandparents, and other people close to them. Whilst experiencing anxiety, many children also reported boredom, lethargy, lack of purpose and low mood; many felt disengaged from school and worried about returning. School had been at the centre of most children's social lives and younger children, in particular, struggled to maintain contact with friends. Children also missed seeing their relatives and some had been unable to see their parents at times. Many similar themes emerged in the Teenagers' Experiences of Life in Lockdown (TELL) study⁹⁸. The textbox on the next page assembles some quotes from the TELL study.

Loneliness is directly linked to worse mental health among youth⁹⁹. 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 lockdown¹⁰⁰ compared to 10% pre-COVID-19¹⁰¹. 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 15% of parents in the rest of England⁹⁶. Parents/carers themselves were also more likely to have often been lonely during the first lockdown in the North compared to the rest of England⁹⁶.

Sleep is also important for mental health¹⁰², but was significantly affected during the pandemic, with between 32% and 55% of school-aged children and adolescents reporting that they were often too worried to sleep during lockdown¹⁰³. Data from March 2021 shows that over a quarter of 6-10 year olds and over a third of 11-16 year olds continued to report sleep problems⁹⁰. In one study, 48% of parents reported a shift in the sleeping patterns of children, including staying up until much later in the evening during the lockdown⁹⁶.

Mental health among ethnic minority children and young people

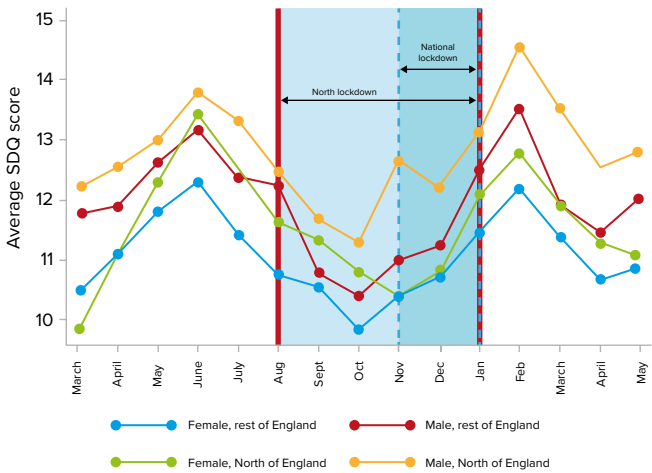
The national survey data available both pre- and post- COVID-19 suggest that ethnic minority children have similar or better mental health than their White British counterparts, though patterns are varied across indicators^{83,86,104–106}. For example, the NHS Digital survey of over 3,000 children reports that rates of 'probable mental disorder' were lower among the broad 'Black and minority ethnic' group than the White group: 8% compared to 19% in July 2020, and 4% compared to 13% in 2017⁸³.

However, assessing ethnic differences in the prevalence of mental illness is controversial and complex since rates of recognition, reporting, and diagnosis are likely to vary between ethnic groups, and routine methods for measuring mental illness in clinical and research settings may function differentially across groups. Furthermore, national data employ very broad ethnic group categories and often include only small ethnic minority samples. Local data from the Leeds 'My Health, My School' pupil perception survey revealed that secondary pupils identifying as Chinese or Mixed, along with those identifying as White, reported the worst mental health¹⁰⁷.

Importantly, ethnic minority children and young people face some particular risk factors for poor mental health. Experiences of racism and fear of racist incidents, both at community level and within statutory organisations, are consistently reported as undermining the mental health of ethnic minority children and young people in

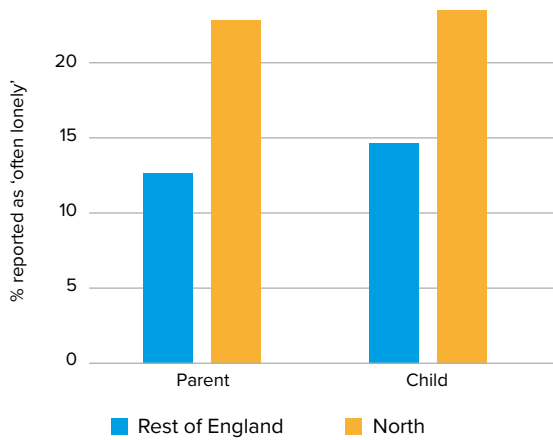
Figure 4.3. Mean 'Strengths and Difficulties Questionnaire' scores by region and gender, controlling for the effects of age, family income, and Special Educational Needs. Higher scores indicate more problems.

Thick red vertical lines represent the beginning and end of regional lockdowns; dashed blue vertical lines represent the beginning and end of national lockdowns. Schools were shut March-June 2020 and reopened in June 2020. There is a notable and sharp reduction in the scores when schools reopen, and increase when they close in January 2021*



*Regional lockdown was assessed by calculating the proportion of the population experiencing regional lockdown restrictions in a given month, for the North and for the rest of England.

Figure 4.4. Percentage of parents who reported that they or their child were 'often' lonely, in the first 100 days of lockdown.



England^{107–110}. Available quantitative evidence supports that link¹¹¹. The immigration system creates particular risks, with up to 15,000 children across the UK growing up separated from a parent because of the Minimum Income Requirement. Many of these children suffer from depression, night terrors, social isolation and feelings of guilt⁴⁸.

The COVID-19 pandemic appears to have created some particular risk factors for poor mental health among ethnic minority children, including disproportionately high rates of COVID-19 illness and mortality among ethnic minority communities, the heightened racist rhetoric around the spread of the virus¹¹², and family financial stress¹¹³. An online survey of 796 young people aged 16-24 in April 2020 showed that 27% had poor mental health and 10% had self-harmed since lockdown, with those identifying as Black/Black British having the highest odds of experiencing poor mental health¹¹⁴.

An online survey of 2,002 13–24-year-olds in April 2020 found that Black and Mixed ethnicity respondents reported higher levels of anxiety and depression as measured by the Hospital Anxiety and Depression Scale, compared to White and Asian respondents¹¹⁵.

However, much of the COVID-19 related research has failed to include sufficient samples of ethnic minority children and young people to draw firm conclusions.

Compelling data for adults show that ethnic minority people, and particularly Black groups, have an overwhelmingly negative experience of mental health services. Young Black men are heavily over-represented in secure services.

There is poor access to mental health promotion and preventative services across all ethnic minority groups. "Circles of Fear" have been described that perpetuate these unmet needs and oppressive cultures of care¹¹⁶. Furthermore, the 'securitisation' of mental health (and of public services generally) via the Prevent programme has introduced new forms of institutional racism that further undermine access to appropriate mental health support for Muslims¹¹⁷, who are predominantly from ethnic minority communities.

Less is known about the situation for other ethnic minority children and young people, but available evidence is worrying. Nationally they appear to be underrepresented in mental health services with evidence being particularly consistent for those from South Asian families¹⁰⁴. Referral routes also vary by ethnicity, with young people from ethnic minority backgrounds more likely to be referred through education, social, and other services that are less likely to be voluntary, than via primary care, compared to White British children¹¹⁸. Local data from Leeds support this picture, with the Asian and Black population particularly underrepresented in mental health services¹⁰⁷.

Qualitative research with young people, parents and stakeholders from Leeds revealed significant obstacles to discussing mental health and seeking support from family, friends and services across all minority groups and across gender¹⁰⁷. Though obstacles to support manifested in various ways, a lack of trust in Eurocentric services and feeling excluded were common themes.

Similar findings were reported in YMCA's survey of young Black Britons, with over a quarter reporting lack of trust in the NHS¹¹⁰. Ethnic minority children and young people rely heavily on community-based services that can offer safe spaces and a sense of belonging¹¹⁹. Such services have been in sharp decline in past years and further closures during the pandemic lockdown were a source of great concern to ethnic minority communities.

Unaccompanied and separated children were particularly affected by the cessation of face-to-face frontline services during the outbreak of COVID-19. It is likely that many experienced increased isolation and inadequate support, placing them at increased risk of mental health crisis¹¹³.

It is worth noting that Kooth, the online 'mental well-being community', appears to attract a disproportionate number of young people from ethnic minority backgrounds¹²⁰. The Adira hair care project in Sheffield is an example of innovative practice (see textbox on the next page). These initiatives, which show potential to engage and impact positively on the health and well-being of young ethnic minority people, require support for scale-up, evaluation and sharing of lessons learnt.

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

Many children and young people experienced positive aspects of lockdown, including spending more time with family, and becoming more independent and responsible⁹⁷. Whether or not children experienced lockdown as negative or positive depended on their family circumstances, their experiences of school, and to some extent their age, gender, and ethnicity.

Children aged 7-13 years living in Bradford reported higher levels of happiness and lower feelings of sadness during the first lockdown compared to when asked pre-pandemic – the proportion of children describing feeling happy all of the time rose from 36% to 53%, whilst the number of children feeling sad all of the time reduced from 4%

Quotes from young people in the Teenagers' Experiences of Life in Lockdown study

"I feel that because I was meant to be doing my 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 'haven't earned it'."
(18 year old, Manchester)

"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 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'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 have ADHD so I hated being inside all day but now I have to be and it really sucks. I miss being social in person. I don't like sitting still in front of my laptop to talk to people."
(16 year old)

"[My parents'] income has significantly decreased. My parents have simply become a bit more careful about spending money during the food shop and are mindful that none of our food gets wasted. Although, this is never something my parents have worried about before."
(17 year old)

"I've already got a history of mental health issues, being shoved into a house in the middle of nowhere with none of my friends, and any sense of normality shredded has certainly not helped."
(18 year old)

"My moods have been a lot worse since lockdown with depression and an eating disorder getting even worse."
(17 year old)

Source: Demkowicz et al (2021)⁹⁸

to 1%, and the proportion of children reporting never feeling sad rose from 20% to 25%¹²³.

Children of Pakistani heritage were more likely to report feeling sad less often during the pandemic compared to White British children, whereas boys had a greater likelihood than girls of feeling sad more often. Social relationships – particularly feeling left out by other children before the pandemic – appeared to account for some of these changes in wellbeing. Schools and children’s services should consider what learning can be drawn from children’s positive experiences of lockdown.

Mental health support for children and adolescents during the COVID-19 pandemic

Demand for mental health support fluctuated during the COVID-19 pandemic. Child and Adolescent Mental Health Services reported reduced referrals during lockdown, but there was a rapid surge when schools re-opened in September 2020. That increase has continued, with analyses of the NHS Digital data showing that 8,552 children and young people were referred for urgent or emergency crisis care between April and June 2021, and 340,694 children were in contact with children and young people’s mental health services at the end of June 2021⁸⁴, a significant increase on pre-COVID referrals.

NHS Digital reported that half of those concerned about mental health with a probable disorder delayed seeking help during the pandemic⁸³. Delays were in large part attributable to changing working practices in Child and Adolescent Mental Health Services¹²⁴, and disruption to schooling.

Available data suggests that referrals to mental health services dipped early on in lockdown, but subsequently soared, with referrals in September 2020 72% higher than in September 2019¹²⁵. And while 40% of the highest performers on mental health service spending and waiting times for children in England (2019/20) were in the North of England, the commitment must be sustained. This will require an increase in spending budget.

Recommendations

The main objective moving forward should be to reverse the trend of increasing mental ill-health that predates the COVID-19 pandemic. 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 lifecourse and highlights the importance of early detection and prompt access to professional treatment:

- **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 to monitor parental mental health moving forward and provide targeted support 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 where and how to find support.** Ensure smooth pathways between services. There must be rapid access to evidence-based support for those who need it. Children and adolescents, and their carers, 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 NHS specialist services is only part of the answer. We also need a broader systems response to children’s mental health, incorporating

Promising practice: The Adira Hair Care Project, Sheffield.

Hair is central to Black culture and identity and has been a significant site of social control exerted by the White establishment over Black bodies¹²¹. Black hair care and styling have also been important symbols of resistance to this oppression¹²².

The Adira Hair Care Project, Sheffield, offered Black and Afro-Caribbean people with mental health issues, including young people, the opportunity to have their hair styled for free. Referrals were received from statutory services and community organisations. The work was funded by the National Survivor User Network and the National Lottery Fund. Service users reported significant improvements in their mental health and sense of well-being.

“Hair care for the type of hair I have is not accessible for me due to the high costs involved. However, it is an aspect of self-care that is so important and has such a positive impact on black mental health.”

“It’s an opportunity for people to feel loved in one way or the other.”

“Thanks so much to the @adiraorguk Black Hair Care Project. I’m really happy with my hair! And having it done has helped me feel less stressed too because now I have time to do my caring and get ready for school without worrying about doing my hair in the morning. THANK YOU”

More information: <https://www.shefnews.co.uk/2021/03/25/a-new-haircare-project-highlights-mental-health-issues-in-the-black-community/>

schools and the voluntary sector. Schools are key sites for children’s wellbeing and mental health, with the main stressors during and before the pandemic for young people related to school and feeling under pressure. These stressors have undoubtedly been exacerbated by the catch-up narrative following lockdowns. Thus, schools are important places for discussion of mental health.

- **Sustain commitment to the implementation of Mental Health Support Teams across England.** This objective was championed by the Children’s Commissioner. Even before the pandemic, NHS services were not able 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. Central to the Green Paper on Children’s Mental Health¹²⁶ 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 to cover 3,000 schools in England by 2023, so supporting 3 million pupils and accelerating the Mental Health Support Teams programme¹²⁷. NHS England also announced £40 million allocated to address the impact of COVID-19 on children and young people’s mental health.

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

Authors: Sally Barber, Daniel Bingham, Maria Bryant, Andrew Daly-Smith, Alison Fildes, Jason Halford, Carolyn Summerbell, Rizwana Lala, Calum Webb

This chapter examines physical activity levels, food intake, and levels of food insecurity, and the prevalence of obesity in children living in the North of England since the beginning of the COVID-19 pandemic. Before the pandemic, these outcomes in children were generally worse in the North compared with the South of England (except for some inner parts of London).

These geographical differences can, in part, be explained by relative levels of deprivation. But that’s not the full picture. Even after adjusting these outcomes for deprivation, a substantial divide remains, suggesting more deep-seated structural issues. The COVID-19 pandemic has had a profound impact on the daily lives of children. Among the most significant changes were opportunities to be physically active, and access to food and different types of food.

Given that these factors determine growth and body fatness, it is important to ascertain whether the pandemic has also had an impact on levels of childhood obesity. Sadly, the evidence suggests that the pandemic has exacerbated North-South inequalities in physical activity levels, food insecurity, and obesity, for children.

While the legacy of these 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 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)¹²⁸. According to the Everybody Active, Every Day governmental report, physical inactivity costs the UK an estimated £7.4 billion each year¹²⁹.

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 early part of the COVID-19 pandemic, with a reported 2% decrease across England in 2019/20¹³⁰. 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; usual, everyday opportunities to be physically active (active travel to school, playtimes, Physical Education, after-school activities, play in parks and playgrounds, playing with friends, and organised sport and recreation) were no longer available. Physical activity behaviours are known to track from childhood into adolescence, then into adulthood,

Figure 5.1. Children meeting physical activity guidelines, by region of England, academic years 2018/19 and 2019/20

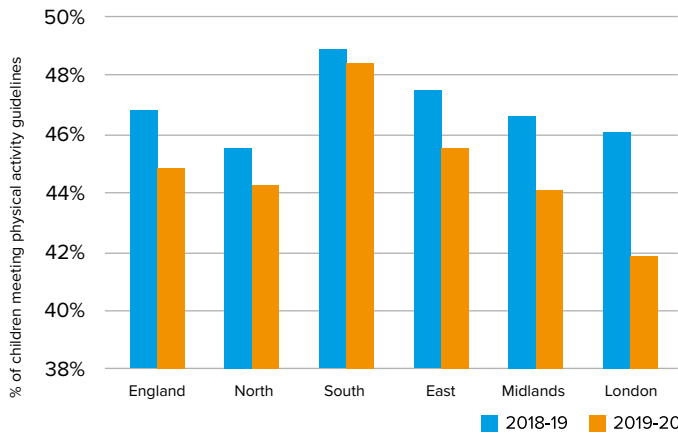
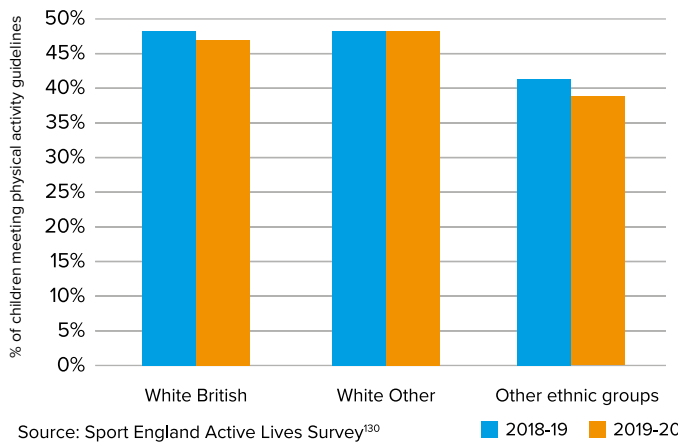


Figure 5.2. Children meeting physical activity guidelines, by ethnicity category, academic years 2018/19 and 2019/20



and although the legacy impact of the pandemic 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 country¹³⁰.

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 during the pandemic compared to their ethnic minority counterparts¹³⁰.

Researchers in Bradford have examined how physical activity levels of children in the city changed from before COVID-19 to during the first national lockdown in March 2020. They found a 40% reduction in the number of children being sufficiently active¹³¹. Of further concern are the stark ethnic inequalities reported.

Only 23% of Pakistani-heritage children reported being physically active every day, compared to 34% of their White British peers. The main reason for the difference between these ethnic groups was that fewer children of Pakistani heritage were leaving the home environment daily. When they did, it was for shorter periods of time than their White British peers.

Not leaving the home environment, and leaving for shorter periods of time, predicted whether or not children met physical activity guidelines even after accounting for the child's ethnicity, neighbourhood deprivation levels, age, and gender. Several studies have previously shown that ethnic minority groups in the UK live further away from green spaces and that their nearby green space is of poorer quality compared to other groups. A study published in 2019 exploring structural, community and individual determinants of green space use amongst low-income multi-ethnic families concluded that initiatives to increase green space use should tackle structural quality issues, addressing fears about safety, while simultaneously encouraging communities to reclaim their local green spaces¹³².

Planning and regeneration

The data presented throughout this report illustrate how important the places in which children live are for their physical activity, health and wellbeing. In May 2021 the Queen's Speech outlined a Planning Bill to reform the English planning system and address housing shortages. However, as Fiona Howie, chief executive of the Town and Country Planning Association, said:

"If we are truly committed to building back better, we need the built environment to support communities to thrive, and the government must recognise that homes cannot be delivered in isolation from the other elements that are key to complete, healthy and sustainable places."¹³³

A positive step towards improving environments for children's health is for local authorities to put park and green space improvements at the heart of 'place making'. See the textbox below for an example of this in Bradford.

Physical activity in schools

Children spend a large amount of their time in school. Schools have

the potential to provide a levelling environment for more and less disadvantaged children. Whole-school health promotion interventions targeted at those living in the most disadvantaged areas, which take an 'upstream' approach, can improve health outcomes and reduce health inequalities.

The Government has allocated School Physical Education and Sports Premium funding to schools since 2013 and have committed to the same for 2021/22. It is imperative that the funding is sustained longer-term and is allocated according to need, such that more disadvantaged schools receive more funding – particularly given schools' responsibility for providing 30 minutes of in-school physical activity daily, as recommended in the latest Obesity Plan.

Traditionally, schools have tended to focus on implementing singular interventions without addressing the need for system change, e.g. senior leadership, social environment school policy. However, the School Physical Education and Sports Premium funding could be better spent by schools if they focused on whole-school physical activity programmes whereby physical activity is promoted to all members of the school community through supportive policies, environments and sustainable opportunities (see, for example, textbox on next page). This should be complemented by singular interventions that are known to have good reach and do not increase inequalities, such as The Daily Mile¹³⁴.

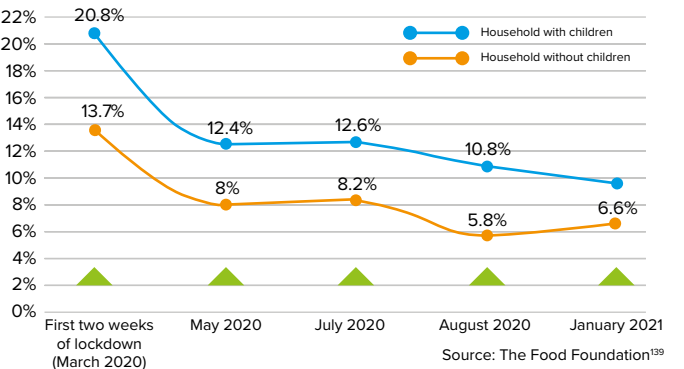
Food and Food Insecurity

A healthy balanced diet is critical to children's growth and development. The pandemic had multiple effects on children's access to food, and the type of food available to them, and in turn their dietary intake. School closures meant that most children, including many of those who would normally receive free school meals, didn't eat in school or receive free school lunches; the organisational challenges around this issue were well reported in the media.

Many parents of children who would normally receive free school meals found it harder to secure paid employment to cover their bills during the pandemic and, where their options for work were limited to manual labour jobs or jobs that could only be done in person rather than online, many parents struggled to combine paid employment with looking after family members at home. For the 12 months ending September 2020, the highest average estimated weekly hours worked was 30.9 hours, in London.

The lowest was 27.9 hours, in the North East. Average hours worked decreased in all regions of England compared to the same period in the previous year, but the largest decrease was in the North West (3.2 hours), while the smallest was in the South East (2.7 hours)¹³⁶. For many parents of children, the pandemic resulted in a sharp drop in income and an increase in the need to buy more food to feed the

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



family now at home. Many families on low incomes, struggled to feed their family, let alone provide a healthy diet for their children.

"We must act with urgency to stabilise the households of our vulnerable children. No child in the UK should be going to bed hungry."
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 mental health problems, geography, and problems of digital exclusion. However, food insecurity is typically more tightly defined as the lack of financial resources required to ensure reliable access to food to meet dietary, nutritional, and social needs¹³⁸.

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 prevalence of low and very low household food security was 11% in the North East 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 whole¹⁴⁰.

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 areas¹⁴¹. 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 are in Liverpool), and the most deprived food desert in England is in Hull¹⁴².

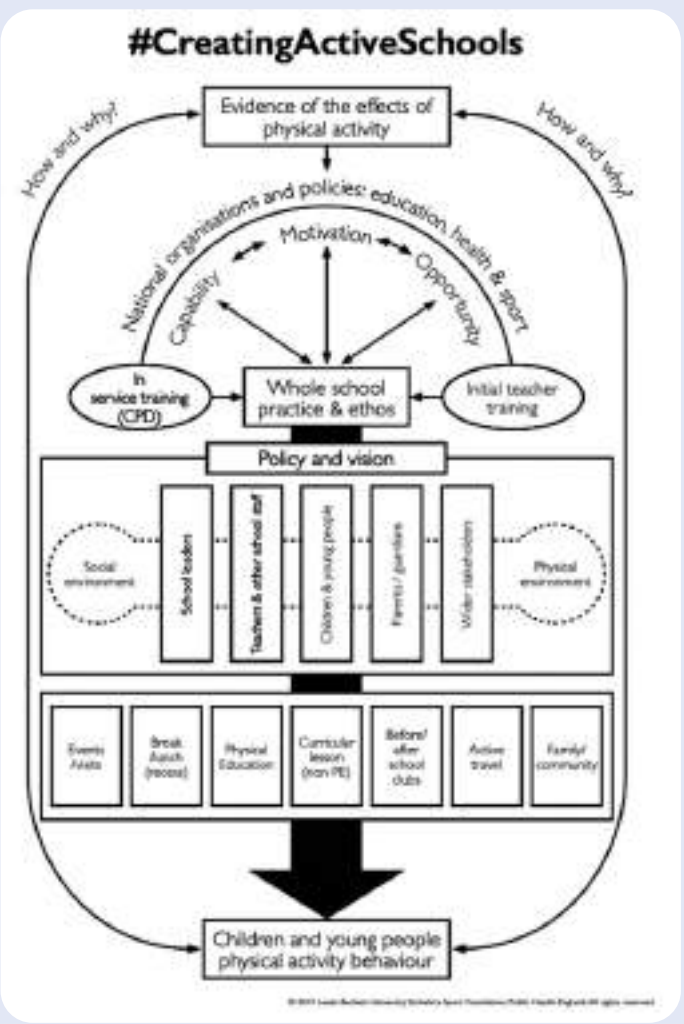
The collective evidence is that the COVID-19 pandemic has exacerbated the issue of food security across the UK. In January 2021, over a fifth of people reported having less income now than they did before the pandemic, and 2% reported losing all their income as a result of the pandemic¹³⁹.

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

Promising practice: The Creating Active Schools Framework.

The Creating Active Schools Framework (Figure 5.3) was developed by 50 regional, national and international stakeholders who understood the many factors that need to be addressed within a school to create organisational change for physical activity¹³⁵. Unlike previous approaches, the Creating Active Schools approach targets operational change, focussing on school policy, the environment, key stakeholders and then, finally, individual opportunities. Schools are supported through organisational change training for the senior leadership team and school-based Creating Active Schools lead. The approach empowers schools, using co-production to enable an autonomous approach that seeks to mobilise and enhance the specific assets within each individual school. Schools across Yorkshire and Humber are beginning to use the framework to transform their physical activity provision for children.

Figure 5.3. Creating Active Schools Framework.



"If I make it a high priority as a head teacher then other people will understand its importance. Actually what we are realising is children are making more progress in the classroom by getting their physical activity needs met."
Chris Tolson, Headteacher, St James Academy, Bradford

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. These are integrated with new footpaths and a wooded 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 healthier and safer ways to connect local community areas.

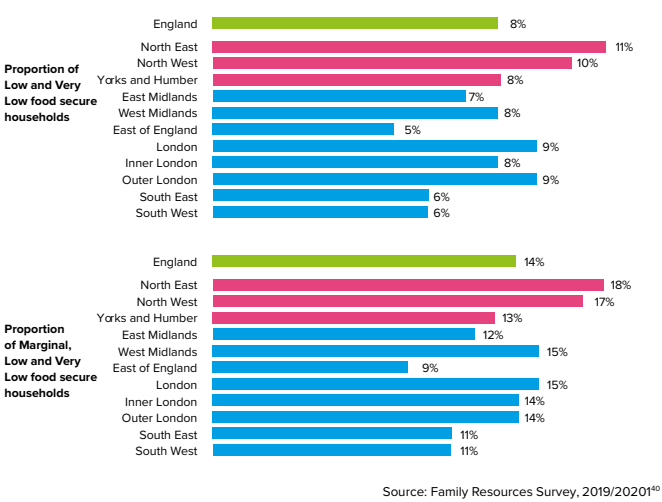
As the project develops, more work is planned to further improve the connectivity of surrounding streets, support people to access the

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 Ferriby, Bradford Council's Executive Member for Healthy People and Places, said: "This is a fantastic initiative that has taken many years of painstaking planning by the community, ward councillors, partner 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 Arshad Hussain, local ward councillor, said: "This park has quickly become a haven for local children and families to play and connect."

Figure 5.5. Proportion of households experiencing food insecurity by region.



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)⁵⁸.

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 more¹⁴⁷.

In addition to the likely impact on physical health, there was a clear relationship between food insecurity and mental health, with mothers more than three times as likely to have depression or anxiety if they were food insecure⁶⁴.

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 pandemic¹⁴⁸.

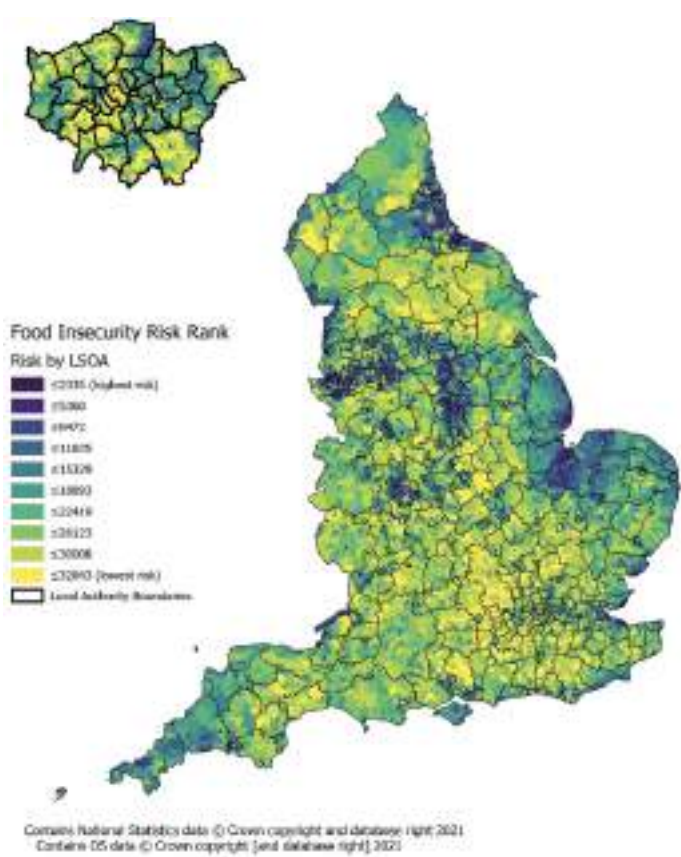
Educational institutions played a key role in this and 42% of the new services that were set up in response to COVID-19 were school-based. Services reported increased demand for culturally acceptable foods (including Halal foods), indicating a shift towards greater demand across all ethnic groups; however, many services also reported limited opportunities for providing such foods, given that most were dependent on donations.

weeks of lockdown, in March 2020, 21% of households with children under 18 years old reported experiencing food insecurity (see Figure 5.4), while in May 2020, in a nationally representative survey, 12% of parents reported that their children had directly experienced food insecurity¹³⁹. These effects persisted despite the easing of national restrictions in the summer of 2020.

In January 2021, an estimated 2.3 million children were living in households that experienced food insecurity in the last six months. Government, private and voluntary sectors responded in a variety of ways, including alternative school food provision¹⁴³.

Evidence suggesting that Free School Meal vouchers and furlough may have prevented a much worse situation led to calls for the expansion of Free School Meals eligibility¹³⁹, the extension of the holiday food programme across England, and an increase in the value of Healthy Start Vouchers. But despite recent government investment in the Healthy Start scheme, over 250,000 children under five who are food insecure are still ineligible. There are also concerns

Figure 5.6. Risk of food insecurity by Lower Super Output Area, England.



Source: <https://www.mylocalmap.org.uk/iaahealth/>

that current plans to digitalise Healthy Start vouchers from October 2021 risk excluding even more families.

"I work full-time. It's been very difficult. I was previously receiving benefits and receiving Free School Meals. But I decided to go full-time and be a role model for my children. My monthly salary just about pays off all my bills and just a bit more for food. We try and get the basics that will carry us over to next month to get the things we need and cover us. The last 4 or 5 months when the kids were off school, I had to rely on food banks and donations to get through. Without that, I wouldn't have put food on the table."

Marni, a single mum of four girls between the ages of 6 and 16.

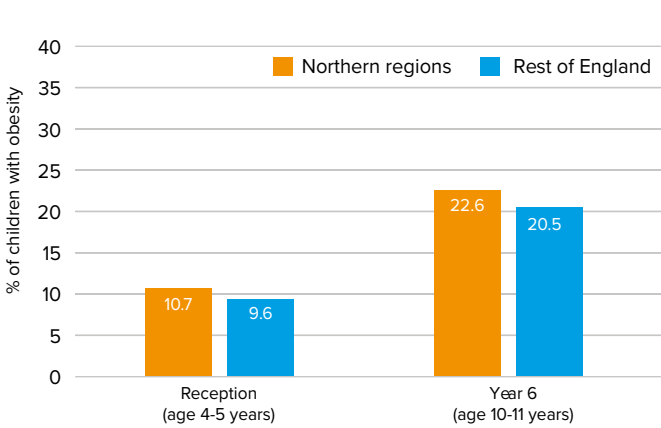
Source: quote reproduced from the Food Foundation, 2021¹³⁹

Food insecurity and ethnicity

The Trussell Trust's State of Hunger report found that people of Black ethnic background were over-represented among those referred to a food bank¹⁴⁴, and a recent analysis of the Family Resources Survey data shows that households where the head was Black were most likely to be food insecure¹⁴⁰. In 2018/19, the highest percentages of Free School Meal eligibility (a measure of income that does not capture all those who are food insecure) was seen in White minority groups — 56% among Traveller of Irish Heritage pupils, and 39% among Gypsy/Roma pupils. This was followed by Bangladeshi and Pakistani pupils¹⁴⁵.

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% (1.74 million) in January 2021. Children living in the North East are most likely to be eligible for Free School Meals (27.5%) and the rates are lowest in the South East (16%)¹⁴⁶. The Food Foundation's analysis of repeated nationally representative surveys concluded that ethnic minority households had consistently experienced higher food insecurity than White families throughout the COVID-19 crisis and that inequality in food insecurity had widened between these two groups over this period¹³⁹.

Figure 5.7. Obesity prevalence in the North and the rest of England, at reception and Year 6, 2019/20



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, the UK Government called childhood obesity "one of the biggest health challenges this country faces"¹⁴⁹. Its Obesity Plan seeks to halve the prevalence of childhood obesity by 2030, with a focus on encouraging individual behaviour change, product reformulation and restricting unhealthy food marketing¹⁵⁰. One projection is that halving childhood obesity by 2030 could save the NHS £37bn¹⁵¹.

Data on children's weight in England are normally collected annually at the beginning and end of primary school by 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 six (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 is strongly associated with socioeconomic deprivation¹⁵³. Children from the most deprived areas in England are more than twice as likely to be living with obesity as those from the least deprived areas.

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.

Marked differences in healthy weight by ethnicity are also evident, with more 10- to 11-year-old Asian and Black children living with obesity than in other ethnic groups. In addition, more Asian children are underweight compared with other ethnic groups²⁷.

We analysed neighbourhood rates of childhood obesity, examining the intersection of deprivation and ethnicity. A neighbourhood 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 third nationally for housing and income, and have relatively large ethnic minority populations. In all but low deprivation

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 resource 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 believes 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.

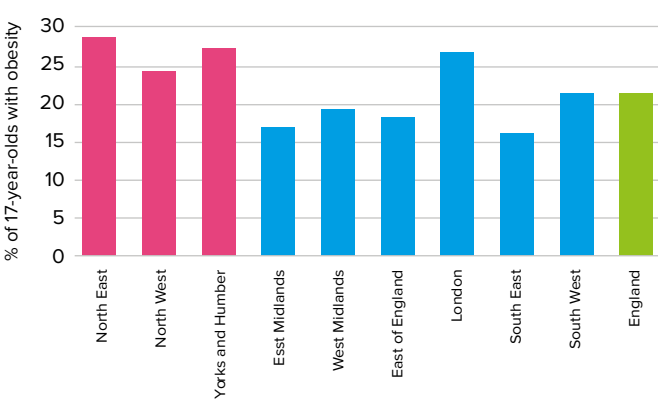
This mixture of grassroots support and community-based events has proved to be high-impact and sustainable. 83% of members say that using TBBT enables them to feed their families and 97% say it is good for their community.

"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 never claimed benefits until October 2020 due to COVID. We managed to stay afloat from March 2020 without work or income but then things became 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 something 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 it! I can't thank you all enough" **Paula, Manchester**

More information: <https://www.breadandbutterthing.org/>

Figure 5.8. Obesity prevalence at age 17, by region



Note: Obesity defined on the basis of UK90 threshold for children
Source: Millennium Cohort Study

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 5.9).

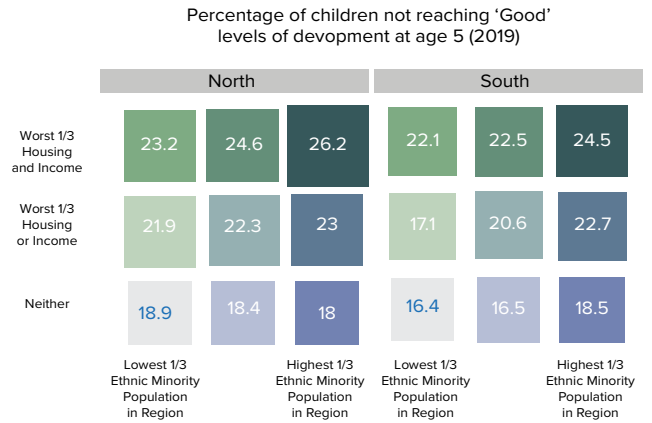
The National Child Measurement Programme was paused during the COVID-19 pandemic due to school closures. As such, there are no data yet available to assess whether the pandemic has affected child weight. Nevertheless, rising socioeconomic deprivation due to the pandemic is cause for serious concern about likely widening inequalities in over- and under-weight among children.

Policy response and the need for whole system actions
The North-South variation in the prevalence of childhood obesity in England is certainly fuelled by poverty. Policies that aim to reduce food poverty and food insecurity, as outlined above, and investment in early years services (see Chapter 2) are key to realising the Government's ambition to halve the prevalence of childhood obesity by 2030, whilst also reducing health inequalities. It isn't that the existing Government Obesity Plan is wrong – all of the strategies within it are sensible, evidence-based, and theoretically effective. 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 was on changing individual behaviours rather than changing the environments in which people live. Alone, therefore, the Obesity Plan is likely to have limited impact¹⁵⁴.

The research suggests that reducing child poverty is a pre-requisite to reversing and reducing the overall prevalence of, and inequalities in, childhood obesity across England¹⁵⁵. Beyond this, we need a whole system approach, with a broader set of initiatives targeting, in particular, educational settings, town planning and industry. Strategies must ensure access to health services according to need, with an appropriate balance of prevention and management of childhood obesity within emerging integrated care systems.

The elephant in the room is what this would cost. In the challenges of operating in a pandemic-recovery economy, will local authorities

Figure 5.9. Percentage of children in Year 6 living with obesity, by deprivation-minority ethnicity intersection' and correct the label across the top to '% of children in Year 6 with a BMI within the 'obese' range (2017-2020)



Note: Size of each square proportional to the outcome, and colour-coded according to both deprivation and ethnic density
Source: Author's analysis of Public Health England Local Health Indicators.

and industry have the financial resource and political will to invest in tackling inequalities in childhood obesity in England, above other pressing priorities?

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 Sport 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 concept 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 standards¹⁵⁶.

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-class 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 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 play 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 addressing health inequalities. Local authority sport and leisure 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 leisure 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 these functions if we want healthier environments to be part of our COVID-19 recovery plan¹⁵⁷.

Urban green spaces, such as parks, playgrounds, and residential greenery that local governments develop and maintain can promote mental and physical health, and reduce morbidity and mortality. Local council libraries, museums and art galleries have also been shown to improve social cohesion. They also provide educational opportunities, develop digital skills, assist with job applications, and increase employability. Environmental and regulatory 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 health. Collectively, these Cultural, Environmental and Planning (CEP) services have been cut by 50% over the last decade. Whilst similar cuts have taken place across the countries of the UK, only in England have the cuts been regressive, reducing funding most in the most deprived areas (Figure 5.10). The consequences for public health are likely to be severe and last for many years to come. For example, research suggests that cuts to spending on CEP services may be associated with increased childhood obesity, particularly in more deprived areas¹⁵⁷.

Socioeconomically deprived and ethnically diverse areas also have more takeaway outlets. Between 2008 and 2012, 20% of children from a range of age and socioeconomic groups ate food from takeaway outlets, at home, once or more times per week. Food from takeaway outlets often provides children with high energy intake from unhealthy fast foods such as burgers, pizzas and chips¹⁵⁸. Local authorities have powers under the National Planning Policy Framework and accompanying Planning Practice Guidance to limit the proliferation of hot food takeaways¹⁵⁹.

The Government's Childhood Obesity Trailblazer Programme is testing local powers to address health inequalities among selected local authorities until 2022. The Pennine and Lancashire consortium of local authorities report capacity issues in regulating hot food takeaway location and menu content.



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, Place 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.

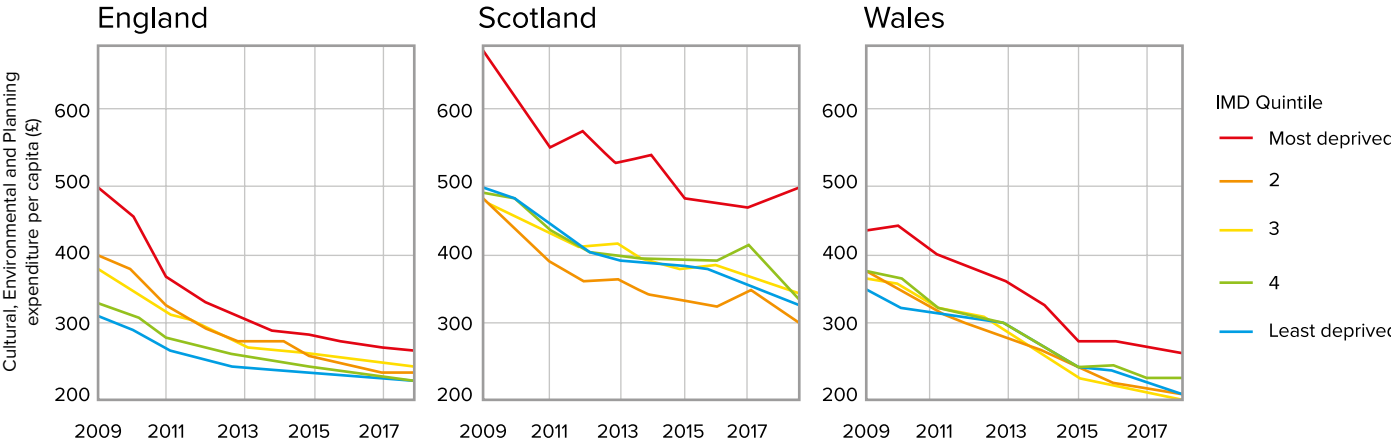
Industry
The 2018 Soft Drink Industry Levy taxes some drinks containing 5g of sugar or more per 100 ml. Since the introduction of the levy, sugar in products subject to it has been reduced by 44% on average. In 2017, Public Health England set a voluntary target for industry to reduce sugar content by 20% in foods that contribute the most sugar to children's diet, including cereals, yogurts, and confectionery¹⁵⁰. 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 pizzas, 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 screen advertising largely promotes unhealthy food and drinks, and even short-term exposure produces minor increases in energy intake by children across a range of ages¹⁶⁰. Placing food in stores at eye-level and branding packaging with characters appealing to children influences children's food preferences.

Research indicates that advertising restrictions could contribute

Figure 5.10. Gross expenditure per capita on Cultural, Environmental and Planning services by country and level of deprivation.



Source: <https://pldr.org/2021/09/30/what-did-local-government-ever-do-for-us/>

to reducing children's consumption of unhealthy food and drink. By April 2022, planned legislation will ban in-store promotion of unhealthy food by end-of-aisle and checkout placement and multi-buy promotions. The UK Government intends to introduce a 9pm watershed on advertising foods high in fat and sugar to children, with policy expected by late 2022. The Departments for Health and Social Care and Digital, Culture, Media & Sport have consulted on a total online ban for products high in fat, sugar and salt, and options for front-of-pack labelling to give consumers more nutritional information.

Health services

There are four tiers of weight management services in England. These cover universal health campaigns (Tier 1: prevention), local authority weight management services (Tier 2: treatment), and clinics run by specialists that seek to support children with complex and severe obesity (Tiers 3 and 4: treatment). As part of the National Child Measurement Programme, parents receive a letter outlining if their child is living with overweight or obesity.

However, the framing of these letters has been found to contribute to an avoidance of weight management services¹⁶¹. 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 £62m on childhood obesity services, a real term decrease of 11% since 2016/17. However, the UK Government has announced a £100m 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 initiatives to motivate people to maintain a healthy weight, including a free NHS 12-week weight loss plan app and upskilling for healthcare professionals.

Obesity specialists argue that the tiered system is blocking patients' access to treatments. Researchers have estimated that only 23% out 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 Paper¹⁶². 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 inequality.

RECOMMENDATIONS

Physical Activity

- Consider and involve children and child health in planning and regeneration decisions.
- Prioritise 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

- Ensure that the Free 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.
- In line with the 2021 National Food Strategy report, make the Free 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 receiving 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 Scheme to all households 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 cabinet-level ministerial post responsible for Food Insecurity within the Levelling Up agenda.
- Increase benefits to a level sufficient to ensure that everyone can afford essentials, and to ensure 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 address the problems of digital exclusion. Food can bring communities together, combating loneliness and improving wellbeing.
- Revise plans to digitalise Free School Meals and Healthy Start vouchers. Current plans risk excluding people without access to technology or technological literacy, leaving the most vulnerable behind, and at present many local food banks and grass-roots organisations are not equipped to accept digital forms of these vouchers.

Childhood obesity

- Change current Government food standards in early years' settings (nurseries) from voluntary to mandatory.
- Introduce specific standards for local authorities on building healthy environments, particularly in areas where children live and play. With regard to planning policy for takeaway food outlet regulation – and given the rise of online takeaway food ordering and delivery platforms during the COVID-19 pandemic – we recommend joined-up policy action across, and collaborative working with, neighbouring local government areas.
- Review and further develop the Government's policy on the advertising of foods and beverages high in fat and sugar targeted at children, including energy drinks, and particularly screen and online advertising.
- Create a central mechanism to assess need and provision of weight management services for children across all areas of England, and review and refresh the tiered system, within an integrated care system model.



Schools and education

Authors: Mark Mon-Williams, Charmele Ayadurai, Caroline Bond, Amanda Ellison, Mai Elshehaly, Emma Murphy, Uta Papen, Pamela Qualter, Beng H See, Amanda Waterman

The pandemic has lifted the lid on the unacceptable levels of disadvantage suffered by children and young people in our most deprived areas. We know that inequality and vulnerability are holding back educational attainment and social mobility, damaging pupil and school outcomes. 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. 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, schools' efforts, and the accumulating evidence, demand a policy response.

The achievements of staff within educational settings during the COVID-19 pandemic

NHS workers were rightly applauded through the pandemic for their vanguard role in fighting the consequences of COVID-19. In stark contrast, little attention was paid to the incredible work undertaken within educational settings (schools, nurseries, early years provision, etc.) to support children and young people.

There is now a tendency to describe schools as having been "closed" during the COVID-19 pandemic – even though they were providing services to vulnerable children and the children of key workers, whilst working hard to support the educational needs of all of their children and young people (see Case study on next page).

Indeed, educationalists were at the forefront of national efforts to support children with vulnerabilities through the most challenging circumstances experienced by a generation since the Second World War. The efforts made by educational establishments to feed children, and support other basic health and wellbeing needs, have been criticised¹⁶³, on the grounds that they detract from a pure education focus.

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 inequalities 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.

Inequalities 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 societies. But the pandemic also showed that schools inadvertently reflect – and amplify – the inequalities that blight our country. Children in the North of England are at greater risk of being born into

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 between the four of us."

"I found it hard because my parents were working a lot, 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."

unhealthy environments¹⁶⁴.

Schools in the North of England have a disproportionate number of children in poverty, children with poor levels of development on entering school (see Chapter 3), vulnerable children, children who have suffered from neglect and abuse, and children in local authority care (see Chapter 7)¹⁶⁴. There is evidence that disadvantage can dent aspirations¹⁶⁵. Thus, many schools will 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 gates.

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 inequalities, with statistics detailing the 17% higher mortality rate in the North, the average of 41 additional days in lockdown, falling wages (versus rises in other parts of the country), higher unemployment rates, and decreased parental and child mental

wellbeing (see Chapter 4 and earlier NHTA COVID-19 report¹⁵). These factors all 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 time¹⁶⁶, and the most limited resources for delivering in-school and online teaching during the pandemic¹⁶⁷.

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 now face a steeper uphill battle in working to mitigate the negative consequences of the lockdown period.

The digital divide

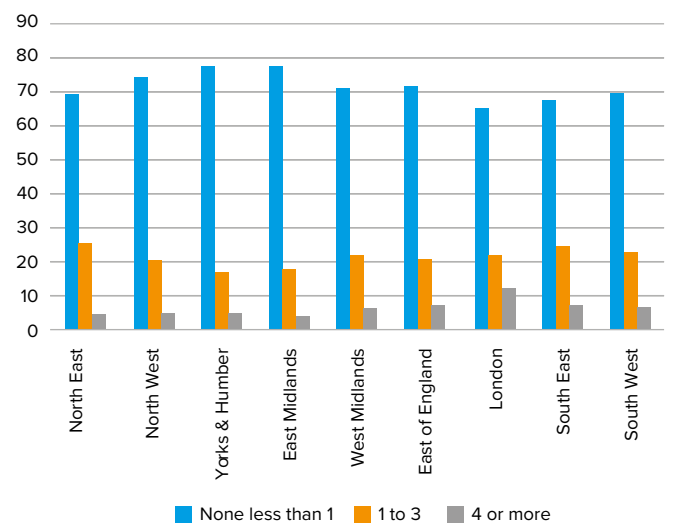
The broader inequalities affecting schools were well illustrated by the digital inequality exposed throughout the pandemic. Schools in our most deprived areas were less likely to have the necessary digital technology for remote teaching, and their teachers were less likely to be trained in the use of online platforms.

The Teacher Tapp survey reported that teachers, especially those in deprived schools, were ill-prepared for distance teaching¹⁶⁸. A recent survey¹⁶⁹ 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 platform, the figure was 23% for the most deprived schools¹⁷⁰. These structural inequalities translated into fewer online lessons for children in the North than in the South of England (Figure 6.1).

The unequal implications of the shift to remote education were also revealed in data from the 'Born 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' (25%) compared to children from White British (19%) and other ethnic groups (20%). This pattern was also reflected in access to books (17% of children of South Asian heritage had access 'only some of the time' compared to 5% 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

Figure 6.1. Percentage of children receiving online schoolwork, at different frequencies of delivery*, by region.



Notes: * Live or real-time lessons or meetings Source: Green (2020)¹⁷¹

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, it has over 50% of children on pupil 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. For Olivia, the priority was to provide care and support for both children and parents. Olivia reported that many of the parents were "petrified" 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 luncheons to 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, the teachers 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 hardware, internet, printers, 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 a box outside the school or, for many, delivered to their homes. All this had to be paid from the school budget.

* Name changed to protect confidentiality

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 14% 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
School closure to ineligible pupils affected some disadvantaged 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)¹⁷².

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 (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 pandemic¹⁷³. Some parents reported feeling overwhelmed, and normal support networks were disrupted. Children with SEND often benefit 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 lockdowns on those schools serving our most deprived communities.

Case study: local authority in Greater Manchester.

Since schools re-opened, Sarah*, a trainee 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-

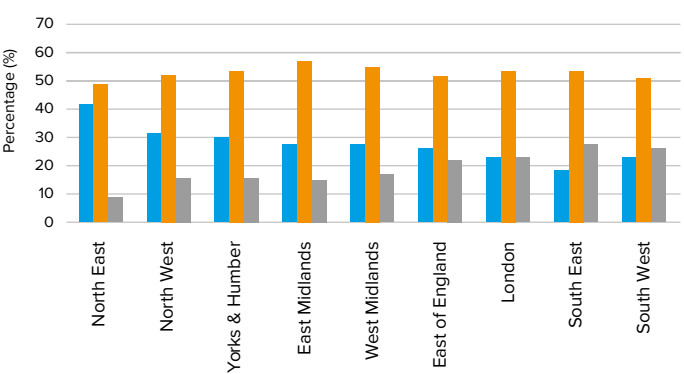
establish her friendships in school.

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.



Notes: * Lessons such as worksheets, assignments, watching videos Source: Green (2020)¹⁷¹

The home learning environment

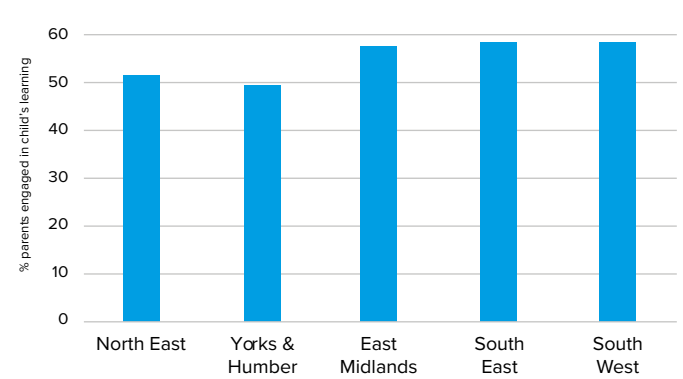
During the lockdown period, children's experiences of learning were much affected by differences in access to resources (such as laptops) and parents' ability to help with schoolwork. For children receiving Free School Meals, a proxy measure of disadvantage, parents were less likely to be working during the lockdown¹⁷¹.

However, these parents found it more difficult to help their children: they reported not feeling confident about home-schooling, and they were least likely to understand their children's learning tasks¹⁷⁴. Some disadvantaged children had little learning experience during lockdown¹⁷⁵. Families raising children with SEND also face more stressors^{176,177}, which are likely to have an adverse effect on the quality of family relationships¹⁷⁸. Thus, family resource inequality extends both to the amount of time spent learning, and to the resources available to assist learning¹⁷¹.

There were also regional differences in parental home-schooling support related to regional deprivation¹⁷⁹. Specifically, the Northern regions of England saw lower levels of parental engagement than the South (Yorkshire and the Humber, 50% parental engagement; South 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' initiative¹⁸⁰), 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.

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



Notes: Data are not available for the North East, West Midlands, East of England, and London Source: Lucas et al. (2020)¹⁷⁹

A widening attainment gap

Children growing up in disadvantaged communities have lower educational attainment. Children who experience persistent disadvantage leave school on average 22 months behind their peers¹⁸¹. 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 worker¹⁸².

This figure drops to 65% where a child lives in poverty or needs a social worker. It plummets yet further to 13% where a child experiencing disadvantage also has Special Educational Needs. Figure 6.4 shows the large regional differences and North-South 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. 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 were rated as 'Requires Improvement' or 'Inadequate' in 2016 improved

by one Ofsted grade by 2019, exceeding the 25-school target. This equates 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 110 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's 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 68.3% 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 directly benefited from speech and language therapy, and 232 of them were subsequently discharged from therapist services due to no

Case study:
Bradford Opportunity Area.

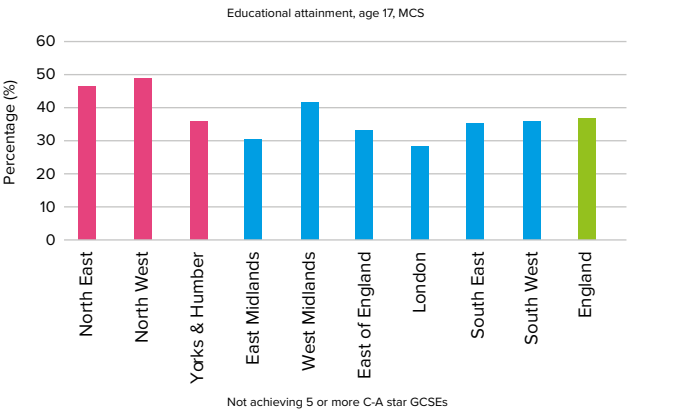
The Bradford Opportunity Area has enabled the creation of a community of practice across the 208 schools in Bradford (supported by the Chief Executive Officers of the Academy Trusts and the Head teachers of the schools).

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 NHS Hospital Trust and the regional universities, 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 tackling inequalities, 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, and have already demonstrated impact in and beyond the classroom on a national stage.

Figure 6.4. Percentage of young people not achieving 5 or more GCSEs at C-A grade, by region.



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 gains¹⁸³.

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 estimates¹⁸⁴. The gap for Year 1 pupils is also around seven months for both reading and maths, and the gap for Year 2 pupils has widened¹⁸⁵.

There are also regional disparities in the degree of learning loss as a result of the pandemic¹⁷⁴. By the second half of the 2020 autumn 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 respectively¹⁸⁶. In maths, at primary level, differences by region were even larger, with the North East and Yorkshire and Humber experiencing 4.0 and 5.3 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 students 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, children whose first language is not English, and those who normally received additional classroom support¹⁸⁷. This has major implications for children and young people in the Northern regions, given the number of electoral wards experiencing high levels of deprivation within this region.

Impact on adolescents

Young people's experiences of schools and disadvantage under lockdown were captured in the Youth Under Lockdown Survey¹⁸⁸. Young People frequently expressed significant levels of stress and anxiety over missed exams, uncertainty regarding missed schooling, exam grading processes, and potential disadvantage in progressing to later stages of education. Many young people frequently expressed how much they missed the social aspects of school, their friends, and the routine and purpose that it provided in their lives. Many commented on feelings of isolation, loneliness and low mood as a result (see Chapter 4).

These issues are likely to be compounded as young people progress to higher education without the experience or confidence that sitting exams within school would normally provide. There is rapidly accumulating anecdotal evidence from institutions such as universities that the impact of the pandemic continues to play out in young

people's lives - despite them graduating from the school system. There is a need to recognise and mitigate the consequent problems for young people at university and beyond, and for educational institutions.

A role for the education system in mitigating the covid inequality legacy

The findings outlined in this chapter illustrate the need for government to provide additional support to educational establishments in our most deprived areas. This is key to the effective 'levelling up' of these areas. Educational systems have an important role to play in addressing the 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 not 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 9).

Educational establishments need to be partners in the recovery work and efforts to address inequalities. They are ideally placed to capture the voice of 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 their ills. Better jobs and opportunities for culture and leisure are shown to protect against vulnerabilities. Educational establishments need to be connected to and supported by businesses. Schools can help 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.

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, we must resource and 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 teachers – in partnership with professionals from other services – a route to engage with children and families, and offer support at the earliest opportunity, without taking vulnerable children into clinical or other non-routine spaces. 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 equality of access and effective safeguarding.

Educational establishments can ensure that the voices of children and young people, their families, and their communities are heard. These voices must drive forward effective change (see Chapter 9).

Reflections from teachers in the North of England.

“We are 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] attended every day”.

“Many of our disadvantaged pupils come from homes where... parents are not confident themselves with basic literacy and numeracy skills.”

“There hasn’t been enough focus on supporting students’ wellbeing and instead there has been a relentless drive for us about educational progress at this extremely anxious time (...) As things are now, students who are privileged will have done far more learning than those from deprived backgrounds and all we will have achieved is widening the gap between Pupil Premium and non Pupil Premium student.”

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

“I work with students with a range of special needs from low income families. The pastoral support for students facing a tech hardware gap or other challenges 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.”

2. 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 new 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 resource, 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 be given 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, linking 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 these 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 extended lockdowns and because many pupils were unable to consistently attend school during the summer of 2021.

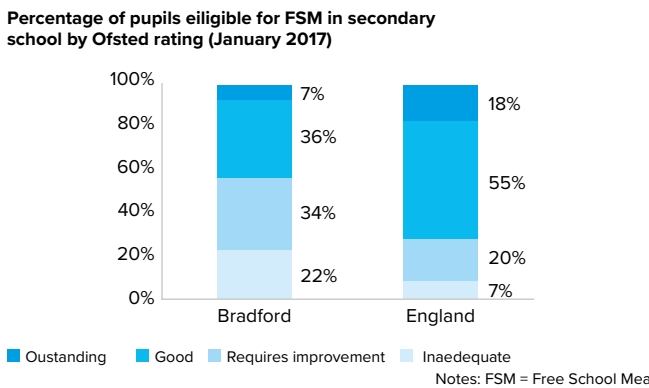
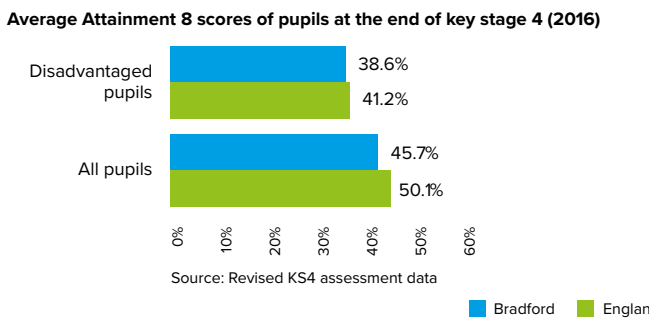
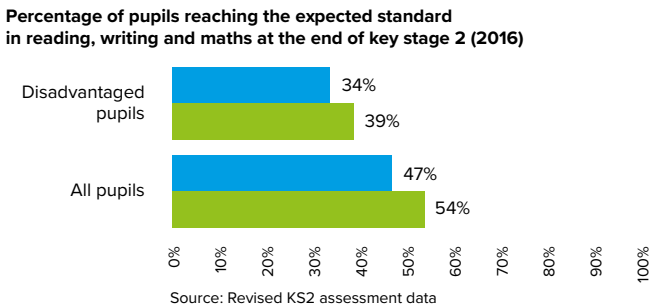
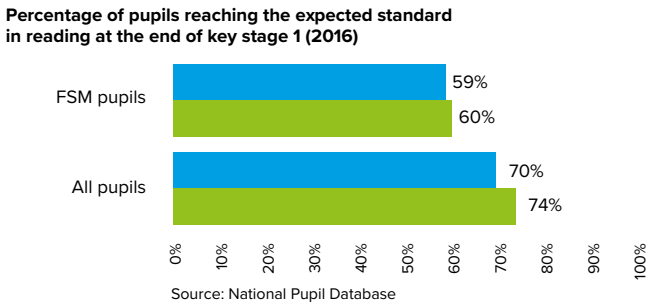
Prioritising strong pupil and staff relationships and collaboration with parents/carers will ensure a firm foundation for meeting children's needs and a return to learning. For example, schools are well positioned to offer a practical, evidence-informed response to the ongoing psychological impacts of the pandemic, from bereavement and loss through to social isolation, using resources such as the Recovery Curriculum¹⁹⁰ (see Chapter 4).

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 urged

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



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.

Children in care

Authors: Karen Broadhurst, Philippa Bird, Jayne Erlam, Steffi Doeblér, Bachar Alrouh, Emmerline Irving

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 carers, the outlook for the North is bleak. Increasing family adversity, pressures on preventative services and the continued remote or 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 out-of-home placements and critical shortfalls 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, while 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 2020¹⁹².

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 face¹⁹³.

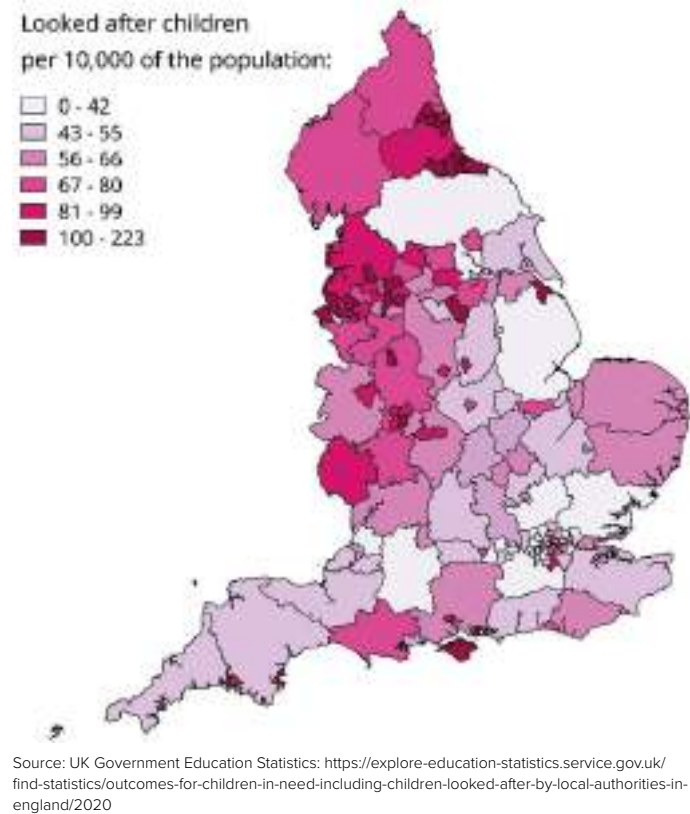
Pre-pandemic challenges in the Northern regions

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 care¹⁹³.

Unprecedented cuts to Children's Services since 2008/9 have forced local authorities to reshape and restrict services against a backdrop of greater need^{194,195}. Between 2010/11 and 2017/18, whereas the number of children in need increased by 7%, in line with population growth, there was a sharp 77% increase in child protection assessments¹⁹⁵, reflecting a shift in the balance of activity away from prevention, and resulting in escalating rates of children in care¹⁹⁶. The steepest increases of rates of children in care since 2008/9 have been in the most deprived local authorities¹⁹⁷. 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 7.1). In the year ending

Figure 7.1. Looked after children per 10,000 children, by local authority in England, 31 March 2020



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 97.4 in the North, compared to 61.8 in the rest of England¹⁹². 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 authorities¹⁹⁵. It also results in multiple costs beyond children's social care. Children in care require help from health, welfare, education and justice services because they are more likely to:

- Have special educational needs
- Have mental health difficulties
- Experience school exclusion
- Be involved with youth justice
- Have experienced adversity and trauma

The compounding costs are particularly challenging for areas in the North of England, where numbers of looked after children are very high.

A North-South divide in the provision of children’s homes

A marked concentration 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 in care lives 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 behavioural difficulties
- Live further away from their birth families¹⁹⁸

In England, there are currently 12,175 registered children’s home places (all types) for children, but provision falls short of demand and availability is uneven across England^{191,199}. There are far more children’s homes in the North of England, and homes in the North provide placements for children from across the whole of England. The 2016 Narey Review drew attention to the concentration of children’s homes in the North West¹⁹⁸.

Today, there continues to be an uneven distribution, with 1 in 5 of all children’s home places in the North West. There are 952 children’s homes in the North of England, and just 1,426 children’s homes in the whole of the rest of the country (Table 7.1).

Although children placed out of area by local authorities remain the responsibility of the local authority of origin, demand is felt most acutely by the services local to the child’s placement. Where a child is in distress or goes missing, local services must respond to this need. Each year Ofsted receives approximately 27,000 - 28,000 ‘incident notifications’ concerning children in children’s homes, which include police being called to the home or children going missing²⁰⁰.

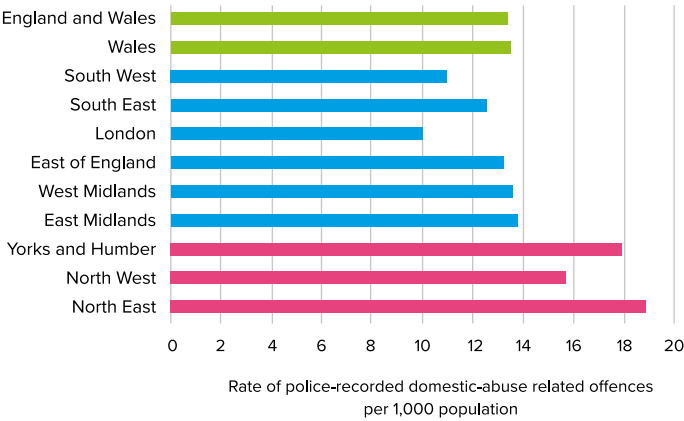
The picture for secure children’s homes is similar – more places are available in all three regions of the North, whereas there are no places in the West Midlands or London. Children are placed in secure children’s homes when they pose a serious risk to themselves or

Table 7.1. Number and percentage of registered children’s homes* and places, by region, 31 March 2020.

Region	Number of children’s homes	Children’s homes, % of England Total	Number of children’s homes places	Children’s homes places, % of England Total
North West	590	24.8	2,156	21.5
West Midlands	428	18	1,573	15.7
North East and Yorkshire and Humber	362	15.2	1,671	16.7
South East	276	11.6	1,430	14.3
East Midlands	243	10.2	1,036	10.3
South West	179	7.5	629	6.3
East of England	178	7.5	867	8.6
London	122	5.1	671	6.7
England	2,378	100	10,033	100
North of England	952	40.0	3,827	38.1
Rest of England (not North)	1,426	60.0	6,206	61.9
N	2,378	100	10,033	100

*Includes residential special schools registered as children’s homes.
Source : <https://www.gov.uk/government/statistics/childrens-social-care-data-in-england-2020main-findings-childrens-social-care-in-england-2020>

Figure 7.2. Domestic abuse-related offences recorded by police, in Wales and by region of England, in the year ending March 2020.



Source: Home Office Data Hub – Police recorded crime. Available from ONS²⁰⁵

others. The concentration of secure children’s home places in the North means that some of the most vulnerable children have to be placed at considerable distance from their birth families.

There is an acute shortage of secure children’s homes in England, with around 25 children waiting for a secure children’s home placement on any given day¹⁹¹. 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 1983²⁰¹.

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

Children may require statutory intervention for multiple reasons. However, the fact that children in the poorest areas of England are disproportionately at risk of entering care is well established^{197,202}. Chapter 2 of this report describes the deteriorating living standards of families in the North. 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^{193,203,204}.

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 the March 2020 lockdown, all three regions of the North recorded the highest rates of domestic abuse-related crimes in England²⁰⁵. Domestic abuse rates are highest in the North East, where the rate is 19 per 1,000 population, almost double the London rate of 10 per 1,000 population (Figure 7.2).

Prevention and early identification are key to reducing family adversity and childhood trauma and to preventing children from requiring 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.

Children in care - where are we now?

Evidence is still emerging of how the pandemic has exacerbated the already adverse position of children at risk or in care in the North. Updated statistics on children in care are not yet forthcoming. However, there is clear evidence that children in care have faced significant restrictions on family contact due to social distancing requirements, including with parents, siblings and grandparents²⁰⁶.

This has placed considerable strain on foster placements, with the Association of Directors of Children’s Services reporting increased

placement disruption¹⁹³. Foster carers themselves have experienced reductions in direct support and respite provision due to the pandemic²⁰⁷.

Children involved in family court proceedings since March 2020, have encountered extensive backlogs and delays in the resolution 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 weeks²⁰⁸.

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 delayed 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^{204,209}. The prospect of systems recovery is bleak, given that the family justice system went into the pandemic in crisis 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 reduced²¹⁰

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 2020/21⁹¹. At the same time, there has been growing concern over the placement of children in unregulated children’s homes because of a mismatch between need and the availability of foster carers or approved children’s home placements during the pandemic²¹¹.

Family adversity: what is the outlook for the North?

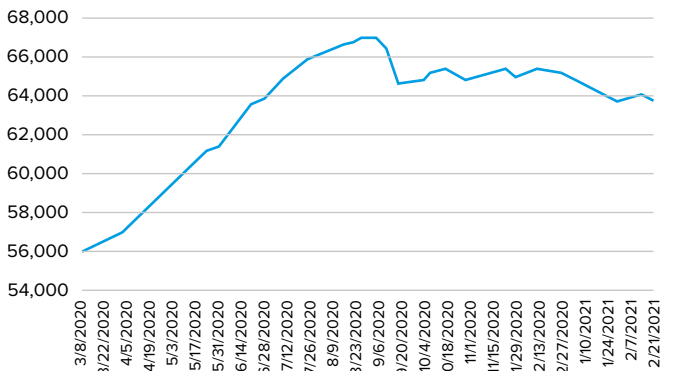
The COVID-19 pandemic has heightened the challenges experienced by children, particularly those living in families facing ill-health, insecure incomes, and other adversities. The evidence from the Association of Directors of Children’s Services is that the pandemic has tipped an increasing number of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

Case study: Mental distress and police detention in the North West

Children can be detained by the police under section 136 of the Mental Health Act 1983, where their mental distress poses an immediate danger to themselves and/or others. A child or young person who is detained by the police should be taken to an appropriate place of safety for assessment by appropriately qualified and skilled health colleagues. However, despite calls to address the shortage of places of safety, shortages remain across England²⁰¹.

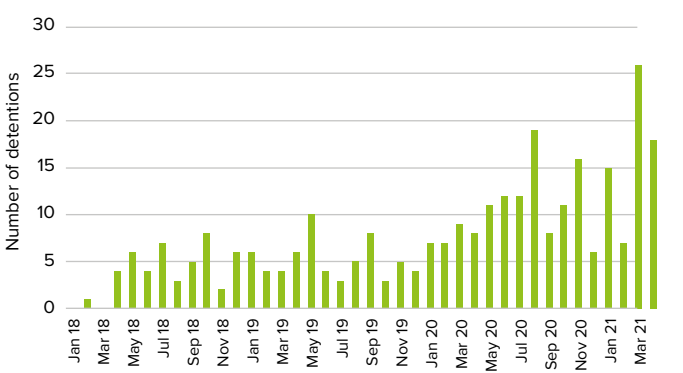
We acquired de-identified data covering all section 136 detentions in one NHS Trust in the North West of England, between December 2017 and April 2021. Cases pertaining to children aged 18 and under were extracted, including data on the reason for detention. Twelve interviews were conducted with police officers involved in the detentions. The data provide evidence of the growing shortages of places of safety for children in acute mental distress (Figure 7.4). Police officers had no choice but to take children to Accident and Emergency Hospital Departments or general paediatric wards, and provide supervision, typically overnight, pending arrival of a suitably qualified health professional.

Figure 7.3. Outstanding cases in family courts (public and private), 2020-21.



Source: HMCTS weekly management information during coronavirus - March 2020 to February 2021. <https://www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-2020-to-february-2021>

Figure 7.4. Number of section 136 detentions of children and young people by month, 2018-21.



Source: De-identified data covering all section 136 detentions in one NHS Trust in the North West of England, between December 2017 and April 2021

resulting in a larger population of children now requiring statutory intervention¹⁹³.

During the pandemic and national lockdowns, the additional pressures on families – including financial concerns, isolation, mental health challenges, changes in alcohol consumption patterns, and changes in risk of domestic abuse – have increased children’s exposure to major adversities.

There has been a sharp increase in adults reporting depression during the pandemic compared to pre-pandemic²¹². In early 2021, 21% of adults experienced depression – more than double the pre-pandemic rate. People living in the most deprived fifth of areas were more likely to experience depression during the pandemic (28% of people) compared to the least deprived (17% of people). Police data have also shown an increase in domestic abuse offences during the pandemic²¹³.

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

“All of 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 might be acting more aggressive than normal.”

Young person engaged with a community group in Bradford²¹⁴

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 this is very welcome¹⁹⁶. 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 high¹⁹³.

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 accounting adequately for area-level deprivation.
- Addressing the long-standing deficits in mental health provision

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 300) 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 bed availability.



for parents, including outreach services more closely tailored to the needs of vulnerable parents.

■ Reinvesting in services that tackle domestic abuse, and recognising the part that domestic abuse plays – not only in children entering care, but also in high conflict divorce and separation cases, which also feature disproportionately in the North.

Local authorities in the North will struggle to re-direct funds to early family help, because of the costs already tied to a large population of children in their care. The marketisation of children’s residential care has added to the strain on the North. A far greater number of children with the most complex difficulties are placed in the North West in particular, where there is a greater availability of residential beds.

Priorities include:

- Additional targeted investment in the North to ensure sufficient provision of preventative services to stem the flow of new children entering care.
- Addressing the uneven geographic distribution of children’s residential care, including secure provision, to reduce the disproportionate burden on the North. A recognition of the disproportionate costs to a range of services in the North, due to the number of children with complex difficulties in care, is long overdue.

The end to COVID-19 restrictions requires a major reset of services that have been delivered entirely remotely – early help and statutory children’s social care as well as services provided by the courts.

Priorities include:

- Challenging continued remote [only] delivery, which may be seen as cost-saving, particularly in the family courts, which were overwhelmed pre-pandemic. Although remote ways of working have value, the mode of delivery must not compromise the support and protection of children.
- Addressing the backlog of cases in the family courts to ensure timely permanency decisions, including the reunification of children to parents or kin.

Finally, the short-term and lifelong impacts of the pandemic on children must be addressed. Vulnerable children were already suffering developmental disadvantage pre-pandemic, and the impacts are likely to have been exacerbated over the last 18 months.

Priorities include:

- Providing resources and services to support ‘catch up’ in all facets of children’s development.
- Addressing the long-standing deficits in mental health provision for children and adolescents – including children at risk of acute mental health crisis, and including funding for appropriate places of safety.

Ultimately, however, there is a need for an overarching, long-term, equitable plan for children in the North, to address their disproportionate pre- and post-pandemic 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 divide between the North and the South, and ensure a sustainable financial plan to ‘level up’ opportunities for vulnerable children in the North.

What do police officers tell us? Section 136 detentions in one North West NHS Trust.

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 offer 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”



Ethnic minority children and young people: health and wellbeing

Authors: Sarah Salway, Stephanie Ejegi-Memeh, Calum Webb, Ghazala Mir, Rizwana Lala, Nazmy Villarroel-Williams

Context

The children of the North of England are increasingly ethnically diverse. In an average local authority in the North of England, 21% of school aged pupils now identify as being from an ethnic minority background, and this figure ranges from 6% to 66%. In 2020/21, 27% of school children in Yorkshire and Humber identified as being from an ethnic minority background. This figure was 25% in the North West, and 12% in the North East²¹⁵.

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%) (Figure 8.1).

Other chapters in this report present useful data on child poverty (Chapter 2), perinatal and infant mortality (see Chapter 3), mental health (see Chapter 4), physical activity, obesity and food security (see Chapter 5) and educational inequalities (see Chapter 6), by ethnicity. However, a focused chapter is warranted given the persistent role of interpersonal, cultural and structural racism in shaping the lives of ethnic minority children and young people.

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, rather than policy responding to this worsening situation, there is a concern that the push for quick pandemic recovery

Promising practice: Leeds City Council Needs Assessment

In 2019, Leeds City Council undertook a focused needs assessment to paint a detailed picture of mental health and service access in the city, to better understand the needs of ethnic minority children and young people and identify gaps in local provision.

A range of approaches was employed to draw in statistical evidence and firsthand accounts from ethnic minority young people. This has informed subsequent action, with work underway to develop city-wide initiatives that reduce the risk of mental health problems, and improve equitable access to mental health services.

More information: <https://forumcentral.org.uk/mental-health-in-equalities-experienced-by-young-people-from-minority-ethnic-groups/>

solutions will result in the further dilution of attention to ethnic diversity, disadvantage and discrimination. Moreover, the current national government has repeatedly denied the role of structural and institutional racism in shaping the lives of the UK’s ethnic minority people^{216,217}, and has promoted a narrative that undermines a sense of belonging and being a valued member of society^{218–220}.

As such, while we should highlight shared experiences that can unite diverse communities and challenge the health-damaging socioeconomic circumstances afflicting large numbers of children across the country, it is also imperative that intersectional inequalities are understood, and racism tackled.

Here, we identify four broad, inter-linked areas for urgent attention. We need to:

■ Increase understanding about ethnic minority children and young people, their experiences and needs

■ Address socioeconomic deprivation

■ Tackle racism at interpersonal, cultural and structural levels

■ Make health and well-being policies and services work for ethnic minorities.

Know your population
Those charged with developing strategies and services aiming to promote children’s health and wellbeing have been slow to recognize and respond to ethnic diversity. Even basic, up-to-date demographic information is lacking. Nationally reported statistics on children’s health and wellbeing, including Public Health Profiles²³ frequently overlook ethnic make-up, and national surveys, including the UK Household Longitudinal Study²²¹, do not support analyses by ethnic group and region due to inadequate sample sizes. 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 almost no attention to racism as a determinant of poor health²²³.

This absence of data and analysis hides local patterns, renders some groups completely invisible, and precludes investigation of the key drivers of health disadvantage. Promising work that gives 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. Unemployment^{224,225}, precarious employment and low paid work²²⁶ 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 households^{227,228}, with ethnic minority families further disadvantaged by obstacles to benefit uptake^{229,230} and entitlement rules, notably the benefit cap^{231–233} and two-child limit on Universal Credit²³⁴.

Figure 8.1. Child poverty rate by ethnic group, UK 2017-2020

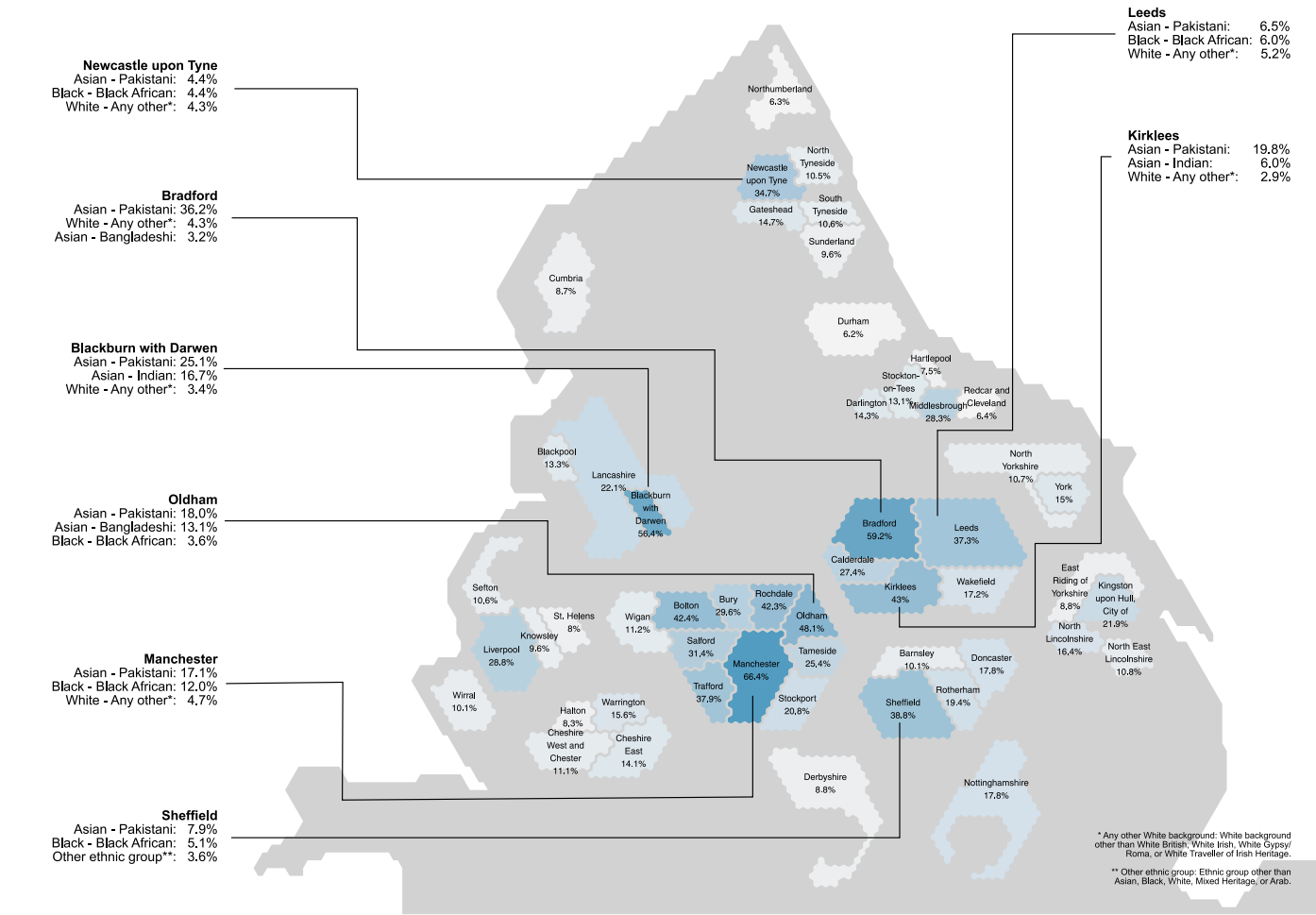


Table 8.1. Child poverty rate and composition by ethnic group: UK 2017-2020.

	Child poverty rate (%) (After Housing Costs)
White	19.8
Mixed/Multiple Ethnic Groups	34.7
Indian	24.1
Pakistani	50.4
Bangladeshi	59.2
Chinese	31.2
Any other Asian background	41.8
Black/African/Caribbean/Black British	41.8
Other Ethnic Group	42.8
All	22.1

Source: Family Resources Survey data, Department for Work and Pensions.

high minority ethnic density (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 8.2. Percentage of children* in persistent low income, by ethnic group of head of household, UK, 2010/11-2013/14 and 2013/14-2016/17.

	2010-11 to 2013-14		2013-14 to 2016-7	
	<70% of median income (before housing costs)	<70% of median income (after housing costs)	<70% of median income (before i housing costs)	<70% of median ncome (after housing costs)
White	20	26	21	26
Mixed/multiple	24	33	21	36
Asian/Asian British	35	45	42	50
Black: African/ Caribbean /Black British	33	45	32	47
Other ethnic group	38	54	-	-

Source: Table produced from UK Household Longitudinal Survey data analysed and published by Department for Work and Pensions: <https://www.gov.uk/government/statistics/income-dynamics-2010-to-2018>

* Children are those aged under 16 or aged 16 to 18 in full-time non-advanced education in the first interview of the period considered. See Background information and methodology at above link for more information.

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 exacerbated²³⁷. Recessions affect ethnic groups differentially, with unemployment rising more sharply among ethnic minority groups than majority White^{224,225}. 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 disadvantage²³⁸. 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.

Pakistani and Bangladeshi workers were particularly heavily concentrated in shut-down sectors²³⁹. Government job retention and creation initiatives have paid scant attention to ethnic dimensions²³⁸. 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 group²⁴⁰. Furthermore, loss of earnings was more likely to be mitigated via borrowing and transfers from friends and family among the non-White group.

This raises concerns about depleted savings and growing debt, particularly since we know that having any savings was much less likely among ethnic minority households. Joseph Rowntree Foundation’s recent report highlights the differential impact of COVID-19 on ethnic minority households with higher risks of redundancy, low pay and being trapped in poverty than White households²⁴¹.

While data are limited and not broken down by region, socioeconomic conditions are likely to be particularly stark for families within the immigration system. There are a range of additional factors undermining socioeconomic security for families and children in different immigration categories during the pandemic²⁴².

Those without immigration status (‘undocumented’) are commonly entirely reliant on charities and community support networks for food, health and social care support – most of which suspended their face-to-face support during the pandemic. Moreover, responses aimed at mitigating COVID-19 impacts on vulnerable children - such as the introduction of Free School Meal vouchers following public pressure - are unlikely to reach some of the most vulnerable children, whose immigration status may be a barrier to eligibility²⁴³.

The requirements of lockdown led to a withdrawal of informal temporary housing support from friends or community members and there is evidence of an increase in minority ethnic women with no recourse to public funds, and children in particular, presenting as homeless and seeking financial support and accommodation through local authorities since the start of the pandemic.

Such individuals may then be subject to accusations of trying to cheat the system and lengthy delays during local authority assessments. The combination of insecurity and racism can have serious impacts on mental health of parents and children²⁴³.

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 17% less than their White counterparts²⁴⁴.

Racism and discrimination are the driving forces behind these inequalities, and there has been little to no improvement over recent decades^{110,245–247}. 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 economy²⁴⁶.

Tackle racism at interpersonal, cultural and structural levels

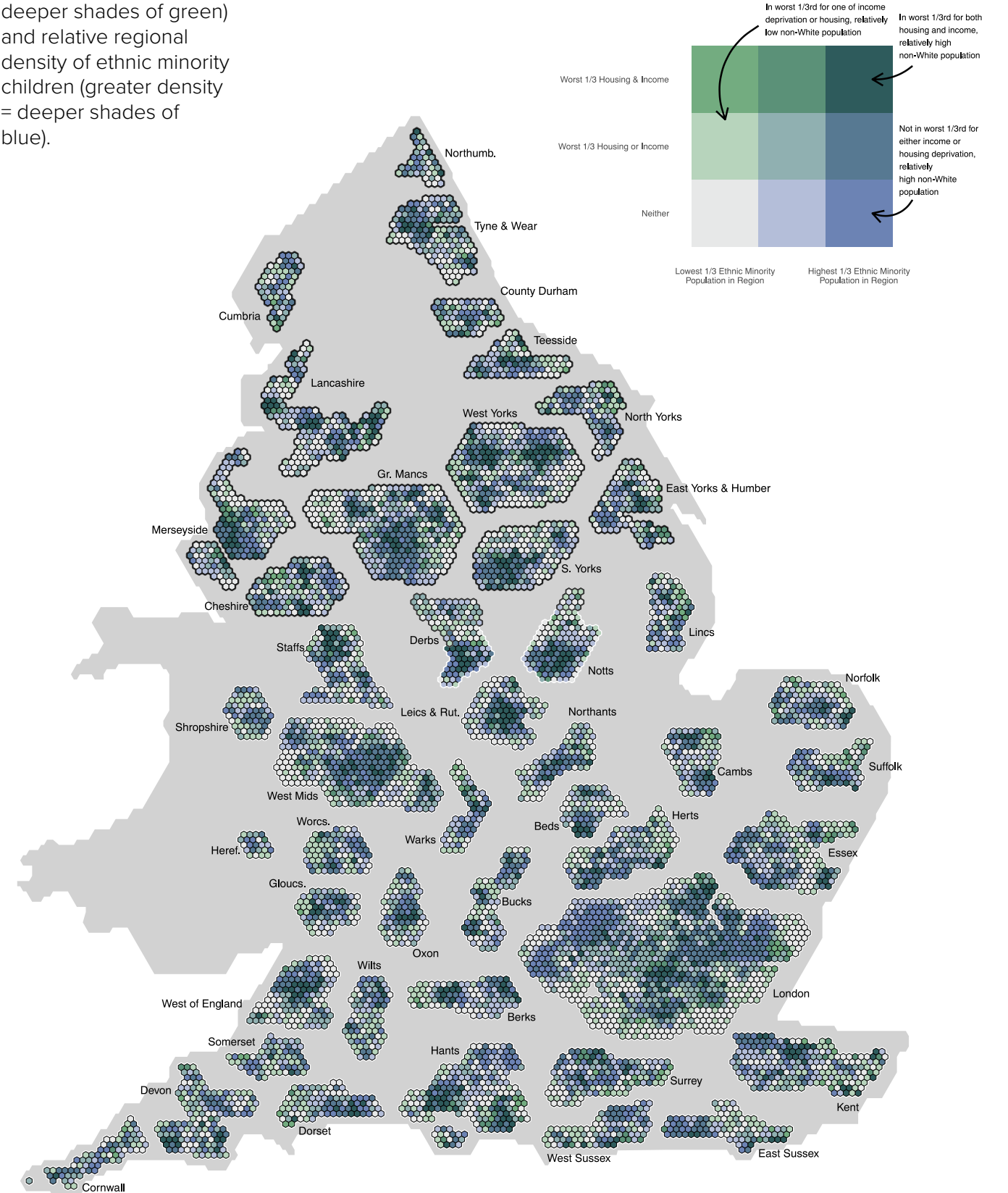
Racism is best understood as an organised social system that operates at different levels, and manifests in both overt and covert ways¹¹¹. The health and wellbeing of ethnic minority children and young people is undermined by interpersonal, cultural and structural racism¹¹¹.

Evidence suggests that racism is not only emotionally damaging but that its effects accumulate over the lifecourse, leading to activation of stress responses, harmful hormonal adaptations and adverse impacts on both mental and physical health^{248–251}. The pervasive nature of racism and its impact on ethnic minority health has been consistently highlighted in the UK^{16,252–254}. Racism based in religious, as well as ethnic, identity is also a serious cause for concern²⁵⁵.

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.

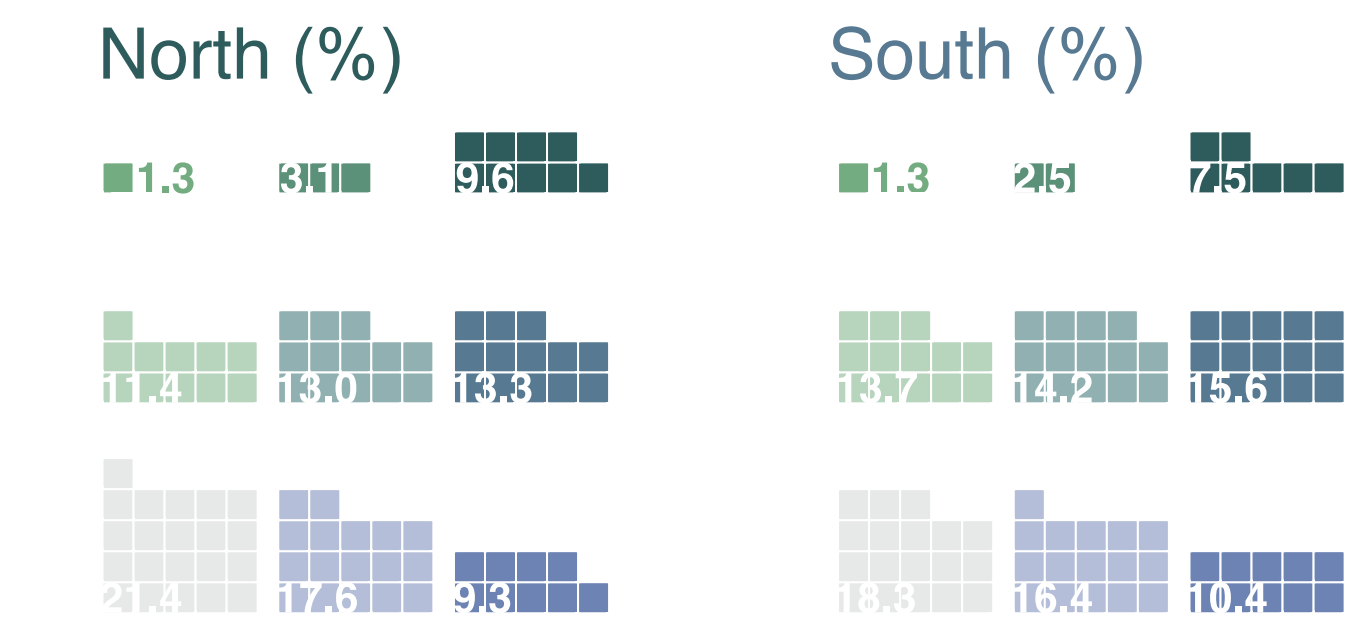
Ethnic minority children and young people in Britain consistently report experiences of interpersonal racism in educational, health and social settings^{110,256–259}. In one study, 95% of young Black people reported having witnessed the use of racist language at school¹¹⁰. In another²⁵⁸, a Scottish Muslim pupil recalled the lasting impact of

Figure 8.2. Map of neighbourhoods in England, shaded by combined low income and housing deprivation (greater deprivation = deeper shades of green) and relative regional density of ethnic minority children (greater density = deeper shades of blue).



Data source: Indices of Multiple Deprivation 2019, ONS Population Estimates, Census 2011. Non-contiguous Hex Map of MSOAs from House of Commons Library licensed under Open Parliament License 3.0.

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.



being singled out by a teacher for laughing though all students were laughing:

"I felt it was targeted at me since I was the only Brown person in the class. I felt so left out. And she kept me outside the class in the hallway for the whole rest of the period. [...] They put me in a room, closed the door on me, and I had to stay there alone for the whole day. That was the most depressing thing I've experienced in my life. [...] The whole year. I felt it. I would put my hand up to answer questions, and she would look at me, like so disgusted."

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 neighbourhoods²⁶⁰. Consultation exercises with young people in Northern cities have highlighted racism and discrimination as a deep concern and priority for action to improve well-being.

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

(Bradford Schools Pandemic Recovery Summit²⁶¹)

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 highlighted²⁵⁹.

"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 during childhood. This may therefore be an opportune time to take action²⁶². However, the evidence base on effective interventions to reduce interpersonal racism remains weak²⁶³. 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 change²⁶⁴.

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^{257,264}. 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 levels²²³.

Specifically acknowledging and naming racism has been reported as important to ensure that initiatives aimed at young people from minority ethnic backgrounds are effective¹¹⁹. 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^{223,265,266}. 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^{107,223}. Persistent under-funding of community projects in general, and a reluctance to fund ethnic-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"²⁶⁷.

UK policy and societal attention directed towards ethnic minority young people is overwhelmingly negative, focusing on individual and community deficits rather than structural disadvantage^{256,268}. 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

activism^{260,268,269}.

Cultural racism also pervades the Islamophobia to which young people in many Northern towns are commonly subjected and frequently remains unacknowledged in work to address ethnic inequalities, reflecting the international experience of children and young people from Muslim minorities^{270,271}. Muslim girls and young women are overwhelmingly portrayed as down-trodden and backward²⁷².

Cultural racism is also perpetuated via schools. Phoenix²⁷³ found African-Caribbean young women constructed as 'inadequate learners and devalued femininities'. Such narratives perpetuate inequalities and legitimise inter-personal racism and differential treatment²⁷⁴.

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^{260,268}. Runnymede Trust's "Reframing race project", launched in 2019, seeks to reframe the public conversation around children and young people from minority ethnic backgrounds, race, racism and racial justice²⁷⁵, 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^{223,259}. 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 cohesion²⁵⁹.

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 under-documented^{223,262}.

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 Trust²⁷⁶.

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 groups²⁶⁷. Recognising structural racism means acknowledging that racism persists within institutions even when individuals themselves are not explicitly prejudiced²⁶⁷.

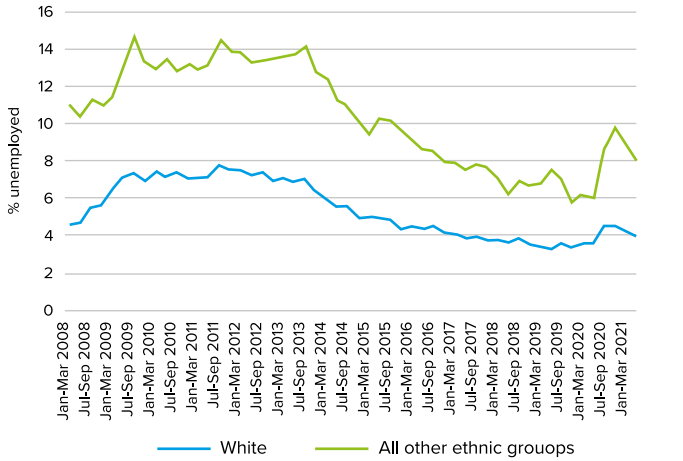
Structural racism has multiple dimensions and leads to disadvantage in accessing key economic, physical and social resources²⁷⁷. Evidence suggests that the health of ethnic minority groups is likely more affected by structural, rather than interpersonal racism²⁷⁸. While highly contested within the current government in England today, structural racism is acutely experienced by many children and young people of ethnic minority background¹¹⁰. For ethnic minority children and young people, structural racism impacts particularly in the arenas of school, criminal justice, employment, as mentioned above.

While Chapter 6 identifies the key role of schools in COVID-19 recovery and addressing inequality, much work is needed to make this a reality for ethnic minority children.

Structural racism in British schools is reflected in: the overwhelmingly White teacher workforce (85.7% compared to 78.5% of the working age population²⁷⁹); the failure to reflect the diversity of contemporary society and our colonial legacy within the curriculum; the lack of explicit anti-racist policies and differential impacts of policies and processes on ethnic minority children; and the rise of policing within the school setting^{257,280}.

The disproportionate rates of exclusions experienced by some ethnic

Figure 8.4. Unemployment rates among those aged 16+ years by broad ethnic group over time, UK.



Note: White category includes respondents in England, Wales and Scotland identifying themselves as 'White - Gypsy or Irish Traveller' and respondents in Scotland identifying themselves as 'White - Polish'.
Source: <https://www.ons.gov.uk/employmentandlabourmarket/peoplein-work/employmentandemployeetypes/datasets/labourmarketstatusbyethnicgroupa09>

Promising practice: Unity Gym Project, Sheffield.

Unity Gym Project (UGP) is a Sheffield based youth charity, committed to the promotion of health and wellbeing. The project undertakes a range of activities to tackle interpersonal, cultural and structural racism, including the provision of an inclusive space at the heart of the Broomhall community where "differences are celebrated, knowledge is exchanged and talent is shared".

"I was an active kid with no activities to exert that energy, my attention wasn't good which led me to find school difficult, Unity Gym introduced me to basketball through Street Games CLUB1 event. I had the opportunity to attend to watch Sheffield Sharks Vs Giants now a year later I am taking part in sport and playing for local basketball team. It has also given me an opportunity to attend Street Games sports festivals / residential where I made new friends."

Abdi J

Supported by modest funding from the Sheffield City Council Cohesion Fund and the University of Sheffield, participatory filmmaking was undertaken as part of the project. This was a way to enable 'counter-storytelling'; young people experiencing racism, stigma and socioeconomic marginalisation were able to tell the stories that they wished to tell, and thereby challenge dominant narratives about their lives and their communities.

More information:

<https://www.youthandpolicy.org/articles/unitydoc/>
<https://www.youtube.com/watch?v=DmoWYK9T3Dc>

minority pupils, particularly Black Caribbean (10.4% for temporary exclusion in 2018/19), Mixed White/Black Caribbean (10.7%), Irish Traveller (14.6%) and Gypsy/Roma (21.3%) compared to White British (6.0%)²⁸¹, are a huge cause for concern given the variety of negative outcomes that ensue²⁸². This persistent inequality demands attention to systemic racism (both structural and cultural)^{282,283} and building a sense of belonging for all children in schools²⁸⁴.

There is extreme concern among pupils, parents and teachers regarding the resurgence of police-school partnerships²⁸⁰, which has

been referred to as the ‘weaponization of schools’ against Black and Muslim youth²⁸⁵.

Significant Northern community-led responses, including the ‘No Police in Schools’ Manchester campaign led by Kids of Colour and the Northern Police Monitoring Project highlight the stigmatising effect of this policy, which creates a climate of low expectations and hostility²⁸⁶.

These educational policy directions can be seen as an extension of the structural racism that permeates the criminal justice system in the UK. They come at a time when Black Lives Matter protests have reignited conversations about racism and the role of the police in society. Shankley and Williams²⁸⁷ provide a compelling summary of the racialised nature of the British criminal justice system, documenting: the White domination of roles with power (93.4% of police officers, 93% of court judges, 94% of prison officers); a rate of stop-and-search that remains eight times higher among people of Black ethnicity than White people; and the policy focus on ‘gangs’ that lacks an evidence base and serves to pathologise and alienate young ethnic minority people.

National statistics show that Black young people are over-represented among those in custody, and this over-representation has increased substantially in the past decade²⁸⁸. Use of force on young people in custody is consistently lower among White than ethnic minority detainees²⁸⁹. Greater understanding of the role of structural racism as a fundamental cause of health inequalities is needed²⁷⁸. New knowledge generation and action must embed opportunities for ethnic minority children and young people to collectively share their experiences, highlight concerns, inform decisions, and hold those with power to account^{110,290}.

Initiatives such the Ubele’s “Young emerging leaders collective” in London²⁹¹, Unity Gym Sheffield (Textbox previous page), and Young Manchester²⁹⁰ can be as sources of inspiration for multi-level action on racism and meaningful involvement of young people. See Chapter 10 for further discussion of meaningful participation of children and young people in the COVID-19 recovery.

Embed ethnic equality into health and wellbeing policies and services
Evidence suggests that health services and public health programmes frequently overlook or misconstrue the needs of ethnic minorities.

They fail to counter ethnic minorities’ disproportionate exposure to health-damaging environments at household and neighbourhood level. Healthcare systems and processes, and the practices of healthcare professionals, reflect the cultural and structural racism of wider society described above, contributing to poorer access, uptake, experiences and outcomes of services.

Earlier chapters provide more detail on the patterns of ethnic inequality and inadequate service responses across pregnancy and early years (see Chapter 3), child mental wellbeing (see Chapter 4), and nutrition (see Chapter 5). Dental health is another area of concern, as outlined in panel on the right.

Poor experience has created a distrust of health and social institutions within ethnic minority communities²⁵⁹. The YMCA found that 27% of Black and Mixed youths thought that a lack of trust in the NHS was a barrier to maintaining good physical health¹¹⁰. The picture during COVID-19 has been no different.

Despite the stark reality of disproportionate morbidity and mortality from COVID-19 among ethnic minority communities in England^{259,300,301}, health policy during the pandemic has repeatedly overlooked these groups. Leadership has been far from inclusive and policies have not considered how responses might disproportionately affect particular groups of people.

There have been more than 60 Judicial Review challenges on government policy that result in inequity – mostly relating to

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/Irish traveller children most affected (59.6%)²⁹².

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 teeth extracted²⁹³. The prevalence of tooth decay amongst 5-year-old children varies regionally and is highest in the North West (31.7%) and lowest in the South East (17.6%). At a local authority level, over half of 5-year-olds (50.9%) in Blackburn and Darwen experience tooth decay when compared with 1.1% in Hastings, East Sussex.

Ethnic minority children experience greater levels of decay on front teeth, which can lead to bullying and mental health concerns²⁹². Prevalence of front tooth decay is 13.6% amongst Asian children and 15.7% in the other ethnic groups, compared with 3.6% in White children. Severe dental decay contributes to some of these children being underweight²⁹⁴ because pain and infection can further compromise food intake²⁹⁵.

Policy and practice have not responded well to the dental health needs of ethnic minority children. Dentistry’s prevention approaches have been shown to stigmatise working-class and ethnic minority mothers by assuming a knowledge and skills deficit^{296,297}. Little attention is paid to how intra-household dynamics in low-income ethnic minority households may compound child dental health needs. National public health policy has also largely ignored the complex inter-relationship 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 care^{298,299}.

health and social care cases (e.g.³⁰²). Responses to the needs of disadvantaged groups during COVID-19 have often come from within disadvantaged communities themselves and from professionals with links to these communities.

Community groups and voluntary organisations have challenged injustices and led the way on providing information and resources to those whose exclusion has intensified during the pandemic. Pressure to address inequity 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^{303,304}.

These pandemic events demonstrate the persistent lack of attention to racism and disadvantage among ethnic minority communities and the importance of increased representation of ethnic minority people within decision-making arenas.

Conclusion and recommendations
Producing this chapter has further highlighted the limited data and insight relating to the health and wellbeing of ethnic minority children and young people in the North of England. Significant evidence gaps persist, and new data collection efforts during the pandemic have continued to exclude these groups.

That said, the evidence available paints a worrying picture of persistent socioeconomic disadvantage underpinned by systemic racism, resulting in poor health and curtailed life-chances, 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 meaningful involvement 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 Observatory, with particular attention to intersections 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 racism. Link this to mechanisms for promoting anti-racist practice in public and commissioned services.
■ Co-create safe spaces for active listening and meaningful involvement of children and young people from ethnic minority backgrounds to ensure decisions affecting their health and wellbeing are informed by their insights and experiences.
■ Develop the infrastructure and partnerships required to improve the amount and granularity of data about health and social determinants of health in small-areas by ethnic group to enable identification of, and adequate responses to, intersecting forms of oppression, especially those associated with poverty, gender, and racism, without which the true scale and nature of ethnic/racial injustice, and religious discrimination, remains obscured.

Address socioeconomic deprivation

Over-arching

■ Embed Equity Impact Assessments into all COVID-19 recovery and other 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.
■ Reinstate the Universal Credit uplift.
■ Rescind the two-child benefit cap.
■ Reinvigorate the actions recommended by the McGregor-Smith review to tackle labour market discrimination, particularly in publicly funded institutions.
■ Implement a real Living Wage and improve workers’ rights across all sectors.



Local

■ Provide effective support to people needing to claim benefits (including support for digital literacy and access and language needs).
■ Put pressure on local employers to ensure a real Living Wage and require this from all services commissioned through public finance.

Tackle racism

Over-arching

■ Acknowledge systemic (structural and cultural) racism at national, regional and local levels and challenge its denial within policy and practice.
■ Expose and address policy, practice and public discourse that stigmatises and pathologises ethnic minority young people and the communities to which they belong (e.g. the Prevent programme).
■ Represent ethnic minority populations in leadership roles at national, regional and local levels.

National

■ Ensure transparent and credible processes for addressing structural and cultural racism at the level of national policy.

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.
■ Overhaul local systems and processes of decision-making to give ethnic minority children, young people and families a driving, rather than a marginal, role.
■ Ensure all publicly funded services including schools have strong anti-racist policies that provide guidance on how to respond to interpersonal student racism, and set out clear institutional actions and commitment to anti-racism.
■ Ensure Community Safety Partnerships have strong anti-racist policies that set out clear actions and commitment 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 more inclusive policies and resource allocation that: target inequalities and discrimination; enhance accessibility and appropriateness of services; and improve outcomes³⁰⁵.
■ Explicitly acknowledge racism as a determinant of health and healthcare outcomes and embed action on ethnic inequality across the commissioning cycle^{306,307}.
■ Embed high quality Equality Impact Assessments and Health Equity Audits into all national and local health 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 practice³⁰⁸.

Local

■ Invest in capacity building and collaboration with communities. Seek out and support 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 2021-22 as an opportunity for cross-sector working including local authorities, NHS services and community organisations to tackle ethnic health inequalities and racism.

The economic impacts of child health

Authors: Rose Atkins, Luke Munford, Clare Bamba

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 country³⁰⁹. 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 a 2018 'Health 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 £1.20 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 adulthood³¹⁰.

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)^{15,62}.

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).

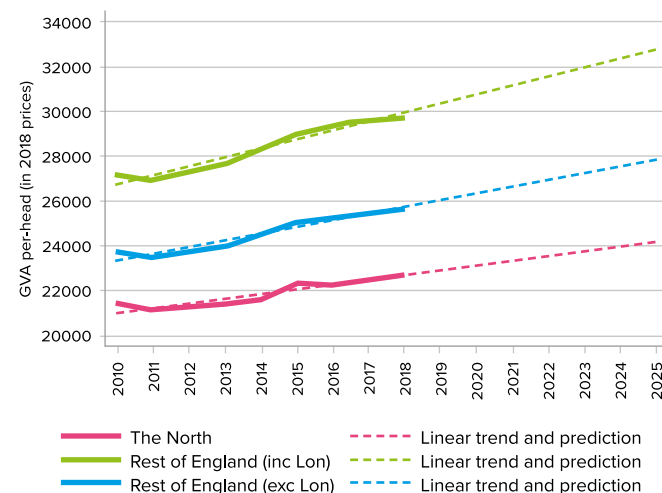
Figure 9.4. shows the percentage change in gross weekly pay between 2019 and 2020. Throughout large areas of the North, pay reduced considerably. Table 9.1 displays the percentage change in gross weekly pay at regional level. Males living in the North of England saw large percentage reductions in pay, with males living in the North East seeing average pay fall by 3.3%. In the North West, the average pay of males fell by 1.9%, and in Yorkshire and Humber, the average pay of males fell by 2.4%. Females living in all three Northern regions saw a slight increase in pay between 2019 and 2020 – though there was considerable heterogeneity at local authority level.

Early-life skills development and their impact on labour market outcomes

Child health can shape and influence the economic performance of future generations. Today's children are the workers of tomorrow. Cognitive ability, non-cognitive skills and health in children act alongside one another to determine wellbeing across the whole lifecourse³¹¹.

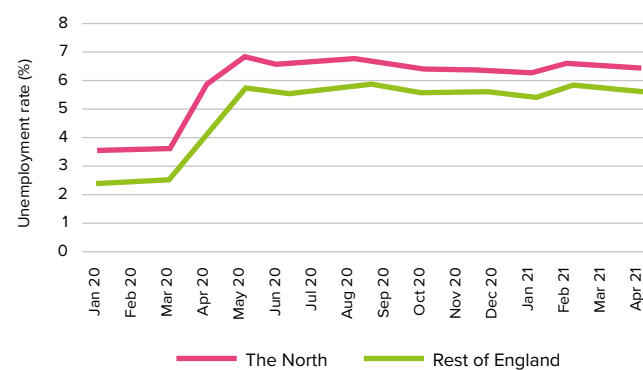
The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and adult health^{312–314}. Dynamic, multi-period models

Figure 9.1. Gross Value Added per head, in 2018 prices, over time, by part of England.



Source: Bamba et al (2020)¹⁵

Figure 9.2. Trend in percentage unemployment rate between March 2020 and March 2021 for the Northern regions and the rest of England.

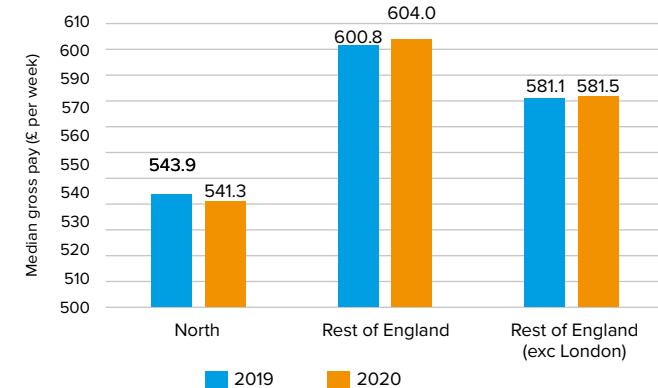


Source: Munford et al (2021)⁶²

of child development show how these capabilities are shaped by one another and highlight the importance of investing in each of them, particularly in early life³¹⁵. A negative shock to, or persistent undermining of, any of these capabilities is likely to have a lasting negative impact on wellbeing.

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

Figure 9.3. Median annual gross pay in 2019 and 2020, by part of England.



Source: Munford et al (2021)⁶²

Table 9.1. Percentage change in median gross weekly pay between 2019 and 2020, by region and gender.

Region	Male	Female	Total
North East	-3.3	2.9	-0.6
North West	-1.9	1.3	-0.1
Yorkshire and The Humber	-2.4	3.1	-1.0
East Midlands	1.3	3.3	1.6
West Midlands	-0.9	3.4	0.9
East	-3.4	3.2	-0.3
London	0.2	0.1	0.1
South East	-2.0	0.2	-0.8
South West	-3.0	0.0	-0.9

Source: NOMIS, Annual Survey of Hours and Earnings - resident analysis

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.

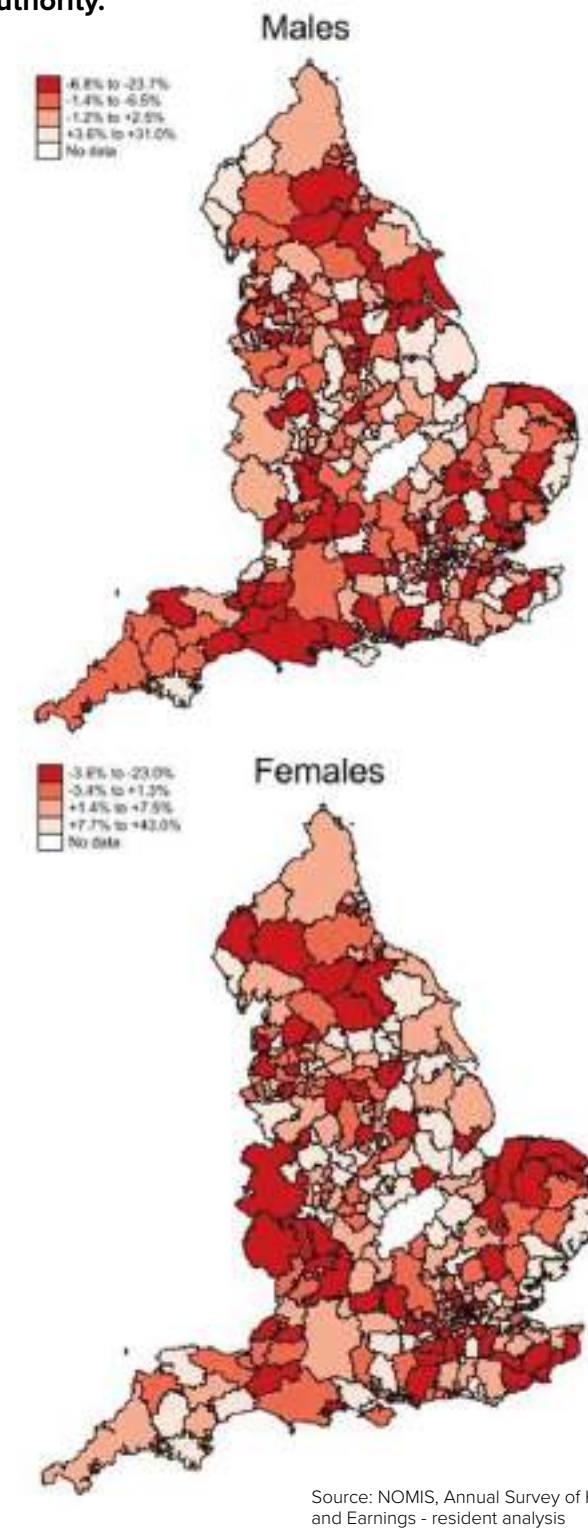
Chapter 6 highlights how the interruption to in-school learning during the pandemic has led to a widening of the attainment gap between advantaged and disadvantaged pupils, and, given the concentration of deprivation in the Northern regions, between the North and the rest of England.

This too is likely to have resulted from a disruption in the development of both cognitive and non-cognitive skills³¹, 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

Figure 9.4. Percentage changes in median gross weekly pay between 2019 and 2020, by local authority.



England is likely to lead to a 1.7-2.2% reduction in wages for males, and a 2.2-2.7% reduction in wages for females. This is comparatively higher than the potential wage reduction in the rest of England (1.0-1.3% for males and 1.3-1.6% 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 detrimental impact on key capabilities^{332,333}. Children exposed to abuse and neglect as a result of the lockdowns 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, happy, healthy, and fulfilled lives. Healthy children have been shown to be more likely to obtain good grades, be in employment, and earn higher salaries³³⁴.

Having outlined the evidence on how children’s health and cognitive and non-cognitive skills in early life may affect labour market outcomes over the lifecourse, 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 Statistics³³⁵. 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 benefits³³⁷. 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 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 obese³⁵². 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 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.

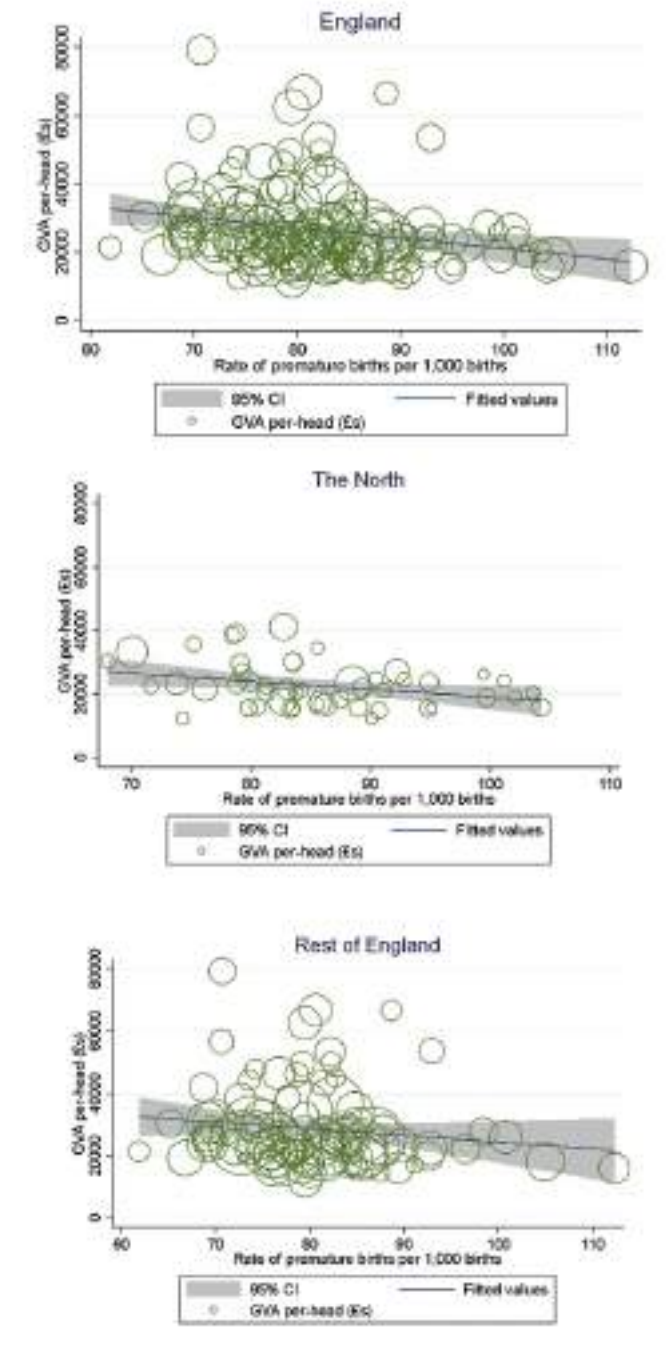
Given the clear evidence of the impact of child health and development on employment chances and labour market outcomes at individual level^{334,337}, it is imperative that we improve the health of children at societal level: not only for the long-lasting impact it will have on children’s lives, but also the effect it is likely to have on the economy.

Modelling the likely impact of the pandemic on the economic prospects of young people

Attainment gap

The most up-to-date figures on the attainment gap reported by the

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



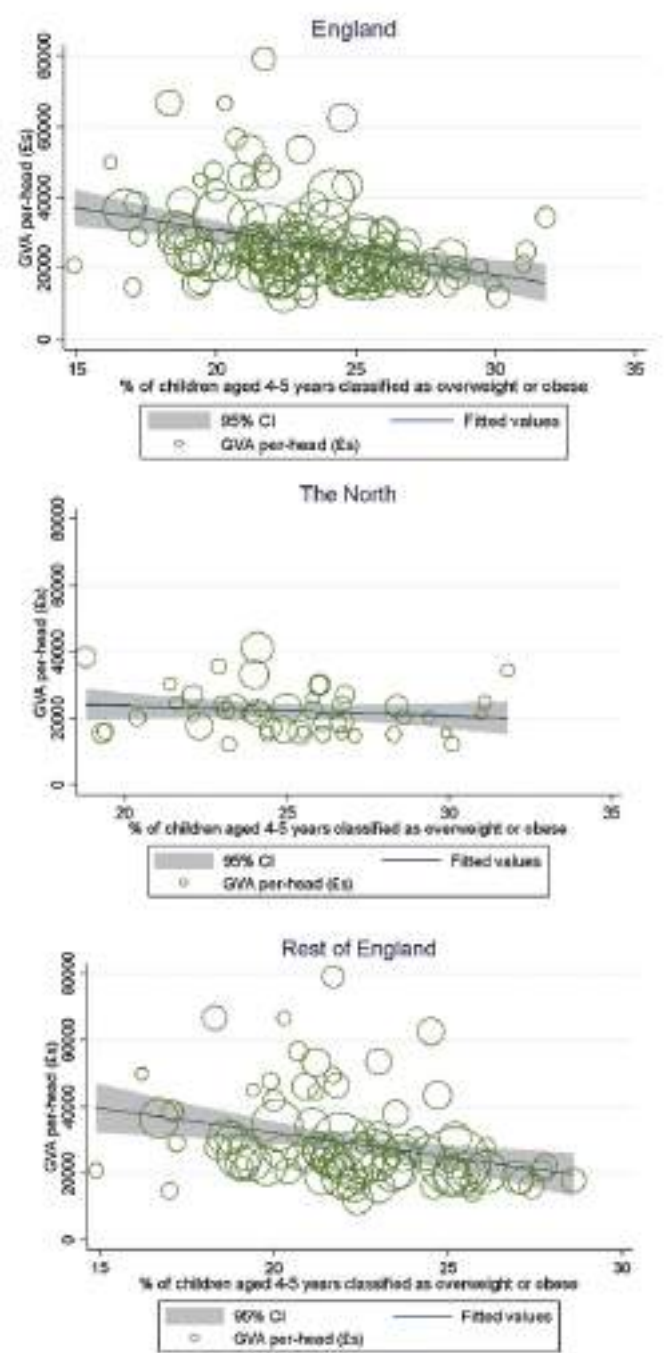
Note: Each circle is an upper-tier local authority. The size of the circle represents the relative size of the population denominator, such that larger areas are represented by larger circles. Local authorities with Gross Value Added per-head of over £100,000 are excluded.

Department of Health correspond to the second half of the autumn term 2020/21 (for further information, see Chapter 6)³³⁹. They show that 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 females³⁴⁰.

We estimate that in the absence of urgent intervention, the widening

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.

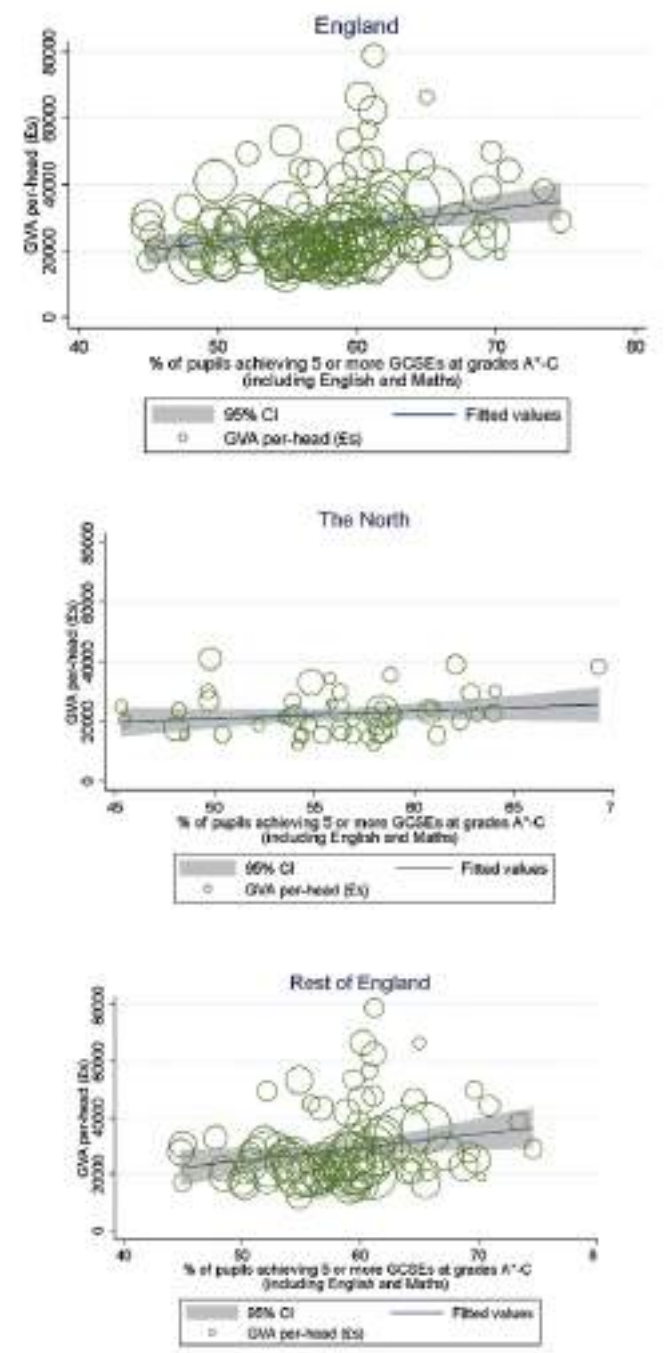


of the attainment gap will result in a 1.7%-2.2% reduction in wages for males in the North of England and a 1.0%-1.3% reduction in wages for males in the rest of England. This increases to a 2.2%-2.7% reduction in wages for females in the North of England and a 1.3%-1.6% reduction in wages for females 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 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 2018³⁴¹. The

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.



Office for National Statistics estimate the future lifetime earning of a male entering the labour market in 2018 to be £642,747 and the future lifetime earning of a female entering the labour market in 2018 to be £380,183. These figures are likely to be out-of-date for the cohort of children who are still in school now. However, if we use these estimates, we will get very conservative lower bounds on the expected loss of lifetime earnings that this widening attainment gap may cause (Figure 9.8).

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).

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

Authors: Helen Stalford and Eleanor Drywood

Figure 9.8. Conservative estimates of the loss of lifetime earnings due to loss of education during the COVID-19 lockdowns.

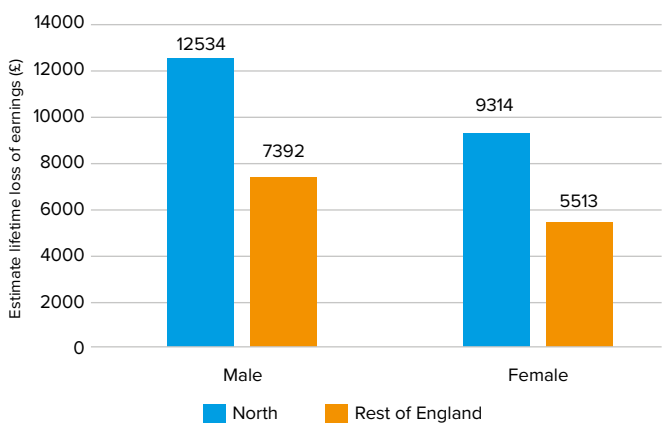
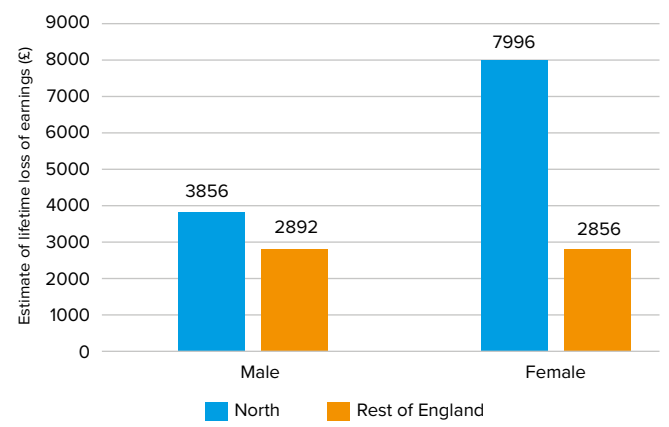


Figure 9.9. Conservative estimates of the loss of lifetime earnings due to worsening childhood mental health during the lockdowns



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 even 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 social care.
- 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 decrease unemployment amongst young people – especially in the regions hardest hit.
- Develop area-level measures of child health: overall, physical, and mental health.
- Conduct more research into the relationship between child health and economic performance. In particular, we need to better understand the likely causal pathways between these phenomena in order to identify entry points for policy.

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 outcomes³³⁴. 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 13% increase in depressive symptoms is associated with 2.4 fewer months of education³⁴², 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 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 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 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 33% more in lifetime earnings than males living in the rest of England (£3,856 compared to £2,892). Females living 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 £13.2 billion in lost wages in the North (£4.4 billion for males and £8.8 billion for females).

Chapter 4 presents trends in the average Strengths and Difficulties Questionnaire score, a commonly used measure of children’s mental health and wellbeing. Higher scores indicate more mental health problems. The chapter reports a sharp, notable reduction in these scores when schools reopen following a lockdown, and an increase when they close in January 2021.

A Strengths and Difficulties Questionnaire score greater than 17 indicates ‘socioemotional behavioural problems’ which suggests the presence of a mental health problem³⁴³. Between March 2020 and May 2021, the proportion of children reporting a score greater than 17 increased by 0.8 percentage points for boys in the North of England and 1.0 percentage points for boys in the rest of England. For girls these increases are much greater, with an increase of 6.1 percentage points in the North of England and 4.3 percentage points in the rest of England.

The lifetime costs of childhood mental health conditions are estimated to amount to around £220,000 in lost family income³⁴⁴. In the absence of intervention, we estimate that the average male in the North of England will lose £1,760 in lifetime family income, and the average male in the rest of England will lose £2,200. For females, we estimate an average lifetime loss of £13,420 in family income 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 country, the findings outlined in this chapter are worrying. Yet again, it appears that the North of England

“In their responses to COVID-19, States must adopt an effective, child rights-based response that protects and benefits those in most vulnerable situations while advancing efforts to respect, protect and fulfil children’s rights”

(UN Committee on the Rights of the Child, 2021)³⁴⁵

Context

The evidence presented in this report highlights how the multiple public health, social and economic effects of COVID-19 impact on children in profound, distinct and enduring ways. As shown in Chapter 2, the North of England is comprised of regions which consistently rank highly on child poverty indices in the UK. This prompts particularly urgent questions, not only about how future generations will bear the burden of the pandemic for years to come³⁴⁶, but also about how those legacies will compound existing regional inequalities.

An abundance of research demonstrates that the prioritisation of children’s rights, services and remedies from the very early stages of children’s lives is the best way to achieve sustainable, positive change for society more broadly^{347–355}. Much of this work highlights the benefits of investment in children to both prevent and address crisis situations, such as poverty, criminal offending and asylum. And much of it is underpinned by a clear acknowledgement of our legal obligations to uphold the rights and welfare of children.

These efforts offer a powerful illustration of how a COVID-19 recovery plan explicitly grounded in the obligations, values and processes associated with children’s rights has much to offer in mitigating the ongoing effects of the pandemic³⁵⁶.

In reality, however, the UK’s record of investment in children is shameful; historically, in times of economic and political crisis, children have tended to be the primary targets of public cuts rather than investment³⁵⁷.

Recent research completed for the international, comparative non-governmental organisation, KidsRights³⁵⁸, ranked the UK one of the lowest (169 out of 182) for its ability to deliver on key areas of children’s rights, lower than states with significantly more troubled economic and political systems such as Iran, Iraq, Afghanistan, Albania and Syria. This is primarily attributed to the UK’s failure to put in place the fundamental legal, political, procedural and economic building blocks that make it possible to respond to children’s most basic needs.

The case for a children’s rights-based approach to COVID-19 policy planning in the North of England

The process of creating an environment in which children can thrive is commonly referred to as a *Children’s Rights Based Approach*³⁵⁹. A *Children’s Rights Based Approach* to developing law, policy and planning is inspired by broader efforts to adopt a human rights-based approach to development co-operation, at UN level, over the past two decades³⁶⁰. A *Children’s Rights Based Approach* also underpins action on the Sustainable Development Goals³⁴⁵.

Placing children’s rights at the heart of the COVID-19 recovery strategy requires that:

- COVID-19-related programmes, policies and technical assistance further the realisation of children’s rights as laid down in international and domestic law.
- Children’s rights standards and principles guide all programming in all sectors and in all phases of the programming process.
- All child-related programmes and policies develop the capacities of ‘duty-bearers’ to meet their obligations (e.g. those responsible for delivering public services, researchers, and other adults charged with children’s care and welfare), and the capacities of ‘rights-holders’ – children – to claim their rights³⁶¹.

Rights, like economic resources, do not trickle down to benefit all children in all regions in equal measure. It is increasingly evident, therefore, that meaningful change to structures, processes and outcomes affecting children are most effective when they are designed, managed and delivered at the closest possible level to where children are living. For this reason, regional initiatives grounded in a children’s rights-based approach are as effective as – if not more effective than – national-level efforts.

The key features of a children’s rights-based approach to COVID-19 recovery for children in the North

There is extensive research on the key features of a children’s rights-based approach to policy planning. This can be used as a blueprint for the COVID-19 recovery in the North of England. The main features are:

1. A COVID-19 recovery strategy for the North must be grounded in children’s rights principles and provisions

Any attempts to develop a COVID-19 recovery strategy for children must be informed by a sound understanding of what children’s rights are and how they should be applied in practice.

An essential reference point in determining the nature and scope of children’s rights is the UN Convention on the Rights of the Child 1989 (UNCRC), which was ratified by the UK in 1991. The UNCRC represents the most comprehensive, globally approved catalogue of children’s civil, political, social and economic rights, including their right to the highest attainable standard of health (Article 24), the right to an adequate standard of living (Article 27), and the right to education (Article 28)³⁶².

These provisions are accompanied by extensive guidance on how to implement these obligations in light of variable regional, cultural, social and economic contexts. As such, the UNCRC offers a ready-made framework for auditing how children’s interests and needs should be accommodated within any given system. It also imposes legally-binding obligations by which all public authorities, at all levels – centrally and locally – should be held to account.

The UNCRC is strongest when it is incorporated directly into domestic law and policy because it enables individuals to hold public authorities to account for failing to comply with them, and to enforce those obligations directly before the courts³⁶³. This is why the Human Rights Act 1998, which incorporates the European Convention on Human Rights into domestic law, has been so powerful in vindicating individuals’ rights. Whilst progress has been made to incorporate the

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, and has been adopted by over 100 cities worldwide, supports local governments and organisations in realizing 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 right 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 local as much as a national commitment to responding to the needs of children to the maximum extent of their available resources (Article 4).

Of the six cities in the UK that have officially signed up to the Child Friendly City programme, Liverpool is the only one located in the North of England. Liverpool City Council, in collaboration with an extensive network of children, public services, civil society organisations, academics and private businesses, has committed to a five-year programme of action (2018-2023).

This includes delivering comprehensive training on children's rights in context, enacting child friendly policies and procedures that are informed by children's wishes and experiences, ensuring that an adequate proportion of the local budget is earmarked for children's services, and ongoing evaluation of the effects of these adaptations on children and society more generally.

Other cities in the Northern regions have also made important strides. In 2012, inspired by the UNICEF Child Friendly Cities programme, Leeds City Council launched 'Child Friendly Leeds'. Through youth voice groups, projects, consultations and events, this initiative has sought to put the voice of the child at the heart of the city's strategies for health, education and economic prosperity. In 2020, Bradford Council declared its intention to work towards UNICEF Child Friendly City status, recognising the potential benefits of prioritising children's rights.

UNCRC into domestic law in different parts of the UK, including Wales and, more recently, Scotland, it remains largely absent and distant from English law and policy.

The panel 'The Child friendly Cities Programme' above illustrates how, notwithstanding any legal incorporation of the UNCRC into English law, there are creative 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's services are 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 Assessments³⁶⁴. Children's Rights Impact Assessments are firmly rooted in children's rights standards and principles as set out in the UNCRC. They require relevant, updated expert evidence-gathering to inform anticipated impacts of laws and policies on children, as well as consultation with children and young people who are likely to be affected by the proposed measures.

In 2018, the Department for Education established its own Children's Rights Impact Assessment tool to enable some scrutiny of the potential impact of proposed laws and policies on children. This has been applied, to some degree, to proposed education and social care legislation (such as the Education and Adoption Act 2016; and The Children and Social Work Act 2017).

Much needs to be done to improve the rigour, scope and impact of these impact assessments, however. The swathe of emergency law and policy brought in as a result of COVID-19 exposed the Government's highly tokenistic and ineffective application of Children's Rights Impact Assessments, most notably by the Court of Appeal in the case of *Article 39, R (On the Application Of) v Secretary of State for Education* [2020] EWCA Civ 1577 (24 November 2020).

This involved a challenge to the Government's amendments to children's social care regulations brought in shortly after the first UK

lockdown. The changes introduced by the emergency law included: the removal of the requirement for social workers to visit children in care every six weeks and for the welfare of children in care to be independently reviewed every six months; the removal of the requirement for independent visits to children's homes every month; and reductions in suitability checks on prospective foster carers.

The Court of Appeal found that the Secretary of State for Education had acted unlawfully in removing such safeguards for children in care by neglecting, as part of its Children's Rights Impact Assessment, to consult the Children's Commissioner and other bodies representing the rights of children in care. This judgment demonstrates the ability to use Children's Rights Impact Assessment obligations to hold public bodies to account for failing to consider fully the potential impacts of proposed laws and policies on children.

Whilst this case exposed central Government's fragile commitment to developing legal and policy responses based on expert evidence and meaningful consultation, the pandemic has provided an opportunity for the development of strong impact assessment processes at a more regional level.

3. Routine and meaningful participation of children and young people in local recovery planning
Any COVID-19 recovery plan, if it is to respond effectively to the interests and needs of children, needs to be directly informed by their 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 in 137 different national contexts³⁶⁶. The study emphasises that listening to the views and experiences of children at an earlier stage of governments' pandemic responses, and genuinely acting on them, would have avoided some of the policy missteps and widening regional inequalities which have resulted from those missteps.

Relatedly, research published by the Department for Education in February 2021 revealed significant regional disparities in the impact of the disruption to schooling caused by COVID-19, with pupils in some parts of Northern England losing twice as much learning over

COVID-19 impact assessments in Scotland.

A much more meaningful model of Children's Rights Impact Assessments has been developed in Scotland, interestingly in the context of COVID-19 legislation. Most notably, this process has been conducted independently of Government at the request of the Scottish Children's Commissioner. This was in direct response to concerns that legislation intended to protect public health could adversely and significantly impact on a wide range of children's human rights. The Scottish Children's Commissioner noted in particular:

*"It is at times of crisis that hard-won human rights protections are most vital, and most at risk. It was concerning therefore that much of the emergency legislation was passed by the Scottish and UK Parliaments at speed and without the opportunity for robust or detailed scrutiny. Parliaments play critical roles as human rights guarantors and as such need the time, capacity and evidence to hold governments to account. [Children's Rights Impact Assessments] are a key part of that accountability model and give parliamentarians the information they need in order to question and challenge the exercise of executive power"*³⁶⁵

Importantly, the Scottish COVID-19 Children's Rights Impact Assessments revealed significant gaps in data particularly relating to children living in poverty, those deprived of liberty, and those receiving treatment for mental health conditions, making it difficult to monitor the impact of the pandemic on those groups.

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 nationally consistent system of data collection and evaluation 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.

the same periods as those in London¹⁸⁶ (see Chapter 6).

These widening inequalities will have serious consequences for future regional inequalities in educational attainment and earnings (see Chapter 9). Attempts to respond to widening attainment gaps and lost opportunities must include in-depth consultation with children in the regions most affected.

Other chapters in this report underscore the importance of foregrounding children's voices, to advocate connecting to children and their families by making use of education settings at the heart of communities (see Chapter 6), and also in the context of planning and regeneration (see Chapter 5), and in combatting ethnic inequalities (see Chapter 8). Chapter 8 makes a powerful case for listening to 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 13 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 20,000 children and young people in Bradford that were brought together for a 'Pandemic Recovery Summit' in early 2021²⁶¹.

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.



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 health risks and benefits associated with vaccination³⁶⁷.

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-making³⁶⁸.

The UN Committee on the Rights of the Child underlines 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."*³⁶⁶

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 inroads have been made at 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, both by the children experiencing it now and by future generations of young people. In the absence of any explicit and comprehensive prioritisation of children in a national COVID-19 recovery strategy, there has never been a better time to explore how to embed a children's rights-based approach into a more regionally focused recovery planning. The good news is that this is not a new endeavour.

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.

Whilst 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 outlay early on in a child's life is a sound investment that yields benefits for society more generally (see Chapter 9)³⁵⁷.

Centring children in post-pandemic local planning is, therefore, not just a legal and moral duty; it is an essential strategy for achieving sustainable recovery.

Recommendations:

- Local COVID-19 recovery strategies must be grounded in internationally recognised human rights-based values and principles, notably those contained in the United Nations Convention on the Rights of the Child 1989.
- Children's Rights Impact Assessments must be used to anticipate and evaluate the specific impact of COVID-19 recovery strategies on children and young people.
- Relevant data needs to be collected, disaggregated and published so that the various impacts of the pandemic, and the impacts of any interventions on children, can be routinely evaluated.
- Children should be consulted and listened to in the development of COVID-19 recovery strategies in the North.
- Any new COVID-19-related laws, policies and processes relevant to children need to be made available to them in accessible formats and languages so that children understand and can enforce their rights.
- Children must be specifically consulted on and considered in all local budgetary decisions relating to the COVID-19 recovery.

Children's rights budgeting in Wales.

The Welsh Assembly Government set a new standard in children's rights budgeting when, in 2008, it was the only devolved region to include an analysis of spending on children and young people.

Subsequently, the Rights of Children and Young Persons (Wales) Measure 2011 was passed, placing a duty on Ministers and local authorities to have due regard for the UNCRC, which extends to local authorities demonstrating how they are working towards eradicating child poverty.

This duty has been further developed at local level: Swansea Council has embedded children's rights into its workforce development planning, and trained staff and children on how to influence budgetary decisions as part of its broader Children and Young People's Rights Scheme.

More information: <https://doi.org/10.3390/socsci10030100>



CONCLUSIONS

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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 hemmed in 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

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

Student delegate to the Schools Pandemic Recovery Summit

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

John F. Kennedy

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.

This report is full of numbers and statistics, with charts and tables compiling evidence of how COVID-19 has affected the children and young people of the North. Throughout, a series of case studies and stories,

foregrounding individual experiences and best practice policies and interventions, emphasise just how vital it is to keep the voices of children and young people themselves at the heart of COVID-19 pandemic recovery strategies and the 'levelling up' agenda.

In March 2021, young delegates from 18 secondary schools in Bradford, educating 20,000 young people, met to create a manifesto that can serve as a foundation for bringing young people's voices into recovery efforts in the years to come. Here are their top ten most important insights for us to act upon:

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 like making sure every family 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.beckfootrust.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 – countries with greater levels of socioeconomic equality. And although over the past decade we have become increasingly aware of the growing epidemics of mental illness, self-harm and knife crime, these were not met with policies focused on the underlying root causes of

poverty and inequality. Northern children entered this pandemic at a disadvantage, but all children in the UK were more vulnerable than they should have been.

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



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