Acknowledgements

This report is a joint piece of work between the Northern Health Science Alliance (https://www.thernhsa.co.uk/) part-funded by Research England, and the NIHR Research Partnership (https://www.nihrresearch.org.uk/) and academics from the Northern NRH Applied Research Collaborations (ARCs), North East and North Cumbria (reference NRHR200173), Greater Manchester (reference NRHR200174), North West Coast (reference NRHR200182), Yorkshire and Humber (reference NRHR200168) and the NHRI School of Public Health Research (reference PD-SPH-2015), UK Prevention Research Partnership Collaboration, AcEaR [reference MR/P037327/1] and the Medical Research Council (MRC) [reference MR/P008577/1]. The views expressed in this publication are those of the authors and not necessarily those of the National Institute for Health Research, the Department of Health and Social Care, the UK Prevention Research Partnership or the MRC.

The editorial team would like to thank Dr Aase Viladsten, University College, London, and Dr Nicholas Adjei, University of Liverpool, for analysis of the Millennium Cohort Study used as a source for graphs in this report. Dr Diana Smith, University of Southampton provided the food insecurity risk index map for Chapter 5. We are also grateful to our Advisory Group: Tae(hours) Bignall, Dr Satchi Karunanithi, Anne Longfield and CBE Dr. Mathew Mathai, Richard Slogett and Prof Cheng-Hock Toh, and Policy/Manchester.

The funders had no role in data analysis, decision to publish, or preparation of this manuscript.

Contents

Foreword 4
Executive Summary 5
60 Second Summary 6
Who is the Child of the North today? 7
Detailed Chapter Findings
Child of the North Recommendations 11

Chapter 1: Introduction 13

Chapter 2: Poverty, Inequality and Deprivation
Child Poverty in the North 14
Impact of Child Poverty 14
The Role of Social Security and Cuts to Local Authority Funding 15
COVID-19 and Children and Inequality Recommendations 19

Chapter 3: Pregnancy and Early Years
Existing health inequalities in pregnancy outcomes pre-COVID-19 pandemic 20
Perinatal and infant mortality among women from ethnic minority communities 21
School readiness and COVID-19 22
Recommendations 23

Chapter 4: Child mental wellbeing
Widening health inequalities during the COVID-19 pandemic 25
Recommendations 26

Chapter 5: Physical activity, obesity and food insecurity
Physical activity 29
Planning and regeneration 30
Physical activity in schools 30
Food Insecurity 31
Childhood obesity 32
Inequalities in childhood obesity: deprivation, and ethnicity 33
Policy response and the need for whole system actions 34

Chapter 6: Schools and education
Inequalities within the educational system 37
The digital divide 38
The disproportionate impact of the COVID-19 pandemic on children with Special Educational Needs and Disabilities 38

Acknowledgements

Editorial Team
Bennett, Davara - University of Liverpool
Davies, Hannah - Northern Health Science Alliance
Mason, Kate - University of Liverpool
Parkinson, Stephen - NIHR Research Partnership
Pickard, Kate - University of York
Taylor-Robinson, David - University of Liverpool

Authors
Aleixou, Alexandra - University of Liverpool
Alrouh, Bacher - Lancaster University
Alton, Rose - University of Manchester
Ayudura, Chenele - Durham University
Bamba, Clare - Newcastle University
Barber, Sally - Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust
Bhopal, Sunil - Newcastle University, Great North Children's Hospital
Bridges, Sally - Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust
Bingham, Daniel - Bradford Institute for Health Research
Bird, Philippa - Leeds Teaching Hospitals NHS Trust
Bont, Carolina - University of Manchester
Bradshaw, Jonathan - University of York
Bryant, Maria - University of York
Creswell, Cathy - University of Oxford
Daly-Smith, Andrew - University of Bradford
Deakinowicz, Ola - University of Manchester
Dickerson, Josie - Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust
Dobson, Stiff - Lancaster University
Drywood, Eleanor - University of Liverpool
Egelo-Memeh, Stephanie - University of Sheffield
Ellison, Amanda - Durham University
El-Osta, Austen - Imperial College London
Elshahiya, Mai - University of Bradford, Wolfson Centre for Applied Health Research
Enam, Jayne - Lancaster University
Fittox, Alison - University of Leeds
Gillbrant, Stephanie - University of Manchester
Halford, Jason - University of Leeds
Humphrey, Neil - University of Manchester
Irving, Emmerline - West Yorkshire Health and Care Partnership
Lala, Riwarwa - Manchester University NHS Foundation Trust
Mac, Ghazala - University of Leeds
Man-Williams, Mark - University of Leeds, Wolfson Centre for Applied Health Research
Munford, Julie - University of Manchester
Murphy, Emma - Durham University
Papan, Ula - Lancaster University
Quaker, Pamela - University of Manchester
Rankin, Judith - Newcastle University
Salway, Sarah - University of Sheffield
Sanders, Anna - University of Manchester
See, Beng H - Durham University
Stafford, Helen - University of Liverpool
Summatar, Carolyn - Durham University and Fuse, NIHR Centre for Translational Research in Public Health
Sutton, Matthew - University of Manchester
Villarreal-Williams, Nazmy - University of Sheffield
Waterman, Amanda - University of Leeds, Wolfson Centre for Applied Health Research
Webb, Calum - University of Sheffield
Wickham, Sepha - University of Liverpool
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 lead 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 weeks of offline schoolwork per day, compared with 20% country-wide.

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

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

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.

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 £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 lifetime earnings.

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 (55%), 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 North-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, disproportionally affecting children in the North of England.

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

Detailed findings

- When the pandemic hit, 23% 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 35% 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.

- 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 1000 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, likely 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.
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, 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

- The local authorities with more than 10,000 children per 10,000 in care, 21 or 26% are in the North.
- All of the English regions of the country, except the North where the prevalence of children in care per 10,000 of the child population was 97.4 in the North, compared to 68 in the rest of the England.
- The North records a number of extreme outliers with very high rates of children in care; in Blackpool, 223 per 10,000; children 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.
- All five criteria 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 other services because they are more likely to have special educational needs, have mental health difficulties, experience sexual exploitation, are 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 12,275 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 426 children’s homes in the whole of the rest of the country. A far smaller number of places are available for children with the most complex needs.

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

Physical activity, obesity and food insecurity

Childhood obesity is more prevalent in the North of England and the children of the North are less likely to be physically active.

Regular physical activity during childhood and adolescence is an important foundation for a happy, healthy and longer life. Physically active play, sport and travel have considerable health, psychological and wellbeing benefits to both individuals and health care systems, preventing chronic disease such as obesity, heart disease, stroke, cancer, chronic respiratory disease and diabetes.

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

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

Detailed findings

- 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 South 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 takeout 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 (6%).
- Tooth decay among five-year-old children varies regionally and is highest in the North West (37.7%) and lowest in the South East (17%). As a result, children in the North experience 2.7 times the prevalence of tooth decay compared to children in the South East.
- 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 more than double the national average 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 11% and 17% for the North East and North West respectively, compared to 11% in the South East, and 14% for England as a whole.
- School closures, lockdown and online learning have all led to interruptions in the delivery of off-school workday per school year, 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 (52% in Yorkshire and the Humber, 69% 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 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 Humberside experienced 4.0 and 3.9 months’ learning loss respectively, compared to less than a month of learning loss in the South West and London.
- In a survey conducted across all Bradford schools, teachers expressed concern over the disproportionate effect of COVID-19 on vulnerable children and children with Special Educational Needs and Disabilities. Key issues included the lack of access to specialist services such as children’s social services, Speech and Language Therapy, and counselling. Education psychologists across the North West described similar concerns.

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 disadvantage 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 children have experienced a 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 well being needs of children and young people, especially in our most disadvantaged areas. These problems, school’s efforts, and the accumulating evidence, demand a policy response.

Detailed findings

- During the UK’s first lockdown, across primary and secondary schools, only 14% of children in schools in the Northern regions were receiving four or more pieces of off-school workday per school year, compared with a country-wide average of 20%.
- 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.

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 Humberside, were significantly and negatively affected by the COVID-19 pandemic and the associated lockdowns.
- Loneliness is directly linked to worse mental health among youth. 23% of parents in the North reported that their child was ‘often’ lonely compared to 15% of parents in the rest of England.
- Parents/carers themselves were also more likely to have often been lonely during the first lockdown, 23% in the North compared to 13% in the South.
- In the North, 55% of parents of school-aged children felt that lockdown had caused them and their child to feel significantly more depressed, compared to 44% in South. For school closures, the figures were 45% in the North, compared to 33% in the South.
- Parents in low-income families experienced higher levels of stress, depression, and loneliness 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 children 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.

The Child of the North: Building a fairer future after COVID-19
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 (18%), 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, it 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 action to worsen 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 14 times more low-weight births per 100 (8.4%) in the most ethnically diverse, high deprivation third of neighbourhoods than in the least deprived, least ethnically diverse third of neighbourhoods (0.6%). 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 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 homogeneously 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 health and young people cannot be understood and addressed without attention to racism in its many forms.

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 and wellbeing of children at societal level. This will have a 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 €10786.
- A 10 percentage point increase in the percentage of children who achieve five or more GCSEEs at grade A–C (including English and maths) is associated with an increase in Gross Value Added per-head of €4241.
- 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 65% more than women living in the rest of England (€8,314 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 billion compared to €2.812). 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 €3.2 billion in lost wages in the North, €4.4 billion for men and €3.8 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 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.

5 Government should prioritise support to deprived localities by increasing the spending available to schools in poorer areas relative to those in more affluent areas.

6 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.
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 Leeds. For boys, the gap was greater still, at 27 years – a life expectancy of 95.3 years in Kensington and Chelsea, compared to 68.3 years in Blackpool. The neighbourhoods where children have the lowest life expectancy were in urban areas in the major cities of the North, including Leeds, Newcastle, Manchester, Liverpool and Blackpool.

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

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

Greater exposure to child poverty is a major cause of the North-South divide in children’s life chances. The 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 11 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 health. We know a lot about how poverty gets ‘under the skin’. It can lead to persistent disruptions to child development, particularly brain architecture, stress responses, and metabolic balance over the lifecourse, affecting the risk of many adult chronic diseases. Material factors are important. The homes of children living in poverty are

**Pathways to inequalities in child health**

- **Socioeconomic conditions**
  - **Inequalities across the lifecourse**
    - Educational attainment
    - Income
    - Physical and mental health
  - **Parent health**
  - **Lack of resources for managing child health problems**

- **Biological mediators**
  - Basal development, immune system, metabolic regulation, etc.

- **Psychosocial stressors**
  - Parental and child

- **Differential exposure and susceptibility**
  - Material resources (e.g. food, transport, clothing, heating, school costs)

**Figure 11. Pathways to inequalities in child health**

**“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)
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 when both exposures are present. Figure 1.2 shows that these harmful common exposures lead to large negative impacts on child health.

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 when both exposures are present. Figure 1.2 shows that these harmful common exposures lead to large negative impacts on child health.

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

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 Chapter 2, 3, 5). The UK child poverty rate has contributed to rising inequalities in infant mortality and children becoming looked after in England. These trajectories of poor health stemming from childhood exposure do not live in poverty.

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 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.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

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

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and South of England and the UK, focusing on the percentage points from 2009/10. It is estimated that 38 billion a year is lost through poverty and other social determinants of health.

Child poverty in the Northern regions will be a levelling down of skills, still-stifling health inequalities and reduced societal productivity in the long term. Although there is no easy 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.

Evidence shows that children from all backgrounds are vulnerable to adverse life experiences, and that poverty is a significant contributor. However, evidence also shows that poverty is not a downstream consequence of or limited to interventions for mental ill health, but that these risk factors will be for child health.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

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

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and South of England and the UK, focusing on the percentage points from 2009/10. It is estimated that 38 billion a year is lost through poverty and other social determinants of health.

Child poverty in the Northern regions will be a levelling down of skills, still-stifling health inequalities and reduced societal productivity in the long term. Although there is no easy 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.

Evidence shows that children from all backgrounds are vulnerable to adverse life experiences, and that poverty is a significant contributor. However, evidence also shows that poverty is not a downstream consequence of or limited to interventions for mental ill health, but that these risk factors will be for child health.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

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

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and South of England and the UK, focusing on the percentage points from 2009/10. It is estimated that 38 billion a year is lost through poverty and other social determinants of health.

Child poverty in the Northern regions will be a levelling down of skills, still-stifling health inequalities and reduced societal productivity in the long term. Although there is no easy 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.

Evidence shows that children from all backgrounds are vulnerable to adverse life experiences, and that poverty is a significant contributor. However, evidence also shows that poverty is not a downstream consequence of or limited to interventions for mental ill health, but that these risk factors will be for child health.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

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

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and South of England and the UK, focusing on the percentage points from 2009/10. It is estimated that 38 billion a year is lost through poverty and other social determinants of health.

Child poverty in the Northern regions will be a levelling down of skills, still-stifling health inequalities and reduced societal productivity in the long term. Although there is no easy 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.

Evidence shows that children from all backgrounds are vulnerable to adverse life experiences, and that poverty is a significant contributor. However, evidence also shows that poverty is not a downstream consequence of or limited to interventions for mental ill health, but that these risk factors will be for child health.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

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

This chapter describes child poverty and other social determinants of health before the pandemic and over time for children in the North and South of England and the UK, focusing on the percentage points from 2009/10. It is estimated that 38 billion a year is lost through poverty and other social determinants of health.

Child poverty in the Northern regions will be a levelling down of skills, still-stifling health inequalities and reduced societal productivity in the long term. Although there is no easy 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.

Evidence shows that children from all backgrounds are vulnerable to adverse life experiences, and that poverty is a significant contributor. However, evidence also shows that poverty is not a downstream consequence of or limited to interventions for mental ill health, but that these risk factors will be for child health.

Second, to mitigate the consequences of poverty, we need a fresh focus on children and their rights. Children’s rights and the universality of services for everyone, with a scale and intensity that is proportionate to the level of need, with a shift in investment towards the early years whenever possible. It is critical that we 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 health and development of all children.

The message is clear: The North-South divide stems from historically poor policies affecting generations of children. We must not make these same mistakes again.
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 interactions of child poverty and ethnicity, as well as other aspects of identity such as gender, disability, and age.

### Impact of child poverty

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

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

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

This accounted for almost a third of the overall rise in infant mortality over that period, indicating that child poverty was making a significant contribution to rising infant mortality in deprived areas. A recent analysis at small area level also shows rising infant mortality and stalling life expectancy in England between 2014 and 2019, particularly in Northern urban areas with high levels of poverty.

Another recent report using data on deprivation (from the Index of Multiple Deprivation) and child mortality (up to age 17) showed that, between April 2019 and March 2020, there were significantly more deaths in the most deprived areas of the UK than in the least deprived, with most deaths occurring in the first year of life. More than a fifth of all child deaths might have been avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This is equivalent to 700 fewer children dying every year.

2. Mental health was deteriorating for children and young people prior to the COVID-19 pandemic. Using data from the Millennium Cohort Study, a recent study found that 96% of young people aged 17 reported high levels of psychological distress, 24% reported having self-harmed and 7% reported having self-harmed with suicidal intent. Young people from more disadvantaged families, in the lowest 40% of the income distribution, were twice as likely to report having

---

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

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

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

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

**Figure 2.7.** For each local authority in the Yorkshire and Humber region, proportion of Lower Layer Super Output Areas counted among those with the 10% highest child poverty rates nationally.
The Child of the North: Building a fairer future after COVID-19

The proportion experiencing psychological distress was also higher among those from lower income families. Child poverty has a lasting impact on child and adolescent mental health. A single transition into poverty has been linked to child psychological distress, independent of parental employment status.

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

Another recent study using trajectory modelling found that persistent poverty and/or persistent parental mental ill health affects poverty in four in ten UK children. The combination of both affects one in ten households where someone is in paid employment, and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment.

Childhood obesity is twice as common in the most deprived areas of England than the least deprived areas, and the prevalence of severe obesity among children is the highest in the wealthiest 10% of the country than the poorest 10% 27. These inequalities are more transient or persistently – were more likely to be living with obesity and persistent parental mental illness.

The proportion experiencing psychological distress was also higher among those from lower income families. More than 75% of children living in poverty are actually in households where someone is in paid employment, and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment.

Austerity measures have also meant cuts to local authority budgets, leading to substantially reduced public expenditure on services for children. Poverty and parental mental ill health affects obesity each doubled 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 affects one in ten households where someone is in paid employment, and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment.

Starting from a higher level of spending in the North, austerity measures have had a greater impact on the health of children in the most deprived areas of England than in the least deprived areas. The introduction of the benefit cap, the under-occupation penalty, the abolition of discretionary social services and the NHS can implement to support and mitigate the effects of poverty.

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.

The Resolution Foundation suggests that rising unemployment and the removal of the £20 uplift on 6th October 2021 will lead to a further rise in child poverty. Many households have sought support from a welfare system that has been transformed by the cuts resulting from austerity policies.

Combined, rapid changes to the welfare system and cuts to local authority spending have had directly affected child poverty and subsequent negative health and wellbeing outcomes for children and young people.

COVID-19 and child poverty and inequalities

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

Many households have sought support from a welfare system that has been transformed by the cuts resulting from austerity policies. During the pandemic, by May 2020, the number of households claiming Universal Credit jumped by more than 1 million to 4.2 million. By December 2020, nearly 6 million people were claiming Universal Credit, a rise of 22% (95% CI 1,751 to 7,399), with the number rising to 9.1 million overweight children are included (95% CI 2.689 to 15.660) compared to only £283 in the rest of England (or £347 per child in 2021) – twice the pre-pandemic figure.

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

The Resolution Foundation suggests that rising unemployment and the removal of the £20 uplift on 6th October 2021 will lead to a further rise in child poverty. 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 Universal Credit, a rise of 22% (95% CI 1,751 to 7,399), with the number rising to 9.1 million overweight children are included (95% CI 2.689 to 15.660) compared to only £283 in the rest of England (or £347 per child in 2021) – twice the pre-pandemic figure.

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 2000.
- Introduce 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

To varying degrees, local authorities, local services and the NHS can implement to support and mitigate the effects of poverty. Collective action between local government, the voluntary sector and local business can go some way towards mitigating the impact of child poverty.

Local authorities can use their advice services (e.g. welfare rights advice) to support benefits uptake and help claimants negotiate the complexities of the benefit system.

Local authorities may also use discretionary payments to support families in poverty. They also have the power to use their discretion to vary council tax benefit for families with children.

Schools and other educational providers can limit costs during school holidays 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 Commission. 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.
Context
Experience 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. 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 the highest socioeconomic status classes compared to women from the lowest socioeconomic status classes.

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 East (Figure 3.2). The Doh North report published in 2014 showed that worse child health is a key driver of the North-South divide in adult health and life expectancy, with those born in the most deprived areas of the North, on average, living almost 10 years less than those born in the least deprived areas in the South.

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.37 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 (10), Black Caribbean (8), Bangladesh (6), Indian (4), 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 Pakistan group than other ethnic groups;45 Prematurity and low birth weight also contribute importantly to higher infant mortality among babies in the South Asian and Black groups;46 Figure 3.3 shows the average percentage of low birth weight infants born in areas with different combinations of socioeconomic deprivation and ethnic minority diversity. There were around 14 times more low-birth weight per 100 (6.4%) in the most ethnically diverse, high deprivation third of neighbourhoods than there were in the least deprived, least ethnically diverse third of neighbourhoods (5.8%). Even in similarly deprived neighbourhoods, low birth weights were around 12% higher in the most ethnically diverse neighbourhoods (8.4%) compared to the least ethnically diverse (5.5%).

This pattern was approximately the same across the North and the South. Over and above socioeconomic deprivation, some migrant women are exposed to particular stress during pregnancy and childbirth as immigration rules can enforce family separation, leaving women alone. This lack of social support is likely to increase risk of poor birth outcomes47–49 and family separation has a detrimental impact on children.

The quality of care that ethnic minority women receive during pregnancy, labour and birth has been called into question repeatedly over the past decades.50 A series of studies document dissatisfaction with care, poor communication, and discriminatory treatment51–54, as well as a failure to respond appropriately to particular needs.55,56 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.

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 systems and the

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

**Under 18s conception rate per 1,000 2018**

<table>
<thead>
<tr>
<th>Area</th>
<th>Recent trend</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td>16,738</td>
<td>16.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td></td>
<td>986</td>
<td>24.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td></td>
<td>2,550</td>
<td>21.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorks and Humber</td>
<td></td>
<td>1,938</td>
<td>19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td></td>
<td>1,843</td>
<td>10.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td></td>
<td>1,260</td>
<td>15.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td></td>
<td>1,915</td>
<td>13.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td></td>
<td>1,595</td>
<td>15.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td>1,127</td>
<td>13.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Low birth rate of term babies 2018**

<table>
<thead>
<tr>
<th>Area</th>
<th>Recent trend</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td>16,224</td>
<td>2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td></td>
<td>2,017</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td></td>
<td>767</td>
<td>3.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorks and Humber</td>
<td></td>
<td>1,711</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td></td>
<td>3,382</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td></td>
<td>2,225</td>
<td>2.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td></td>
<td>1,219</td>
<td>2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td>1,851</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td></td>
<td>1,241</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Infant mortality rate 2016-18**

<table>
<thead>
<tr>
<th>Area</th>
<th>Recent trend</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td>7,608</td>
<td>3.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Midlands</td>
<td></td>
<td>1,206</td>
<td>5.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td></td>
<td>1,391</td>
<td>4.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td></td>
<td>628</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorks and Humber</td>
<td></td>
<td>750</td>
<td>4.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td></td>
<td>1,569</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td>1,240</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td></td>
<td>549</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Promising practice: BL3 Maternity Hub, Bolton

BL3 Maternity Hub opened in June 2021. The hub is a partnership between Bolton NHS Foundation Trust and Bolton Council of Mosques, and is led by a Specialist Cultural Liaison Midwife, Banash Nazmean. 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, women – everything can be shared amongst the women [here].”

More information: https://www.boltonft.nhs.uk/2021/06/63-455

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 with higher incidence rates 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 inequalities (see Chapters 2 and 8).

Many families lived in very challenging circumstances during lockdown, including food and housing insecurity, which will have implications for their long-term financial security, health, and wellbeing. Evidence shows that already vulnerable families were hit hardest by the pandemic, 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.

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 pregnant women have been significantly reduced during the pandemic. The risk of COVID-19 to pregnant women was unknown, and so stringent restrictions on their activities were imposed to prevent infection. Examples include: a switch to remote-consultation for midwife and health visiting services; women being required to attend separate appointments alone; and partners being extremely restricted in time allowed in hospital before and after the birth of their baby. Limited contact with 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 pregnancy, and at critical points in their routine care such as scan appointments. A significant proportion of new mothers in the UK reported feeling isolated (58%), lonely (43%), and worried (31%) during the COVID-19 pandemic and initial lockdown. In the UK, in response to the first wave of the COVID-19 pandemic, up to 63% of health visitors were redeployed. Whilst high levels of redeployment were not seen universally across the North, the area has increased vulnerabilities with known worse outcomes for infants of reception. Thus, 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 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, has been decreased by 53% in real terms between 2010/2011 and 2016/2017.

Women described a worsening of their mental health during the pandemic. Reports of clinically significant depression increased in mothers from 11% before COVID-19 to 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 insecure. Key factors associated with becoming depressed or anxious during the pandemic were loneliness, and financial, food and housing insecurity. Due to changes in service provision during the pandemic, some women were not able to access specialist mental health services.

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

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

The longer-term impact of the COVID-19 restrictions on pregnant women and newborns is a matter 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’ relationship 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’ organisation worked with, and that this was affecting bonding and responsive care. However, for some families, the opportunity to spend more time at home was experienced positively, with more emotional and physical support from partners being at home, less stress, more opportunity for responsive breastfeeding, and more contact time with the baby.

Health visiting and early years’ services during COVID-19

Health visitors play a key role in ensuring all children get the best start and early years’ services per child aged 0-4 years. The North and the rest of England, 2010/11 - 2018/19 (2018/19 prices).

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

Note: Data used are based on 2011 Census for Region, and last three years of Low Birth Weight (under 2500g) data. Source: Author’s analysis of Public Health England Local Health Indicators.

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

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

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

Figure 3.6. Percentage of children not reaching ‘good’ levels of development at age 5.

Note: Size of each square proportional to the outcome data. Source: Author’s analysis of Department for Education data and local health indicators.
A four times greater decrease in spending in the most deprived areas compared to 2017. These early childhood experiences impact on educational attainment and employment. These differences are particularly apparent in the North 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%, with uptake in the North higher than that of the South of England. In 2020, uptake of the 3-year-old early entitlement, after it was available to all 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 emotional, cognitive, and socio-emotional development17. Because attendance is particularly beneficial to more deprived children, inequalities in development will increase, disproportionately affecting children in the North of England. Evidence suggests that young children in low-income families in high-quality early education programmes could close the gap in educational outcomes by as much as 20-50%18.

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 development19, and service providers have noted consequences for the physical development of children in deprived homes in particular20.

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 language21. Of particular concern among providers were children living in poverty, children with additional educational needs and disabilities. The pandemic will have further widened the learning gap for many of these children, and will have an onward impact throughout their lives.

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

A loss skilled workforce will likely also lower rates of national economic growth22. 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 life23.

Since data have been mostly produced at a national level, there are still gaps of understanding available to 40% of 2-4 year olds conducting 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 child health and wellbeing need to be closely monitored.

A focused investment in the early years must be prioritised as we come out of the pandemic, with additional investment in priority areas and services through serious financial investment can start to reduce health inequalities and break the intergenerational cycle of inequality seen across the North. There is a clear need to take a lifetime 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 to invest the level of support needed.

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

Acknowledgments

NHR North East N Cumbria Applied Research Collaboration.

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

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

The mental health of ethnic minority children and young people in statutory organisations, are consistently reported as undermining Importantly, ethnic minority children and young people face some up until much later in the evening during the lockdown 96.

Secondary pupils identifying as Chinese or Mixed, along with those Leeds 'My Health, My School' pupil perception survey revealed that national data employ very broad ethnic group categories and often routine methods for measuring mental illness in clinical and research However, assessing ethnic differences in the prevalence of mental illness is controversial since lockdown, with those identifying as Black/Black British having compared to 10% pre-COVID-19 101. Figure 4.4 shows that there were increases in the prevalence of loneliness during the lockdown, including spending more time with family, and becoming involved in various activities, and some experienced a worsening of pre-existing cultures of care 116. Furthermore, the 'securitisation' of mental health and wellbeing Positive effects of the COVID-19 pandemic on mental health and wellbeing

The mental health of 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 patterned varieties across indicator89,90. 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 201790.

However, assessing ethnic differences in the prevalence of mental illness is controversial and complex since rates of recognition, reporting, and diagnosis vary between ethnic groups, and routine methods for measuring mental illness in clinical and research settings may function differently 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 health 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 associated with undermining the mental health of ethnic minority children and young people in England109,110. Available quantitative evidence supports that link114. 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, combined with the rapid social and economic impacts from the lockdown27,43. The Lynch study34 found that 17% had poor mental health and 10% had substantially since lockdown, with those identifying as Black/Black British having the highest odds of experiencing poor mental health111.

An online survey of 2,002 12-14-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 respondents27.

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. Compiling 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 care98. Furthermore, the 'securitisation' of mental health (and of public services generally) via the Prevent programme has introduced new forms of surveillance that further undermine access to appropriate mental health support for Muslims25, who are disproportionately from ethnic minority communities.

Less is known about the situation for other ethnic minority children and young people. In some studies, they appear to be under-represented in mental health services with evidence being particularly consistent for those from South Asian families. For example, this can be explained by ethnicity, with people from ethnic minority backgrounds more likely to be referred through educational, social, and other services that are less likely to be voluntary, than via primary care, compared to White British children26. Local data from Leeds support this picture, with the Asian and Black population particularly under-represented in mental health services25.

Qualitative research with young people, parents and stakeholders from Leeds revealed significant obstacles to discussing mental health and wellbeing. These included: parents/carers being uncomfortable discussing mental health with their children, preferring not to discuss mental health problems, being concerned about the implications of discussing mental health issues, being worried about their child having to cope alone, and feeling excluded were common themes.

In a qualitative study of mental health among parents, children and young people from Leeds, 31% of children and 34% of parents felt disengaged from school and worried about returning. School had been at the centre of most children's social lives and with increasing levels of lockdown, including spending more time with family, and becoming involved in various activities, and some experienced a worsening of pre-existing activities, and some experienced a worsening of pre-existing connected to ethnic minority communities.

It is worth noting that Kothari, the online 'mental well-being community', appears to attract a disproportionate number of young people from ethnic minority backgrounds35. The Adira hair care project is an initiative that offers a crisis focused support package in South London. Such services have been in short supply 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 frontlines 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 crises.

I have been struggling with the fact that I cannot physically see my counsellor and I am finding it hard to access new help/therapies.

I have ADHD so I have been having a bad day all day but now I have to be and it really sucks. I miss being socialised in person. I don’t like sitting still in front of my laptop to talk to people. 

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.”

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.

“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.”

Frame your Qualitative research with young people, parents and stakeholders from Leeds revealed significant obstacles to discussing mental health and wellbeing. These included: parents/carers being uncomfortable discussing mental health with their children, preferring not to discuss mental health problems, being concerned about the implications of discussing mental health issues, being worried about their child having to cope alone, and feeling excluded were common themes.

I have ADHD so I have been having a bad day all day but now I have to be and it really sucks. I miss being socialised in person. I don’t like sitting still in front of my laptop to talk to people. 

I have been struggling with the fact that I cannot physically see my counsellor and I am finding it hard to access new help/therapies.

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.

“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.”

I have been struggling with the fact that I cannot physically see my counsellor and I am finding it hard to access new help/therapies.

I have ADHD so I have been having a bad day all day but now I have to be and it really sucks. I miss being socialised in person. I don’t like sitting still in front of my laptop to talk to people. 

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.

“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.”

I have been struggling with the fact that I cannot physically see my counsellor and I am finding it hard to access new help/therapies.
The Child of the North: Building a fairer future after COVID-19

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 reopened in September 2020 that continued, with analyses of the NHS Digital data showing that 8,552 children and young people were referred for urgent or emergency 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 2020, 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 pandemic48. Delays were in large part attributable to changing working practices in Child and Adolescent Mental Health Services49, 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 201950. 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 lifecycle 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 track 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 remain inadequate. NHS England needs to increase the pace at which services expand to meet the commitments in the NHS Long-Term Plan, which include the expansion of NHS Services for children and adolescents. As part of this aim, we must:

  - Make sure that all young people and parents/carers know how to find mental health pathways between children and services. There must be rapid access to evidence-based services 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 does not mean that schools and the voluntary sector. Schools are key sites for children’s wellbeing and mental health, with increasing risk and pressure before and the pandemic for young people related to school and feeling under pressure. These pressures have undoubtedly been exacerbated by restricted opportunities and learning 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 unable to meet the level of need for mental health provision for children and adolescents. It is unlikely that they will have capacity to deal with the unprecedented surge following the pandemic. Central to the Green Paper on Children’s Mental Health was the implementation of Mental Health Support Teams to facilitate joint working between schools and the NHS, with graduated levels of support available across schools and specialist services.

In May 2021, NHS England announced the creation of around 400 Mental Health Support Teams to cover 3,000 schools in England by 2023, so supporting 3 million pupils and accelerating the Mental Health Support Teams programme51. 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.

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 bodies52. Black hair care and styling have also been important symbols of resistance to this oppression53.

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 (radiosurgery 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/

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 that increase the beginning of the COVID-19 pandemic. Before the pandemic, these outcomes were generally worse in the North of England compared to 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, access to food, and different types of food.

Given that these factors determine health and body mass, 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 resulted in the North–South inequalities in physical activity levels, food insecurity, and obesity, for children.

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

Physical activity

Regular physical activity during childhood and adolescence is an important foundation of a happy, healthy and longer life. Physically active play, sport and travel have considerable health, psychological and social benefits in children and adults, including:

- Preventing chronic disease such as obesity, heart disease, stroke, cancer, chronic respiratory disease and diabetes54.

According to the Everybody Active report, physical inactivity costs the UK an estimated £7.4 billion each year55.

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% of children were meeting the physical activity guidelines, compared to 47.3% in the rest of England. Perhaps not surprisingly, these sub-optimal levels were seen in all other regions of England. The South also experienced a smaller reduction in the proportion of children meeting physical activity guidelines prior to and during the COVID-19 pandemic.

and although the legacy of the impact on physical activity remains uncertain, it is imperative that we act now to minimise the risks of ill health through inactivity, with a particular focus on addressing inequalities.

Children living in some areas of England have been disproportionately affected, as have some ethnic minority groups. Figure 5.1 shows that more children living in the South of England were negatively impacted by COVID-19 pandemic compared to the North of England.

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

<table>
<thead>
<tr>
<th>Region</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>North</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>South</td>
<td>44%</td>
<td>45%</td>
</tr>
<tr>
<td>East</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Midlands</td>
<td>46%</td>
<td>45%</td>
</tr>
<tr>
<td>London</td>
<td>47%</td>
<td>46%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ethnicity Category</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>White Other</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>44%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Source: Sport England Active Lives Survey56

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) became no longer available. Physical activity behaviours are known to track from childhood into adolescence, then into adulthood,

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 tussauds 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 Services team developed the site, working closely with the Sport England-funded programme, JUMP/ local families; local councillors; and the wider communities of the Bradford district.

Councillor Sarah Ferby, Bradford Council’s Executive Member for Healthy People and Neighbourhoods, 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 teams. 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 Anshad Hussain, local ward councillor, said: “This park has quickly become a haven for local children and families to play and connect.”
The Child of the North: Building a fairer future after COVID-19

Tracking food insecurity through the pandemic in Bradford.

Families participating in the Born in Bradford study reported an increase in food insecurity from 14% pre-COVID to 20% in the first wave (April - June 2020)148.

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 more148.

In addition to the likely impact on physical health, there was a clear relationship between food insecurity and mental health, with children and young people having to miss more school, report higher levels of depression, and have lower self-esteem than those who were less affected by the pandemic149.

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 pandemic150.

Educational institutions played a key role in this and 42% of the new food banks 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.
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 points.

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

The National Child Measurement Programme was paused during the COVID-19 pandemic due to school closures. As such, there are no data yet available to assess whether the pandemic has affected childhood obesity. Nevertheless, rising socio-economic deprivations 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’s 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 impact.156

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 England.157 Beyond this, we need a whole system approach, with a broader set of interrelated targeting, in particular, educational settings, town planning and industry. Strategies must ensure access to health services according to need, with an emphasis on early years settings. In settings for under-5s (nurseries), there is a need to re-invest in these functions if we want healthier environments to be part of our COVID-19 recovery plan.158

There is a need to re-invest in these functions if we want healthier environments to be part of our COVID-19 recovery plan.158

Urban green spaces, such as parks, playgrounds, and residential gardens, can be important for children’s health, preventing obesity and helping to improve social cohesion. They also provide educational opportunities, develop digital skills, assist with job applications, and increase employability. Educational and regulatory services provided by local government also play a vital role in public health.

However, local authority budget cuts over the last 10 years have impacted planning services, and more so in disadvantaged areas. There is a need to re-invest in those functions if we want healthier environments to be part of our COVID-19 recovery plan.159

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 confectionery.160 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 food brand advertising promotes unhealthy food and drinks, and even short-term exposure promotes minor increases in energy intake by children across a range of ages.161 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

The 2018 Soft Drink Industry Levy taxes some drinks containing 5g of sugar or more per 100 ml. Since the introduction of the levy, sugar in products subject to it has been reduced by 44% on average. In 2017, Public Health England set a voluntary target for industry to reduce sugar content by 20% in foods that contribute the most sugar to children’s diet, including cereals, yogurts, and confectionery.160 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 food brand advertising promotes unhealthy food and drinks, and even short-term exposure promotes minor increases in energy intake by children across a range of ages.161 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...
to reducing children’s consumption of unhealthy food and drink. By April 2022, planned legislation will ban in-store promotion of foods 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 Children Measurement Programme, parents receive a letter outlining if their child is with overweight or obesity.

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

In 2018/19, local authorities in England spent £62m on childhood obesity services, a real-term decrease of 1.9% 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 incentives 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 motivated people 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 weight management services for children, including energy drinks, and particularly screen and online platforms during the COVID-19 pandemic – we recommend joined-up policy action across, and collaborative working with, neighbouring organisations are not equipped to accept digital forms of these vouchers.

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

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

“I found it hard because my parents were working a lot, I didn’t get as much help. I am used to getting help.”

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

“it 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.”
The Child of the North: Building a fairer future after COVID-19

The digital divide

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

The Teacher Tapp survey reported that teachers, especially those in deprived schools, were ill-prepared for distance teaching. A recent survey showed that around two thirds of teachers had little or no online platform.

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

The unequal implications of the shift to remote education were also revealed in data from the ‘Bare in Bradford’ birth cohort study, collected throughout the pandemic. Children of South Asian heritage were more likely to have had access to computer equipment only some of the time (25%) compared to children from White British (9%) and other ethnic groups (20%). This pattern was also reflected in access to books (7% 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 their classmates’ lack of access to digital resources.

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

School closures during the global pandemic were particularly detrimental for children with SEND. While children without SEND had less severe disruptions to their education, children with SEND had greater difficulties in maintaining educational continuity.

Key issues included the lack of access to specialist services such as children’s social services, Speech and Language Therapy, and counselling. An example was the findings of a North West described similar concerns (see Case study on next page).

These children and their parents experienced loss, worry, and changes in mood and behaviour as a result of the rapid social changes imposed during the pandemic. Some parents reported being overwhelmed, and normal routines 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 on children with SEND. Children and young people in deprived areas had worse outcomes during the pandemic.

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 peers. A child has an 80% chance of passing maths and English at GCSE if they neither live in poverty nor require the support of a social worker.

This figure drops to 65% where a child lives in poverty or needs a social worker. It plummeted yet further to 38% where a child experiencing disadvantage also has Special Educational Needs. The report shows the large regional differences and North-South divide in educational qualifications for young people, based on an analysis of the nationally representative UK Millennium Cohort Study.

Notes: * Name changed to protect confidentiality

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, over 50% of the pupil premium and more than 10% with education 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. Initially, Olivia, the principal, called parents and support for both children and parents. Olivia reported that many of the parents were ‘paralysed’ by the virus, the pandemic, and the lockdown. Olivia wrote a parking 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 ‘kunches’ 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 internet, hardware, printers, pens and paper to make use of these materials. Subsequently, every Monday, full packs of materials, including everything from pencils to worksheets, were made available to every family that needed them. These were either delivered from a box outside the school or, for many, delivered to their homes. All this had to be paid from the school budget.

The home learning environment

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

However, these parents found it more difficult to help their children: they reported not feeling confident about home-schooling, and they were least likely to understand their children’s learning tasks.

Some disadvantaged children had little learning experience during lockdowns as they were not referred to exclusive education settings. These children also faced more stressors, which are likely to have an adverse effect on the quality of teachers’ relationships. Thus, family resource inequality extends both to the amount of time spent learning, and to the resources available to assist learning.

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

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

Case study: local authority in Greater Manchester.

Since schools re-opened, Sarah*, a trainer 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 reversion in social and communication skills and interaction development. For example, Sarah saw 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-integrate.

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, which was rated as ‘Requires Improvement’ or ‘Inadequate’ in 2016 improved
The Child of the North: Building a fairer future after COVID-19

The Opportunity Area also fostered a holistic approach to the health and education of children. Over 6,000 primary-age pupils were over 45 schools, reducing reliance on supply cover. The programme Teacher recruitment and retention interventions filled 225 vacancies schools had access to a consistent supply of high-quality teachers. 2 of 11.5 percentage points and 14.3 percentage points, respectively. These figures had risen to 68.3% and 70.5%. Disadvantaged pupils at Key Stages 1 and 2 was 64% and 64.4% respectively. By 2019, percentage of pupils reaching the expected standard in mathematics of Bradford, with more planned.

In the North Yorkshire Coast Opportunity Area, in 2016, the network included the local authority, the NHS Care Trust, Trusts and the Head teachers of the schools). 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

The Bradford 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

The Bradford 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

The Bradford 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

Case study: Bradford Opportunity Area.

The Opportunity Area also fostered a holistic approach to the health and education of children. Over 6,000 primary-age pupils were over 45 schools, reducing reliance on supply cover. The programme Teacher recruitment and retention interventions filled 225 vacancies schools had access to a consistent supply of high-quality teachers. 2 of 11.5 percentage points and 14.3 percentage points, respectively. These figures had risen to 68.3% and 70.5%. Disadvantaged pupils at Key Stages 1 and 2 was 64% and 64.4% respectively. By 2019, percentage of pupils reaching the expected standard in mathematics of Bradford, with more planned.

In the North Yorkshire Coast Opportunity Area, in 2016, the network included the local authority, the NHS Care Trust, Trusts and the Head teachers of the schools). 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

The Bradford 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.

The Bradford 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 school. 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 university, and is working to jointly explore how children and young people can be supported as the pandemic recedes.

The Centre for Applied Education Research have accepted the challenge of meeting the needs identified by the children of Bradford in a 2021 Schools Pandemic Recovery Summit.
The UN has warned of a looming mental health crisis and urged that governments need to act now to prevent a pandemic of mental health problems among children and young people. In particular, teachers must be supported to maintain the level of care and support for children and young people in their care. Policies need to reflect the evidence that building schools or improving school leadership in deprived areas per se will not tackle the wicked problems that underpin educational inequalities. A whole system approach across government departments, including directed resources, is required to reverse the tide of inequality, and genuinely level up opportunities for children and young people in the UK.

3. Make a reality of multi-agency working.

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 enabled by a single point of leadership.

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 enabled by a single point of leadership.

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 teachers and early years professionals. The post-lockdown problems of risk and vulnerability are likely to be felt particularly in the North due to external factors 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 bereavement support materials for schools.

6. Support staff in educational settings.

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

The UN has warned of a looming mental health crisis and urgent Figure 6.4. Attainment scores for children in Bradford compared to the National average, 2016.

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

The 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 has marked concentric areas of children’s homes in the North of England adds to the already intense pressure on services in the North. Approximately 1 in 10 children in care live in a children’s home.

These homes accommodate children and young people with the most complex difficulties. Relative to other children in care, these children are more likely to:
- Have experienced multiple moves in care
- Have poorer mental health
- Have a statement of Special Educational Needs
- Have more behavioural difficulties
- Live further away from their birth families

In England, there are currently 12,175 registered children’s homes places (all types) 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, and just 1,426 children’s homes in the whole of the rest of the country (Table 7).

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 area of the child’s placement. Where a child is in distress or going 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

- Disproportionate at risk of entering care
- Have more complex difficulties
- Live further away from their birth families

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 available in the West Midlands or London. Children are placed in secure children’s homes when they pose a serious risk to themselves or 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 1,426 secure children’s home places on any given day. The lack of appropriate secure homes is considered a key factor in the increasing detention of children by the police under the Mental Health Act 1983.

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

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

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

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 - are we now?

Evidence is still emerging of how the pandemic has exacerbated the already adverse position of children 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 grandparents.

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

Children involved in family court proceedings since March 2020 have encountered delays in court processes 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 be completed. This is a marked increase in duration from the same period in 2020, when the average was 34 weeks.

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

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

During the last decade:
- Government funding for the family justice system fell by 21% in real terms
- Legal aid budgets fell by 40%
- Court buildings closed
- Judge sitting days reduced

There are worrying signs that the care experience of children with the most complex needs may have been compromised during the pandemic. Complaints to Ofsted about providers of residential care have risen by 18% during the year 2020/21. At the same time, there has been growing concern over the placement of children in unregistered children’s homes because of a mismatch between need and the availability of foster carers or approved children’s home placements during the pandemic.

Family adversity: what is the outlook for the North?

The COVID-19 pandemic has 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.

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-pandemic. In early 2021, 27% of adults experienced “depression – more than double the pre-pandemic rate. People living in the most deprived fifth of areas were especially 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 pandemic.

Children and young people have themselves highlighted the widespread 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 are acting more aggressive than normal.”

Young person engaged with a community group in Bradford

Cautionary steps to address the shortage of places of safety, shortages remain across England.

We acquired de-identified data covering all section 166 detentions in all NHS Trusts in the North West of England, between December 2017 and April 2021. Cases pertaining to children aged 18 and under were included, including data on the reason for detention. Twelve interviews were also 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 have 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 suitable health professional.
mental ill health and domestic abuse, and provision of treatment and support.

Taken together, the evidence on adverse trends in family adversity and increasingly overwhelmed services does not suggest that the numbers of children in care are likely to fall in the North in the near future. In particular, local authorities in the North will struggle to refocus services on prevention, because they cannot avoid the huge costs associated with children who are already in their care.

Recommendations

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

Priorities include:
- Implementing policies to reduce child poverty, including improvements in the real value of the National Living Wage, and increases in child benefit, the child element of Universal Credit, and child tax credits (see Chapter 2).
- Increasing funding for preventative services (health visiting, child tax credits (see Chapter 2).
- Improving 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, child tax credits (see Chapter 2).
- Improving 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).

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). Y et 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.
- The reason why children are detained is most often harm to self (95%).
- The age of children detained ranged from 9 to 18 years.
- 53% of detentions were repeat detentions; some children had been detained more than 10 times.
- Most detentions took place outside of working hours or at the weekend.
- Most children were detained in hospital Accident and Emergency or paediatric wards, pending assessment within working hours.
- The length of time for which children were detained by a police officer frequently breached regulation (24 hours maximum) owing to assessment waiting times or bail availability.

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

One police officer, describing a child curled up and sleeping on the floor of an Accident and Emergency department: “wholely, wholly inappropriate.”

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

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

“For looked-after children placed away from their home location – there is no local information.”

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

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

“For looked-after children placed away from their home location – there is no local information.”
The Child of the North: Building a fairer future after COVID-19

CHAPTER 8

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 East.

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), maternal 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 minorities.

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 worrying situation, 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. 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, thus promoting a narrative that undermines a sense of belonging and being a valued member of society.

As such, while we should highlight shared experiences that unite diverse communities and challenge the health-damaging socioeconomic circumstances affecting 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

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.

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 Profiles frequently overlook ethnic make-up, and national surveys, including the UK Household Longitudinal Study, 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 categories. At the local level, Joint Strategic Needs Assessments lack health-related information on ethnic minority child and young people, and pay almost no attention to racism as a determinant of poor health.

This absence of data and analysis hinders local patterns, renders some groups completely invisible, and precludes investigation of the key drivers of health disadvantage. Promising work that 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, precarious employment and low paid work 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, with ethnic minority families further disadvantaged by obstacles to benefit uptake and notably the benefit cap.

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

An analysis of the UK Household Longitudinal Study for 2013/14 to 2016/17 found that almost half of children in households with an Asian/British or Black head were living in persistent poverty compared to a quarter of those in households with a White head (Table 8.2). The Department for Business, Energy and Industrial Strategy reported that in the two years to March 2019, 9% of White households were in fuel poverty, compared with 18% of households in the aggregated ‘all other ethnicities’ group. Gypsy, Traveller and Roma populations remain unenumerated in most national datasets, but available evidence suggests they experience extreme socioeconomic deprivation.


<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Child poverty rate (%) (After Housing Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19.8</td>
</tr>
<tr>
<td>Mixed/Multiple Ethnic Groups</td>
<td>34.7</td>
</tr>
<tr>
<td>Indian</td>
<td>24.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>50.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>55.9</td>
</tr>
<tr>
<td>Chinese</td>
<td>31.2</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>41.8</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>41.8</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>42.8</td>
</tr>
<tr>
<td>All</td>
<td>22.1</td>
</tr>
</tbody>
</table>

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

These data reveal that high minority ethnic density (dark grey) is 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

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

Figure 8.3. child poverty rate by ethnic group, UK 2017-2020
country. In the North, ‘low’ deprivation neighbourhoods are twice as likely to have relatively high White, rather than relatively high non-White, child populations (22% versus 9%).

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

Post-pandemic, we can expect these ethnic inequalities to be further exacerbated. Recessions affect ethnic groups differentially, with unemployment rising more sharply among ethnic minority groups than majority White. 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 interaction of racial and age-related labour market disadvantage. Preliminary data from the Department of Work and Pensions indicate that 13% of Black and 7% of Bangladeshi young adults were furloughed and 17% less than their White counterparts.

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 children.

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 counterparts.

Racism and discrimination are the driving forces behind these inequalities, and there has been little to no improvement over recent decades. Beyond the individual and societal effects of racism and ethnic inequalities in the labour market, there is also a huge productivity cost, it has been estimated that full utilisation of ethnic minority talent would deliver a £24 billion per year boost to the UK economy.

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 ways. The health and wellbeing of ethnic minority children and young people is undermined by interpersonal, cultural and structural racism.

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

Interpersonal racism is the most readily recognised form of racism, manifest as verbal abuse and physical attack but also often as brief and commonplace slights, indignities, incivilities or oversights.

Ethnic minority children and young people in Britain consistently report experiences of interpersonal racism in educational, health and social settings. In one study, 95% of young Black people reported having witnessed the use of racist language at school.

In another, a Scottish Muslim pupil recalled the lasting impact of
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, or let me sit 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 disgustingly. [Omar, Age 14-16]

Research including South Asian parents in the North found considerable energy being devoted to both monitoring children’s exposure to, and supporting their ability to weather the impact of, interpersonal racism within schools and neighbourhoods. Consultation exercises with young people in Northern cities have facilitated positive intergroup contact, perspective-taking or empathy. 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, undermining the need for sustained action at systemic levels.

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

Chapter 10 of this report makes the powerful case for foregrounding structural racism and structural disadvantage, or neglect the needs of ethnic minority groups and the processes of racism that are embedded in laws, policies, and practices of institutions that reproduce inequality, reflecting the international experience of children regarding the resurgence of police-school partnerships and the failure to reflect the diversity of contemporary age population; the failure to acknowledge, 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. I had the opportunity to attend to watch Sheffield Sharks VS Giants now a year later; I’m 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

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.

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

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.”

Abdi J

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

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.

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

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. I had the opportunity to attend to watch Sheffield Sharks VS Giants now a year later; I’m 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 socio-economic 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
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/Traveller children most affected (5.9% vs. 3.2%).

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 dental extractions (110). 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 (60%) in Blackpool and Darwen experience tooth decay when compared with 11% in Hastings, East Sussex.

Ethnic minority children experience greater levels of decay on front teeth and in particular attention to interactions between ethnic and regional disadvantage, and between ethnic and religious discrimination.

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

Recommendations

Know your population

Over-arching

Develop and sustain adequately resourced and evidence-based approaches to child and young person-led policymaking, with representation of roles with power (93.4%) of ethnic minority children, and youth.

Represent ethnic minority populations in leadership roles at national, regional and local levels.

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 strategic framework, with particular attention to interactions between ethnic and regional disadvantage, and between ethnic and religious discrimination.

Policy and practice have not responded well to the dental health needs of ethnic minority children. Dentistry’s prevention approaches have been shown to stagnate working-class and ethnic minority mothers by assuming a knowledge and skills deficit (126). 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 recognised this complex inter-relations 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 (125,126).

Policy and practice have not responded well to the dental health needs of ethnic minority children. Dentistry’s prevention approaches have been shown to stagnate working-class and ethnic minority mothers by assuming a knowledge and skills deficit (126). 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 recognised this complex inter-relations 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 (125,126).

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 (125,126).
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 6% per-person per-hour lower than in the rest of the country310. This productivity gap costs the UK economy around £4.4bn 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 projection 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 £2.20 per person per hour, generating an additional £13.2bn in UK Gross Domestic Product. In this chapter we outline the relationship between the health of children and economic productivity in adulthood311.

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). In the long term, this negative impact on wellbeing.

We know that individuals with better non-cognitive skills in childhood and adolescence are rewarded in the labour market in adulthood312–314. We model these expected long-term effects, in the absence of urgent intervention, later in the chapter.

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

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>-3.3</td>
<td>2.9</td>
<td>-0.6</td>
</tr>
<tr>
<td>North West</td>
<td>-1.9</td>
<td>1.3</td>
<td>-0.1</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>-2.4</td>
<td>3.1</td>
<td>-1.0</td>
</tr>
<tr>
<td>East Midlands</td>
<td>13</td>
<td>3.3</td>
<td>16</td>
</tr>
<tr>
<td>West Midlands</td>
<td>-0.9</td>
<td>3.4</td>
<td>-0.9</td>
</tr>
<tr>
<td>East</td>
<td>-3.4</td>
<td>3.2</td>
<td>-0.3</td>
</tr>
<tr>
<td>London</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>South East</td>
<td>-2.0</td>
<td>0.2</td>
<td>-0.8</td>
</tr>
<tr>
<td>South West</td>
<td>-3.0</td>
<td>0.0</td>
<td>-0.9</td>
</tr>
</tbody>
</table>

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 outcomes321–325. 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%-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 skills: with, on one hand, 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 unemployment321–322. We also know that individuals with better non-cognitive skills in childhood and adolescence are rewarded in the labour market in adulthood312–314, 321.

We model the expected long-term labour market effects of an increase in the attainment gap resulting from the pandemic. We show that, in the absence of intervention, the learning loss in the North of England is likely to lead to a 17.2%-22% reduction in wages for males, and a 22.7%-26% reduction in wages for females. This is comparatively higher than the potential wage reduction in the rest of England (0.5%-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 affected323. We also know that adverse childhood experiences can have a significant detrimental impact on key capabilities324, 325. Children exposed to abuse and neglect as a result of the lockdown are also likely to face disproportionate long-term impacts on their life outcomes.

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. Productive adults in the future.

The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and adult health311, 326. Dynamic, multi-period models 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 life327. 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 in children and adolescents and alongside one another to determine wellbeing across the whole lifecycle328.

The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and health. Dynamic, multi-period models 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 life327. A negative shock to, or persistent undermining of, any of these capabilities is likely to have a lasting negative impact on wellbeing.

The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and adult health311, 326. Dynamic, multi-period models 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 life327. 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 in children and adolescents and alongside one another to determine wellbeing across the whole lifecycle328.

The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and adult health311, 326. Dynamic, multi-period models 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 life327. 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 in children and adolescents and alongside one another to determine wellbeing across the whole lifecycle328.
Building a fairer future after COVID-19

The association between child health and economic performance at local authority level

Healthy children are much more likely to go on to live longer, happier, healthy, and fulfilled lives. Healthy children have been shown to be more likely to obtain good grades, be in employment, and earn higher salaries.[334,337]

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

We measure the economic performance of local authorities using Gross Value Added. This is a sub-national measure of productivity and is reported at local authority level by the Office for National Statistics.[338] We use data from 2018, and we use population counts to calculate Gross Value Added per-head. We consider three measures of child health or performance, each from a different stage of childhood.

First, we consider the rate of premature births (less than 37 weeks gestation, expressed as a rate per 1,000 of all births).[336] In longitudinal studies shorter gestational duration even within the term range is associated with poorer socioeconomic outcomes in adulthood, including education, income, and likelihood of claiming welfare or disability benefits.[339] 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 obese.[340] 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).[341] 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 £7,314).

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,[335,336] 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 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 19 months in the North of England and 1 month in the rest of England.

The learning loss in Maths was 3.8 months in the North of England and 2.4 months in the rest of England. Taking an average over the reading and Maths learning losses, we estimate that the overall learning loss was 2.9 months in the North of England and 1.7 months in the rest of England. Evidence suggests that an extra year of education results in a 7%-9% labour market return for males and 9%-11% labour market return for females.[337]

We estimate that in the absence of urgent intervention, the widening of the attainment gap will result in a 1.7%-2.2% reduction in wages for males in the North of England and a 1.0%-1.3% reduction in wages for 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 the 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 2018.[339] The Office for National Statistics estimate the future lifetime earnings of a male entering the labour market in 2018 to be £642,747 and the future lifetime earnings 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 in 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 (£2,534 compared to £7,352). Females living in the North will lose 69% more than females 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 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 outcomes346, 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 and wellbeing. Higher scores indicate more mental health problems. Chapter 4 presents trends in the average Strengths and Difficulties Questionnaire score, a commonly used measure of children’s mental health and wellbeing, across the North and the rest of England. A Strengths and Difficulties Questionnaire score greater than 17 indicates ‘sociocommunal behavioural problems’ which suggests the presence of a mental health problem347. 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 10 percentage points for boys in the rest of England. For girls those increases were greater with an increase of 4.1 percentage points in the North of England and 4.3 percentage points in the rest of England.

Given the evidence presented in Chapter 4 and other evidence indicating that a 13% increase in depressive symptoms is associated with a 2.4 fewer months of education348, 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 1.2% 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 9.8). As children grow into adulthood, males in the North will lose £3,856 in lifetime earnings than males living in the rest of England (£3,856 compared to £2,856). 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 £33.2 billion in lost wages in the North (£4.4 billion for males and £8.8 billion for females). The estimates in this chapter suggest that wages in the North and the rest of England will fall further behind those in the rest of the county, for both males and females. Urgent intervention is needed to prevent these regional inequalities widening any further.

Policy recommendations

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

- Increase investment in the systems that support the health of children, particularly those living in deprived areas and those most affected by the COVID-19 pandemic across welfare systems, health and education systems.
- 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 increase educational attainment amongst young people – especially in the regions hardest hit.
- Conduct multi-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.

In their responses to COVID-19, States must adopt an effective, child rights-based approach that protects and benefits those in most vulnerable situations while addressing challenges to respect, protect and fulfil children’s rights.

(UN Committee on the Rights of the Child, 2020)

The evidence presented in this report highlights how the multiple public health, social and economic effects of COVID-19 impact on children in profound, direct 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 come349, 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 broadly350. Much of this work highlights the importance of ‘early intervention’ as a means to both prevent and respond to both mental health 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 pandemic351.

In reality, however, the UK’s record in investment in childhood is shameful, historically, in terms of economic and political crisis, children have tended to be the primary targets of public cuts rather than investment352.

Recent research completed for the international, comparative non-governmental organisation, KidsRights353, ranked the UK one of the lowest 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 was 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 challenge 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 Approach354. 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 decades355. A Children’s Rights Based Approach also underpins action on the Sustainable Development Goals356.

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 where children are affected by the COVID-19 pandemic.
- All child-related programmes and policies develop the capacities of duty-bearers to meet their obligations (e.g. those responsible for delivering programmes of work, ensuring access to measures that protect children’s health and care), and the capacities of ‘right-holders’ – children – to claim their rights.
- Rights, like economic resources, do not trickle down to benefit all children in all regions in equal measure. It is exceedingly 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

An essential reference point in determining the nature and scope of children’s rights in the North of England 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].

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 – nationally 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 by the courts. 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
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 was launched in 1996, in Scotland, in response to ensuring both that children’s rights be upheld without discrimination (Article 2); the best interests of the child be a primary consideration (Article 3); local governments should be committed to ensuring children’s rights to life, survival and healthy development (Article 6); children have the right to voice and have their opinions taken into account in decisions that affect them (Article 12); Building a child friendly city also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes. It also requires clarity on who bears responsibility for implementing a particular law, policy or programme, as well as transparency in decision-making processes.
The Child of the North: Building a fairer future after COVID-19

CHAPTER 11

CONCLUSIONS

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

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.

Recommendations

- 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.

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 devastating 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 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, educated 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:

- “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

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.bradfordtrust.org/schools-pandemic-recovery-summit/

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

Children and Young People’s Rights Scheme.

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

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.
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 – vulnerabilities that we and many other families and organisations have argued about for many years.

The COVID-19 crisis has brought into sharp relief the pre-existing vulnerabilities of too many Northern children to the policies, practices and perceptions 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.

To address the child poverty crisis, we argue that the Northern Children's Commissioner's Review of Child Poverty, which made 16 recommendations, should be brought forward. The Government has already shown a willingness to listen to and act on children’s voices, and the result of this will be no less than a fairer future for all children in the UK.

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

The rests of the page contain an extract from the child poverty report. The report includes a section on the impact of COVID-19 on children, particularly in the North of England, and how this has highlighted existing inequalities. The report also includes a section on the role of government and local authorities in addressing child poverty, and the importance of evidence in informing policy and practice. The report concludes with a call to action for the Government and other stakeholders to take decisive action to reduce child poverty and improve the lives of children in the UK.
The Child of the North: Building a fairer future after COVID-19