A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP
ON A FIT AND HEALTHY CHILDHOOD

THE IMPACT OF SOCIAL AND ECONOMIC INEQUALITIES ON CHILDREN'S HEALTH

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THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this Report is a sub-group of the All Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the APPG is to promote evidence-based discussion and produce reports on all aspects on childhood health and wellbeing including obesity; to inform policy decisions and public debate relating to childhood; and to enable communications between interested parties and relevant parliamentarians. Group details are recorded on the Parliamentary website at: https://publications.parliament.uk/pa/cm/cmallparty/150929/fit-and-healthy-childhood.htm

The Working Group is chaired by Helen Clark, a member of the APPG secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the previous page.

The report is divided into themed subject chapters with recommendations that we hope will influence active Government policy.

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EXECUTIVE SUMMARY

A child born into circumstances of social and economic inequality in the 21st century United Kingdom will start life with one hand tied behind their back.

Nowhere is the disparity of experience more marked than in that of health and this, in turn, impacts the entire life course. In the same way that priority is given to securing the national infrastructure, prioritising the health of children from all areas and in all circumstances from the outset would therefore seem to be prudent rather than profligate. Yet as this Report demonstrates, successive Governments have skimped rather than saved; failed to build upon existing policy and played a costly policy game of 'catching up later' instead of deploying the early intervention measures that are cheaper and more effective in the long term.

The current scenario is not entirely bleak. There are examples of good practice both nationally and internationally that go some way towards combating the socioeconomic inequalities that blight children's lives. Yet in the United Kingdom, despite increasing awareness of the problem, there is no overarching strategy to take from the best of present and past models and forge new frameworks and structures to enable all families to offer their children the best start in life. This will require policy makers to adopt fresh thinking and work in partnership with representatives from industry, the voluntary sector, communities, advertising and media. Barriers between sectors and Government Departments must be breached; voluntary 'advice' replaced by statutory provision where necessary and new posts created. Professionals from all walks of life must accept a need to re-train and re-appraise the way that they work with children and families. Local authorities, devolved nations and even countries should pool expertise. But finally, the impact of social and economic inequalities on children's health will cost money; not for today's society alone but for the generations that will succeed it. At the moment, whilst cuts in benefit further entrench existing inequalities for some families in every community, others not so far away, demonstrate daily that:

'For whosoever hath, to him shall be given, and he shall have more abundance' (Matthew, 13:12 King James Bible).

However, the second part of the quotation:

'but whosoever hath not, from him shall be taken away even that he hath'

serves as a grim warning to the entire nation that it will be footing the bill unless the Government takes action to address the social and economic inequalities that are currently disadvantaging the adults of the future. The policies advocated during the course of this Report are not financially excessive but neither do they all come free.

If we are serious about children's health, we must invest now to address the social and economic inequalities that are holding them back – saving later on the lasting prosperity that will therefore be achieved.

Helen Clark: March, 2018.

SUMMARY OF RECOMMENDATIONS:

There are many recommendations flowing from this Report. The recommendations also appear at the end of each relevant section.

1. 'SOCIAL AND ECONOMIC INEQUALITIES' DEFINED: AN HISTORICAL OVERVIEW OF THEIR CONTRIBUTION TO CHILDREN'S HEALTH OUTCOMES

Recommendations:

1.1 Government commitment to equity from the outset, making a substantial and visible investment in measures directed at the Early Years

1.2 Policy in all departments to be audited for its effect on child health and wellbeing

2. ADDRESSING SOCIAL AND ECONOMIC INEQUALITIES AS THEY AFFECT: CHILD MENTAL HEALTH; CHILDREN WITH A DISABILITY; CHILDREN FROM ETHNIC, CULTURALLY DIVERSE AND MIGRANT COMMUNITIES; LOOKED-AFTER CHILDREN

Recommendations:

2.1 Government to commission research into the effect on child mental health of living with income poverty, debt, poor housing and in circumstances whereby one or more adults have mental health problems

2.2 The influence of social and economic inequalities to impact all policies on children's mental health and wellbeing

2.3 National secure and long-term funding streams to be established for Child and Adult Mental Health Services (CAMHS)

2.4 Integrated services for disabled children to be guaranteed stable funding in all local authority areas

2.5 Guaranteed funds for Early Identification services in all local authority areas (disabled children and children with mental health problems)

2.6 Improved and up to date information to be readily accessible about the availability of services and access pathways for BME communities and improved engagement strategies devised to interact with families from these communities

2.7 Policy makers to ensure that all measures reflect the needs of diverse ethnic, cultural and migrant communities so that interventions can be designed that will enhance young people's health and wellbeing

2.8 **An integrated governmental approach to the requirements of all children and young people; in particular those deemed 'in need' or looked after by the State.**

3. 'COUNTING THE COST'

Recommendations:

3.1 **Government to commission a detailed estimate of spend on Early and Late Intervention measures and to publish an impact assessment comparison of relevant budgets**

3.2 **All councils to appoint a Healthy Start co-ordinator as per the Government scheme *https://www.healthystart.nhs.uk/* and an integrated programme of activities to reach a minimum local uptake of 80% *(London Food Link, 2017, 'Beyond the Food Bank': London Food Poverty Profile https://www.sustainweb.org/secure/BeyondTheFoodBank2017.pdf)***

3.3 **National Government and Local Government Association to initiate a joint campaign to promote local initiatives that help parents to cook healthily with their children in the most deprived areas of society; producing a bank of best practice examples and holistic local working opportunities aimed at boosting the life skills of disadvantaged families**

3.4 **The Department of Health to commission a cost analysis of the impact of socioeconomic inequalities on children's health and where possible, commit to increase funding in percentage terms in line with costs identified**

3.5 **Initiative to combat inadequacies in oral health associated with some ethnic minority and migrant groups via care guides and practitioner signposting in the relevant languages**

3.6 **Measures to safeguard and improve dental health to be embedded in all children's services at strategic and operational levels**

3.7 **Department for Education to insist that PE provision, and specifically the use of the PESS premium, is part of every Primary OFSTED inspection**

3.8 **Reception and Early Years' Physical Activity to be included for spend within PESS premium funding with specific mention of play**

3.9 **Funding investment in playworker provision; in particular targeting areas of social and economic inequality and deprivation with a 'playwork means safe and healthy communities' campaign**

3.10 **All Government initiatives in advancement of physical activity to prioritise a targeted approach; supporting measures that extend provision in under-served, disadvantaged communities with as little cost as possible to users**

3.11 In order to drive a radical policy re-set, Government finance earmarked for early childhood development should be considered as *infrastructure* spend and treated as such in terms of its inclusion in Government targets in this area. Investment should not be seen as a cost but figures should also be included in attempts to close productivity gaps.

4. THE ROLE OF PARTNERSHIP WORKING INCLUDING DATA SHARING BETWEEN LOCAL AUTHORITIES, INDUSTRY AND THE VOLUNTARY SECTOR TO COMBAT SOCIAL AND ECONOMIC INEQUALITIES AND BOOST CHILD HEALTH OUTCOMES

Recommendations:

4.1 Departments of Health and Education to lead on the creation of a cross-Governmental working group (including local authorities, industry and the voluntary sector) to examine how to surmount barriers to pro-active health interventions

4.2 All local authorities involved in the commissioning of public health to appoint resident representatives to their board or working groups to ensure that local initiatives are properly appropriate for the local areas under consideration

4.3 Local Government Association (LGA) to be commissioned to produce a best practice guide for all local authorities, including accessible examples of interventions currently taking place

4.4 A common framework to be established by the Government to collect research data across all departments and sectors that will allow its issue in a clear, timely and easily accessible format

4.5 A proportion of the sugar tax to be earmarked for data collection

4.6 'Healthy School' interventions at national and local level to be widened from the present 100% focus on term time, to calendar year delivery enabling positive holiday plans to be created for vulnerable families

4.7 Statutory services and their commissioners to offer Easter and summer school food provision free at the point of use in up to a quarter of schools or equivalent community settings in the most vulnerable communities

4.8 Embed dental health in all children's services at strategic and operational levels in order to reduce the social and economic inequalities that are a determining factor in the oral health of children Commissioners, healthcare practitioners, specialist societies, the voluntary sector, consultants in dental public health and the Royal Colleges to be engaged in creative partnership.

5. THE ROLE OF ADVERTISING, MAINSTREAM AND SOCIAL MEDIA IN ENCOURAGING HOLISTIC CHILD HEALTH INITIATIVES. HOW CAN WE CAPITALISE UPON THE LATEST DIGITAL DEVELOPMENTS?

Recommendations:

5.1 **All Government health campaign messaging to be comprehensive, inclusive and holistic with dental health integral to content**

5.2 **Professionals who interact with children and families on health matters to receive initial training and continual professional development (CPD) about the signposting and use of relevant mainstream and social media articles and campaigns**

5.3 **Professionals to receive initial training and CPD in combining face to face and digital interaction in contact with children and families**

5.4 **All Government-initiated health campaigns to use a mix of traditional and social media tools; capable of adaptation according to local/geographical circumstance and need.**

6. THE ROLE OF THE STATUTORY SERVICES IN AMELIORATING THE ADVERSE HEALTH EFFECTS OF SOCIAL AND ECONOMIC INEQUALITIES

Recommendations:

6.1 **Further research into the effectiveness of central Government funding upon children's health outcomes**

6.2 **A holistic approach to nutrition and physical activity to be embedded within a whole-school policy for all school-aged children**

6.3 **Breakfast clubs to be available in all schools; free to all children in infant primary schooling; free to all others from low-income families and with a minimum charge to children from higher income families**

6.4 **A comprehensive review of the Primary Physical Education and Sport Premium including Ofsted inspection procedure, differentiated guidance and outcomes for physical activity, teacher development, pupil attainment and participation in competition and sport**

7. EXAMPLES OF INTERNATIONAL GOOD PRACTICE AS A GUIDE TO PRACTICAL POLICY MAKING

Recommendations:

7.1 **UK Government to compile a directory of best practice examples from global healthy eating programmes to combat inequalities and serve as a guide when making future public health interventions in the UK**

7.2 **UK Government to sponsor evidence-based educational programmes with built-in evaluation tools to encourage parents to prepare healthy meals and to promote physical activity and healthy eating in school. The Department for Education to set targets to ensure consistent standards across the primary sector.**

8. POLICIES AND PRACTICE IN THE DEVOLVED UK

Recommendations:

8.1 **Statutory inclusion of Physical, Social Health and Wellbeing Education on the curriculum of all UK countries from early years to school leaving age**

8.2 **Increase funding for research into children's health and wellbeing**

8.3 **Increase funding for child mental health and maternal health**

8.4 **Close screening of all children from pre-natal to childhood across a range of health indicators**

8.5 **Health care professionals to inform expectant mothers on maternal physical activity, nutrition and breastfeeding**

8.6 **Free resources for families and schools on nutrition and physical activity that build upon initiatives such as Change4Life and Healthy Schools**

8.7 **Alignment of policies throughout the UK (where possible) to address the adverse effects of social and economic inequalities on the health and wellbeing of children and young people.**

9. A WAY FORWARD FOR GOVERNMENT THAT WORKS FOR EVERY CHILD

Recommendations:

9.1 **Central Government to collate and facilitate the cascading and trial of best practice early intervention measures**

9.2 **An annual 'Best practice in early intervention' summit to be hosted by the Government involving local authorities and relevant business, community and charity partners**

9.3 **The 30 hour free childcare provision to be extended to all UK children in order to develop a fully integrated society that does not institutionalise inequalities. Meal and recipe guidance to contain essential statutory content**

9.4 **The discontinued Infant Feeding Survey to be revised and reinstated**

9.5 **The Government should review and extend the service available as part of the Healthy Start programme, both in terms of available food options and in the creation of a learning-based module to improve the nutritional life skills of the most disadvantaged families**

9.6 **An urgent review of all Departmental budgets to factor in essential spend on social and economic inequalities**

9.7 **A new cross-departmental Ministerial post on Social Mobility with particular focus on encouraging policy collaboration on this issue between relevant Departments. The post holder should report to a new Cabinet Minister for Children.**

INTRODUCTION

'Power has only one duty – to secure the social welfare of the people' Benjamin Disraeli.

The adverse effect of social and economic inequalities upon children's lives is neither novel to the United Kingdom nor anywhere else. Research trends bolster the widely held truism that there are significant gaps in outcome between children living in poverty and their financially advantaged counterparts.

In 2017 a Nuffield Trust study of patient records *('Admissions of inequality: emergency hospital use for children and young people': Kossarova, Cheung, Hargreaves and Keeble, Dec 2017)* found children living in economic deprivation to be 70% more likely to receive emergency treatment at Accident and Emergency wards for conditions like asthma and diabetes that are capable of being addressed in non hospital settings. Nigel Edwards, Chief Executive of the Trust observed:

'It is an indictment of how we are looking after the most vulnerable in our society that deprived children are now more likely to experience unplanned admissions for asthma than their counterparts did ten years ago.' The Daily Mail, 24th December 2017).

The Royal College of Paediatrics and Child Health (RCPCH) *('The State of Child Health' January 2017)* examined 25 health indicators, adding epilepsy, mortality, breastfeeding and obesity to diabetes and asthma, and found that:

- **Young people in the UK experienced low wellbeing compared with other comparable countries**
- **In 2016, 40% of children in England's most economically deprived areas were overweight or obese as opposed to 27% in the most affluent areas**
- **In 2014 the UK had a higher infant mortality rate (3.9% per 2,000 live births) than almost all comparable Western European countries**
- **Smoking during pregnancy (relevant to baby health) was highest in deprived populations**

The uncompromising data finds correlation in a systematic review conducted by Kerris Cooper and Kitty Stewart *('The Inequalities Project' London School of Economics, July 2017).* Fifty five out of 61 studies spanning eight countries over the past 30 years showed that increases in income had

a positive effect on children's cognitive outcomes; also their birth weight, physical health and social and behavioural development.

In Cooper's words:

'We can now confidently say that money itself matters and needs to be taken into account if we want to improve children's outcomes' (The Guardian, 12th July, 2017).

Precisely how improvement is to be achieved – not the fact that it is urgently needed – is the major issue for policy-makers today.

A UNICEF publication *'Children of the Recession: The impact of the economic crisis on child well-being in rich countries'* delineates *'a strong and multifaceted relationship between the impact of the Great Recession on national economies and a decline in children's wellbeing since 2008.'* The thesis is that children are *'suffering most and will bear the consequences the longest, in countries where the recession has hit hardest'* and the UK is cited as one of the countries with the greatest increase in the numbers of children living amidst conditions of severe material deprivation. The response of successive governments to the pressures of financial crisis is therefore considered to be significant.

Research undertaken by Frank Field MP in 2010, found that *'non financial elements'* including maternal mental health and the home learning environment were more likely to be determinants of child health and welfare than income. However, the Cooper/Stewart Inequality Project suggests that investment in education (for example, the pupil premium paid to schools educating the poorest children) education and nursery places may accrue less benefit if the child's family income is falling simultaneously. Child poverty in the UK has increased substantially since the 2013 benefit cuts and Alison Garnham, Chief Executive of the Child Poverty Action Group believes that the end product of the cuts has been to:

'Tip more families into poverty and make already poor families significantly worse off. When hard-up families have more money coming in we know that the extra is spent on fruit, vegetables, books, clothes and toys' (The Guardian, 12th July 2017).

In the seven years since the publication of his research (initially commissioned by former Prime Minister, David Cameron) Frank Field has been no slouch in apportioning blame to the *'mega, mega, mega cuts'* for

the decline in child health and wellbeing *'to the extent that we are seeing the emergence of destitution' (The Guardian, as above).*

Similarly, writing for The Kings' Fund, David Buck *('The conundrum of children and young people's health: time to address it' January 2017)* contends that there has been a disconnect between Government rhetoric (significantly, the Green Paper on children's mental health) and practical delivery:

'We welcome the Prime Minister's focus on children's mental health, but it's time that the contradiction of resources and wider policies not aligning with what we know about the importance of children's and young people's health and wellbeing is addressed.'

Kerris Cooper and colleagues do not slight the merit of 'interventions' such as readily available and accessible parenting classes, but maintain that the economic context in which these take place cannot be ignored. The increasing gap between outcomes for children from rich and poor families and the burgeoning costs of addressing the inevitable consequences of deprivation is irrefutable.

What must be faced squarely is that the financial reasoning propelling cutting public services and state benefits may itself be a false economy:

'The UK is one of the richest countries in the world; we can and must do better, for the sake of each individual, and that of the nation as a whole . . . poor health in infancy and childhood, and young adult life will ultimately mean poor adult health and this in turn, will mean a blighted life and poor economic productivity' Neena Modi, President of the RCPCH.

The Commissioner for Children and Young People in Scotland, Bruce Adamson, has said that government financial decisions must give primacy to their effect on the welfare of children:

'Experiencing poverty is a violation of children's rights and their human dignity. Children have the right to benefit from social security and the UN Convention on the Rights of the Child makes clear that in order to fulfil children's rights, support must be given to parents.

Along with the Children's Commissioners from the other parts of the UK, I remain deeply concerned about how children are disproportionately affected by decisions made on welfare, such as calculating Universal Credit entitlement and how it is then paid.

The UK must ensure that children's best interests are a primary consideration when taking decisions that significantly impact on families' ('Universal Credit contributing to child poverty: Communities and Third Sector Children and Families Poverty and Social Justice' 17th January, 2018).

This Report will not supply all the answers to the conundrum of social and economic inequalities as they impact children's health outcomes but neither will it flinch from asking the questions.

Something must indeed be done.

1. 'SOCIAL AND ECONOMIC INEQUALITIES' DEFINED: AN HISTORICAL OVERVIEW OF THEIR CONTRIBUTION TO CHILDREN'S HEALTH OUTCOMES

'The notion that material poverty predisposes, however circuitously, to poverty of health and life expectancy has a long pedigree' (Scrambler, G. (2011). Review Article: 'Health inequalities' Sociology of Health and Illness, 34(1):130-146

There have been striking improvements to the health of the UK population as a whole during the past 150 years, courtesy of major public health initiatives; notably effective sewage removal, access to clean drinking water, slum clearance programmes, advances in medicine and the advent, on July 5th 1948, of the National Health Service under the Act of 1946.

Overall, the health of UK children is on an upward curve. Between 1980 and 2009 the mortality rate of those aged between 1-14 years fell by 61% *('State of Child Health' RCPCH 2017)* accompanied by a steady neonatal and post-neonatal mortality rate decline in England and Wales. Health promotion, disease prevention and treatment and a range of successful immunisation programmes served to consolidate progress.

However, some sections of the population are not faring as well as others and children in poverty are likelier to experience poor health alongside adverse developmental, educational and long-term social outcomes. Scrambler *(as above)* has argued for the existence of a link between material disadvantage relative to others and health inequalities. Wealthier, better-educated people, residing in good quality housing, are likely to enjoy more robust health. Scrambler also suggests that other inequalities intersect with socioeconomic classifications (SECs) such as race, gender, sexuality, intellectual ability and family size; noting that health is inextricably intertwined with social position.

Various studies have examined the relationship between inequality and health including the 1980 Black Report *(Black, D., Morris, J., Smith, C. and Townsend, P. 'Inequalities in Health: Report of a Research Working Group' London; Department of Health and Social Security).*

This Report stressed the impact of *'cultural/behavioural'* factors; particularly *'material/structural'* as reasons for the presence of health inequalities. Black exposed stark differences in the mortality rates of infants (in the month after birth) born to fathers in the lowest social class when compared to those in the highest social class. Babies whose fathers were judged to

belong in the lowest social class were twice as likely to die compared to those in the highest social class. This health differential did not improve for surviving infants.

In 1997, the incoming Labour Government asked Donald Acheson to update Black. He queried the reliability of the measures originally chosen to denote socioeconomic status (SES), not least their level of influence in the persistence of health inequalities.

The Acheson study observed that sometimes measures selected will be due to ready availability such as employment status, level of education or indices based upon living in a specific neighbourhood. In the UK, it is customary to use occupational social class as a measure of SES with 'I' denoting those in the 'professional' class and 'V' applying to those deemed to be 'unskilled.' However, Acheson and Black both found that whilst average mortality fell in the 50 years prior to 1997, health inequalities either remained static or increased *(Acheson, D. 1998, 'Independent Inquiry into Inequalities in Health Report' London: The Stationery Office).*

Significant inequalities were noted between social classes, differing racial, cultural and religious groups, the sexes, and across the age-range. Persistent health disparities were linked to social determinants like income, education, employment, material environment and lifestyle. Data using the measure of occupational social class shows mortality and morbidity rates to be generally higher in the unskilled class when compared to those in the professional class.

In 1999, following publication of Acheson's Inquiry, Prime Minister Tony Blair (addressing the annual Beveridge Lecture) pledged to halve child poverty by 2010 and eliminate it altogether by 2020; thereby improving child health outcomes *(18/03/99 Toynbee Hall, London).* Child poverty was unexpectedly placed in the political limelight and the targets to be achieved within a generation featured in subsequent Spending Reviews and Budget announcements *(HM Treasury Cm 4807 Cm 4808 Cm 5674 Cm 6237 Cm 7227).*

The Marmot Review *(Marmot et al, 2010. 'Fair Society, Healthy Lives' http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review)* revitalised the debate about the impact of socioeconomic inequalities on health, concurring with Black and Acheson that the root causes of health disparity lie in social factors like poverty. Marmot considered fairness and social justice to be crucial in tackling health inequalities and highlighted the importance of early childhood as the

cornerstone of life-long health and demonstrably a more effective object of policy than later interventions. Relative poverty dropped substantially in the decade after Blair's 1999 pledge (from 3.4 million to 2.6 million children) but the child poverty targets as set out in the Pre Budget Announcement:

'Our fourth ambition is that by the end of the next decade child poverty will be reduced by half, on our way to ending child poverty within 20 years (Chancellor of the Exchequer; Pre Budget Announcement, HC Deb 09 November 1999: Vol. 337 Col.883)

and the Spending Review:

'substantial progress towards eradicating child poverty by reducing the number of children in poverty by at least a quarter by 2004' (HM Treasury, Spending Review 200: Public Service Agreements 2001-04 {Cm 4808 2001-02})

were missed.

However, the 2010 Child Poverty Act, one of the last measures secured by the outgoing government, was boosted by all party support and the Coalition Government re-affirmed commitment to ending child poverty by 2020 in the White Paper: A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives *(Cm 8061).*

The 2015 General Election ushered in a new government with an outright majority and many of the acclaimed provisions of the Child Poverty Act 2010 were repealed.

The Welfare Reform and Work Act 2016 removed a duty to ensure that targets were met; the duty to produce a poverty strategy renewed triennially and the duty to consult the devolved governments, children, local authorities and parents. The Government renamed the instrument the Life Chances Act 2010. Had it not been for the revising Chamber *(HL Deb 25th Jan 2016 (Report Stage): Vol.768 Col. 1059)* the Bill (as approved by the Commons) would have removed the Secretary of State's duty to publish data derived from low-income households, relative and absolute statistics.

This was widely reported as an attempt to redefine Child Poverty and dubbed *'the obituary notice for compassionate conservatism' (HC Deb 1st July 2015 Vol 597 Col 1506).*

A Private Member's Bill; Child Poverty in the UK (Target for Reduction) {HC} Bill 25, 2016-17) sought to establish a child poverty target consisting of four poverty measures:

- **Relative low income**
- **Combined low income and material deprivation**
- **Absolute low income**
- **Persistent poverty.**

It was adjourned at Second Reading *(3rd Feb 2017:Vol. 620 Cols 1363-72)* and later lapsed due to the 2017 General Election.

Today it is generally accepted that children from the most deprived geographical areas are likelier to be overweight or obese than their counterparts in affluent areas. By age five, children in poverty are twice likelier to be obese than their least deprived peers, and by age 11, thee times likelier *(NHS Digital, Statistics on Obesity, Physical Activity and Diet, England 2017, Health and Social Care Information Centre, March 2017)*. These inequalities are increasing and some studies *(e.g. Non, A.L., Roman, J.C., Gross, C.L., Gilman, S.E., Loucks, E.B., Buka, S. L. and Kubzansky, L.D. 2016 'Early Childhood Social Disadvantage is Associated with Poor Health Behaviours in Adulthood' Annals of Human Biology, 43(2): 144-153)* link childhood social disadvantage with poorer health-related behaviours in adulthood.

The connection between deprivation and overweight/obesity is present in the devolved UK. As deprivation increases, the number of children at a healthy weight decreases and those measured as overweight or obese rises. Overweight and obesity prevalence for children living in the most deprived areas is greater than for those living in the least deprived areas: in England, 25.8% compared to 18%; in Scotland, 25.1% compared to 17.1% and in Wales, 28.5% compared to 22.2%. The pattern directly contradicts that of the early 1970s, where obesity prevalence was greater in children from the most affluent areas *(Smith, S., Craig, LCA., Raja, EA., McNeill, G& Turner, SW. 'Growing up before growing out: secular trends in height, weight and obesity in 5-6 year-old children born between 1970 and 2006' Archives of Disease in Childhood, 2013; 98(4): 269-273)*.

Oral health is also an indicator of SES related inequality. 31%-41% of 5 year-olds across the UK have some tooth decay, but rates are higher for those in deprived populations in England, Northern Ireland and Wales where children are at least three times likelier to experience severe tooth decay than those living in the most affluent areas. Governments have sought to

mitigate this via fluoridisation of water supplies (Water Industry Act 1991 and Water Act 2003) however, not only is fluoridisation a discretionary choice made by local governments, but in places like Birmingham (the first Authority to adopt a water fluoride programme in 1964) tooth decay amongst children *'is significantly higher than the national average' (HC Deb. 31st Oct 2017: Vol.630 Col. 228WH).*

There are similar trends in relation to physical activity. The UK Chief Medical Officer has recommended that children and young people undertake at least 60 minutes of moderate- to vigorous-intensity physical activity per day *(NHS Digital, Health Survey for England 2015: Physical Activity in Children, December 2016: London Health and Social Care Information Centre).* Yet only 9% of 2-4 year olds and 22% of children aged 5–15 years meet the recommended physical activity levels *(Department of Health 2016 'Childhood Obesity: A Plan for Action': HM Government, London).* Only 25.9% of socioeconomically disadvantaged children participate in sport once a week compared to 42% in the highest socioeconomic group *(NHS Digital, Health Survey for England 2015: Physical activity in children. December 2016: London Health and Social Care Information Centre).*

Unless physical activity and sport become integral to every child's lifestyle, the risk of serious poor health is likely.

Maternal antenatal and post-natal poverty and deprivation also carry adverse health consequences for children. It has been argued that smoking during pregnancy is the cause of around 2,200 preterm births, 5,000 miscarriages and 300 perinatal deaths *(Weiser T.M, Lin M., Garikapaty V. et al.'Association of maternal smoking status with breastfeeding practices': Missouri, 2005, Paediatrics 2009; 124(6):1603-1610).*

The Millennium Cohort Study also found the risk of low birth weight to be higher for mothers in poverty, underweight mothers, mothers who smoked during pregnancy and mothers from minority ethnic groups. Deprivation has been found to depress breastfeeding and the 2001 Infant Feeding Survey showed that 46% of mothers in the most deprived areas were breastfeeding, compared with 65% in the least deprived areas.

The World Health Organisation has demonstrated that global inequalities between poorer and richer countries are even more pronounced than those within the UK alone:

'The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the

distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries' (World Health Organisation 2017, *About Social Determinants of Health' http://www.who.int/social_determinants/sdh_definition/en/*

From the above, a distinction between inequality and inequity can be made. People are not 'equal' in terms of 'sameness' and there may be some aspects of poorer health between individuals which are unavoidable. 'Inequity' however, as the WHO clarifies, relates to unfair and avoidable differences in health status; therefore it is inequity which should be the determinant of decision making in these matters.

Acheson argued that three key areas are crucial in addressing health inequalities:

'All policies likely to have an impact on health should be evaluated in terms of their impact upon health inequalities; a high priority should be given to the health of families with children; further steps should be taken to reduce income inequalities and improve the living standards of poor households' (Acheson 1990s, as above).

In 1998, he asserted that tackling health inequalities requires approaches which traverse many areas of public policy as opposed to being the sole remit of the Department of Health. In 2010, Marmot further maintained that addressing health inequalities must begin with measures directed at the earliest years of childhood.

In 2017, the President of the Royal Colleges of Paediatrics and Child Health, Professor Neena Modi, united the two strands of argument by advocating an inclusive, 'all society' approach:

'As citizens we can say very loudly and clearly we do want a focus on child health and wellbeing … we can bring in child health in all national policies and make sure our government does have a strategy that crosses all departments' (BBC: 'UK has 'stark inequalities in child health' report says' 26th January 2017).

It is a good starting point for decision-makers today.

Recommendations:

1.1 Government commitment to equity from the outset, making a substantial and visible investment in measures directed at the Early Years

1.2 Policy in all departments to be audited for its effect on child health and wellbeing

2. ADDRESSING SOCIAL AND ECONOMIC INEQUALITIES AS THEY AFFECT: CHILD MENTAL HEALTH; CHILDREN WITH A DISABILITY; CHILDREN FROM ETHNIC, CULTURALLY DIVERSE AND MIGRANT COMMUNITIES; LOOKED-AFTER CHILDREN

Social and economic status can be categorised as a person's social and economic position in relation to others, based upon income, education and occupation *(Kawachi, I., Subramanian, S.V. & Almeida-Filho, N. 2002 'A glossary for health inequalities' Journal of Epidemiology & Community Health, 56(9) 647-652)*.

Socioeconomic inequality is therefore the gap between those with the highest status and those with the lowest status. It is widely accepted that socioeconomic inequalities can impact aspects of a child's life including their education, healthcare, home and social environment and that these aspects inevitably overlap.

Child mental health

Evidence from The Children's Society *('Poor Mental Health: The links between child poverty and mental health problems' March 2016)* demonstrates that children from low-income families living in poor housing and possibly with debt, are at risk of experiencing mental health problems. The Society argues that unless they are consistently identified by government as a target group (as in *'Future in Mind', Department of Health, March 2015)* they will remain largely invisible and thus unable to access necessary mental health support.

The connection between adult mental health problems and poverty is generally recognised *(Mental Health, The Poverty Site (http://www.poverty.org.uk/62/index.shtml)* but the effect on child mental health of growing up in deprivation needs greater emphasis and scrutiny. Children in the least affluent households are up to three times likelier to develop mental health problems *(Green, H., McGinnity, A., Meltzer, H., Ford., T., Goodman, R., 'Mental health of children and young people in Great Britain' 2001)* In 1979, child poverty was defined as lacking:

'The resources to obtain the type of diets, participate in the activities and have the living conditions and amenities that are customary in the societies in which they belong' ('Poverty in the United Kingdom' 1979).

The Children's Society cites the following factors as impacting adversely on child mental health:

- **Welfare changes: the fluctuating nature of some child mental health conditions makes it difficult for applicants to demonstrate the consistency required for the receipt of Disability Living Allowance**
- **Parental/carer mental ill health**
- **Inadequate housing including interior heating and a poor surrounding neighbourhood *('Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention' Chartered Institute for Mental Health, 2002, http://www.cieh.org/jehr/housing_mental_health.html)***
- **Growing up in a family beset by problem debt/unemployment/ persistent low income**

Additional research into all of the above is imperative, including the relationship between physical activity and child mental health and wellbeing. The First Joint Report of the Education and Health Committees (Session 2016-17, HC 849, para 18) states that:

'Evidence to our inquiry also suggested that a rigid focus on academic attainment is squeezing out subjects such as music and time for physical activity which help develop life-long skills to improve well-being.'

The Report further observes that:

'If the pressure to promote academic excellence is detrimentally affecting pupils, it becomes self-defeating. Government and schools must be conscious of the stress and anxiety that they are placing on pupils and ensure that sufficient time is allowed for activities which develop life-long skills for well-being,' (at para 19).

Another way in which the mental health of all children (regardless of particular socioeconomic status) could be addressed is via Personal, Social, Health and Economic education (PSHE). The PSHE Association has said:

'As a non-statutory, non-examined subject, PDHE education is not held to the same standards of rigour as other subjects and PSHE teachers are not given the curriculum time or training they need to deliver to the standards we should expect,' (PSHE Association: 'A curriculum for life: The case for statutory Personal, Social, Health and Economic (PSHE) education,' 2017).

The Association also notes that:
'Unlike in the independent sector, where delivery of the subject is a core expectation, PSHE education is currently a non-statutory subject in state schools. In effect, this means schools don't have to teach it, and when lessons are provided they are often not as rigorously planned or delivered as other subjects. The status of PSHE is different form all other subjects as it is neither part of the national curriculum – like subjects such as maths or science – nor part of the basic curriculum, like religious education,' (PSHE Association 2017 as above).

The Local Government Association supports statutory PSHE and its inclusionary nature would clearly encompass children from less affluent socioeconomic backgrounds:

'PDSE has proven benefits to mental and physical heath, online and offline safety and in preparing children for life and work. Many pupils miss out on these benefits because it does not have statutory status…….we support compulsory PSHE in all primary and secondary schools; inclusive of academies, special schools, free schools and maintained schools and for parents to be given the right to withdraw their child,'(Local Government Association, response to the DFE consultation 'Changes to the teaching of Sex and Relationship Education and PSHE,' 2018).

The Daily Mile initiative currently being rolled out in UK schools is accessible for pupils of any economic status:

'The Daily Mile is already delivering real benefits for pupils with SEN or ASN… students who do their 15 minute Daily Mile … report feeling happier, healthier and more settled upon their return to class. Improved mental health and wellbeing correlates with improvements in children's focus and behaviour in class, leading to improved attainment and greater social cohesion with their teachers and peers, across year groups' (The Daily Mile Foundation, January 2018).

Measures designed to level the playing field for children disadvantaged by socioeconomic inequalities will assume increasing importance for their mental health, because the forthcoming policy indications are not auspicious:

'Over the coming five years, the Government will introduce a large number of changes affecting benefits, tax credits, income tax liabilities and earnings. This raises concerns about the potential negative impact on children's mental health linked to the increase in the number of children living in

poverty' ('Poor Mental Health: The links between child poverty and mental health problems' The Children's Society, March 2016).

The Government announcement of a child mental health plan *('Children with mental health problems 'guaranteed' treatment in four weeks' The Guardian, 23rd November, 2017)* places a four week cap on treatment waiting time, prioritises service delivery in school (rather than off-site settings) and identifies difficult backgrounds and poverty as significant factors in the increased figures for child mental health problems. However, budgetary and staffing restrictions make it probable that (pilots aside) these potentially beneficial changes to child and adolescent mental health services (CAMHS) will not be fully rolled out across England until 2021. Meanwhile:

'About 60% of children and young people with learning disabilities and mental ill health live in poverty' ('Disability in the United Kingdom 2016 Facts and Figures' The Papworth Trust 2016 www.papworthtrust.org.uk).

Children with a disability

'I see parents too stressed to cope, in appalling housing, leading to no energy to focus on the needs of their disabled child'('Poverty and Child Health: Views from the frontline' May 2017, Royal College of Paediatrics and Child Health).

This doctor encapsulates the way in which socioeconomic inequalities jeopardise the health and life chances of disabled children. Existing services don't meet their needs and the children and their families face levels of strain and discomfort that are frequently intolerable. A BMA report in 2016 *('The child with a disability', Dr. Max Davie)* lists key features, referencing a survey from Contact a Family *('Counting the Costs' 2014: Research into the finances of more than 3,500 families with disabled children across the UK')*. Findings included a demonstrable increase (since 2012) in the number of families with disabled children lacking sufficient heating, food and family leisure activities, and recorded a detrimental impact on overall family health. Almost half of those surveyed reported bouts of illness as a result of going without, over 90% suffered anxiety and debt-incurred stress, and 22% claimed that their disabled child's condition had worsened due to deprivation. The Centre for Welfare Reform *(http://www.centreforwelfarereform.org/library/by-az/briefing-on-how-cuts-are-targeted.html)* blames funding cuts for *'a lack of financial and practical support for disabled children and their families'* leading to *'disabled children not being properly supported to go to mainstream schools'*; thereby *'excluded from local*

services and recreational opportunities.' **In extreme instances, the remaining 'solution' has been to take children into care.**

Contact a Family *(as above)* has claimed that 33% of families with one or more disabled children are worse off because of benefit changes and 65% of professionals interviewed in a survey for The British Academy of Childhood Disability are recorded as experiencing the direct impact on such families of austerity measures *(British Academy of Childhood Disability and British Association for Community Child Health, 2014 'Impact of Austerity, Measures on families with Disabled children'; Survey of BACCH and BACD members and Child Development Team leads, November 2014 and January 2015, London: BACD and BACCH).*

Financial pressures besetting families with a disabled child can exacerbate a situation that is of itself costly. Disabled children are amongst the most likely to experience poverty and children from poorer backgrounds are more likely to become disabled than their peers from more affluent backgrounds. Out of the 40% of disabled children in the UK living in poverty, almost a third is classified as living in 'severe poverty'. 38% of children live in workless households compared to 16% of all children and 89% of mothers with disabled children do not work compared with 39% of mothers with non-disabled children. The annual expense of bringing up a disabled child is 3 times greater than that of bringing up a non-disabled child. This bleak picture is not lightened by future projections. Disabled children aged 0-16 form the fastest growing group amongst the population of disabled people *(The Papworth Trust, 'Disability in the United Kingdom 2016: Facts and figures')*.

Lack of money in the disabled child's household means that visits to the doctor or hospital can be prohibitive according to The Royal College of Paediatrics and Child Health. Doctors have reported that parents cannot afford time off work to visit infants in Special Care Baby Units or purchase the petrol to visit their babies in neonatal intensive care units. Children with long term conditions may find that their parents cannot pay for the extra services and equipment necessary to manage their conditions and the pressure of financial scarcity may have an adverse effect upon the parents' own mental health, thereby affecting their care for any children with demanding heath conditions and disabilities. The outcomes for disabled children in such families are frequently worse than for those in better-off families *('Poverty and Child Health: Views from the frontline' May 2017 Royal College of Paediatrics and Child Health)*.

Findings from a study by Emerson *(2003,'Mothers of children and adolescents with intellectual disability: social and economic situation, mental health status and the self-assessed social and psychological impact of the child's difficulties' Journal of intellectual disability Research, 47(4-5).385-399)* showed that families supporting a child with an intellectual disability (ID) were significantly economically disadvantaged in comparison with families supporting a child without such a condition. Mothers of the sampled ID children also reported that their child's difficulties resulted in greater social and psychological impact than mothers of sampled children with no ID. Additionally, children with intellectual disability may experience an increased risk of poor health in comparison with their peers.

Exposure to socioeconomic disadvantage contributes towards this disparity *(Gore N., Emerson, E., & Brady, S., 'Rates of breastfeeding and exposure to socioeconomic adversity amongst children with intellectual disability' Research in developmental disabilities, 39, 12-19)* and indicates the necessity of combating poverty amongst these children and their families as it can lead to worsened outcomes in comparison with children born in a more privileged position or setting. Children with a disability may also be likelier to become targets of bullying *(Chatzitheochari, S., Parsons, S., & Platt, L., 2016 'Doubly disadvantaged? Bullying experiences among disabled children and young people in England' Sociology, 50(4) 905-713)*. This suggests that school can also be a site or environment of social inequality; reflecting characteristics of the community in which it is placed.

The importance of maintaining good oral health is extremely important for disabled children, and one study examining oral health inequalities for children and adolescents with disabilities identifies that the prevalence of poor oral health is increased in children with disabilities and worsens with age *('Inequalities in Oral Health for Children with Disabilities: A French National Survey in Special Schools' Martine Hennequin, Veronique Moysa, Didier Jourdan, Martine Dorin, Emmanuel Nicolas, 2008)*.

Poor oral health is a factor for co-morbidity when associated with systemic disease. It increases the likelihood of infectious complications for patients presenting with systemic diseases such as congenital cardiac disease, immunodeficiency or diabetes, and plays a direct role in the aggravation of chronic respiratory disease; the main cause of mortality in disabled people. For patients with epilepsy or mental deficiencies, both neurological and behavioural problems may be related to undiagnosed and untreated oral pain.

Families who are unable to maintain regular medical appointments will also be unlikely to keep dental appointments for their disabled child. However, the need for disabled children to have equality of access to dental care with their general dental practitioner (GDP) rather than being sent to salaried services or dental hospitals *('Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults' Department of Health, 2007)* is a funding matter affecting access, service utilisation and specific training for dental professionals.

The negative impact of austerity upon the health prospects of disabled children has been noted by professionals. A British Academy of Childhood Disability survey *(British Academy of Childhood Disability and British Association for Community Child Health, 2014 'Impact of Austerity Measures on Families with Disabled Children': Survey of BACCH and BACD members and Child Development Team Leads November 2014 and January 2015, London: BACD and BACCH)* found that 65% of respondents had observed the direct impact on families of austerity policies. The same point is made by a doctor in the survey published by the Royal College of Paediatrics and Child Health *('Poverty and Child Health: Views from the frontline, May 2017):*

'In my personal opinion, the combination of the recession and continuing austerity measures have put increasing pressures upon families and their children.'

In such a climate, even discharging a child from hospital may be laden with unavoidable risk:

'Children who are going home with complex needs – home oxygen or wheelchair, etc. – that the housing is unsuitable for. For example a block of flats with no lifts.'

Children from ethnic, culturally diverse and migrant communities

A recent UK survey *(T.B. Born & H. Aldridge, 2015 'Poverty among young people in the UK' https://www.npi.org.uk/publications/children-and-young-adults/739/)* found the poverty rate for young non-white British people to be nearly double that of a comparative white group (47% v 29%). Minority ethnic children are likelier to grow up in conditions of poverty and poor housing *(Equality and Human Rights Commission, 2016 'Race report: healing a divided Britain' in 'Equality and Human Rights Commission Report on the Need for a Comprehensive Race Equality Strategy')* and long-term health outcomes for children from minority backgrounds are worse.

Across multiple health outcomes, racial ethnic minority children experience earlier illness onset, more severe diseases and a poorer quality of care than white children in the UK *(Williams, D. R., Priest, N.,& Anderson, N.B. 2016, 'Understanding the associations among race, socioeconomic status and health: Patterns and prospects' Health Psychology, 35(4), 4017)*. The prevalence of obesity and overweight in black Caribbean and African children is higher.

Inequalities in the prevalence of dental caries associated with some ethnic minority groups are more pronounced among pre-school children than any other age group. Many epidemiological studies and clinical surveys draw links between race/ethnicity and oral health status but the actual cultural beliefs and values that may influence oral health practices are under-reported.

Health disparities between ethnic groups are not particular to the United Kingdom.

African American and poor children in the United States suffer disproportionately from asthma and a study from Rice University sociologists contends that racial and socioeconomic gaps in the proportion of children in Houston with asthma may be due to social inequalities in the neighbourhoods where those children live. The study found that of 12,000+ children in Houston with asthma, the highest incidence was amongst African American children and most frequently amongst African American children from the poorest neighbourhoods *(Ashley W. Kranjac, Rachel T. Kimbro, Justin T. Denney, Kristin M. Osiecki, Brady S. Meffett, Keila N. Lopez, 'Comprehensive Neighbourhood Portraits and Child Asthma Disparities' Maternal and Child Health Journal, 2017; DOI: 10. 1007/s10995-017-2286-z)*.

In the United Kingdom, there is growing concern that the mental health services are failing black and minority ethnic (BME) communities *(Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. 2016, 'Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England' BMJ open, 6(11), e012337)*. Barriers that these groups face are identified (both from within their community and through the service provision process) and include social stigma, cultural identity, financial factors, lack of awareness, insensitivity and discrimination.

The difficulties encountered by refugee and child migrant communities living in England are especially acute. These children are among the most vulnerable to poor health and development *(Equality and Human Rights*

Commission, 2016, as above) due both to the effects of their experiences in the country of origin and subsequent poor social and economic circumstances in the UK. Prior to the 2014 Immigration Act, for example, access to NHS care was free for temporary migrants but now they must pay an additional charge on entry, to cover potential health service costs.

The GP registration process is a road block to this group *(Cha, E.U. 2013 'Inequalities and multiple discrimination in access to and quality of healthcare' http://fra.europa.eu/en/publication/2013/inequalities-discrimination-healthcare and Poduval, S., Howard, N., Jones, L., Murwill, P., McKee, M.,& Legido-Quigley, H. 2015, 'Experiences among undocumented migrants accessing primary care in the United Kingdom: a qualitative study' International journal of health services, 45(2), 320-222).* Registration is invariably refused to people who lack appropriate documents and practice managers and surgery staff may feel themselves pressured by immigration authorities to check the status of patients suspected of overstaying their visas *(Equality and Human Rights Commission 2016 as above)*. 'Healthwatch' Hertfordshire *(https://www.healthwatchhertfordshire.co.uk/)* reports feedback from community development workers that many people from Polish communities have low engagement with the NHS (including GP registration levels) because their understanding of how the UK health system operates is negligible.

Studies in Norfolk and Kent have illustrated multiple obstacles faced by Polish people when attempting to access health and welfare service. These include language barriers and a lack of adequate information in an appropriate format. A national study *(Lakasing, E., & Mirza, Z.A. 2009, 'The health of Britain's Polish migrants: a suitable case for history taking and examination' Br J Gen Pract, 59(559), 138-139)* has shown that Polish organisations report high levels of depression, suicide and poverty amongst migrant workers. 'Healthwatch' Hertfordshire has received anecdotal information from Polish migrants who claim that their income has increased, but their social status and family support have diminished, resulting in deterioration in mental health. These issues have had a predictable, cumulative and adverse affect upon young people from these families.

The National Inclusion Health Board in England has identified vulnerable migrants as a group with poor health; focusing in particular on low-paid/unemployed migrant workers, asylum seekers, refused asylum seekers, refugees, unaccompanied asylum- seeking children, undocumented migrants and trafficked persons *(Inclusion Health, 2013)*. It can be inferred that the difficulties faced by these groups impact their young people's

health and wellbeing. In recent years there has been growing recognition of the vulnerability of immigrant adolescents in particular, and their susceptibility to reduced levels of wellbeing and increased involvement in 'at risk' behaviours *(Inchley, J. et al, 2016, 'Growing up unequal: gender and socioeconomic differences in young people's health and well-being' Health Behaviour in School-age-children (HBSC) study).*

The levels of social and economic inequalities amongst children of ethnic, culturally diverse and migrant communities in the UK have been magnified by global migration and the rising numbers of young people with immigrant roots. Barriers to engaging in healthier lifestyles have had a direct impact upon young people's health and wellbeing *(Brooks, F., Magnusson, J., Klemera, E., Chester, K., Spencer, N., & Smeeton, N. 2015. HBSC England national report 2014, Hatfield, UK; Hertfordshire university).* Migrant and refugee children who have been forcibly displaced to high-income countries are members of marginalised groups and research has found that parental worries about financial difficulties have negative consequences on their mental health *(Fazel, M., Reed, R.V., Panter-Brick, C., & Stein, A..2012, 'Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors' The Lancet, 379(9812), 266-282).*

A further study has linked the low socioeconomic status of Bosnian refugee adolescents to depressive symptoms and poor self-esteem *(Sujoldzic, A., Peternel, L., Kulenovic, T., & Terzic, R. 2006 'Social determinants of health – A comparative study of Bosnian adolescents in different cultural contexts' Collegium Antropologicum, 30(4), 702-711).* Children and adolescents who flee persecution in their own countries (for the most part, geographically distant and low-income settings) to resettle in high-income countries like Britain often endure great physical and mental challenges during their displacement, combined with negative health outcomes. This downward trajectory continues after arrival in new settings that are necessarily unfamiliar and can even be hostile.

Looked-after children

'Looked-after' children are either subject to a care order or have been accommodated by the local authority on a voluntary basis *(*Carr, *H. and Gosley, D. 2017 'Law for Social Workers' 14th ed. Oxford University Press).* Their number is increasing year on year and it is estimated that at least 100,000 enter and leave the care system in England annually *(Bywaters, P. 2017, 'Identifying and Understanding Inequalities in Child Welfare Intervention Rates: comparative studies in four UK countries.' Briefing Paper*

1: England, February 2017 http://www.coventry.ac.uk/Global/08%20New%20Research%20Section/16469-17%20CWIP_0617.pdf).

At 31st March 2017, Department for Education statistics revealed:

- **72,670 Looked-after Children in England**
- **5% of these under 1**
- **13% aged 1-4**
- **19% aged 5-9**
- **39% 10-15**
- **24% over 16**
- **75% white British**
- **565 male, 44% female**
- **18% (4,560) unaccompanied children and young people seeking asylum.**

'The Child Welfare Inequalities Project' *(Coventry University 2017 http://www.coventry.ac.uk/research/research-directories/current-projects/2014/child-welfare-inequality-uk/cwip-project-outputs/)* examined available data on 35,000+ children who were either classified as looked-after or had been placed on a child protection plan in March 2015. The study, by academics at Coventry, Sheffield, Huddersfield, Cardiff, Edinburgh, Stirling and Queen's Belfast Universities concluded that poverty was the largest influence on children being taken into care. Paul Bywaters, Professor of Social Work at Coventry University said:

'We've known for years that child abuse and neglect is linked to poverty, but there's been a fundamental gap in our understanding of how a child's family circumstances and neighbourhood deprivation or locality impacts their chances of the state intervening to improve their life chances … with further austerity measures and fundamental changes to local government financing on the horizon, time is very much of the essence in tackling this most vital of social issues' The Guardian, 28th February, 2017).

Nuffield Foundation research has indicated that children living in the North East or North West of England are 70% likelier to undergo care proceedings than their counterparts living in the south east or London *(http://www.nuffieldfoundation.org/vulnerable-birth-mothers-and-recurrent-care-proceedings* and *http://www.nuffieldfoundation.org/supervision-orders-and-special-guardianship).* The researchers, led by Professors Karen Broadhurst and Judith Harwin have called upon policy-makers to give the north priority attention with more resources and

preventive family support plans in place to alleviate the risk of children becoming subject to care proceedings. Professor Broadhurst commented:

'We've been concerned about the disproportionate removal of children from poor areas since the 1980s, so why aren't we doing anything about it – and why is resource allocation not more closely aligned to deprivation?' (The Guardian, 3rd July 2017).

Health prospects for children in statutory care deserve scrutiny. For example, they have poor levels of oral care, dental neglect and disease, little regular dental attendance before care entry and higher needs for treatment when they attend a dental surgery. Looked-after children are not a homogenous group but while every child and young person's experiences are unique, research has drawn common themes concerning the Adverse Childhood Experiences (ACEs) that have triggered care admissions. These children fare less well than the wider population in many respects over time, with higher rates of mental and physical health problems, special educational needs, substance and other abuse, poverty and social and emotional challenges *(Wade, J. 2014 'The Mental Health and Wellbeing of Young People Leaving Care' In Rahilly, T. Hendry, E. 'Promoting the Wellbeing of Children in Care' Messages from Research, Leicester NSPCC: https://www.nspcc.org.uk/globalassets/documents/research-reports/promoting-wellbeing-children-in-care-messages-from-research.pdf).*

The Education Select Committee's Inquiry into Fostering *(First Report of Session 2017-19: HC 340)* has raised concerns with regard to the mental and psychological health needs of Unaccompanied Asylum Seeking Children; in particular over resources and immigration status:

'Growing numbers of UASC also place additional burdens on the foster care system as 41% are said to have mental or psychological heath needs; are also more likely to remain in care until they are 18 than other young people, thereby requiring longer support from local authorities, and will require placement with experienced and highly-skilled carers.'

National statistics provide one lens into the number of children accommodated by local authorities and the reasons why. What is missing is a wider narrative that highlights the inequalities experienced by children and young people classified as 'looked-after'; national data about the impact of their early years and care experiences; information about their parents' circumstances; support services provided and how these may have influenced outcomes in every aspect of their later lives.

Recommendations:

2.1 Government to commission research into the effect on child mental health of living with income poverty, debt, poor housing and in circumstances whereby one or more adults have mental health problems

2.2 The influence of social and economic inequalities to impact all policies on children's mental health and wellbeing and for PSHE to become a statutory subject in all schools

2.3 National secure and long-term funding streams to be established for Child and Adult Mental Health Services (CAMHS)

2.4 Integrated services for disabled children to be guaranteed stable funding in all local authority areas

2.5 Guaranteed funds for Early Identification services in all local authority areas (disabled children and children with mental health problems)

2.6 Improved and up to date information to be readily accessible about the availability of services and access pathways for BME communities and improved engagement strategies devised to interact with families from these communities

2.7 Policy makers to ensure that all measures reflect the needs of diverse ethnic, cultural and migrant communities so that interventions can be designed that will enhance young people's health and wellbeing

2.8 An integrated governmental approach to the requirements of all children and young people; in particular those deemed 'in need' or looked after by the State

3. 'COUNTING THE COST'

The Marmot Review *(2010 as above)* highlights the unacceptable financial burden of inequalities when stating that:

'The cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness.'

The Review contains the following information:

'By comparing the current situation, with its considerable levels of inequality, with one in which everyone had the same health outcomes as the richest 10 per cent of the population in England, it is estimated that there are currently:

- ***Productivity losses of £31-33 billion per year***
- ***Lost taxes and higher welfare payments in the range of £20-30 billion per year.***

Direct healthcare costs in England associated with treating the consequences of inequality amount to £5.5 billion per year for treating acute illness and mental illness and prescriptions. These activities represent approximately one third of the NHS budget. In consequence, it is likely that the full impact of health inequalities on direct healthcare costs is considerably greater than this. Taking an alternative approach, by modelling the costs of treating the various illnesses that result from inequalities in obesity this time in England and Wales, it is estimated that inequalities in obesity currently cost £2 billion per year predicted to rise to nearly £5 billion per year in 2025.'

A perfunctory approach to inequalities does not come cheap.

Cost-saving potential of early intervention measures

Early intervention as a policy tool is designed to reduce adverse outcomes in later years by encouraging preventative action in the lives of children, parents and carers. Measures may be universally applied, or designed for specific groups that are considered to be at high risk of disadvantage. Early interventions foster productive relationships and behaviours so that successive generations may be afforded the best chance to flourish whilst acquiring positive parenting skills. Preventative policies make clear financial sense. They are cost-effective and cheaper to implement than playing 'catch up' with the hefty price tag of neglect.

It is never too soon to start. The 2013 report, *'Preventing disease and saving resources' (UNICEF https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources_policy_doc.pdf)* calculated that moderate increases in breastfeeding could garner substantial financial savings to the NHS. The report findings demonstrate that for just five illnesses, moderate increases in breastfeeding would reap NHS cost savings of up to £50 million and tens of thousands of fewer hospital admission and GP consultations. In addition, the analysis of three conditions (cognitive ability, childhood obesity and Sudden Infant Death Syndrome) suggests that modest improvements in breastfeeding rates could save millions of pounds and, in the case of SIDS, children's lives. The report prescribes investment in effective services to improve and sustain breastfeeding rates, arguing that this will produce a positive financial return within several years – maybe even within one year.

A case for early intervention can also be made for oral care. The Public Health England National Dental Epidemiology survey of five year olds in England (2015) showed that 25% of those surveyed had experienced tooth decay; with on average, 2/3 affected teeth. The vast majority of tooth decay was untreated.

People carrying a high risk of poor oral health generally live in areas categorised as socially and economically disadvantaged. Tooth decay increases for children likelier to have a sugar-rich diet who do not brush their teeth twice daily with fluoride toothpaste. In 2015, the average cost of hospitalised tooth extraction for a child was £836 and in 2015-16, tooth extractions in children aged 0-19 years cost approximately £350.5 million. The majority of these were due to tooth decay. For children aged 0-4 years, the bill for extractions was approximately £7.8 million. Tooth decay is largely preventable, but in 2014, NHS dental treatment costs for all ages came to £3.4 billion with an estimated additional £2.3 billion in the private sector. The Children's Oral Health Improvement Board (launched in 2016) has a collective ambition for every child to grow up without tooth decay as a key component of the goal for each child to enjoy the best start in life. Local authorities have a significant role in improving the dental health of their population by promoting good oral habits and practice.

There are a number of interventions to prevent tooth decay that can save money in the long term and reduce the number of children requiring time off school for treatment. The programmes below are demonstrably effective interventions for improving dental health and reducing tooth decay in 5 year olds:

- **Targeted community fluoride programmes have meant an extra 3,049 school days gained per 5,000 children; Public Health England estimates that after 5 years, the return on investment is £2.29 for every £1 spent and £2.74 after 10 years for every £1 spent**
- **Water fluoridisation schemes**
- **Provision of toothbrushes and paste by post and health visitors**
- **Targeted supervised tooth brushing schemes for nurseries and primary schools in areas where children are at high risk of poor oral health (PHE estimates that after 5 years, the ROI for targeted supervised tooth brushing is £3.06 for every £1 spent. After 10 years, this increases to £3.66 for every £1 spent. After 5 years, targeted supervised tooth brushing can mean an extra 2,666 school days gained per 5,000 children)**
- **PHE's sugar reduction programme supports children and families to consume less sugar and reduce risk of tooth decay**
- **Health professionals, such as midwives and health visitors, should support and encourage women to breastfeed**
- **Cut down on sugar consumption**
- **Soft drinks industry levy**

A 2015 report published by the Early Intervention Foundation *'Spending on Late Intervention' (http://www.eif.org.uk/publication/spending-on-late-intervention-how-we-can-do-better-for-less/)* found that nearly £17 billion per annum is spent by the state in England and Wales on short-run Late Intervention. The money cuts across a number of different public agencies at national and local level including local authorities, the NHS, schools, welfare, police and the criminal justice system. The largest burden at £6.5 billion is borne by local authorities, followed by welfare costs of £3.7 billion and the NHS at £3 billion. A comprehensive 'bottom-up' estimate of spending on Early Intervention has yet to be collated, but existing estimates suggest that this spend represents a much smaller proportion of relevant budgets than the cost of Late Intervention.

Combating cost as a barrier to healthy eating

Professor Martin Caraher; Centre of Food Policy, City University, London has said:

'The new poverty is that one in five families are living below the poverty line, putting them at risk of food poverty. Over 4 million children are at risk and 4 million suffer from serious nutrient-related health problems. People still go hungry but the outcomes of food poverty are as likely to be overweight and obesity as hunger. It is the same groups that are hungry and also obese'

(Watts M. 2013 'Tackling Food Poverty and Beating the Nutrition Recession' *http://bant.org.uk/wp-content/uploads/2014/01/BANTNEWS_OCT2013_ISSUE_53.pdf).* A report in 2017 from the Centre for Social Justice *('Off the Scales: Tackling England's childhood obesity crisis')* examines the economic burden of obesity and deploys an array of statistics to demonstrate that *'we are snowballing towards a National Health Service (NHS) crippled by the mounting cost of obesity. NHS England is estimated to spend between £5.1 billion and £6.1 billion a year on the cost of illness related to overweight and obesity, and a further £8.8billion on type 2 diabetes alone (almost a 10th of the entire NHS budget).'*

For many UK families, cost is a major obstacle to healthy eating. Industry-commissioned research, *(www.earlylifenutrition.co.uk/the-big-conversation/ 2014)* illustrated the widely-held canard that 'healthy' food is, perforce, expensive and that cooking from scratch *'costs too much.'* It is predictable, therefore, that fast food outlets are burgeoning in deprived areas and that the consumption of cheap snacks and takeaway meals is likelier to form a substantial component of the diet eaten by children from economically poor homes.

The unhealthy chosen food often arrives in large portions, leading directly to future body weight issues and soaring costs to the NHS *(Parliamentary Office of Science and Technology, 2016, 'Barriers to Healthy Food' post note Number 522, Houses of Parliament).* Data from The National Child Measurement Programme from 2006/07 to 2011/12 also unites economic deprivation with child obesity and suggests that the prevalence of obesity among Reception (4-5 years) and Year 6 (10-11 years) children in the most deprived 10% of the population was roughly twice that for the least deprived group *(Public Health England, 2013, 'Social and Economic Inequalities in Diet and Physical Activity')*

Food prices overall are on the rise *('Barriers to Healthy Food' as above)* with statistics showing that:

- Food costs are currently 8% higher in real terms than in 2007
- Food prices are increasing by 10% more than other goods. A healthy diet for a single pregnant mother could cost £30.34 per week; equivalent to 57% of the Job Seekers' Allowance for the under 25 age group
- The average household spends 11% of income on food (not including food bought away from the home).

Concerns relating to the long term outcomes of an unhealthy diet are unlikely to be foremost in the minds of the 36% for whom healthily balanced meals are financially prohibitive. An Ipsos-Mori survey *('Child Hunger in London – Understanding Food Poverty in the Capital' Greater London Authority, August 2013)* found 8% of parents reporting that their children skipped meals because there was no money to purchase them. Sustain has defined food poverty as:

'Worse diet, worse health, worse access, higher percentage of income on food and less choice from a restricted range of foods. Above all, food poverty is about less or almost no consumption of fruit and vegetables' (Sustain, 2017, 'What is food poverty? Beyond the Food Bank': London Food Poverty Profile 2017) https://www.sustainweb.org).

However, families require support to recognise that, far from being a cheap and acceptable option, convenience foods can be an expensive, unhealthy choice and that meals made from scratch using fresh ingredients need not represent an insurmountable barrier. However, as The Big Conversation *(above)* has shown, many parents are ill-equipped to make informed decisions about food and wrestle with an overload of information that is often contradictory and perplexing. In such circumstances the snacking and takeaway habit is stubborn.

The low quality diet amongst socioeconomically-deprived communities presents a public health challenge. Professor Tim Lang *(Sustain survey as above)* defines food poverty as the '*inability to obtain healthy and affordable food.*' The multiple reasons for this include a lack of shops or trouble reaching them, transport difficulties, low income, fear of crime, lack of knowledge about what constitutes a healthy diet and an absence of cooking skills. People on restricted incomes have the lowest intake of fruit and vegetables and are likelier to suffer from diet-related diseases such as cancer, diabetes, obesity and coronary heart disease. Food poverty in general results in a surplus of unhealthy junk food and spending on food is skimped when other basic needs such as rent and fuel must be accommodated.

The challenges below illustrate the barrier posed by social and economic inequalities to the diet of UK children today:

- **Making healthy food choices for children easier and making them the social norm – In 2012 a Netmums survey of 2000 members found 25% of families living on credit cards and 1 in 5 mothers skipping meals so**

that their children could eat *(Watts M, 2013, 'Tackling Food Poverty and Beating the Nutrition Recession' The Health Bank)*

- Breakfast Provision at School – The Magic Breakfast charity claims that over half a million UK children arrive at school each day too hungry or malnourished to learn, *('School Breakfasts on the National Agenda. Magic Breakfast: Fuel for learning' www.magicbreakfast.com)*
- Free School Meals – In 2014 the free school meal eligibility entitlement was extended to include each child in their first three school years, amounting to an extra 1.5 million children (many from 'working poor' families) previously denied access to free school meals. *(School Meal Information 2017, https://www.gov.uk/apply-free-school-meals: Application for free school meals)*
- Holiday Hunger – the All Party Parliamentary Group for Hunger has alleged that children from the poorest backgrounds are undernourished when they return to school after the holiday period *(Graham L, 2014, '170 Days: Innovation in Community Projects that address School Hunger' (US) Winston Churchill Memorial Trust, London)*
- Food Banks – The Trussell Trust (at 428 centres, the UK's biggest food bank network) distributed 587,000 three day emergency food packages from April-November 2017 *(Trussell Trust 2017, 'How Food Banks Work' www.trusselltrust.org)*. Christmas is a crisis period; other red lights include food bank use, delayed wages, domestic violence, illness and increased unemployment, debt, refused crisis loans, homelessness, and food price rises.
- Failure to teach children to cook and shop for food – 90% of respondents to a national survey could not cook a meal from basic ingredients without help *(Adams J. et al, 2015, 'Prevalence and socio-demographic correlates of cooking skills in UK adults: cross-sectional analysis of data from the UK National Diet and Nutrition Survey' International Journal of Behavioural Nutrition and Physical Activity 12 (1):99)*
- Food Deserts developing across the UK – A food desert develops when there is over 1,600 metres to the nearest grocer and less than that distance to the nearest takeaway shop. There is a strong association between the density of fast food outlets and geographical deprivation. Takeaway snacks and fast food are usually high in calories, saturated fat and salt; low in fibre, fruit and vegetables. They are usually available at burger bars, kebab vans, chip and sandwich shops *(Tedstone A., 2016, 'Obesity and the environment – the impact of fast food' https://publichealthmatters.blog.gov.uk/2016/10/21/obesity-and-the-environment-the-impact-of-fast-food/)*.

The National Curriculum has now made cooking and food education compulsory for children until the end of Key Stage 3 but there has been no national evaluation of the change. What is needed is a radical and definitive culture shift in the UK Government's approach to the eating habits of children:

To quote Professor Kelly Brownell of Yale University:

'The reality stares us in the face. Poverty drives people towards cheap food, packaged snack foods, sugared drinks and fast foods. Poverty discourages physical activity and encourages excess calorie consumption. Blaming the victims for making bad choices is common, but more helpful would be an honest assessment of the conditions that create the problems, and solutions based on the causes. Bold action is necessary' (Brownell K, 2007, 'Culture matters in the Obesity Debate' LA Times, 21st September, 2007).

Combating cost as a barrier to physical activity

A large body of evidence suggests that regular physical activity boosts the health and wellbeing of all children; especially those affected by social and economic disadvantage. To some extent, this has been recognised by the Government. One aim of the sports strategy is to engage children and young people from disadvantaged communities who have hitherto been under-represented and under-engaged by existing provision *(Department for Culture, Media and Sport,' Sporting Future: a New Strategy for an Active Nation' 2015).*

The Chief Medical Officer has recommended that children and young people complete at least 60 minutes of moderate to vigorous physical activity per day *(Factsheet 3, 'Physical activity guidelines for children and young people: 5-18 years')* but most are currently failing to meet this requirement. Only 23% of boys and 20% of girls between the ages of 5-15 are attaining the target and in London, the figure stands are a mere 16% of 5-15 year olds *(NHS Digital, 'Physical Activity in Children' Health Survey for England, 2015/16).*

Playgrounds are one of the best ways of increasing children's physical activity *(www.playscotland.org/wp-content/uploads/The-Play-Return-A-review-of-the-wider-impact-of-play-initiatives1.pdf).* However, research undertaken by the Association of Play Industries has uncovered a steep decline in playgrounds across England. 214 playgrounds have been closed with a further 234 earmarked for closure by local authorities

(http://www.api-play.org/upload/public/Nowhere%20to%20Play/NowheretoPlayFinal.pdf).

Children with a playground within 1km of their home are five times more likely to be of a healthy weight *(http://link.springer.com/article/10.1007%2Fs10900-008-9104-x).* For many children living in deprived areas - who are more than twice as likely to be obese than those in more affluent areas *(NHS, National Child Measurement Programme - England 2015-16)* - playgrounds represent their only chance to play outdoors.

Within the overall figure, socioeconomic factors are predominant. Members of low-income households are less likely to play organised sport and access sports coaching (as consistently revealed by Sport England's Active Lives surveys). Within school, on average, across all Key Stages, pupils were offered less than two hours of P.E. per week *(Youth Sport Trust, 'National PE, School Sport and Physical Activity Survey Report' 2015).* The Primary PE and School Sports Premium (ring-fenced funding; doubled since September 2017 and available for primary schools to boost the quality of PE and sport activities offered to children) should be an efficient means of combating undesirable trends. However, a practitioner notes some serious flaws in the delivery of PESS premium:

'In my experience, it appears that the bulk of the premium is being used to make up shortfall in school budgets rather than being used to give all children access and opportunity to high quality physical education. If the money was just used correctly in every school it would be sufficient to give every child a high quality experience to benefit all aspects of a healthy lifestyle. There is enough in my opinion, for schools to be very creative in its use so that they can cater for all pupil need' (Kathryn Sexton; Juka Dance, 2018).

Criticisms of the PESS are widespread and some are here taken from a monitoring website set up by Active Matters. Cross-sector comments show that in the absence of accredited checks, balances and underpinning theory, 'throwing money at problems' is doomed to failure. Observations include:

- **Reception classes excluded from the grant; making the funding of play activities unlikely**
- **The bulk of the premium frequently used to compensate shortfall in overall school budgets rather than affording all children access to high quality physical education**
- **Department for Education not checking how money is spent; use of the PESS premium not intrinsic to every Primary OFSTED inspection**

- Schools 'strapped for cash' and deploying 'creative accountancy' *('only the blatantly reckless Academy trusts being caught out' Active Matters).*

Outside school, accessing sports or supervised physical activity opportunities is frequently financially prohibitive for low-income families. Ukactive and Premier Sport research has demonstrated that the fitness levels of the most economically-deprived children fell significantly over school holiday periods compared with their more affluent peers. Report authors pinpointed the costs of summer holiday activities as significant in the disparity. *(http://www.ukactive.com/home/more/10148/page/1/school-summer-holidays-driving-victorian-era-health-inequalities-among-children).* Free or low-cost provision traditionally offered or funded by local authorities has been adversely affected by budget restrictions. In London £22 million has been axed from council youth services since 2011/12 and the average council has cut the youth services budget by nearly £1 million; an average of 36%. In some boroughs the figure is higher and Barking and Dagenham (which has the highest rates of childhood obesity in the country) has had its youth services budget cut by nearly 70% *(Berry, Sian, 'London's Lost Youth Services: The dramatic disappearance of support and facilities for young people in London' Jan 2017).*

The availability of play provision is more complex. Lester and Russell *(Lester, S.& Russell, W. 2010 'Children's Right to Play: An Examination of the Importance of Play in the Lives of Children Worldwide' Working Paper No. 57,The Hague The Netherlands, Bernard van Leer Foundation)* identified the impact of socioeconomic status on children's spatial patterns, thereby influencing where they live and the community resources available to them. Poorer children have fewer and less varied toys and cuts in funding for local play provision is therefore particularly detrimental to their wellbeing *(Gleave, J. & Cole-Hamilton, I., 2012, 'A World Without Play: A Literature Review on the Effects of a Lack of Play on Children's Lives' Play England).*

The outlook is further complicated in that children from wealthier families may experience 'play poverty' because their freedom is restricted by over-zealous parents ('helicopter parenting'). In striking contrast, research with Roma children in Transylvania (some of the poorest and most disadvantaged children in Europe) concluded that their summer-time play was *'rich in many of the most fundamental aspects of a healthy play experience' (Brown, F. 2017 'The Play Behaviour of Roma Children in Transylvania' International Journal of Play 5th Anniversary Special Issue. Abingdon: Taylor Francis).*

On the one hand, poor children lose out because they live in inadequately resourced areas and their parents cannot afford to purchase many toys to play with; on the other hand, those from wealthier backgrounds lose out because their free-play opportunities are severely restricted. Clearly, both issues are likely to have a negative impact on a child's longer term health and wellbeing.

Ensuring that money is not the dominant factor in the quality of children's play experiences should be central to a national approach. The Welsh Government has a requirement (Play Sufficiency) for local authorities to assess the sufficiency of play opportunities in their area. Identified insufficiency requires them to create an action plan to address the relevant issues. In January 2014 (recognising the link between social and economic inequalities and the quality of children's play provision) Welsh Ministers announced preparations for the commencement of Section 11(3) of the measure. This places a duty on local authorities to secure sufficient child play opportunities in their area in response to the findings of their local play sufficiency assessment.

In response to their particular sufficiency assessment, Wrexham Borough Council commissioned research to assist the authority's implementation of Section 11(3) *(Long, A. 2014, 'Wrexham Play Sufficiency Research Project' Leeds Beckett University)*. The study found that the presence of playworkers signalled reassurance to communities and enabled them to address possible concerns held by parents, children and other community members. This entails of necessity a firm commitment to long term, sustained and staffed opportunities in communities. Playwork offers a safe and secure form of provision, directed by a child's agenda and appealing to all sections of society. It can benefit child health and wellbeing by potentially overcoming the negative impact of social and economic inequalities on children's ability to play.

In conclusion, it is perhaps worth reassessing the way in which 'health spend' is customarily considered. Over the course of recent government administrations, the overriding priority has been to finance ambitious infrastructure projects; Crossrail, HS2, Heathrow expansion to name but some. All these schemes are designed to reap a greater economic benefit to the country than the initial committed outlay via an increase in productivity, tax revenues and employment rates. The cost-benefit ratio for Crossrail, for example, is estimated at 1:1.97 *(National Audit Office 2014 report)* whilst the estimates for HS2 come in at between £1.80 and £2.50 *(Government official statistics, 2012).*Successive Governments have used these ratios to justify substantial investment in the projects and yet the figures themselves pale

beside recent studies on the impact of intervention in public health. A BMJ study *('Return on investment of public health interventions: a systematic review' 2017)* found that:

'The media return on investment for public health interventions was 14.3 to 1.'

A 2013 study conducted by the American Public Health Association and the Canadian Public Health Association estimated a return on investment from public health of up to 3900%. Public spending on public health interventions specifically aimed at children's health provide significant return on investment with a cost-benefit ratio that is absent from other major Government projects. If infrastructure is (as is commonly accepted in the UK) the basic physical, social and economic foundation required for the operation of a society, then investment in public interventions in children's health must, and should, be seen as an integral part of the Government's overall infrastructure spend.

Recommendations:

3.1 Government to commission a detailed estimate of spend on Early and Late Intervention measures and to publish an impact assessment comparison of relevant budgets

3.2 All councils to appoint a Healthy Start co-ordinator as per the Government scheme *https://www.healthystart.nhs.uk/* and an integrated programme of activities to reach a minimum local uptake of 80% *(London Food Link, 2017, 'Beyond the Food Bank': London Food Poverty Profile https://www.sustainweb.org/secure/BeyondTheFoodBank2017.pdf)*

3.3 National Government and Local Government Association to initiate a joint campaign to promote local initiatives that help parents to cook healthily with their children in the most deprived areas of society; producing a bank of best practice examples and holistic local working opportunities aimed at boosting the life skills of disadvantaged families

3.4 The Department of Health to commission a cost analysis of the impact of socioeconomic inequalities on children's health and where possible, commit to increase funding in percentage terms in line with costs identified

3.5 Initiative to combat inadequacies in oral health associated with some ethnic minority and migrant groups via care guides and practitioner signposting in the relevant languages

3.6 Measures to safeguard and improve dental health to be embedded in all children's services at strategic and operational levels

3.7 Department for Education to insist that PE provision, and specifically the use of the PESS premium, is part of every Primary OFSTED inspection

3.8 Reception and Early Years' Physical Activity to be included for spend within PESS premium funding with specific mention of play

3.9 Funding investment in playworker provision; in particular targeting areas of social and economic inequality and deprivation with a 'playwork means safe and healthy communities' campaign

3.10 All Government initiatives in advancement of physical activity to prioritise a targeted approach; supporting measures that extend provision in under-served, disadvantaged communities with as little cost as possible to users

3.11 In order to drive a radical policy re-set, Government finance earmarked for early childhood development should be considered as *infrastructure* spend and treated as such in terms of its inclusion in Government targets in this area. Investment should not be seen as a cost but figures should also be included in attempts to close productivity gaps.

4. THE ROLE OF PARTNERSHIP WORKING INCLUDING DATA SHARING BETWEEN LOCAL AUTHORITIES, INDUSTRY AND THE VOLUNTARY SECTOR TO COMBAT SOCIAL AND ECONOMIC INEQUALITIES AND BOOST CHILD HEALTH OUTCOMES

'The need for integrated care co-ordinated around and tailored to the needs of the child or young person and their family is clear and fundamental to improving their health outcomes. Integration means the joins between services and commissioning responsibilities are invisible because organisations are working in partnership to deliver the best care across whole pathways and life stages. It means children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps and that resources are focused on the same goals' (White Paper 2013 'Improving Children and Young People's Health Outcomes: a system wide response' Department for Education).

The 2013 White Paper was a positive signpost in public health provision. Partnership between industry, local authorities and the voluntary sector can deliver lasting and beneficial outcomes for children and families in the greatest need, but resistance to change and wariness of data sharing are prevalent. Confidence in the latter could be furthered by a steer from central government (possibly via the use of some sugar tax revenue to support improved data collection). An inclusive partnership approach involving industry can succeed in targeting the most deprived families and communities:

'If encouraged, industry can play a vital role in the delivery of certain programmes alongside local authorities and the voluntary sector. Industry can often provide missing elements necessary in the final make up of any activity, including through the provision of consumer data and insights, operational expertise and financial support'(Danone Nutricia, 2018).

The Third Centre Research Centre *('Partnership Working' 2012)* contends that local authority, industry and voluntary sector partnerships are likelier to succeed when community residents are involved as active partners rather than passive beneficiaries and the initiatives below demonstrate a holistic and integrated approach.

Holiday Hunger Projects

'Holiday Hunger' typifies an escalation of food poverty levels in the UK and the existing schemes to combat it do so in full recognition of its extent.

Research by Kelloggs reveals that *'one in eight children don't get enough to eat during the holidays with many returning to school noticeably thinner, according to teachers' (https://www.trusselltrust.org/wp-content/uploads/sites/2/2015/06/Kelloggs-Holiday-Hunger-release.pdf).*

Currently, no single 'catch-all' solution to Holiday Hunger exists, but partnerships like the Tower Hamlets' initiative, involving the local authority, the voluntary sector and global financial organisation, Morgan Stanley, are helping to alleviate the problem *(https://www.morganstanley.com/about-us/giving-back/healthy-cities)*.The aim is to establish pro-active partnerships in the most vulnerable communities in order to create local holiday plans with families in need for the 170 days per year of school closure. The Tower Hamlets Food Poverty Action Plan, submitted to the Health and Wellbeing Board on 7th November 2017 advocates a mixture of activities for children including educational support, healthy food provision and skills development for parents such as improving healthy cooking capabilities and activities for the holiday duration.

Charlton Manor Primary School, Greenwich, finances a Summer School via a combination of Pupil Premium money and profit from hiring out the school hall. A Summer School workforce has been recruited consisting of *'a mixture of teaching assistants, some of the school's teachers (who may do 1 or 2 weeks each) and volunteers from the local Housing Association' telephone interview with Tim Baker by Phil Veasey, 20th December 2017).* A partnership in Acton Town for a Christmas appeal has linked up Berrymede Junior School, The Independent newspaper and the Felix Project:

'As the school gates opened and children streamed out to meet their parents, the crowd gathering at Felix's bright green gazebo found a bundle of recipe cards alongside piles of fruit and vegetables' http://www.independent.co.uk/helpahungrychild/help-a-hungry-child-felix-project-scheme-primary-school-children-healthy-food-a8111856.html0.

The Stoke North 'Food and Fun' pilot in 2017 taking place during a 6 week time span from Monday-Friday over the extended summer break, trialled various methods including direct food delivery alongside multisport and craft activities for primary school children in their own school; direct food delivery alongside multisport at a secondary school, and adding packed lunches to an existing holiday activity for predominantly primary school children. The pilot partnership members were Synectics Solutions, City Learning Trust, Port Vale Foundation Trust, Swan Bank Church, North Staffordshire Allotment Network, Root'n'Fruit, The Greggs Foundation, City Catering, Public Health, Co-operative Working, The City Council,

Staffordshire Police, Tesco, YMCA and Stoke-on-Trent Foodbank alongside 23 volunteers.

Eat Like a Champ

This evidence-based healthy eating educational programme developed in 2010 by Danone and the British Nutrition Foundation, aims to promote healthy lifestyles in children at the formative age of 9-10 years. It is teacher-led and is designed to inspire children to live healthy lifestyles. Eat Like a Champ encourages children to make realistic shifts towards the healthier habits that contribute to sustainable behaviour change. The programme includes events with Danone volunteers and celebrity champions and has inspired over 200,000 participants to adopt healthier lifestyles since 2010. A 2015/16 evaluation by the Children's Food Trust showed that it has a greater impact upon those from more deprived backgrounds (classes with a high percentage of free school meals had a net improvement of +7% in healthy eating compared to a 3.2% among others after 6 weeks).

Healthy Eating for Young Children – HEY!

HEY! Is a health literacy programme which aims to improve the health outcomes and life chances of children aged 1-4 years. HEY! Was created in 2011 in a collaboration between 4Children, Wiltshire County Council, the Community Health and Learning Foundation (CHLF) which is the UK's leading health literacy organisation, and Danone. In 2013, HEY! Was endorsed by the Royal Society for Public Health (RSPH). Danone provides an annual grant to the CHLF to allow it to run the initiative across the UK. The seven week Health Literacy Programme, with sessions running for three hours each week, is delivered in children's centres and topics covered include budgeting, food safety, portion size and cooking skills. The emphasis is on active and practical learning with language, literacy and numeracy (LLN) skills embedded in the resources. Course participants can earn a RSPH Level 1 Award in Health Improvement. Since 2011, the scheme's reach has grown by 58% and, to date, over 12, 2000 participants have attended 140+ courses in 80 different children's centres across 60 UK locations. HEY! aims to raise the health outcomes and life chances of young children most in need aged 1-4 years, by engaging their parents and carers in healthy eating and skills-for-life learning. In 2015, an independent evaluation showed this being achieved via focusing on health literacy, community cohesion and social inequality.

Greenhouse Sports

Greenhouse Sports is a charity with the objective of offering opportunities to young people living in disadvantaged, under-served areas of London to participate in high quality, extra curricula sports programmes. It prioritises an innovative partnership model of working with schools. Highly qualified, inspirational coaches are embedded full-time within schools to increase the sports sessions already available during the day and offer additional opportunities during weekends and holidays. Participants bear no costs and schools are only eligible for partnership if at least 67% of pupils live in postcodes classified as high-deprivation, according to the Department for Communities and Local Government's 'Income Deprivation Affecting Children' index (IDAC). Special educational needs schools also qualify for partnership.

Partnerships are based upon a joint-funding approach between each school and Greenhouse Sports. The school's contribution is used to leverage a larger proportion of funding from the charity; itself well-placed to attract investment from sources including statutory bodies (such as Sport England and sport national governing bodies) corporate sponsors, trusts and foundations and individual donors. The model enables both Greenhouse Sports and the school to focus upon 'whole child' development and data sharing is used as an evaluation tool. An external analysis of the programme's impact was undertaken by a Loughborough University team and peer-reviewed by Pro Bono Economics. Findings included improved health and wellbeing outcomes, better school attendance and higher rates of academic achievement *(https://www.greenhousesports.org/wp-content/uploads/2018/01/final-web-Examining-the-Impact-of-Greenhouse-Sports-Programmes-in-Schools-01-18.pdf)*.

The Daily Mile

This scheme (unique in that it has a specific Government recommendation in the Childhood Obesity Strategy) is currently being considered for inclusion as part of a 'healthy rating toolkit' for use by head teachers in England. It has been introduced into English schools in various ways; via County Sports Partnerships (CSPs) Local Authorities and NHS Clinical Commissioning Groups (NHS CCGs) and sometimes in a combination of the above. The tendency has been for Education and Health to agree joint implementation and for PE/sport to offer direct support to schools. In Essex, Cheshire West and Surrey, the CSPs Active Essex, Active Cheshire and Active Surrey have been pivotal in the delivery and quality control of the programme. The Daily Mile has been adopted by at least one school in every London Borough and some Boroughs with higher levels of

deprivation have found that it aligns very well with attempts to close the socioeconomic gap and offer inclusive health solutions to every child.

The above schemes and many others, illustrate that dynamic partnerships between local authorities, industry and the voluntary sector are most likely to succeed with a 'bottom up' rather than 'top down' approach. Partnerships impelled by managerial (often financial) pressures and service outcomes are destined for ultimate disappointment if residents and users remain unengaged. Their voices must be fully heard when setting partnership objectives, determining goals and measuring output; in other words, those preaching inclusion must also practise it.

Recommendations:

4.1 Departments of Health and Education to lead on the creation of a cross-Governmental working group (including local authorities, industry and the voluntary sector) to examine how to surmount barriers to pro-active health interventions

4.2 All local authorities involved in the commissioning of public health to appoint resident representatives to their board or working groups to ensure that local initiatives are properly appropriate for the local areas under consideration

4.3 Local Government Association (LGA) to be commissioned to produce a best practice guide for all local authorities, including accessible examples of interventions currently taking place

4.4 A common framework to be established by the Government to collect research data across all departments and sectors that will allow its issue in a clear, timely and easily accessible format

4.5 A proportion of the sugar tax to be earmarked for data collection

4.6 'Healthy School' interventions at national and local level to be widened from the present 100% focus on term time, to calendar year delivery enabling positive holiday plans to be created for vulnerable families

4.7 Statutory services and their commissioners to offer Easter and summer school food provision free at the point of use in up to a quarter of schools or equivalent community settings in the most vulnerable communities

4.8 Embed dental health in all children's services at strategic and operational levels in order to reduce the social and economic inequalities that are a determining factor in the oral health of children Commissioners, healthcare practitioners, specialist societies, the voluntary sector, consultants in dental health and the Royal Colleges to be engaged in creative partnership.

5. THE ROLE OF ADVERTISING, MAINSTREAM AND SOCIAL MEDIA IN ENCOURAGING HOLISTIC CHILD HEALTH INITIATIVES. HOW CAN WE CAPITALISE UPON THE LATEST DIGITAL DEVELOPMENTS?

The role of traditional media in influencing opinion and direction of social policy has been covered extensively by this APPG in previous Reports – as it has by many other organisations. Familiar strains of disquiet are summarised here:

'Unfortunately, there's more to it than what the headline or the story may reveal. Concerns include dumbing down the details, using inappropriate headlines and examples, exploiting our fears and anxieties, and a lot more.

In an ideal world, we should trust our mainstream media; there should be enough checks and balances in democratic systems to highlight outright flaws, lies, distortions etc. But of course, reality is always different and various factors combine to distort reality.

How can the ordinary public know when the stories are sensationalised or twisted to mean something more than what actual studies are finding? How can we evaluate whether what we are reading should be treated cautiously or not?' (http://www.globalissues.org/article/788/health-in-the-media).

The MMR triple jab vaccine scare (later discredited) resulted in a decrease in child immunisation for nearly a decade and is perhaps the clearest justification of the maxim not to believe everything that is printed in a newspaper. However, the mainstream media continues to be pivotal in placing the child health and wellbeing issue firmly on the national radar. Without blanket coverage of the obesity epidemic; arguably there would not be a National Government Strategy on Child Obesity for experts and enthusiasts to improve! Professionals interacting with children and families should be able to signpost helpful advice and recommend caution where appropriate using discriminatory skills acquired as part of continuous professional development (CPD). However, the growth in popularity of social media applications such as Instagram and Facebook has spawned a wide audience, with parents and caregivers regularly accessing and sharing information. People will always avail themselves of mainstream media, but news apps and online parenting guides are often free of charge and not exclusionary on grounds of income. They offer an opportunity to promote wide public engagement in beneficial health initiatives, community building and participation.

More than 7 in 10 adult internet users (72%) have a social media profile and use is correlated to age. A majority of internet users aged 16-24 (93%) 25-34 (90%) 35-44(80%) and 45-54 (68%) have a profile such as a Facebook or Twitter account. Video is increasingly seen as an important communication method by social media providers and brands marketing their products via these sites *(http://www.bbc.co.uk/news/business-40732036)*. A 2015 Ofcom report found that viewing short form videos is popular. 72% of people claimed to watch these (such as clips and music videos on services such as YouTube) with 32% saying that they watched daily or at least weekly. Many now regard this method as an important source of information as well as entertainment and 47% of internet users said that they accessed YouTube when seeking information online, rising to 57% of 16-24 year olds (*https://www.ofcom.org.uk/__data/assets/pdf_file/0018/13482/uk_0.pdf*).

The use of animated videos to convey health messages has been shown to result in long term knowledge retention *(Schnellinger M., Finkelstein M., Thygeson MV et al. 'Animated video vs pamphlet: comparing the success of educating parents about proper antibiotic use' Paediatrics 2010; 125(5):990-6)* and in orthodontics it was found that presenting audio-visual information through the YouTube website to orthodontic patients resulted in a significant increase in patient knowledge (*https://www.ncbi.nlm.nih.gov/pubmed/28642554*). Short videos can give a significant amount of information in a short time sequence, be watched repeatedly and supply consistent information. They can be shared on social media and if published on YouTube, watched with subtitles in multiple languages translated by machine learning or human translation (*https://support.google.com/youtube/answer/6373554*).

The British Society of Paediatric Dentistry uses social media extensively to communicate with patients, parents, health professionals and decision makers. The launch of the Dental Check by One campaign *(http://bspd.co.uk/Patients/Dental-Check-by-One)* aiming to get children to visit a dentist by their first birthday, was shared on Facebook and viewed over 132,000 times *(https://www.facebook.com/bbcbreakfast/videos/1863410140339782/)* as well as being watched by millions of people when featured on BBC Breakfast – an example of mainstream and social media operating simultaneously to beneficial effect.

Change4Life has recently launched a campaign *(https://www.gov.uk/government/news/new-change4life-campaign-encourages-families-to-make-sugar-swaps)* aiming to reduce sugary snack consumption by encouraging parents to *'Look for 100 calorie snacks, two a day max.'* This 8 week campaign, led by Public Health England in tandem with an industry

sponsor will see a national media campaign featuring a dental health message for the first time in many years. The holistic approach unites common risk factors for obesity and dental disease. A BSPD initiative, 'Brush DJ' *(https://www.brushdj.com/)* is an award-winning, free toothbrush timer app that plays two minutes of music taken from the user's device to encourage brushing for an effective length of time. The app also allows users to set reminders to brush twice a day, floss, use a mouth rinse and when next to see their dentist, hygienist, therapist or orthodontist. Evidence-based age specific information is given as per the Public Health England toolkit, 'Delivering Better Oral Health.'

Social media is becoming increasingly influential in campaigns designed to improve the health and wellbeing of children. Change4Life in conjunction with Disney and Sport England launched a '10 Minute Shake Up' campaign to boost children's activity levels. The 10 minute options on offer feature popular Disney characters and are designed to be undertaken anywhere, by any group size *(https://www.nhs.uk/10-minute-shake-up/shake-ups)*

Other Change4Life campaigns concentrate on supporting families to change dietary patterns. A Be Food Smart app highlights the amount of sugar, saturated fat and salt in food that children consume every day. The free app is designed for wide reach and helps families to select healthier options by scanning the barcode of products thereby enabling parents to compare brands. It also includes food detective activities with 'child appeal' and mini missions to involve the whole family *(https://www.gov.uk/government/news/new-change4life-campaign-encourages-parents-to-be-food-smart)*.

Registered charity Action on Sugar works to build consensus with the Government and food industry over the harmful effects of a sugar-rich diet and achieve a reduction in the amount of sugar in processed foods. The Sugar Awareness Week is promoted on social media and supports parents, schools, councils, leisure facilities, fast food restaurants, manufacturers and Government Departments in making long term sustainable changes. Consensus Action on Salt and Health (CASH) is a national social media campaign emphasising the harmful health effects of a high salt diet. The overall aim is to cut salt intake to an average of 6g per day for adults (less for children) – a reduction estimated to potentially reduce stroke by approximately 22%, heart attacks by 16% and achieve a saving of 17,00 UK lives. To date, many supermarkets and food manufacturers have adopted a policy of gradually reducing the salt content of their products. The Association for Nutrition registered nutritionists and registered British

Dietetic Association dieticians also disseminate key public health messages via social media accounts such as Twitter and Instagram.

Advertising and marketing are significant influencers of children's eating habits and dietary preferences. The majority of food and drink that they see advertised is high in fat, salt and/or sugar – for example fast foods, soft drinks, sugar-sweetened cereals, savoury snacks and confectionery *(Public Health England, 2015 'Sugar Reduction: The evidence for action' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf)*.

Evidence has shown that the marketing of these foods contributes to children's purchase requests, preferences and consumption patterns with television and internet advertising equally impactful *(Boyland, E.J., Nolan, S., Kelly, B., Tudur-Smith, C., Jones, A., Halford, J.C.,& Robinson, E. 2016, 'Advertising as a cue to consume: a systematic review and meta-analysis of the effects of acute exposure to unhealthy food and non alcoholic beverage advertising on intake in children and adults' The American journal of clinical nutrition' ajcn120022)*.

However, recent research into app and game design has demonstrated the potential of using games that incorporate healthy eating. A University of Exeter study *(Porter, L., Bailey-Jones, C., Priudokaite, G., Allen, S., Wood, K., Stiles. K. & Lawrence, NS. 2017, 'From cookies to carrots; the effect of inhibitory control training on children's snack selections' Appetite)* found that children who played a 7 minute brain-training game made healthier choices when asked to select foods afterwards. Those aged 4-11 were shown images of healthy and unhealthy foods with a cartoon face alongside each image (happy for healthy and unhappy for unhealthy). Children were not told that the game was about this topic. Afterwards, they played a shopping game whereby a limited number of food items were chosen in one minute. Healthy choices increased from around 30% of foods chosen to over 50% in children who undertook the brain training. This is an example of selecting a health issue which interacts with advertising and digital media and creating a positive product to address it.

Researchers who developed a game called RePlay Health found that attitudes toward public health issues were more accepting and understanding after playing the game *(Kaufman, G., Flanagan, M., Seidman, M., Wien, S., 'Replay health: an experiential role-playing sport for modelling healthcare decisions, policies and outcomes' Games for Health Journal, 2015; 150422113609002 DOI:10.1089/g4h.2014.0134)*.The game is a role-playing sport, requiring players to assume different identities and carry out various

activities to improve their health, with each player presented with opportunities also to improve the health of their community via voting on policy initiatives. The researchers indicated that active engagement with the game's characters and events altered the players' preconceptions about health and health policy. The results of a questionnaire, completed by young adult participants before and after playing the game, indicated its potential to have a lasting impact upon players. It is part of a broad initiative to promote learning about public health policies and spending priorities, but the research indicates potential for public engagement and attitude change via digital media such as apps and games.

Digital media research has also shown that interactive websites can encourage positive child health outcomes. Pregnant women who received vaccine information via an interactive website monitored by a clinical expert were likelier to vaccinate their children than those who did not use the resource *(Glanz, J. et al, 2017 'Effectiveness of a Web-based Intervention to Increase Uptake of Maternal Vaccines' in Open forum infectious diseases, Vol.4, No. Suppl 1, p. S457, Oxford University Press).* The study results indicate that websites with interactive components have the potential to complement face-to face clinical interventions. While it is understood that patients use the internet to obtain healthcare information, doctors and healthcare professionals could potentially combat misinformation by giving patients access to websites that are clinically accurate, engaging and offer ways to communicate with experts and other patients; much like a forum.

Social networking sites enable people to create their own content and therefore further participation *(Loss, J., Lindacher, V., & Curnbach, J. 2013, 'So social networking sites enhance the attractiveness of risky health behaviour? Impression management in adolescents' communication on Facebook and its ethical implications' Public Health Ethics, 7(1), 5-16)* with the opportunity, for example, of establishing a Facebook site and enrolling participants to become 'fans' of it. This can readily be adopted by health promotion intervention using the Facebook site to both distribute health messages and prompt an exchange of ideas amongst users. Digital developments encourage parents, caregivers and communities as well as children to engage and participate in new initiatives in real time. Holistic health measures that address current concerns and issues will have broad appeal and have the potential to cut across social and income barriers in promoting positive messages about health and welfare that are of benefit to all children.

Recommendations:

5.1 All Government health campaign messaging to be comprehensive, inclusive and holistic with dental health integral to content

5.2 Professionals who interact with children and families on health matters to receive initial training and continual professional development (CPD) about the signposting and use of relevant mainstream and social media articles and campaigns

5.3 Professionals to receive initial training and CPD in combining face to face and digital interaction in contact with children and families

5.4 All Government-initiated health campaigns to use a mix of traditional and social media tools; capable of adaptation according to local/geographical circumstance and need.

6. THE ROLE OF THE STATUTORY SERVICES IN AMELIORATING THE ADVERSE HEALTH EFFECTS OF SOCIAL AND ECONOMIC INEQUALITIES

The disparity in educational and health outcomes between pupils from different socioeconomic backgrounds is an unresolved problem and The Children's Society has shown that family financial hardship impacts negatively on the wellbeing of children and young people *(Pinter, I., Ayre, D. and Emmott, E. 2016, 'The Damage of Debt. The impact of money worries on children's mental health and well-being' Children's Society; Pople, L., Royston, S., & Surtees, J. 2015, 'The Debt Trap – Exposing the impact of problem debt on children' The Children's Society & StepChange).*

Healthy eating and physical activity are crucially important for this age group. Nutrition and lifestyle influence wellbeing, growth and overall development *(Wechselbaum, E 7 J.L. Buttriss, 2014, 'Diet, nutrition and schoolchildren: An update' Nutrition Bulletin, 39)* and schools are key statutory providers in addressing health issues, being well-placed in communities to influence pupil behaviour and habits. Socioeconomic inequalities can be identified in school-aged children; those from higher income families, for example, will have greater access to fruit and vegetables than their lower income peers. Differences in nutritional intake and participation in physical activity during this time are also determinants in the risk of obesity and overweight.

The UK Government instituted a Free School Meal (FSM) to ameliorate the nutritional disadvantage of children from low-income families; guaranteeing each child at least one nutritious meal per school day. Evidence shows the FSM contributing to improved concentration and behaviour and the establishment of good eating habits *(Pinter, I., Ayre, D. and Emmett E., 2016, as above).* A DfE report showed 1.4 million children aged 4-15 years to be eligible for FSM support, but up to 200,000 are not accessing it *(Iniesta-Martinez, S.& Evans, H. 2012, 'Pupils not Claiming Free School Meals' Department for Education).* Analysis of DfE data suggests that the following are less likely to claim FSM:

- **Pupils living in less deprived areas**
- **Pupils attending schools with a lower school FSM rate**
- **Pupil from families with higher status occupations (professional)**
- **Pupils living in a family with higher parental qualifications**
- **Pupils of Chinese ethnic origin.**

The school challenge is thus to address issues of stigma and culture when accessing finance earmarked for health provision *(Iniesta-Martinez, S & Evans, H., 2012, as above)*.

The FSM uptake for recipients during a 6 year time span is the current measure of socioeconomic disadvantage in the English school system. It has also been used to monitor gaps in educational attainment and identify ways in which school funding should be allocated in order to support pupils at greatest risk *(Ilie, S., Sutherland, Alex and Vignoles, Anna, 2016, 'Revisiting free school meal eligibility as a proxy for pupil socioeconomic deprivation' British Educational Research Journal 43(2))*.

Since 2014, FSM provision has been extended to all pupils in their infant schooling years (Reception, Year 1, Year 2) *(Dimbleby and Vincent, 2013, 'The School Food Plan' http://www.schoolfoodplan.com/)* with the purpose of improving academic attainment and saving families money, but it is underpinned by the importance of children having good health in order to make educational progress regardless of their socioeconomic status *(DfE and EFA, 2013 UIFSM https://www.gov.uk/guidance/universal-infant-free-school-meals-guide-for-schools-and-local-authorities)*.

Since January 2013, the School Food Plan has advocated a 'whole school' approach to food and childhood nutrition. In addition to universal and statutory provision of FSM, schools have been steered towards adopting a holistic approach to nutrition during the school day. Breakfast clubs are not exclusively targeted at children from low-income households but are a popular means of offering additional childcare for families whilst providing children with an extra meal at the start of the day. The two basic models are open access clubs, free to all children, and those clubs requiring fees from higher income parents. A free club can combat perceived FSM stigma (whilst supporting childcare for working parents) and guarantee a breakfast to all children. However, free provision is usually dependent upon volunteers and alternative forms of subsidy, whereas fee-paying clubs are financially sustainable (if well attended) and typically efficiently run due to being funded.

Some research findings have indicated that over half a million UK children live in households that are unable to eat consistently *(Graham, P.L., Russo, R., Blackledge, J. & M.A., Defeyter, 2014, 'Breakfast and Beyond: The Dietary, Social and Practical Impacts of a Universal Free School Breakfast Scheme in the North West of England, UK' Journal of Sociology Agriculture and Food, 21(3))*. 98% of adults from these households were accustomed to skipping

meals themselves to ensure that their children could eat *(Poverty and Social Exclusion: UK, 2013)*.

Research findings into breakfast club impact on child health are variable. Some researchers *(Simpson, D., Watts, L., Crow, R. and Summerbell, CD. 2001, 'School breakfast clubs, social background and nutritional status' Topic 29)* point to an improvement in the nutritional uptake of children in receipt of FSM from lower income families, but a UK-based study *(Belderson, P., Harvey, I., Kimbell, R., O'Neill, J. Russell, J. and Barker, M.E .2003, 'Does breakfast club attendance affect children's nutrient intake? A study of dietary intake at three schools' British Journal of Nutrition, 90)* has reported that children who attended breakfast clubs had considerably higher fat and salt intakes and lower intakes of carbohydrate compared with those who did not. The research base is limited and evidence about the effectiveness of initiatives is inconclusive, but school breakfast club numbers have risen in recent years; attributed by some sources to UK Government support *(Dimbleby and Vincent 2013, as above)*.

Recent UK research suggests that breakfast clubs could offer young people a structured environment with the inclusion of 30 minutes' physical activity in addition to a meal *(Graham, P.L., Russo, R. and Defeyter, M.A. 2015 'Breakfast clubs: Starting the day in a positive way' Frontiers in Public Health)*. This would make a substantial contribution to helping children achieve the minimum goal of 60 minutes' physical activity per day as recommended by the Chief Medical Officer *(Sport England, 2011, 'Start Active, Stay Active: A report on physical activity for health from the fours home countries' Chief Medical Officers)*.

Promoting active lifestyles through effective whole school approaches to health with an emphasis on high quality physical education makes sense. Recognised benefits include improving skeletal health and reducing risk factors for chronic conditions such as cardiovascular disease, diabetes and cancer. The provision of high quality physical education can also encourage psychological and social benefits including boosting self-esteem and reducing symptoms of anxiety and depression *('Physical Activity and Mental Health in Children and Adolescents' A Review of Reviews, Stuart J.H. Biddle and Mavis Asare, Loughborough University 2011)*. It can also increase self confidence and feelings of self-worth, especially in disadvantaged groups: one school-based activity programme in particular helped in lessening examination-related anxiety and contributed towards improved examination performance *(Lorraine Cale et al, 'Promoting Physical Activity in Schools' 2016, Loughborough University)*.

In March 2013, the Coalition Government announced a new policy to enhance the provision of physical education and school sport in primary schools *(DfE, 2013 https://www.gov.uk/government/news/150m-olympic-legacy-boost-for-primary-school-sport-in-england)*. The Primary PE and Sport Premium is a tripartite Government Department initiative involving the Department for Education, the Department of Health and the Department for Digital, Culture, Media and Sport as part of the London 2012 Olympic and Paralympic Legacy *(Griggs, G., 2017 'Investigating provision and impact of the Primary Physical Education and Sport Premium: a West Midlands case study' Education 3-13: International Journal of Primary, Elementary and Early Years Education, http://www.tandfonline.com/doi/abs/10.1080/03004279.2016.1169485)*.

The Premium was initially fixed at £9250 per school per annum; ring-fenced and overseen by Ofsted with funding committed until 2020. The amount received by schools was subsequently doubled from September 2017 (*https://www.gov.uk/guidance/pe-and-sport-premium-for-primary-schools*). Schools have relative freedom to determine the use of the money, pertinent to pupil need, and DfE guidelines indicate that during the 2013-2020 period of Government investment, the teaching quality of statutory physical education (and young people's behaviours and habits relating to it) should improve. Primary PE and Sport investment outcomes are measured by the following five key indicators *(DfE and ESF, 2017 https://www.gov.uk/guidance/pe-and-sport-premium-for-primary-schools)*:

- The engagement of all 5-18 aged pupils in regular physical activity (of which 30 minutes should be in school)
- The profile of PE and sport raised across the school as a tool for whole school improvement
- Increased confidence, knowledge and skills of all staff in teaching PE and sport
- Broader experience of a range of sports and activities offered to all pupils
- Increased participation in competitive sport

There is little evidence to date about the full effects of the Primary PE and Sport Premium, particularly in terms of young people's health. However, early indications are optimistic, with an increased engagement and participation in PE and sport and perceived improvement in social, inter-personal skills and behaviour, physical skills and fitness *(Callanan, M., Fry, A., Plunkett, M., Chanfreau, J.,& Tanner, E., 2015, 'The PE and Sport Premium: An investigation in primary schools. London' NatCen Social Research)*. The predominant use of the Premium has been to outsource the teaching of

physical education to sports coaches and has been a predictable source of controversy and debate *(Griggs, G. 2017, 'Investigating provision and impact of the Primary Physical Education and Sport Premium: a West Midlands case study' Education 3-13: International Journal of Primary, Elementary and Early Years Education' https://doi.org/10.1080/03004279.2017.1291699, L. Jones & K. Green, 2017,'Who teaches primary physical education? Change and transformation through the eyes of subject leaders' Sport, Education and Society, 22(6), DOI:10.1080/13573322.2015.1061987).*

Earlier in this report, questions are posed by a variety of sources about the monitoring of Premium spend in individual schools. This is not covered by Ofsted inspection and practitioner feedback suggests that a lack of rigorous audit has increased the undesirable likelihood of the money being hijacked from its original purpose to ease shortfalls elsewhere in school budgets. The intention behind the Premium is laudable but its operation is in urgent need of closer scrutiny and comprehensive, widespread evaluation.

Whether its existence will ultimately be credited with achieving a positive, long-term effect upon children's behaviours and attitudes towards physical activity; or whether this will prove to have been negligible – or even negative in practice – yet remains to be seen

Recommendations:

6.5 Further research into the effectiveness of central Government funding upon children's health outcomes

6.6 A holistic approach to nutrition and physical activity to be embedded within a whole-school policy for all school-aged children

6.7 Breakfast clubs to be available in all schools; free to all children in infant primary schooling; free to all others from low-income families and with a minimum charge to children from higher income families

6.8 A comprehensive review of the Primary Physical Education and Sport Premium including Ofsted inspection procedure, differentiated guidance and outcomes for physical activity, teacher development, pupil attainment and participation in competition and sport

7. EXAMPLES OF INTERNATIONAL GOOD PRACTICE AS A GUIDE TO PRACTICAL POLICY MAKING

In many countries, the co-existence of malnutrition and obesity besets child health policy development. The International Food Policy Research Institute examined the multifaceted aspects of malnutrition and found that 57 out of 129 countries had neither the financial nor political will to address it, resulting in frequent and undesirable 'double day' outcomes. Therefore a school feeding programme for lower or middle income countries may be determinedly focused on calorie intake, but the nutritional quality of food must also be borne in mind because of the positive effects on growth, development, physical and mental health, and addressing the obesity risk.. Future food policy development forecasts are complicated and complex because they unite genuine health concerns with the necessity of economic responsibility *(International Food Policy Research Institute, 2016 Global Nutrition Report. globalnutritionreport.org; Gulland, A., 2016, 'Malnutrition and obesity coexist in many countries' British Medical Journal BMJ2016; 353:i3351)*.

European childhood obesity is rising; yet this is complemented by food insecurity with over 900,000 people in the UK visiting food banks. Greek, Spanish and French charities have also reported significant increases in the number of people requiring emergency food support and the cause of this burgeoning food insecurity is now an urgent health problem impacting family *(Loopstra R., et al, 2015 'Rising food insecurity in Europe' The Lancet Vol 385)*. Lack of action to tackle childhood obesity contravenes the United Nations Convention on the Rights of the Child (Article 24) which recognises *'the right of the child to the enjoyment of the highest attainable standard of health.'* Similarly, the economic costs of overweight and obesity run counter to national prosperity and wellbeing. A global alliance against childhood obesity, advocating a 'whole society' approach and establishing key research priorities is therefore imperative. The approach will demand urgent government action on relevant polices, regulation, fiscal action and investment *(Hanson, M., et al, 2017, 'Time for the UK to commit to tackling childhood obesity' British Medical Journal, 22nd February, BMJ2017; 356; j762)*.

World-wide data supports a need for action. The USDA's Household Food Security Module (routinely used in the US and Canada) is an 18 question survey concerning the severity of household food insecurity and offering insight into where children are stressed by irregular and inadequate food provision in the home. Recent Canadian evidence has shown that food-insecure people used healthcare services more frequently and those severely food-insecure faced annual healthcare costs of 121% in excess of

food-secure people *(Tarasuk, V. et al, 2015, 'Association between food insecurity and annual healthcare costs' Canadian Medical Association, https://www.ncbi.nlm.nih.gov/pubmed/26261199)*.

Cost is a key driver of food choice and evidence has shown that, in many countries, healthier foods are progressively rising in price whilst less healthy processed foods are decreasing A study of relative food prices in Brazil, China, Korea and Mexico found that fruit and vegetable prices rose by 91% between 1990-2012, while some processed foods like ready-meals dropped in price by 20% *(Wiggins, S. et al,2015 Overseas Development Institute (ODI), 'The rising cost of a healthy diet – changing relative prices of foods in high-income and emerging economies')*. In China, green vegetable prices have doubled over the past 20 years and in Korea, cabbage is 60% more expensive. According to the ODI, healthy diets become more expensive as less healthy diets become cheaper, accounting for the rise in obesity rates, numbers of obesity-related diseases and premature deaths *(Wiggins et al, as above)*. In the UK, ice-creams halved in price from 1980-2012 whilst the price of fresh vegetables tripled, suggesting that taxes on unhealthy foods matched by subsidies on healthier alternatives could play a significant role in reversing the worldwide obesity trend. Fresh food price increases in the daily diet also have the knock-on effect of a higher consumption of ready-made meals. In Brazil this form of consumption has increased from 80kg to approximately 110kg per person per year by 2013; the equivalent to each person of eating an additional 140 Big Macs *(Wiggins et al, as above)*.

However, there are some grounds for encouragement. At the 2017 EAT Stockholm Food Forum, Professor Corinna Hawkes (Director of the Centre for Food Policy at City University, London) said that some cities are already *'taking matters into their own hands to try to fix the food system'* and referenced the following case studies:

- Belo Horizonte, Brazil: the first integrated food security policies in the world and the dedicated food agency within the city government has survived for over 20 years
- Nairobi, Kenya: the urban Agriculture Promotion and Regulation Act represented a U turn on long standing opposition to urban farming from city authorities
- Amsterdam, Holland: healthy body weight initiatives require all city government departments to contribute to addressing the structural causes of childhood obesity through their policies, plans and day-to-day working.

- **Canada: The Golden Horseshoe Food and Farming plan established an innovative governance body to promote collaboration between local governments within a city region**
- **The USA, Detroit: the city now has authority to regulate and support urban farming due to changing State-level legislative frameworks.**

The above measures denote an inclusive and progressive process that aligns policy to need whilst also establishing a broader and improved support base for implementation. The initiatives that are listed in greater detail below are indicative of a growing recognition that food policies for health are integral to the modern and well-functioning food economy.

Brazil

Brazil's 2022-2030 Health project offers a forward-looking vision and a commitment to future challenges. The WHO has stated that one of the main contributions to the enormous reduction in worldwide infant mortality has been the example of the Brazilian Human Milk Banks. The 'Bolsa Familia' project provides cash to poor households to alleviate food insecurity and create more demand for food. This was successful in the context of under-consumption of food and food poverty. In 2009, a Brazilian law required 30% of the food budget on the national school meal project to be spent on foods sourced directly from 'family' farms. The nutritional component shaped the policy content *(Hawkes, C., 2012, 'Food Policies for Healthy Populations and Healthy Economies' British Medical Journal, 15th May, BMJ2012:344:e2801).*

Amsterdam

The inter-sector, inter-departmental 'Amsterdam Healthy Weight Programme' (AAGG) launched in 2013 with the objective of *'having no overweight or obese children in Amsterdam by 2033' (Amsterdam Healthy Weight Programme, Summary of programme plan, Amsterdam: City of Amsterdam, 2015).* The AAGG supplies expectant parents and parents of children up to four years of age with information about healthy nutrition plus regular appointments with healthcare professionals. It also works with industry to promote healthy eating and food purchasing at supermarkets, and the programme enjoys political cross party support. Aligned to this, an earlier programme, the Amsterdam School Garden Programme, encourages healthy eating by giving pupils their own plot of land. They are taught to grow food and process it into healthy meals and the scheme targets demographically deprived neighbourhoods. ASGP engages with the food and drinks industry to promote healthy childhood behaviours, and priority neighbourhoods are often given a Neighbourhood Manager who partners with local shops,

businesses and welfare concerns. Various methods of financial support have been allocated to low-income families for sports and physical activity to ensure that poverty does not predicate an increase in obesity. These strategies and the 'Jump In' school programmes supporting physical activity combined with healthy eating, are examples of what can be achieved by local government if used and exercised properly. In 2015, childhood obesity and overweight rates were shown to have decreased by 18% amongst the lowest socioeconomic groups in Amsterdam and by 12% amongst all children *(Amsterdam Healthy Weight Programme, 2015 as above)*.

USA

The WIC programme (Women, Infants and Children) identifies the nutritional risk faced by low-income pregnant, post-natal and breastfeeding women as well as children up to age five. To qualify on the basis of income, applicants' gross income must drop to below 185% of the US Poverty Income Guidelines *('WIC Income Eligibility Guidelines' United States Department of Agriculture Food and Nutrition Service, 2016-04-05)*. The programme provides nutritious foods, nutrition education, breastfeeding support and referrals to health services at no cost. Participants receive monthly food vouchers to supplement their diets and there is a network of participating partner stores. The programme includes educational food and nutrition components and access to wider parental programmes, immunization and child clinics and drug and alcohol treatment programmes. The US Department of Agriculture's Food and Nutrition Service assessed the effectiveness of the food package content (*Committee to Review the WIC Food Packages, 2005, WIC Food Packages: 'Time for a Change', The National Academies)* and found a clear picture of nutritional improvement. Children have always been the largest category of WIC participants.

Sweden

There is regular monitoring of school food and evaluation of food provision in 6 areas: choice, nutritional quality, safety and hygiene, educational resource, environmental sustainability, organisation and policy. Currently, 39% of all primary schools have started to adopt this system.

Finland

All pupils from pre-primary to upper secondary education receive a free, catered, hot meal every school day.

Recommendations:

7.1 UK Government to compile a directory of best practice examples from global healthy eating programmes to combat inequalities and serve as a guide when making future public health interventions in the UK

7.2 UK Government to sponsor evidence-based educational programmes with built-in evaluation tools to encourage parents to prepare healthy meals and to promote physical activity and healthy eating in school. The Department for Education to set targets to ensure consistent standards across the primary sector.

8. POLICIES AND PRACTICE IN THE DEVOLVED UK

The UK Westminster Government devolves health and social care policy to the Northern Ireland Assembly (NI), the National Welsh Assembly and the Scottish Parliament. In accordance with NHS principles *(https://www.nhs.uk/)* each country develops strategies and an infrastructure to address health inequality. The Royal College of Paediatrics and Child Health and the Child Poverty Action Group have claimed that the health of UK children is jeopardised due to social and economic inequalities *('Poverty and Child Health – Views from the Frontline', May 2017)* and in particular they recommend:

- **The restoration of binding national targets to reduce child poverty; backed by a national child poverty strategy**
- **The adoption of a 'child health in all polices' approach to decision-making and policy development**
- **The reversal of public health cuts to ensure that universal early years services including health visiting and school nursing, are prioritised and financially supported, with targeted help for children and families in poverty**
- **The reversal of universal credit cuts which will leave the majority of families claiming benefit worse off.**

The UK Children's Food Trust calls for consistent policies across the board to cover all food provided in publicly-funded places and in the community where children gather (both in and out of school). In such settings, children should be free from all forms of marketing of foods high in fat, saturated fats, sugars and salt *(Mucavele, P. 2017, Children's Food Trust. Presentation at Westminster Food and Nutrition Forum, Keynote Seminar: 'Food in School and Early Years Settings: standards, free school meals and the future for policy').*

Tackling food-related inequalities in order to protect UK children from hunger, obesity and future diet-related ill health is an urgent challenge and Sustainable Food Cities has advocated the following measures:

1. **Establish a multi-agency partnership**
2. **Promote the living wage**
3. **Provide advice, referral and support on food access**
4. **Increase food poverty understanding**
5. **Provide healthy weight services and initiatives**
6. **Reduce hunger and malnutrition**
7. **Increase the availability of healthy options**

8. Curb the development of food deserts and swamps *(Sustainable Food Cities, 2017, 'Tackling food poverty, diet-related ill health and access to affordable healthy food' www.sustainablefoodcities.org).*

The Royal College of Paediatrics and Child Health (RCPCH) '*State of Child Health' (2017)* has made recommendations to improve child health with specific directions for each of the devolved Governments. These are:

Reduce the number of child deaths

It is thought that this can be achieved by prioritising child safety. An annual average of 210 infants, children and young people die in Wales; in Scotland, between 350-450 per year and Northern Ireland has the highest overall UK child mortality rate (precise numbers unavailable). Deaths are most prevalent in the first year of life and in adolescence. Older childhood and adolescent deaths (considered preventable) are aligned to accident, assault and suicide. Northern Ireland has highlighted commissioning and delivering high quality services via a networked approach *('Protect Life 2: A Strategy for Suicide Prevention in Northern Ireland; Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community, 2016-2026').*

Development of integrated healthcare statistics for young people

The Welsh *Pregnancy and Childhood Surveillance Tool, 2015/16* suggests a method of child health data collection; however, gaps exist for later childhood/adolescence tracking. Northern Ireland has the least readily available data in the UK and there is a need for child health measuring metrics to inform future policy. Scotland is unique in that each person has a health identifier used across the NHS in Scotland *(RCPCH, 2017: 'State of Child Health, 2017 Recommendations for Scotland').*

Develop research capacity

Young people's health outcomes in Wales could improve with advancements in health-influencing scientific factors. The *Healthwise Wales* social research project tool *(https://www.healthwisewales.gov.wales/resources/)* currently prohibits responses from under 16s. In both Northern Ireland and Scotland, investment in health research is limited.

Reduction in Childhood Poverty and Inequality

An estimated 200,000 children in Wales, 210,000 in Scotland and 3% in Northern Ireland live in poverty *(RCPCH 'State of Child Health' 2017, as before).* All countries share negative health issues including low birth weight, poor diet and unsatisfactory amount of physical activity, with Wales further registering negatives of maternal smoking during pregnancy and experimental behaviours in young people. '*The Flying Start Project' 2012* in Wales has enabled children and families to receive free childcare, enhanced health visiting services, access to parenting programmes and appropriate language and play groups. However, only a small proportion of vulnerable families are currently in receipt. The '*Child Poverty Strategy for Northern Ireland' 2014* aims to reduce the impact of poverty and number of children living in it by 2020.

Maximise women's health before, during and after pregnancy

Strategies aim to improve maternal mental health, support mothers to achieve a healthy weight and promote breastfeeding. '*The Strategy for Maternal Care in NI' (2012-201)* recognises that Northern Ireland continues to have the lowest levels of breastfeeding in the UK (less than 28% of 6 week- old babies receive any breast milk) the trend being especially marked in young mothers and those living in deprivation. The Scottish Government promotes sustained breastfeeding through the '*Improving Maternal and Infant Nutrition: A Framework for Action'* and the 2010/11 '*HEAT Target, Exclusively Breastfeed.'*

Provide statutory personal, social and health education in schools including sex and relationship education

The new Welsh school curriculum will be operational by January 2020 and has established Health and Wellbeing as one of 6 Areas of Learning and Experience *(Welsh Government, 2015, 'Qualified for Life: A curriculum for Wales – a curriculum for life')*. However, there is no uniform school provision. In Scotland, Relationships, Sexual Health and Parenthood Education is embedded within the curriculum but without the accompanying statutory requirement for sex and relationship education in schools.

Strengthen Tobacco and Alcohol Control

7% of boys and 9% of 15 years old girls in Wales smoke regularly despite '*The Tobacco Control Legislation in the Public Health Bill' 2009*. Wales has recorded the greatest drop across the UK in teenage drinking but is rated only 'average' in Europe with 13% of 15 year olds admitting to drinking alcohol once a week. The Scottish Government has introduced minimum alcohol pricing but a child born in a socially deprived area is likelier to grow up around smokers, be born into a smoking family and have a mother who smoked in pregnancy. '*The Ten Year Tobacco Control Strategy for Northern Ireland' (2012)* contains aims to reduce smoking and afford protection from second hand smoke, focusing on young people and pregnancy, but drug and alcohol abuse are identified as suicide risk factors for this group.

Tackle Child Obesity

In Northern Ireland 28% of children are reported to be overweight or obese (more than in any other UK country) and obesity is the largest human-generated burden on the economy. In Wales, 27% of children start primary school obese *(RCPCH, 2017 'State of Child Health Recommendations for Wales')* and the Welsh Assembly has introduced measures to address the issue including the '*Mind, Exercise, Nutrition, Do It! (MEND) Foundation*' programme; '*Change4Life Wales*' *http://change4lifewales.org.uk;* the '*Health, Healthy and Sustainable Pre School Scheme' (Welsh Assembly 2015)* and the '*Child Measurement Programme*' for children aged 4-5 and 10-11 years. Public Health Wales offers free weight guidance to children *(http://www.wales.nhs.uk/sitesplus/888/page/84909)*. The Scottish Government has addressed childhood obesity as part of achieving two National Outcomes in the National Performance Framework *(http://www.gov.scot/Resource/0049/00497339.pdf)* and an NHS Scotland target was established to deliver an agreed number of child healthy weight interventions by 2010/11. This has led to a series of prevention and treatment services for overweight or obese children *(Connelly, R., 2011 'Drivers of Unhealthy Weight in Childhood: Analysis of the Millennium Cohort Study Scottish Government Social Research Report' Edinburgh: Scottish Government).*

Maximise mental health and wellbeing throughout childhood

Welsh teenagers have the poorest life satisfaction rates in the UK and *'MindEd'*, *https://www.minded.org.uk*, a government funded e-portal, is designed to support mental health issues in young people. As highlighted by the *2006 'Bamford Review of Mental Health and Learning Disability'*

there is a lack of data about mental health problems in children and young people in Northern Ireland. However, an Assembly Research Paper on Mental Health Inequalities *(Russell, R., 2014 'Heath Inequalities in Northern Ireland by Constituency')* showed that a survey of 11 health-related indicators, including life expectancy, suicide rates, the prevalence of mood and anxiety disorders and disability benefit uptake revealed that health inequalities were most prevalent in the urban constituencies of Belfast North and Belfast West (with higher pockets of deprivation). In Scotland, 1 in 10 children start school exhibiting social, emotional or behavioural difficulties *(RCPCH, 2017, 'State of Child Health Recommendations for Scotland')* and early intervention is the favoured method of protecting future adult mental health.

Northern Ireland

The Department for Health *('Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community, 2016-2026'*) specifically recognises the importance of health services for children and young people from birth to 18 by setting out a strategic development plan. Within it, addressing health inequalities is paramount as children from areas of greater deprivation have worse health, including more unplanned hospital admissions, low breastfeeding levels, high maternal smoking levels and low birth weight. Between 2006-2011, Northern Ireland increased funding to maternity and child health by 25.2%. Family and childcare funding has risen by 25.8%; including social services support for families, children in care, child protection, family centres, women's shelters and covering professional health posts.

Scottish Parliament

Despite improvement in the overall health of the population, problems remain entrenched for those living in the most deprived areas of Scotland. The main recommendations designed to reduce health inequalities for children and young people *(Scottish Government, 2008, 'Equally Well: Report of the Ministerial Task Force on Health Inequalities')* targeted the early years, *(http://www.gov.scot/resource/doc/229649/0062206.pdf)* ante-natal services, looked-after children and children in 'at risk' households, advocating holistic support within school and the community. '*The Children and Young People Act' 2014* aims to improve the wellbeing of children and young people from all households and backgrounds.

National Assembly of Wales

The National Assembly has implemented some child health policies intended to address social and economic inequalities; notably the *'Child Poverty Strategy'* the '*Healthy Child Wales Programme'* and the '*Tackling Poverty Action Plan.'* However, it is unlikely that radical improvements will be seen by 2020 despite a stated aim to eradicate child poverty entirely by this date.

Examples of good practice throughout the UK

There is evidence to support the determination of UK countries to combat the adverse effects of social and economic inequalities on child health. As part of the Childhood Obesity Strategy, the Government advocates the Healthy Start scheme which provided an estimated £60 million worth of vouchers (to be exchanged for fresh or frozen vegetables, fruit or milk) to low-income families across England in 2015-16. 1.7 million vouchers were issued each month, benefitting an average 480,000 children but not all eligible families knew about the scheme *(GOV.UK, 2017, 'Childhood obesity; a plan for action').*

Another way of encouraging healthier family food choices may be via subsidies and taxes such as the UK Sugar Tax. Some charitable foundations provide a service to some of the UK's poorest families such as the Greggs Foundation Hardship Fund (supplying £150 vouchers to families in extreme financial hardship, plus vouchers to buy cookers and fridge freezers). The fund gives out £3,000,000 each year and Greggs also runs 450 breakfast clubs, feeding 27,374 children each school day. Some practical examples of UK projects tackling food poverty, diet-related ill-health and access to affordable healthy food are listed below *(Sustainable Food Cities, 2017 'Tackling poverty, diet-related ill-health and access to affordable healthy food' www.sustainablefoodcities.org):*

- **Nationally: 'Make Lunch' charity provides hot meals for families during the summer holidays; responding to holiday hunger**
- **Brighton & Hove: Produced a city-wide food poverty action plan with assistance from the Jamie Oliver Food Foundation**
- **Carlisle: Has a Fair Meal Direct; an innovative service taking locally produced food to some of the most vulnerable families**
- **Birmingham City Council: In 2012 imposed a cap on the number of fast food outlets and outlined a city-level response to food insecurity**

- **Exeter: 'Make Lunch' kitchens supplied free, healthy, cooked food during the holidays for pupils normally in receipt of free school meals**
- **The Welsh Government: Has a primary school free breakfast initiative**
- **Food Cardiff: Piloted 'Food and Fun'; a school holiday enrichment programme to provide nutritious meals during the school holidays**
- **Leeds City Council: Developed a toolkit to help schools and caterers to increase free school meal uptake**
- **Lewisham, London: A 'Putting Food on the Table' project explored food bank usage, recommending a coordinated approach with all food distribution points. Lewisham also advocated borough-wide discussion with key stakeholders in the food poverty debate, making professional debt advice available**
- **Lambeth Larder: A reference book for local and emergency food provides information on food banks, food growing, saving money and budgeting**
- **Lambeth and Southwark: Guys and St Thomas Charity: Bitesize project. They are committed to the strong correlation between childhood obesity and inequalities, the combined lens of urban living and deprivation being critical factors in the development of obesogenic environments. This project takes a whole system, cross sector approach and addresses many of the obesity drivers**
- **The Matthew Tree Project in Bristol: An individualised food poverty service is offered for residents using a social enterprise training and distribution model**
- **Good Food Oxford: Tries to understand the extent, nature and drivers of food poverty in Oxford, and engages with residents in the most deprived neighbourhoods**
- **Scotland: Currently consulting on a Good Food Nation Bill promising to address procurement, waste, health and education, and social justice. The legislation is intended to enhance the National Food Policy**
- **East Renfrewshire: This established summer scheme supplies a hot meal to children in the holidays. In 2014, 1134 children participated and 44% of attendees were Free School Meal pupils**
- **North Ayrshire: Has tried to address the holiday hunger policy gap, feeding 80 Free School Meal pupils in the holidays on Mondays, Wednesdays and Fridays from 2014.**

The inclusive Daily Mile scheme (mentioned above) has continued to work closely with leaders in policy, health and education to assist with national and regional implementation in UK primary and nursery schools. Over 170

schools now run the Daily Mile in Wales; there are over 870 English TDM schools and over 1,000 Scottish schools. This makes a total of over 2,000 schools participating in the UK. The UK Government recommends The Daily Mile in the Childhood Obesity Strategy and by Spring 2016, The Scottish National Party had included it in the party manifesto. In September 2017, Scotland took a step towards becoming the world's first Daily Mile Nation; encouraging workplaces to sign up to the initiative.

Recommendations:

8.1 Statutory inclusion of Physical, Social Health and Wellbeing Education on the curriculum of all UK countries from early years to school leaving age

8.2 Increase funding for research into children's health and wellbeing

8.3 Increase funding for child mental health and maternal health

8.4 Close screening of all children from pre-natal to childhood across a range of health indicators

8.5 Health care professionals to inform expectant mothers on maternal physical activity, nutrition and breastfeeding

8.6 Free resources for families and schools on nutrition and physical activity that build upon initiatives such as Change4Life and Healthy Schools

8.7 Alignment of policies throughout the UK (where possible) to address the adverse effects of social and economic inequalities on the health and wellbeing of children and young people.

9. A WAY FORWARD FOR GOVERNMENT THAT WORKS FOR EVERY CHILD

Social and economic inequalities deny many children their birthright of a healthy start to life, but the temptation to shred all existing policies and consign the past to history should be resisted. Issues affecting child welfare should not be treated as an 'add on'; they are central to the wider health and wellbeing of the nation – but the wheel need not be completely reinvented. Some excellent examples of good practice have been described in the body of this report and a 21st century strategy should cascade best practice and embrace fresh initiatives within a new framework that is responsive to children whatever their circumstances in life.

Adopting past/present Government programmes to combat social and economic inequalities in children's health

The now discontinued Infant Feeding Survey *(NHS Digital Infant Feeding Survey 2012)*, conducted annually from 1975-2010 provided estimates on the incidence, prevalence and duration of breast and other feeding practices adopted by mothers in the first 8-10 months of their child's life. The 2010 study found highest incidences of breastfeeding amongst aged 30 plus women, those who had left education at 18 plus, those in managerial and professional posts and those living in the least deprived areas. Cardiff University *(July 2017)* also found that a quarter of respondents to a research survey said that breastfeeding support was not accessed by mothers from poorer social backgrounds, despite encouragement from the community support workforce. Reviving the Infant Feeding Survey would assist in identifying the impact of inequalities on children's health from the outset. The geographical locations and population specifications (i.e. age, ethnicity) thereby identified could be targeted for additional resources and other means of assistance every five years so that policy interventions were current and reflective of relevant research.

The Healthy Start programme *(https://www.healthystart.nhs.uk)* should be revised and updated. Pregnant women and those with a child under four are potentially entitled to Healthy Start vouchers to buy vegetables, fruit and milk from local retailers. Those eligible can obtain one weekly £3.10 voucher and children under one year qualify for two £3.10 vouchers per week. The vouchers can purchase plain cow's milk (whole, semi-skimmed or skimmed) plain fresh/frozen fruit and vegetables (containing no added ingredients) and infant formula that states that it can be used from birth and is based on cows' milk. Women and children in receipt of the vouchers are also given vitamin coupons to exchange for free Healthy Start vitamins; scientifically designed for pregnant and breastfeeding women and growing children. The potential of the Healthy Start programme could be extended via:

1. **Increasing the available food options: in line with the US *'Women, Infants and Children programme' (WIC as above)*, a wider range of foods could be aligned with the British Nutrition Foundation's 5532 toddler plate by adding more staple varieties such as rice, bread, pasta and potatoes.**
2. **Creating a new learning-based module: the Government could run a complementary local authority-based 'cooking and shopping' learning module to give parents practical tips about preparing the most nutritious meals from the voucher purchase base.**

Childcare is another potential early intervention tool. From September 2017, children in England were entitled to 30 hours of free provision per week. However, only parents already working and who earn at least the national minimum wage qualify. The scheme permits this allocation to run in tandem with claims for Universal Credit, tax credits or childcare vouchers, but a large swathe of families are not covered by the provision and its expansion to all UK children would deliver tangible and practical help to the families most in need.

Similarly the recent 'exemplar' menus and healthy recipe suggestions for use by early years providers are welcome but this measure (which would improve the nutritional intake of all children) is voluntary rather than statutory advice. Figures published in October 2017 show 9.6% of children entering reception classes in 2016/17 presenting as obese in comparison with 9.3% in the previous year. One fifth of year 6 children were found to be obese with 32.4% of girls and 36.1% of boys in their final primary year registered as overweight or obese. The NHS Digital study found that more than twice as many children from deprived areas were obese than those from affluent areas: Caroline Cerny, who leads the Obesity Health Alliance, a coalition of more than 40 organisations, said:

'Each year, the childhood obesity statistics tell the same devastating story.

Obesity continues to rise and it's the children from the most deprived backgrounds who have the odds stacked against them' (The Guardian, 'Obesity among children starting primary school continues to rise' 19th October, 2017).

Making 'advisory' meal guidance more stringent and extending the 30 hour childcare provision to all children could give those in the most deprived areas, and from families in need, a healthier start to childhood. The Government should also allow some of the 'healthy lifestyle' school funding to cover the necessary infrastructure to facilitate wide scale school roll-out of schemes like The Daily Mile that are, by nature, low-cost or free to deliver.

Social mobility

The Social Mobility Unit's *'State of the Nation'* Report (*https://www.gov.uk/government/publications/state-of-the-nation-2017*) references a *'stark social mobility postcode… where the chances of someone from a disadvantaged background succeeding in life is bound to where they live.'*

It goes on to assert that there is *'a self-reinforcing spiral of ever growing division'* with children in some areas getting a poor start in life from which they can never recover.

The concept of social mobility will also reach a wider audience in 2018 as the subject of a new BBC social realism television programme, '*Generation Gifted':*

'Britain is in the grip of a social mobility crisis, with children living in poverty half as likely to achieve top GCSE grades as their wealthier classmates. Over the next three years, this series will follow six promising children from disadvantaged backgrounds to see whether they achieve their potential' (The Daily Mail, 14th February, 2018).

The programme's scheduling will ensure that social and economic inequalities remain at the forefront of public scrutiny during at least three time spans over the next three years. The present Government has, however, acknowledged that social and economic inequalities are a clog on later life chances and the Prime Minister has vowed to champion those who are *'just about managing'* with the implied corollary that concentrating upon the parts of society that have been left behind will increase the rates of social mobility.

The Social Mobility Commission and similar bodies have a key role as monitors of the levels of social and economic inequality prevalent in the UK and the Government could drive long-term improvements in inequalities by focusing on early health intervention. As a 'facilitator in chief' it would collate examples of good practice already underway; choose some for pilot prior to national roll-out and host an annual 'Best practice early intervention summit.' Local authorities could be invited to showcase successful schemes that have been developed either in isolation or in broader partnership with communities, charities and industry.

The Government should maintain a constant focus on this policy area by creating a cross-departmental Ministerial post on Social Mobility. The

Minister should promote collaborative working on this issue between the relevant Departments and report to a new Cabinet Minister for Children.

Successive administrations have raised the issue of social mobility without highlighting the achievable, practical policies that will effect the lasting improvement that children and their families deserve. Social and economic inequalities are perpetuated by health disadvantage and are present from the earliest days of life and beforehand. As has been shown, some current initiatives could and should be extended and past projects reconsidered and revived to alleviate this process – but ultimately, everything has its price and the children born to social and economic inequality will be short-changed if the Government continues to address their needs 'on the cheap.'

Social and economic inequalities are ills that must be cured: their existence is recognised as never before and if we are to forge a way forward that works for every child, procrastination should be abandoned.

The time for action is now.

Recommendations:

9.1 Central Government to collate and facilitate the cascading and trial of best practice early intervention measures

9.2 An annual 'Best practice in early intervention' summit to be hosted by the Government involving local authorities and relevant business, community and charity partners

9.3 The 30 hour free childcare provision to be extended to all UK children in order to develop a fully integrated society that does not institutionalise inequalities. Meal and recipe guidance to contain essential statutory content

9.4 The discontinued Infant Feeding Survey to be revised and reinstated

9.5 The Government should review and extend the service available as part of the Healthy Start programme, both in terms of available food options and in the creation of a learning-based module to improve the nutritional life skills of the most disadvantaged families

9.6 An urgent review of all Departmental budgets to factor in essential spend on social and economic inequalities

9.7 A new cross-departmental Ministerial post on Social Mobility with particular focus on encouraging policy collaboration on this issue between relevant Departments. The post holder should report to a new Cabinet Minister for Children.