Annual Report of the
Director of Public Health
2015-2016

Never too late, never too early: investing in young lives
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Welcome to Liverpool’s Public Health Annual Report for 2015-2016. This year, as well as refreshing the Compendium of Health Statistics for the whole City population, my report focuses on the health and wellbeing of children and young people, as we believe that it is never too early to invest in young lives.

This year in Public Health has been both exciting, with the transfer of Health Visiting Services to the Local Authority, and challenging, with unexpected in year cuts to the Public Health Grant, with promises of more cuts to come.

Taking on responsibility for Health Visiting has given us the ambition and the opportunity to deliver a truly public health focused pre-birth to 19 year old service for the City. This last year has been concerned with preparing for a safe transfer and developing a vision of what this could mean for a future Service and its 'best fit' alongside other children’s services in the community. This together with the work for last year’s Report which highlighted the financial and human costs of failing to promote prevention across the lifecourse, is what has inspired us to consider the health of children and young people in this annual report.

The title of the report shows our commitment to understanding how we can impact on the health and wellbeing of every child or young person in the City, and investing in those approaches. We know that young lives are the future of our City, and as healthy children grow into healthy adults they will be the backbone of regeneration and a thriving economy. Once again we know and emphasise the importance of partnership working for this agenda, and we also need to acknowledge that the health inequalities faced by children and young people both within the City and in comparison with other cities and indeed the country, work against the development of healthy lives.

And so with partners, working through the Health and Wellbeing Board we can make a difference. The report celebrates some of the successes in the City over the last year, and I thank those partners who have provided specific contributions to the report.

I would also like to thank Councillor Roz Gladden who served as Cabinet Member for Adult Social Care and Health during this year, and who supported us throughout with a strong commitment to public health and prevention and was a passionate spokesperson for many of our Campaigns. As we move to 2016-2017 we have a new Cabinet Member for Health and Adult Social Care and I look forward to working with Councillor Paul Brant.

So, in spite of the cuts to budgets, we know what we need to do to improve children’s and young people’s health, and we need to find ways to do it. **Never too early, Never too late, investing in young lives** is our key to future success as a City, our economic growth, and as a place for people of all ages to live, learn, connect, take notice, be active and give.

Dr. Sandra Davies BSc, PhD, MPH, FFPH
Director of Public Health for Liverpool
August 2016
**Investing in young lives**

The 2030 United Nations Agenda for Sustainable Development\(^1\) came into effect on 1st January 2016 and aims to end poverty and hunger, combat inequalities, build peaceful, just and inclusive societies, protect human rights, ensure healthy lives and promote wellbeing for all at all ages. Global achievement of these goals would occur by creating the necessary conditions for sustainable, inclusive economic growth, shared prosperity and decent work for all. Furthermore, the UN calls for protection of the planet so that it can support the needs of the present and future generations, pledging that no one will be left behind. All human beings should be able to fulfil their potential in dignity and equality and within a healthy environment.

There are 17 goals and 169 targets in the Agenda that are integrated, indivisible and balance the three dimensions of sustainable development: the economic, social and environmental. Each of these are fundamental for maximising life chances for children and young people. Environmental sustainability is concerned with replacing used resources while avoiding harms from action. Economic and social sustainability have to find the levels at which they can be maintained, or continue to grow without further resource. It is useful to highlight that Liverpool's Health and Wellbeing Strategy Statement is titled *Liverpool Sustainable City*\(^2\) because we want the city to be able to achieve an equitable level of population health and wellbeing that can be sustained over time indefinitely through the systems we have built and the involvement of all its citizens including children and young people.

Liverpool has seen a recent period of development with improvements in environmental, economic and social aspects of place and people which are threatened by the effects of global economic downturns. Public service reform is changing the way citizens interact with the state as well as the shape of the lives people expect to live, for example, the increased proportion of the population in higher education and the lengthening of working years. The degree of change means that our Sustainable City needs Sustainable Citizens, providing the environment and opportunities that enable them to achieve their potential as individuals and members of society. The Public Health Annual Report\(^3\) for last year looked at some of the costs of not investing in prevention. This analysis, both economic and in terms of health and wellbeing, demonstrated how a large part of that preventive action was across the wider determinants of health rather than in healthcare. This year’s report will therefore look at how investing in Children and Young People could contribute much to the development of Sustainable Citizens.

The health and wellbeing of children and adolescents is important in all social systems. They are citizens in their own right; eventually becoming the future adult population. Improving health and wellbeing in an equitable way for children and young people will increasingly involve significant systemic change to more participative governance models.

The World Health Organization (WHO) European child and adolescent health strategy 2015 – 2020 *Investing in children*\(^4\) proposes four guiding principles:

- Adopting a lifecourse approach
- Adopting an evidence informed approach
- Adopting a rights based approach
- Promoting strong partnerships and intersectoral collaboration

Taking a lifecourse approach to both prevention and development recognises that action can be taken at any life stage to have a positive effect, for example, workplace health or active ageing. While this is often the case, a true lifecourse approach is both cumulative and intergenerational,
recognising that genetic, environmental and lived experience aspects of the lives of parents and grandparents can have effects on children. Children are born into circumstances. Their own situation and experiences are not isolated, but interact and accumulate, leading to changing outcomes for their health, development and wellbeing. The intensity of development in early years and adolescence means that those effects are likely be relatively stronger in infancy and early childhood, but also that further effects will accrue throughout the lifecourse which, if negative, may respond less well to intervention, but can still be ameliorated. A true lifecourse approach looks for preventive action that can be applied at any stage of the generational cycle, whether at the beginning, middle or end of life, that will benefit future citizens. For Liverpool citizens, action to improve population health and wellbeing can never be too early, never too late.

The population’s health and wellbeing and the economy are interdependent. Without sufficient investment, there will be poor health outcomes for the population, while a healthy population is also necessary as the basis for a healthy economy. Investment in the early years of life can deliver the economic benefits of citizens who contribute fully to society, reduce the risk of future need, and increase productivity while changing children’s lives now and in future generations. There is no lack of evidence to show that outcomes for UK children are still poorer than many other European countries, or that the actions we take to improve outcomes are not applied early enough or at sufficient scale to achieve the changes that are needed.

At a relatively macro-economic level, analysis by the New Economics Foundation (NEF) in 2009 found that the cost to the UK economy of continuing to address current levels of social problems including crime, mental ill health, family breakdown, obesity and substance misuse, would be almost £4 trillion over 20 years. The study makes clear that lasting change would require addressing the structural factors affecting children’s lives such as poverty and inequality as well as the psychological and social dimensions of children’s wellbeing. NEF calculate that about £1.5 trillion of those £4 trillion costs could be addressed by targeted and universal investment in preventive measures such as childcare and paid parental leave, raising our children’s outcomes to equal those of the best performing European countries.

<table>
<thead>
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<th>The Annual Report of the Chief Medical Officer 2012 analyses four specific areas to demonstrate the benefits of prevention: preterm birth, unintentional injury, child obesity and child and adolescent mental illness. All costs are at 2012 figures. Public sector costs refer to direct public spend, while societal costs also include lost economic productivity over time.</th>
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<tr>
<td><strong>A preterm birth</strong> is defined as less than 37 weeks from conception. More than 7% of live babies were born preterm in England in 2010/11. Consequences of preterm birth include physical, neurodevelopmental and behavioural problems. The estimated annual costs of preterm birth in England and Wales would be £1.24 billion in additional public sector costs for ages 0-18 (£25,920 per child). Total annual additional societal costs to age 18 would be £2.48 billion (£51,656 per child).</td>
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<td><strong>Unintentional injury</strong> is defined as ‘predictable and preventable’. The main causes are road traffic injury, drowning, poisoning, falls and burns and rates are affected by disadvantage. Severe injuries can be associated with post-traumatic stress, physical disability and cognitive or social impairment. In England in 2011/12, there were approximately 135,000 unintentional injury admissions to hospital for ages 0-14 of which about 5,000 children were hospitalised for at least three days due to severe injury. The estimated annual costs of severe unintentional injury (0-15) in the United Kingdom would be £15.5–87 million for short term hospital costs (£2,949–14,000 per child). Long term societal costs of the worst outcome of traumatic brain injury would be £640 million–2.24 billion (£1.43–4.95 million per child).</td>
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<tr>
<td><strong>Child obesity</strong> is defined against other children of the same age according to expected growth. In 2011-12 obesity prevalence for boys aged 2-15 was 16.6% and for girls was 15.9%. Prevalence is affected by disadvantage. Obesity is associated with problems in childhood including: respiratory disorders, high blood pressure, risk of developing diabetes and psychological and psychiatric problems. Similar issues are likely to persist into adulthood or form a basis for risk. The estimated annual costs of child obesity (3-15) in England would be £51 million for short term costs of treatment (£35 per child). Long term health and societal costs would be £588 million–686 million (£585–683 per child).</td>
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<td><strong>The three most common types of child and adolescent mental health problems are:</strong> emotional, conduct and hyperkinetic. In 2004, nearly 10% of children aged 5-16 in a survey of Great Britain were found to have experienced one of these mental health problems. The estimated annual costs of child mental health problems (5-16) in Great Britain would be £1.58 billion for short term health, social care and education costs (£2,220 per child). Long term health and societal costs would be £2.35 billion (£3,310 per child).</td>
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Figure 1: Estimated annual lifetime costs of preventable childhood events / conditions
Evidence for investing in early intervention is strong on two fronts, biology and impact of financial investment. The brain develops most rapidly in the first three years of life, with the child's own genes providing the blueprint for development but shaped by the environment before and after birth.\(^6\)

In the young child, the brain forms new connections at the rate of 700 to 1,000 per second. This rapid development of the brain lays the foundations for physical and mental health, affecting adaptability, learning capacity, longevity and resilience. When the environment does not provide what the child's brain needs to continue its development, it becomes progressively harder to fix, so early intervention has the best chance of making up for adverse factors.

The impact of investment throughout life in terms of development can be shown in the Heckman curve of rate of return to investment in human capital (Figure 2 below). Investment in the earliest years yields the greatest potential. Heckman\(^7\) proposes that the reduction of social inequalities in children must focus not only on intellectual skills but also 'life skills' such as interaction, cooperation and maintaining self-esteem. The critical period for such skills formation is in the pre-school years. This does not mean that specifically targeted programmes in adolescence could not give a good return, or that investment does not need to continue throughout childhood, but the earlier the development of these skills, the better the return.

![Figure 2: Rate of return to investment in human capital against age](source: James Heckman, Nobel Laureate in Economics [www.heckmanequation.org](http://www.heckmanequation.org))

What appears to be a clear direction in which investment should be made, is not necessarily how it is distributed. The 2010 Marmot Review *Fair Society, healthy lives*\(^8\) highlighted that for the UK the ratio of investment in middle childhood was 1.35 times that in early childhood and investment in late childhood was 1.48 times that in early childhood, with similar patterns of spending proportionately more in later childhood in the majority of European countries.
A chart of USA public spending against the Heckman Curve (Figure 3 below) shows almost the reverse of the investment that might be expected and the WAVE Trust\(^9\) believe that UK spend would look similar.

![Figure 3: Brain's capacity to change against public spend on programmes to change the brain](image)

The evidence for prevention and early intervention for children and young people resulting in an improved and socially just return for the whole of society is overwhelming, however, it needs to be presented in a sufficiently convincing way that overcomes barriers:

(a) the length of time before the return in investment,
(b) the use of unfamiliar measures for determining performance such as Social Return on Investment, and
(c) the need for structural change that may not be validated within a term of government.

The economic environment continues to be challenging, particularly in the public services where, for example, central government has clawed back Public Health prevention funding from local government, and is reducing funding in most areas of public service year on year.

We want our children to live in families that have sufficient healthy food, warm comfortable homes, access to good childcare, healthcare, and social care, strong emotional warmth and attachments in close relationships, pleasant neighbourhoods, can take part in community activities, have meaningful employment and good psychological wellbeing. Many children grow up in very different environments, where relative inequality now means that families can be struggling on low incomes although one or more adult may be working. Such children may be prevented from achieving their full life potential because their life chances are affected by the consequences of their disadvantage. Children from poorer backgrounds or particularly vulnerable groups are more likely to be behind in every stage of education with the gap widening with age. They are likely to have a higher risk of illness, with conditions emerging earlier in life and with unnecessary, avoidable premature death. Not every child wants the same things out of life, some want to go to university, some to follow technical aptitudes, and some want to start a family of their own. Whatever their aspirations in life, child and family poverty must not be allowed to stop them from knowing what they could do, acquiring the learning they need to do it, and developing the confidence in their own value needed to move towards their goals.
Using a definition of child poverty as below 60% of median income after housing costs, the number of children in poverty in the UK fell from nearly 3.5 million at the end of the 1990s to below 2.5 million, but is now rising again. More than 82,000 children live in poverty in the City Region, equating to 25.6% or one in every four children (2012). In Liverpool in 2013 30.5% of children were living in poverty, or one in every three children. More children have been excluded from the classification because the median income has fallen although there is no change to family circumstances. The Liverpool City Region Child Poverty and Life Chances Commission is addressing some of the practical barriers that face low income families in the area including food insecurity and affordable local transport as well as ensuring that maximum value is obtained from funding such as the Pupil Premium and working to reduce inequalities such as unfair wage structures.

The cost of child and family poverty to individuals is enormous and poorer outcomes may persist across the lifecourse for those who experience it. Apart from the questionable morality of allowing it to continue, it also accounts for higher rates of public spend than if it were eliminated. Estimates of the minimum costs of dealing with the increased need engendered by child poverty for the UK were £29 billion for 2013-14. The estimated financial costs cover two elements:

- lower productivity and higher risk of unemployment for those growing up in poverty, and
- the additional public spending on social problems arising from high rates of child poverty.

The public spend element represents the additional spend on services in areas of high child poverty, estimated for 2013-2014 to include £2.75 billion for Children's Social Services, £3.62 billion for school education and £1.46 billion for acute healthcare with a total financial cost of damage to lives caused by poverty across the whole UK population at £78 billion. The Child Poverty Action Group estimated that in 2013, Liverpool's annual child poverty costs would be £340 million each year.

Food Insecurity

Income related problems of food access, ‘food insecurity’ or ‘food poverty’ are becoming a serious issue in affluent countries. What this means in practice is that families cannot be certain enough about their income, week to week, that they are able to plan or shop for meals. Together with the constant drain of rising costs of living such as electricity, gas, petrol or fares, issues with benefit payments, persistent debt, zero hours contracts and the need to cover emergencies such as repairs or shoes for growing children, many low income families are now far beyond mothers missing meals so that there is more food for children, to having no money for food at all for longer than a day. Where there is food, it may be of poor nutritional value as the cheapest available.

Data on food insecurity is difficult to collect and analyse, as the main source of data is from established food banks, which record the number of requests, sometimes with a limit on the number of times the service can be accessed within a time period. This means that the requests are being counted rather than days or meals that people go hungry. Also, there are other sources of emergency food provision such as church groups, that are not currently feeding in data, suggesting that the problem may be significantly undercounted.

The effects of persistent hunger include:
- Children have reduced capability to learn while focused on hunger
- More children measured as underweight in Reception and Year 6
- More anaemic pregnant mothers and infants
- More people admitted to hospital in an emergency found to be malnourished
- Poorer physical and mental health outcomes over time

In 2015-2016 the Trussel Trust which runs three Food Banks in Liverpool recorded that they fed almost 7,500 children.

The Liverpool Mayoral Action Group on Fairness and Poverty has taken action on children going hungry in school holidays, when free school meals are not available. A food and play initiative offers meals and fun activities every day for children on school holidays. A food poverty strategy for the city is in development which will build on initiatives in the city that: help families to learn cooking skills, ensure all eligible children take up free school meals; make breakfast available to all children across the city, and develop cost benefit analysis skills for buying food.
The Joseph Rowntree Foundation have set out their calculation of the costs of poverty (2016) with direct and indirect costs (Figure 4 below).15

Figure 4: Cost of poverty to the UK’s exchequer  Joseph Rowntree Foundation

Equitable life chances for our children and young people will not be achieved just by improving income levels. Marmot's Review looked at reducing inequalities through universal services and targeted services proportionally applied according to need. Reducing inequality leads to things being equal as each person receives the same. However, as the graphic below shows (Figure 5), that does not mean that opportunities are fair. Fairness (or equity as it is sometimes referred as) is achieved by redistribution of resource (in this case, boxes) according to need. While equity is achieved in the second panel, one person has no resource, which would be an issue for population health and wellbeing (e.g. all children need access to universal preventive services to keep the whole child population healthy). The third panel shows how the cause of the inequity could be addressed through
the removal of the systemic barrier (the fence). This is a preferable objective for public health as both inequality and inequity are removed to enable the sustainable provision of necessary universal preventive services to achieve equitable outcomes.

Partnership and intersectoral collaboration is a foundation of area based system improvement. It is clear that population health and wellbeing is an outcome of all systems, not just health and care. One of the key Public Health priorities put forward in last year’s annual report was that Public Health should:

*Work with partners to define the environment the city needs to provide before birth and in early years that will afford every Liverpool child the best start in life*

The priority was written in this way to emphasise that partners must work together to design that environment, to ensure that whatever our youngest citizens need to develop will be available, so that we can grow our sustainable citizens, capable of making their human and economic contribution to our sustainable city.

“Giving children the right platform of physical and emotional health, and cognitive, social and linguistic skills from which to thrive will enhance their lives, help to avoid the human and economic costs associated with adverse childhood and adult experiences and provide a skilled, capable adult population to support a future economy.”

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**Figure 5: Equality, equity and removal of systemic barrier**

Source: unattributed variant of a graphic by Craig Froehle
References and links

5. New Economics Foundation 2009 *Backing the future: why investing in children is good for us all* [www.neweconomics.org](http://www.neweconomics.org)
Child & Young People Profile: Liverpool

A comparison to England

LIVERPOOL FACTS

Children and young people represent 33.2% of the total Liverpool population (0-24 years), similar to the England average (30%).

Children and young people in Liverpool face a difficult start in life, with significantly higher levels of deprivation, child poverty and lone parent families compared to the national average.

KEY

▲ Improved since last period
▲▲ Similar to last period
▼ Worse than last period
□ No comparator

Statistical significance compared to England:

Better
Similar
Worse

For more information and data sources please contact Liverpool Public Health team: healthandwellbeing@liverpool.gov.uk

Based on a template from Halton Public Health Intelligence Team. Icons made by Flaticon and available here: www.flaticon.com
Best start in life

For many people it was Sir Michael Marmot's review of health inequalities in England *Fair Society, Healthy Lives* that brought the lifecourse perspective to thinking about health and wellbeing. Marmot was clear that disadvantage starts before birth and accumulates throughout life so action to reduce health inequalities must also start before birth and follow through the whole of life to break that connection. Giving every child the best start in life was the highest priority recommendation of the review. In their third year, the child's progress is tested in several ways, and help offered where need is identified. Unfortunately, relative poverty is still the most active barrier to reducing inequalities and by the time children are in Reception year, many are not considered to have reached the level of cognitive, social and emotional development expected for their age, with deprivation being the strongest factor.

First 1000 days

The first 1000 days from the beginning of pregnancy to a child's second birthday have more influence on the child's future than any other time in their life. There is a global initiative to improve those first 1000 days so that every child has the same level of opportunity to learn, be healthy and achieve to their full potential. England does not currently have a domestic policy specifically based on the first 1000 days, however, the All Party Parliamentary Group for Conception to Age Two has produced a cross party manifesto raising awareness of ‘1001 Critical Days' for early prevention and proposing a national framework. The WAVE Trust, which is closely linked with 1001 critical days, has called for radical change with a goal of ensuring that every baby receives sensitive and responsive care from their main caregiver, and for parents to be confident to raise their children in a loving and supportive environment.

The first 1000 days are also the best demonstrator of the cyclical nature of opportunities to improve health and wellbeing for the whole lifecourse at the beginning of life. Local policies need to be based on a commitment to primary prevention for all infants and young children in the population with a goal to prevent outright or minimise the impact of risk factors for compromised need or worse, specific harms. This is done by addressing those risk factors directly (e.g. smoking cessation in pregnancy; tackling fuel poverty) or enhancing resilience (e.g. breastfeeding; parenting support; family friendly work policies) so that the physical, psychological, cognitive and social needs of infants and young children can be fulfilled and they become socially and emotionally capable at age two. If policy does not reflect this, then there will continue to be disadvantage, inequality and dysfunction across generations. Children's experiences contribute to the society they create, and the costs of dealing with failure. The economic benefit of breaking these cycles would be enormous.

The prospect of new life can be a vehicle for change often referred to as a ‘Window of opportunity', when parents-to-be and new parents are open and susceptible to offers of help advice and support.
It can also be a tough time for parents and families. New life brings a whole new set of priorities, dilemmas and challenges.

Positive experience may include good education before conception, support and information during pregnancy and as parents, good family and community relationships and internal and external affirmation of a key life event. Less positive experience can have an effect on a child for many years. Events while in the womb can affect the later development of conditions such as coronary heart disease, diabetes and some cancers. Excessive maternal stress, tobacco, alcohol and drug misuse can affect both the emotional and physical development of the child. What women eat and their levels of physical activity during pregnancy can impact positively and negatively on the growing foetus. Low birth weight or pre-term babies weighing less than 2,500 grams at birth have higher risks for infant mortality, respiratory distress and neurological disabilities. Maternal smoking is one of the highest risks for low birth weight babies.

The influence of a negative external environment is referred to as adverse childhood events (ACE). Key examples include: living with a family member who has addictions or mental health problems; exposure to domestic violence; multiple types of abuse; neglect; a caregiver in prison and exposure to collective violence. ACE experience is cumulative and associated with poor outcomes in areas such as: educational attainment; risk of involvement in violence and of imprisonment; substance misuse and mental health problems; unemployment; and obesity, heart disease and cancer. Parents’ own experience of early childhood can dramatically affect how they interact with and cope with having their own child. Understanding how parents were affected can allow for better support or treatment where needed.

Attachment refers to the bond between a child and a caregiver. Secure attachment means that the bond is good enough for the child to use the caregiver as a base from which to explore and return, confident of comfort they receive. Most of the general population are considered to have secure attachment. Insecure attachment results from inconsistent or unresponsive caregiving. Disorganised attachment occurs where the caregiver is chaotic, unpredictable, neglectful or frightening, resulting in physical and mental illness, low educational and employment achievement, and poor relationship skills. Disorganised attachment is found in 15-19% of the population and in 80% of maltreated children.

The mental health of parents is crucial to their relationship with their child. Maternal depression is a significant risk factor for poor child social and emotional development. Poverty, particularly anxiety about persistent debt is associated with sleep deprivation and depression in new mothers. For children to grow and thrive in the earliest days they need loving, secure, reliable relationships forming a strong foundation for their emotional wellbeing and brain development. Good communication at home with caregivers who are able to interpret baby cues pre language helps children with their own language development and builds their ability to learn. Strong families build a child's capacity to form and maintain relationships. Good nutrition in the earliest years of life can profoundly affect capacity to grow, learn, and work. Breast milk really is all a baby needs for the first six months of life. Breastfeeding can offer protective factors such as strengthening the immune system and stimulating health enhancing hormone production, with fewer early hospital admissions for
diarrhoea, vomiting and respiratory infections, and a lower lifetime risk of obesity and diabetes for the child, and better survival rates for breast and ovarian cancer for the mother. Breastfeeding is a new skill for a mother and her baby, (and a new experience for fathers too). They learn together what works best for them with professional support where needed such as Bambis which matches new breastfeeding mums with experienced breastfeeders.

Child health has improved tremendously in the city over the last decade but there is more to do; the health of Liverpool children, although much improved, is generally worse than the England average. Compared to the core cities and our statistical neighbours we do well in some areas but worse in others. For example our immunisation rates are good but more children suffer decayed missing and filled teeth in the early years and 1 in 4 children are an unhealthy weight when they begin school. As children grow it is important to promote good oral health and good positive healthy eating to ensure nutritional needs are met. It is good to provide an environment that encourages curiosity and enables safe play and exploration of the home and community with lots of encouragement to be physically active every day.

<table>
<thead>
<tr>
<th>Maternal smoking at time of delivery 2015-2016</th>
<th>Liverpool = 16.1%</th>
<th>England = 10.6%</th>
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<tr>
<td>Low birth weight 2012-2014</td>
<td>Liverpool = 8.2%</td>
<td>England = 7.3%</td>
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<tr>
<td>Breastfeeding initiation</td>
<td>Liverpool = 53.8%</td>
<td>England = 74.3%</td>
</tr>
<tr>
<td>Breastfeeding continuation at six to eight weeks 2014-2015</td>
<td>Liverpool = 33.3%</td>
<td>England = 43.8</td>
</tr>
<tr>
<td>Infant mortality 2014-2015 (under one year per 1000)</td>
<td>Liverpool = 4.7%</td>
<td>England = 4.1</td>
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School readiness

'School readiness' is a term sometimes referred to as the level of skill a child has in literacy and numeracy when joining a Reception class. However, school readiness is also a broader concept that looks at how prepared a child is to succeed in school in learning, socially and emotionally, in order to give them any help needed. There are many definitions of 'school readiness', however, the measure of school readiness in England is to be assessed as being at a good level of development at the end of the Early Years Foundation Stage (EYFS) in their fifth year. How parents and others interact with a young child, together with the environment in which they grow from birth can all contribute to acquiring social and emotional skills, knowledge and behaviours necessary for success in school and life. School readiness has also been termed 'life readiness' and the level of school readiness at age five has a big impact on future educational attainment and life chances. Not achieving a good level of development at age five means that children are at risk of falling further behind in life skills, which may result in poor outcomes and life chances. The responsibility for reaching a good developmental level is a shared one, between parents, families and communities, early years practitioners from childcare to school, healthcare practitioners and others responsible for the environment in which the child develops through the early years and beyond.

The EYFS covers seven areas of learning and development with seventeen early learning goals (Figure 6 below). When a child is aged between two and three their progress is reviewed for a summary of development in the prime areas. In the final term of the year in which the child reaches age five, a profile is completed for each child, who is assessed against each of the seventeen early learning goals as to whether they have reached a good level of development. The three assessment categories are: meeting expected levels of development, exceeding expected levels of development, or not yet reaching expected levels (emerging). The profile must meet at least the expected level for the three prime areas and the specific areas of literacy and mathematics (1-12 in the table above) to achieve a good level of development. The factors that are likely to have most impact on improving school readiness are: good maternal mental health; learning activities in the home, including speaking to and reading with a child; enhancing physical activity; parenting support programmes and...
practitioners having the skills to assess for levels of additional need or risk and high quality early education.

The Liverpool Mayor’s Education Commission reporting in 2013,\(^5\) recognised that school readiness needed to have the same intensive improvement activity as had allowed for the city's significant improvement in educational attainment at GCSE. Early years and school readiness have been considered by a task and finish group and school readiness is being addressed through a city wide action plan. The importance of the role of parents in relation to the school readiness programme is highlighted and action taken to empower them to support their child's learning.

Another way of looking at school readiness is to describe what the child should be able to do. This poster has been designed by the Professional Association for Childcare and Early Years as part of a government funded toolkit for parents.

### Steps to starting school

Build your child’s confidence so that they start school confident, curious and ready to learn

Access more great advice, tips and downloadable resources at pacey.org.uk/schoolready

<table>
<thead>
<tr>
<th>Children (age 5) achieving a good level of development at the end of reception 2014-2015</th>
<th>Liverpool = 56.5</th>
<th>England = 66.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levels have improved since 2012-13, but the gap with England has widened.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Children (age 5) with free school meal status achieving a good level of development at the end of reception 2014-2015</th>
<th>Liverpool = 45.6</th>
<th>England = 51.2</th>
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</table>

More top tips:

- Get your child ready for their new routine by switching their meal times to match those of the school day
- Encourage your child to explore new environments and interact with new people
- Talk to your child about what they are most looking forward to at school
- Let your child practise putting their new school uniform on and taking it off
- And remember, every child is different and starts school with different abilities
References and links


2 Leadsom A. Field F. Burstow P. Lucas C. 2013 The 1,001 critical days: the importance of the conception to age two period: a cross party manifesto Relaunched December 2015 in Parliament www.1001criticaldays.co.uk

3 WAVE Trust www.wavetrust.org

4 All Party Parliamentary Group Conception to Age Two – The First 1001 Days 2015 Building Great Britons www.1001criticaldays.co.uk

5 Liverpool Mayor’s Commission on Education https://liverpool.gov.uk/mayor/mayoral-commissions/education-commission/
**Prevention and early intervention**

Public health will generally refer to three kinds of prevention:
- primary prevention, tackling the risk factors or enhancing resilience to stop ill health or other forms of harm occurring;
- secondary prevention, minimising harm and outcomes from ill health and stopping progression; by identifying and intervening early;
- tertiary prevention, lessening the impact of chronic ill health or other harms on living well.

Early intervention is likely to be more targeted, taking early action on identified population problems. Acting early should occur across the lifecourse, it does not refer only to acting early in life. The most effective action uses the principle of 'proportionate universalism' meaning that it is applied to improve the lives of the whole population (universally) while targeting greater resource and action at the more disadvantaged along a 'slope' of inequality (proportionally). Universal approaches are usually forms of primary prevention, while targeted approaches may be any of the three types of prevention.

**Childhood immunisation**

Childhood immunisation is one of the most effective population health interventions as it can protect the wider community as well as individual children. The higher the level of vaccination, the more difficult it becomes for a disease to pass between people who have not been vaccinated. This is called ‘herd immunity’. The benefits of routine childhood immunisation last throughout the lifecourse as children who receive all of their routine vaccinations are protected from several potentially serious diseases for life. It is therefore also one of the most cost effective measures that can be taken.

Most childhood immunisations have been delivered by Health Visitors in recent years but from April 2016 all routine pre-school vaccinations will be delivered in GP practices. In 2015-2016 the universal routine immunisation schedule included:
- multiple vaccinations at two, three and four months to protect against disease such as diphtheria, polio and rotavirus.
- measles, mumps and rubella (MMR) at around twelve months
- influenza (flu) at two, three and four years through a new nasal spray
- second doses of some vaccines such as polio and MMR at three years and four months.
- girls from age twelve are now protected from cervical cancer through immunisation against the human papilloma virus (HPV).
- at age fourteen booster doses against tetanus, diphtheria and polio as well as meningitis C protection. During 2016 meningitis protection was changed to cover types A, C, W and Y.
There is also further routine immunisation for those at risk such as vaccination for pregnant women against flu and pertussis (whooping cough), where they and their child need to be protected.

The routine childhood immunisation programme in Liverpool is very effective, with more than nine out of 10 children vaccinated. Vaccine coverage (% of children vaccinated) is above the national average for England for every routine childhood vaccination except the second dose of MMR.

In 2012 there was an outbreak of measles in Liverpool and across Cheshire and Merseyside which was a stark reminder of the importance of vaccination. Measles spread in the community over a year and a half and 300 people caught measles in Liverpool, 68 of whom needed to be admitted to hospital. Fortunately, nobody died. The estimated cost of the outbreak was £4.4 million. The very high vaccination rates in Liverpool prevented the outbreak being much larger, and undoubtedly saved lives.

Vaccination uptake is much higher in some areas than others which means that in some parts of the city there are more children unprotected against potentially life threatening diseases. Many factors can contribute to this inequality in uptake or immunisation gap and it remains a key challenge to close it. Children are less likely to receive their routine vaccinations if they live in a deprived area, if they have a parent who is unemployed, or if they live in a low income household (Hungerford et al, 2016). It is important for the immunisation system to be flexible and respond to the needs of individual children and families. A small immunisation team in Liverpool offers vaccinations to unimmunised children in their own homes to support families who need an alternative to mainstream provision.

Previous gaps in immunisation uptake mean that a significant number of children and young people, particularly those in late adolescence, still lack immunity. Measles is a particular issue in Liverpool as significant numbers of teenagers did not receive either of the two doses of MMR vaccine at the recommended age as MMR uptake rates were not high at that time (Keenan, 2016). Targeted work is to take place in the 2016-2017 academic year to identify and vaccinate this population.

School Nurses are currently identifying unimmunised children at education transitions. School entry at age 4, the end of primary school (Year 6), and the end of secondary education (Year 11) represent important opportunities to check children’s immunisation records, and to offer catch up vaccinations as appropriate. Catch up vaccinations can also be given to secondary school pupils alongside the HPV vaccine and teenage booster immunisations.

The Public Health Outcomes Framework (PHOF) requires a coverage threshold of 90%. The World Health Organisation target is 95% coverage.

Liverpool immunisations within the first year are above the England average of 94.2% and meet the WHO target with 95% coverage. The ward with the lowest uptake is Central with 83.7%.

Liverpool immunisations for the first dose of MMR at two years old are above the England average of 92.3% at 93.6%. The ward with the lowest uptake is Warbreck with 83.1%.

Liverpool immunisations for the second dose of MMR by five years old are below the England average of 88.6% at 87.8%. The ward with the lowest uptake is Knotty Ash with 69.5%, which is significantly below the threshold.

Uptake of nasal flu vaccination in Liverpool schools is at 52%. Uptake for preschool children in primary care is at 24-30%.
**Early Support**

The national Healthy Child Programme (HCP) runs from pre-birth to 19 years with the pre-birth to 5 element led by Health Visiting services and the 5-19 element led by School Nursing services. The HCP is an evidence based universal programme delivered for all children and young people with additional targeted support. It provides an invaluable opportunity to promote child and family health from early in a child’s life and to identify children and families that are in need of additional support and at risk of poor outcomes. The HCP aims to:

- help parents develop and sustain a strong bond with their children;
- maximise child health by promoting healthy behaviours e.g. healthy eating and physical activity to reduce childhood obesity;
- identify health additional needs early, so support can be provided in a timely manner;
- encourage care that keeps children healthy and safe;
- protect children from serious disease, through screening and immunisation;
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be ‘ready to learn at two’ and ‘ready for school by five’.

Health Visitors work to a ‘four, five six’ model consisting of: 4 Levels of the health visiting service; 5 Universal health visitor contacts; and 6 High Impact Areas. In Liverpool the 4 levels of service: Community; Universal; Universal Plus and Universal Partnership Plus, are aligned to a continuum of increasing need with clear descriptions of the child's level of need and the action required.

The five universal contacts are:

- Ante natal contact – from 26 weeks
- Birth visit at 10 – 14 days post-natally
- 6 – 8 week contact
- 9 – 12 month contact
- 2 – 2.5 year contact – readiness to learn

These contacts are mandated for every child and their parents and there must be an active transition of each child to the school nursing service at school age.

The six high impact areas cover:

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (including Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'

The Health Visiting service transferred from the NHS to Local Authority Public Health in October 2015 and includes Specialist community public health nurses, qualified nurses, nursery nurses and health care assistants.

Liverpool also has a Family Nurse Partnership service which forms part of the pre-birth to 5 HCP. The Family Nurse Partnership is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two. Family Nurse Partnership has three aims: to improve pregnancy outcomes, child health and development and young parents' economic self-sufficiency.
The school nursing service also forms part of the Local Authority Public Health Nursing service. It too will be working to a four, five, six model which is in development. The four service levels remain the same as for health visiting. There are five health reviews:

- 4-5 year old health needs assessment
- 10-11 year old health needs assessment
- 12-13 year old health needs assessment
- School leavers – post 16
- Transition to adult services

And the six high impact areas are:

- Building resilience and supporting emotional wellbeing
- Keeping safe – managing risk and reducing harm
- Improving lifestyles
- Maximising learning and achievement
- Supporting additional health and wellbeing needs
- Seamless transition and preparing for adulthood

Health Visitors and School Nurses provide a public health nursing service, working alongside mental health, social and care workers and allied health professionals to meet the needs of vulnerable children.

The Liverpool Families Programme (evolved from the national Troubled Families initiative) started its second Phase in April 2015. Phase 2 requires that the programme works with a further 6,709 families over 5 years (1,394 families each year). The criteria have expanded from the original 3 outcomes of improved school attendance, reduced youth offending and reduced worklessness to include: parents and children involved in crime/anti-social behaviour; children who need help; young people at risk of worklessness; families affected by domestic abuse and violence; and parents and children with a range of health problems. As with partner services, there will be a greater emphasis on early intervention. However, the expanded criteria present a challenge in terms of progress being required across a range of outcomes before achieving return through the 'payment by results' system of funding.
Liverpool's Early Help model aims to provide support as soon as a problem emerges, at any point in a child's life. The model is developing a cohesive Early Help offer embedded within a Whole Family approach to build family resilience. It aims to support the refocusing of resources from crisis intervention to prevention and provide the context for multi-agency partnerships to work together to improve outcomes for children, families and young people, now and into the future. An online directory of services for families and practitioners has been developed\(^3\) and three physical Early Help Locality Hubs were established across the city, launching in September 2015.

**Safeguarding**

Safeguarding is a term now widely represented in the mainstream of policy and practice. It is a broad term, viewed in many ways by different groups, agencies, professionals, and individuals. It provides the basis upon which vulnerable people in the population are protected from harm and that their welfare is promoted. In relation to children, the current definition of safeguarding and promoting their welfare is:

"Protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best life chances".\(^4\)

Clearly, as indicated by the term 'protecting children from maltreatment', child protection is a very important part of safeguarding work undertaken to protect and promote the welfare of children. Equally, protecting children from harm involves much more than just having systems in place to manage child protection.

Most children in Liverpool grow up happily and safely in secure families and communities. Some, however, face significant challenges and risks and our concern is with these, most vulnerable children. The key to making them safer is for public services and the voluntary sector to work together effectively. It is the Local Safeguarding Children's Board (LSCB) that has the statutory duty under the Children Act 2004 for agreeing how the relevant organisations in Liverpool will co-operate to safeguard and promote the welfare of children in its locality. These safeguarding services are constantly operating in a context of challenge and change which means that the LSCB has needed to identify key priorities that required a multi-agency approach to identifying progress and solutions to those challenges. During 2015, the evidence available to the LSCB highlighted the following strategic priorities for the Board. These were:

- Neglect, with its associated co-morbidities of domestic abuse, substance misuse and adult mental health concerns;
- Early Help for Families;
- Child Sexual Exploitation;
- Child and Adolescent Mental Health;
- The Impact of Criminality on Children;
- The Front Door to Child Protection Services and Thresholds;
- Improvement to its Business Processes

All the LSCBs of Cheshire and Merseyside have identified tackling the sexual exploitation of children (CSE) as a key strategic priority. Children who are subjected to sexual exploitation can have serious long term issues affecting their physical and mental health and their overall wellbeing. Sexual exploitation of children and young people under 18 will normally, but not exclusively, involve an adult developing a relationship with the child or young person, grooming or utilising violence, coercion and intimidation to sexually exploit the child or young person. Although young people aged 16, 17 and
18 are able to consent to sexual activity, they can still be subject to exploitation that can continue through to adulthood. Child sexual exploitation can affect the lives of the child or young person's family and carers and can lead to relationship breakdown. Child sexual exploitation is child abuse and is illegal and completely unacceptable.

All agencies have a responsibility to help identify those children and young people at risk of sexual exploitation; agencies also have responsibility both individually and collectively for ensuring that the child or young person is protected from any further risk of harm. All agencies also have a responsibility to do what they can to prevent children and young people becoming victims of child sexual exploitation. There are a number of ways this can be achieved including ensuring that our communities, especially children and young people, are aware of and understand the issues and risks involved in child sexual exploitation. The strategic approach includes: prevention; raising awareness among families and communities; training; disruption of perpetrator activities; safeguarding; and bringing offenders to justice and working with them to stop the cycle of CSE.5

**Complex needs and healthcare**

Children with disabilities and complex health needs can be defined as having one or more of the following conditions; physical, mental or sensory impairment, learning disability, long term medical condition or a social disorder. Children with special educational needs and / or disabilities often experience poorer outcomes than their peers, in health, education and in the transition to adulthood.

Estimating the number of children with disabilities and complex health needs is difficult because different definitions are used to classify disability and not all young people with a disability are known to services. However, local information suggests that in 2015 around one in five children and young people in Liverpool had Special Educational Needs and/or disabilities, equating to almost 13,000 children, down from one in four children in 2011.

Improved outcomes for children and young people with disabilities and complex needs will be facilitated by comprehensive quality assessments, together with prompt access to a range of interventions, which take full account of the child's, young person's and family's priorities. It is particularly important not to focus on a single disease model as children with one condition may have multiple co-existing conditions (comorbidities) which all impact on quality of life. Assessment, care planning and service delivery should take a lifecourse approach with frequent reviews to accommodate changing needs as the child or young person grows and develops. They should also be able to easily access mental health and public health services that consider the whole person. The Children and Families Bill 20146 introduced Education, Health and Care (EHC) Plans for children and young people with complex needs which set out their aspirations for the future and ensures that agencies work together to enable ambitions to be realised. Children and young people with long term conditions or disabilities are likely to need help to achieve their aspirations and life goals, however, prevention and early intervention can be applied to minimise negative impact and maximise positive impact.7
Asthma is the most common long term condition among children and young people. 4,850 young people in Liverpool have been diagnosed with asthma, and there are almost 300 hospital admissions among young people in the city each year which are caused by the condition.

Liverpool children and young people are likely to attend Alder Hey Hospital for secondary care and accident and emergency services. Alder Hey is one of the biggest children's hospitals in Europe, treating around 275,000 patients each year. In October 2015, patients moved into the new 'Alder Hey in the Park', a uniquely designed hospital and research and innovation centre for children's health. The Children and Young People's Design Group of current and former patients aged 10-22, have been involved in the design process since the beginning. The old hospital will be demolished and the site will be used to recreate the parkland on which the new hospital now stands.

For the year December 2014 to November 2015, Alder Hey admitted 40,559 inpatients. Approximately 55% were male and 45% female. Children aged 0-2 were the highest age category at 12,547 admissions followed by the 6-19 year age group at 8,430. Admissions from A&E department are predominantly for age 0-2 with over 4000 admissions. Over 150,000 children and young people were seen in outpatients clinics with 0-2 years and 6-10 years highest with both at around 40,000 patients. Again, approximately 55% were male and 45% female.

Protective factors and exploratory behaviours

The way we live our lives can have a lot to do with our health and wellbeing across the lifecourse and this is sometimes referred to as 'lifestyle factors' as we are considered to have some control over the choices we make. There are positive and negative ways to view many of these, with positive action protecting our health and wellbeing, and negative action or inaction having an adverse effect on our health and wellbeing. Like many other issues covered here, those effects can have lifecourse consequences. There are some activities we try when we are young even though we know that they may not be good for us, because we want to fit in with a certain group, from fear, or because at a young age, we don't truly believe that negative things will happen to us. These are called exploratory behaviours, and include the urge to take risks, e.g. climbing or swimming in dangerous places, going beyond known physical capacity in sports, or engaging in unprotected sex.

Physical activity has benefits throughout life, from women during pregnancy, babies, children, young people, and adults and in later life. It is good for our bodies and can also produce strong emotions of wellbeing. The consequences of inactivity mean that it is now the fourth worst cause of people dying in the UK. Only 1 in 5 adults in Liverpool are active enough to benefit their health. 10% of deaths from Coronary Heart Disease are due to inactivity, but walking briskly for 180 minutes a week can reduce the risk of heart attack by 22% for men and 33% for women. Physical inactivity in adults is responsible for 146 emergency cardiac admissions per year in Liverpool and can increase the risk of cardiac mortality by 30%. People who already have conditions can also reduce their health risks through physical activity. Someone with diabetes who walks for 180 minutes a week is 2.5 times less likely to die of heart disease than an inactive person without diabetes. Physical activity does not refer only to sports but covers all activity that gets people moving such as gardening, housework, and walking to and from a train station. Many 'normal' activities can be enhanced to get more benefit
from them, such as doing stretches while vacuuming, but there are also added benefits to more
social activities such as group walks and team games.

Liverpool is working hard to reduce inactivity and increase participation in physical activity. Liverpool
Active City® wants all children and young people aged 5-18 engaging in physical activity for at least
60 minutes and up to several hours every day while minimising their time being sedentary (sitting).
Physical activities will be closer to seamless over the school day and out of school so that there is
less duplication, more school facilities will be used by more people, and neighbourhoods will
encourage more activities where people live.

Healthy weight is another protective factor, achieved through being active and eating healthy and
nutritious food. Being too much underweight or overweight can have negative health and wellbeing
effects. People’s weight, and their perception of their size compared to others can have significant
effects on their mental health and wellbeing from an early age. Children are measured in Reception
Year (age 4/5) and again in Year 6 (age 10/11). Overweight in children is strongly associated with
being poorer. Overweight and inactivity increase the risk of a range of chronic conditions such as
diabetes, high blood pressure, cardio vascular disease and bowel cancer. The rising weight and
inactivity observed in children could result in them having shorter lives than their parents rather than
the current trend of living longer.

The Liverpool Healthy Families healthy weight programme gives help and support for weight
problems for whole families, as changes such as healthier food and more activity involve everyone
and reduce the whole family’s health risks.

Public health also runs promotional campaigns giving information so that children and parents can
make healthy choices. The Liverpool Sugar Cube campaign shows how much sugar is in each of
several well know branded drinks on a poster and encourages the use of the Sugar Smart app which
reads barcodes and reveals how much sugar is in different foods and drinks.
**Tobacco use is the biggest behavioural risk factor for ill health and early death. Nearly one fifth of deaths in adults over 35 in England are estimated to be caused by the consequences of smoking. Smoking is a major risk factor for lung cancer, chronic obstructive pulmonary disease, heart disease. It also can result in cancers of the lip, mouth, throat, bladder, kidney, stomach, liver and cervix. In 2013 a quarter of people over sixteen still smoked, although that had reduced from 35% in 2005. Two thirds of people who smoke or have smoked began before the age of eighteen, and risks are higher the younger smoking starts. Liverpool is estimated to have the highest number of smokers aged under eighteen, with almost 1 in 5 classed as regular smokers.**

In the 2015 Year 8 survey 1% of pupils report that they are regular smokers. Of the pupils who have ever smoked, they were on average 11 years old when they first started.

Using drugs and alcohol (substance misuse) during childhood and adolescence can have a continuing impact over the lifespan as it can become learned behaviour which normalises that use as a life choice. The consequences of loss of control following substance misuse can include unwanted pregnancies, injury to self or others and criminal behaviours.

Young people are the highest consumers of alcohol in Liverpool and there are possibly 100,000 binge drinkers in the city. There may be over 23,000 children living with adult binge drinkers. Rates of death from Alcoholic Liver Disease in younger adults are rising, however, alcohol specific admissions to hospital for young people have fallen rapidly over the past decade.

The rate of alcohol specific hospital admissions among under 18s in Liverpool has fallen by more than three quarters since 2006-07.

<table>
<thead>
<tr>
<th>2014-2915 Child weight Reception (age 4-5)</th>
<th>Under weight</th>
<th>Healthy weight</th>
<th>Over weight</th>
<th>Obese</th>
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<tr>
<td>Liverpool</td>
<td>0.5</td>
<td>73.3</td>
<td>14.5</td>
<td>11.8</td>
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<tr>
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<td>77.2</td>
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<table>
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<th>Child Weight Year 6 (age 10-11)</th>
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<tr>
<td>Liverpool</td>
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<td>15.4</td>
<td>23</td>
</tr>
<tr>
<td>England</td>
<td>1.4</td>
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<td>14.2</td>
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</tbody>
</table>
The 2015 survey of Year 8 pupils in Liverpool shows that the percentage of pupils who have drunk alcohol in the week prior to the survey has fallen from 40% in 1995 to just 7% in 2015, mirroring the national trend.

As with tobacco use, the earliest drug users are those who are likely to have the severest problems for the longest time. Access to specialist substance misuse treatment intervention including the provision of one to one counselling and practical support such as access to training and learning opportunities, is having a positive impact for young people in Liverpool. Preventive action that delays onset of involvement or allows avoidance can minimise the potential harm of substance misuse. Approaches such as developing communication skills, building confidence and positive self-esteem, setting healthy goals, resilience and problem solving, addressing social norms, resisting peer pressure and anger management can be built into programmes to support young people.

Outreach approaches in which advice and support is provided to young people where they live their lives and set within their own friendship groups demonstrate the importance of the location from which preventive and early intervention approaches are provided in determining the success of these programmes. Outreach approaches have been successfully adopted in Liverpool in the last year. A specialist substance misuse service commissioned by Liverpool Public Health and provided through Young Addaction has implemented a successful Outreach Pilot Programme together with Priority Youth to deliver brief interventions and targeted work on the street and in youth centres. Over 2000 young people have been engaged through this initiative and is now integrated into the service core delivery model.

Targeting of outreach is best achieved through partnership approaches. Young Addaction, Merseyside Police and Residential Social Landlords (RSLs) have worked together to enable delivery of focused outreach activity within Anti-Social Behaviour hotspots. Interventions have included setting up provision for football activities in response to high numbers (between 60-80) of young people congregating in identified local areas through to the provision of brief interventions related to the address of alcohol and cannabis use. Engaging young people in the provision of substance misuse specific advice is further complemented by additional activity to enhance the skills and self-esteem of participants. Twenty five Red Cross First Aid certificates were awarded and a further twenty seven young people received a Short Course Asdan Award for their work in Activity Development and Peer Tutoring.

In Liverpool in 2015-2016 a total of 379 referrals for 10-19 year olds were received for access to specialist substance misuse supports of which 254 were male and 130 were female.

250 young people were able to leave treatment drug free in Liverpool within the past 12 months.

Liverpool Youth Offending Service (YOS) is a multi-agency team that includes social workers, education workers, probation staff, police officers and two seconded nurses. In addition there are substance misuse workers and access to Child and Adolescent Mental Health Services. The first aim of the YOS is preventing young people coming into contact with the criminal justice system, and then to prevent re-offending. Those young people who do attend the YOS are unlikely to have engaged with mainstream health services and the YOS nurses are able to reach a section of the population which would normally be marginalised from services.

The YOS nurses have had a high degree of success in early identification and early intervention as they screen all young people coming into the service on statutory court orders and will then complete a full health assessment if it is needed. The nurses are also able to respond to requests for them to see young people and this has helped them access sexual health services, immunisations and screening for other health conditions. In addition they provided 284 health promotion sessions in the
service in the past year, including smoking cessation, healthy diet, exercise, hygiene including oral hygiene, emotional well-being, sleeping and keeping safe.

| In Liverpool 176 young people were referred to the YOS health team from June 2015 to August 2016. |
| 50 immunisations were given, 26 c-card registrations for condom access, 17 GP registrations, and 31 dentist registrations were facilitated. |

Being in a relationship can have protective aspects but also negative aspects when those in the relationship are unhappy or feel that the relationship is not equitable. There are many different kinds of relationship such as that of a parent and child, or teacher and student, and these have recognised boundaries and expectations. Couple relationships and intimate relationships can be healthy, positive experiences, however, engaging in close relationships can have devastating physical, emotional and mental consequences for young people. A relationship can become physically or emotionally abusive even without sexual contact. For those in sexual relationships over 10% of young people experience intimate partner abuse.

Young people are among those with the highest burden of sexual ill health, with those aged between 15 and 24 having the highest rate of sexually transmitted infections (STIs). Young people are also most likely to become re-infected with STIs. If left untreated, Chlamydia may lead to serious reproductive health consequences; and early diagnosis and treatment of HIV infections is needed to save lives and prevent onward transmission to other partners or through pregnancy.

Most teenage conceptions are unplanned and around half end in an abortion. Teenage conception is strongly associated with disadvantage. While for some young parents, having a child when young can represent a positive turning point in their lives, for the majority, bringing up a child is incredibly difficult. Teenage pregnancy and early motherhood are associated with a range of poor outcomes for both mother and child, including higher infant and child mortality; higher rates of postnatal depression and higher risks for health and attainment throughout the lifecourse.

| In Liverpool, two thirds of diagnoses of new STIs were in young people aged 15-24 years. The most commonly diagnosed infection among young people in Liverpool is Chlamydia, accounting for just over 6 in 10 cases. |
| There were 244 Under 18 conceptions in 2014, down from 492 conceptions in 1998. |

**Emotional health and wellbeing**

Wellbeing is used in many different contexts, but is mostly used to refer to the way people feel and think about themselves and their lives. There are two types of wellbeing, subjective (from the viewpoint of the person) and objective (from the viewpoint of others). Subjective wellbeing can be seen as two elements, 'life satisfaction' for areas such as housing and work, and 'affect' which is more immediate and mostly describes positive and negative emotions about the present. Measuring affect is not always easy as the present feeling is a comparison with how the person themselves has felt internally at other times. Physical and mental ill health are often connected (pain is a subjective experience) and wellbeing assessments should consider the whole person.
The New Economics Foundation have suggested that children's psychological and social wellbeing can be thought of as "emerging from the interaction between their external circumstances, inner resources and their capabilities and interactions with the world around them." (Figure 7 below) \(^\text{10}\). This really describes wellbeing across the lifecourse, although all the elements will change their relations and intensity over time. For example, a very young child's resources may only be the genetically programmed urge to cry, but that behaviour will change as the child becomes aware of differing responses.

Figure 7: New Economics Foundation 'ingredients of wellbeing' with examples of young people's thoughts

Poor mental and emotional wellbeing arises from how someone interacts with their lives and how they are able to respond. Resilience refers to someone's ability to cope with their lives: a person with strong resilience may be able to cope with negative life events and still have good mental and emotional wellbeing; another person without such strong resilience might have much poorer
wellbeing. Some people may also have difficulties coping with the way they experience their lives, although they may not appear to be very problematic to others.

Children and young people who develop problems with mental and emotional wellbeing are more likely to fall behind their peers and also to suffer poor mental health as they get older, reducing their life chances. There is a continuum of mental distress that children and young people experience, just as for other ages, but as it is experienced at the beginning of the lifecourse, addressing it as early as possible can prevent both continuing and cumulative mental and emotional problems.

By the time children are assessed at the end of the Early Years Foundation Stage, around age five, one in five will not have met the expected level in personal, social and emotional development. We know that the very earliest stages of life are highly significant for physical, emotional and mental health as we have set out earlier in this report. One in ten children aged five to sixteen will have a diagnosable mental health problem such as a conduct (behaviour) disorder, anxiety disorder, attention deficit disorder or depression. One in every twelve to fifteen children and young people deliberately self-harm and hospital admissions nationally for self-harm have increased by 68% over the last ten years. By the time they are eighteen, three quarters of those people who develop mental health problems in adulthood have already started to experience symptoms. Children experiencing poverty are four times more likely to develop mental health problems and boys aged 5-10 are twice as likely to have mental health problems as girls.

Mental ill health is the single largest cause of disability in the UK at 28%, but despite mental health having been declared as important as physical health (parity of esteem), the English NHS spend on mental health direct services in 2015 was 13%.

The Liverpool approach to keeping the city's children and young people well is person centred, within the family where necessary and promoting Early Help to prevent problems developing further. The Liverpool strategy aims to make the mental health and emotional wellbeing of children and young people 'everyone's business'.\(^\text{11}\) Services are multi-agency and well integrated as The Liverpool Children and Young People's Mental Health and Emotional Wellbeing Strategic Partnership (Liverpool CAMHS) with development of a Comprehensive Children and Young People's Mental Health Services 0-19 pathway (CCP). The definition of mental health adopted is the best known one from the World Health Organization: a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contributions to his or her community.\(^\text{12}\) As young people have put it – "it doesn't mean being happy all the time, but it does mean being able to cope with things" and "it's about feeling in control or feeling balanced so you can cope with life's ups and downs."\(^\text{13}\)
Six outcomes have been agreed in partnership with stakeholders including children, young people and families:

- Improved mental health of children, young people and their families
- Improved environments so that children, young people and families can thrive
- Increased identification of children and young people with early indicators of distress and risk
- Reduction in mild to moderate distress
- Reduction in the development of moderate to severe distress
- Reduction in life long distress

The Liverpool CAMHS website offers advice and resources for children, young people, parents and people who work with children and young people. Two of the ways people are encouraged to think about their lives are the Five Ways to Wellbeing, which Liverpool has been promoting since its European Capital of Culture Year of Health and Wellbeing 2010, and the MindApples concept. MindApples is promoted as a 5-a-day for the mind and has been used with staff who work with children and young people in Liverpool to raise awareness of mental health as ‘everyone’s business’.

In 2015 Merseyside Youth Association collected and analysed 264 ‘apple’ cards which people had been asked to complete with 5 things that they thought were good for their minds. The categories Social Contact and Physical Activity ranked highest, which is typical of other exercises. The other categories used (in ranked order) were Leisure Activities and Active Mind, Self-care and Relaxation, and Food and Drink. The study also noted that 10% of responses matched the 5 ways ‘Take notice’ which is typical and 9% matched ‘Give’ which is comparatively high.

With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.
References and links


2. Keenan A. 2016 How avoidable is a measles outbreak? Presentation given to the 5 Nations Health Protection conference in Cardiff on 10 May 2016.


14. Liverpool CAMHS http://liverpoolcamhsfyi.com


Achieving potential

The journey through to young adulthood would ideally be crossed by few barriers, overcome by natural resilience and equitable life experience. We know that this is not the case for many of our young people, but that they continue to strive to achieve their own aspirations while dealing with life circumstances. We also know that our children and young people have a Voice in all the issues that concern them, able to push for positive changes to the circumstances of their own lives and those of others because of their willingness to become involved and represent others around them as well as those who follow them.

Young carers

A young carer is defined, in law, as a "person under 18 who provides or intends to provide care for another person" (Children and Families Act 2014). Young carers provide care to another family member at a level which would usually be undertaken by an adult and which is likely to have a significant impact on their normal childhood. While there may be some positive outcomes of caring for young carers such as feeling valued within the family and developing personal and life skills, caring can have an adverse effect on a child or young person's health and wellbeing, development and opportunities.

Intervening early to resolve problems through a whole family approach has the greatest impact on reducing the negative impact of caring and improving young carers' life chances. Early intervention requires better identification by both families and professionals of those children and young people who may take on inappropriate caring roles. Partnership working through a 'no wrong door approach' is key to identifying, assessing and supporting young carers and their families.

The level of unpaid care provided by young people in the city is the highest among the eight core cities in England and significantly above national and regional levels. It is widely acknowledged that this is likely to be the 'tip of the iceberg' given that families may not disclose if their children are carrying out significant caring roles. Within Liverpool, provision of unpaid care is highest in the north of the city.

The Children and Families Act and Care Act 2014, which came into force in April 2015, significantly strengthens the rights of young carers. Young carers, young adult carers and their families now have stronger rights to be identified, offered information, receive an assessment and support using a whole-family approach. As part of the city's commitment to continual improvement for young carers and their families, Liverpool City Council recommissioned services for young carers in 2014-15 through pooled budget arrangements with Liverpool Clinical Commissioning Group. The new four year contracts were implemented from July 2015 and meet the Council's legislative obligations while recognising the restrictions of the current adverse economic environment.

Barnardo's Action with Young Carers delivers a city wide community based service that ensures young carers and young adult carers (up and including the age of 25) are identified and can receive their statutory rights to a carer's assessment, support plan and review. Liverpool's young carers service employs a proactive whole family approach where partnership working is central to delivery. The service is part of the city's Early Help (EHAT) framework and pathway, ensuring that children and young people who are impacted negatively by caring responsibilities can be identified sooner and receive appropriate help more quickly to improve outcomes for the whole family.

The Carers Making it Happen Group, Early Help subgroup and the Children and Young People's Mental Health and Emotional Wellbeing (CAMHS) Partnership all report into the Liverpool Health and Wellbeing Board and Children and Families Trust Board. They provide strategic direction to
ensure the needs of young carers and young adult carers are met effectively and that the resources available across the health and social care economy are maximised.

Liverpool has a long history of ensuring that participation is at the heart of all developments affecting young carers. ‘Keeping the Family in Mind’ sits within Liverpool's young carers service to enhance and support direct service delivery and influence wider strategic development by ensuring the views and experiences of young carers and families are heard by commissioners and service providers. The Service is proud to have retained the Investing in Children Membership Award™ for eight years, requiring services to demonstrate a commitment to dialogue with children and young people that leads to change. Liverpool Universities and College Steering Group for Young Adult Carers in Higher and Further Education works collaboratively to develop their offer to young adult carers, enabling them to enjoy the same opportunities as other young people when accessing further and higher education. Liverpool John Moore's University (LJMU) launched their offer on Young Carer Awareness Day in February 2015 in recognition of the challenges that can be faced by young adult carers in balancing caring responsibilities with student life and to support young adult carers to transition effectively into higher education.

The 2011 census recorded 166,363 young carers in England compared to around 139,000 in 2001 which is highly likely to be an under representation.

Over 5,100 people in Liverpool aged under 25 years were identified as providing unpaid care, which is 3.5% of that age group.

One in 12 young carers spends more than 15 hours a week looking after a parent or sibling, one in 20 misses school and a young carer is 50% more likely to have special educational needs or an illness than a child who does not have caring responsibilities.

Of those young people providing unpaid care in Liverpool, 30% do so for more than 20 hours a week while the figure for England is 25%. 640 young people were recorded as providing unpaid care in the three wards of Kirkdale, Everton and County alone.
**Children in Care**

Looked after children and young people are one of our most vulnerable populations, although they are also a population with rights in law from the United Nations down to local government. There are many different kinds of public care experience, and in any period of twelve months almost one in every one hundred children will access the care system.

People who have spent time in care and have been followed through their lives have been found to have poorer outcomes than people who have not. Previously looked after children are more likely to have physical and psychological ill health, to be unemployed or to be homeless. There is a high risk of teenage motherhood for girls. Children in care are at higher risk of child sexual exploitation. Risk factors for entering care included mothers with low socioeconomic status, receipt of benefits, single parenthood, age, disability, smoking in pregnancy, mental illness, alcohol and learning difficulties. For children, there are associations with low birth weight and disability, injuries and attendance at Accident and Emergency.

The educational attainment of looked after children is significantly poorer than their peers and the gap is not closing quickly, although there have been improvements. A study in 2009 found that looked after children and young people believed that encouragement to attend and do well at school was lacking for many, but that this, together with their own self-reliance, had been a key factor for those who had academic success.

Liverpool's vision is that outcomes for every child in care are at least as good as their peers who are not in care. Liverpool City Council and Children's Trust Board partners commit to the 'Great 8' mandate to:

- Respect young people and honour their identity
- Believe in young people
- Inform young people
- Support young people
- Find care leavers suitable, safe, affordable accommodation
- Champion you throughout your life even when you have left care
- Ensure that all Councillors and everyone in Children's Services, including schools have a copy of 'Liverpool's Great 8' mandate displayed in a place where everyone can see it. All staff and Councillors will have a commitment card to carry with them.

The number of Looked After Children in Liverpool has risen every year since 2009. The rise is a national trend but the number of children looked after is significantly higher than the England average. There are approximately 1000 Looked After Children in Liverpool. Children aged 10-15 years comprise 39% of the looked after population with children under one year making up 4%. There are just over 50% boys and just under 50% girls. The majority of the population (68%) are in foster care placements.

Laurel Road Intensive Outreach and Short Break service supports children and young people on the edge of care, aiming to prevent children and young people from becoming looked after by providing a combination of intensive outreach and short breaks. The service works closely with Everton Football Club's 'Breathing Space' program which also targets children and families on the edge of care.
**Participation and involvement**

The United Nations Convention on the Rights of the Child\(^2\) makes it clear that children have the right to participate in decisions that are relevant to them and their lives. Specifically they should be given an opportunity to influence decisions taken that affect their lives within the family, school and community. When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.

Actively engaging with children and young people enables them to become active participants in society; this can facilitate co-operation and communication, encourage them to take ownership and gives them a sense of responsibility. It contributes to achievement and attainment by fostering increased motivation and engagement in education. Participatory practice facilitates the development of positive and caring relationships - listening to others is central to caring for them. Evidence shows that young people involved in participative work also benefit from increased confidence, self-respect, and self-esteem. All of these benefits contribute to the health and wellbeing of both the individual and wider community.

Encouraging participation requires more than a simple strategy. It is an underlying value and ethos that should be embedded not only throughout individual organisations and agencies but also throughout the entire health, social care, education, civil and political system.

Liverpool has a vibrant culture of young people's participation and this is set develop further with the introduction of a number of key initiatives including a multiagency *Voice of the Child* subgroup reporting directly into the *Liverpool Safeguarding Children Board*. The role of this group is to ensure that the voice of the child is heard and acted upon in all of our targeted and universal services. This will help ensure that services are meeting the needs of the city's children as well as keeping young people safe by giving them a voice. The group has developed an audit tool that is currently being used to investigate how the voice of the child is heard across agencies in Liverpool and how it can be further strengthened.

Liverpool's Youth and Play Service, with funding from Liverpool’s Safeguarding Children Board has this year recruited and trained 11 Young Advisors. This local programme is affiliated to the National Young Advisors network - young people aged between 15 and 24, who show community leaders
how to engage young people in community life, local decision-making and improving services. The programme aims to be self-sustaining and will be entirely funded by local commissions. The Young Advisors are able to support local organisations and commissioners by collecting and collating insight and data from other children and young people in order to inform service development and evaluation.

Brook Liverpool, funded by Liverpool Public Health, operate a needs-led, rights-based approach when providing sexual health and contraceptive services to young people in the city. The service uses a 'you say we did' visual display system in order to action the suggestions of young people and feedback how their views have been acted upon. Brook are currently in the process of developing a young people's participation network which will provide opportunities for mystery shopping and focus group involvement.

Young Addaction provide a drug and alcohol recovery service for children and young people in the city and has developed a service user group known as The Young Addaction Speakers (The YAS). This group of 14-18 year olds are active in providing feedback and developing new ideas and initiatives for the service to take forward. Members of the YAS have been involved in interviewing and recruiting staff for the organisation, ensuring the service continues to meet the needs of young people. In November 2015 this service took part in National Children’s Takeover Day in November where young people from the service, schools, colleges, NEET providers and the Youth Offending Service were invited to give their views to those in positions of influence including commissioners. This initiative is led by the Office of the Commissioner for Children and Young Addaction Liverpool’s model of hearing the views of children from last year is to be included in the national guidance for the year 2016 as a model of best practice.

The Children in Care Council is made up of young people who represent the children in care population and those on the edge of care. The CiCC has evolved over the last couple of years and is now fully recognised as a Participation service with three full time workers, two participation Officers and a Children’s Rights Officer. Members have been involved in:

- CQC style inspection of Royal Liverpool Hospital
- Regular slot talking to student social work students/nursing students LJMU
- Conferences to talk about National issues affecting children and young people.
- Training young people for fair selection and recruitment(interview panels)
- Strengthening families conferences.
- Peer mentoring
- Children in Care reviews
- Child Protection conferences to ensure children’s voices are heard and represented.

Liverpool Children in Care Council and Public Health played a crucial role in coordinating and driving work for the three year Hearty Lives Liverpool project launched in 2013. The programme was funded by the British Heart Foundation and Liverpool City Council and delivered by the Health Equalities Group in collaboration with Liverpool City Council and other local partners. The programme worked with Children in Care aged 11-17 and their carers to devise the most effective methods of supporting healthier lifestyles through the provision of health information, training and support in relation to healthy eating and physical activity. The young people in the CiCC worked closely with Hearty Lives colleagues, residential Care Staff and Foster Carers to set up interventions and decide what would best improve health outcomes, involving as many young people as possible and ensuring that young people in care were placed at the centre of the project. Key legacies of this unique and innovative project include a Food in Care toolkit and the embedding of healthy food training for future foster carers.
In terms of secondary care, young people are placed at the heart of Liverpool's Alder Hey Children’s Hospital NHS Trust. Alder Hey have an active Children and Young People's Forum which includes several former patients. This gives these young people an opportunity to represent the thousands of children who use Alder Hey and be included in the hospital's decision making processes. A Children and young people's design group was set up as an integral element in the development of the new 'Alder Hey in the Park' hospital and developers based their final design on the drawing of a 15 year old former patient.

Young people with experience of the mental health system redesigned the CAMHs materials for Alder Hey Hospital, renaming it Fresh CAMHS. They developed marketing materials including innovative leaflets, posters, website design and badges. Young people from Fresh regularly take part in consultation, interviews, scrutinising materials and policy relating to children who access child and adolescent mental health services.

Liverpool School Health Service identified low confidence and little capacity to deal with a range of mental health issues with school aged children across the city. Public Health was able to identify funding from the Families Programme for two posts to support vulnerable young people, train up staff, to work with and provide a resource for the school health service and other agencies. Fresh CAMH's was able to identify two young people to help with the interview process. Prior to formal interview candidates were asked to make a 10 minute presentation on the National CAMH strategy 'Fit for the Future' to a small focus group incorporating stakeholders of which these young people were a part. The young people not only knew the strategy, they had first-hand experience of the system and were confident, able to actively participate and genuinely influenced decision making.

Liverpool School’s Parliament gives an opportunity for local young people to have a voice on matters of concern and to be heard by those who have influence in the running of the city of Liverpool. The parliament encourages children to participate in a range of events and activities and empowers pupils to make a real difference within their community. The Upper House represents young people aged 11-19 and the Lower House represents young people aged 7-11. Liverpool School's Parliament is an official committee of Liverpool City Council, and all decisions made by the Parliament are passed on to Liverpool City Council. Twelve Junior Lord Mayors are also elected every year, each spending one month undertaking duties with the Lord Mayor.

This year over 5000 Liverpool ballots were completed in the annual Make Your Mark Ballot to decide the key national campaigns for the UK Youth Parliament. The two campaigns agreed were for Mental Health and Tackling Racism and Religious Discrimination. Liverpool decided to combine the two campaigns under the banner of 'Everyone Matters' and an Everyone Matters Day was held in April.
2016 at Liverpool Town Hall. Liverpool, with London and Cape Town, were the only cities outside of North America to hold this event.

The European Youth Parliament UK (EYPUK) EurVoice community outreach scheme to engage 11-18 year olds which began in Liverpool as a joint venture with Schools Parliament won the UK Charlemagne prize for development and participation in European integration projects. EurVoice Merseyside 2015 took place in December and involved 80+ Key Stage 3 students from Liverpool, Knowsley and Sefton.

Working with Merseytravel, Parliament followed the successful introduction of My Ticket with its extension up to 18 years from July 2016. Additionally, from January 2016 Arriva will reduce the cost of its Family Ticket from £15 to £12.

A free resource for schools on Child Sexual Exploitation (CSE) is being developed. Schools Parliament has been contacted by the Health Board of Victoria, Australia, about its possible use there. In January Upper House took part in DIVERcity Equality Review for Liverpool Council. Both Houses were involved in contributing to the Liverpool Challenge in March including the 'Recycle Michael' campaign with the Liverpool Environmental Advocate team (LEAT). Parliament was also represented at a conference in Brussels on Children's Working Rights. Bay TV has invited Parliament to take part in discussion programs. MSPs took part in a Radio City workshop organised by the Police and Crime Commissioner which involved producing adverts and short programme to warn young people of the dangers of becoming involved in criminal activities. Parliament is involved in the 'You're Welcome' consultation on behalf of Public Health England looking at issues facing young people accessing health services.

**Educational attainment**

The Liverpool Mayor’s Education Commission reported in 2013 that there was a large attainment gap in the city with poor performance as children entered school but performance at GCSE that was as good as or better than the national average following intensive work improve results. Children should have the potential to perform even better throughout school if they were building on positive foundations in early years. The Commission highlighted other attainment gaps caused by factors such as deprivation, gender and ethnic group that would need to be addressed to develop equitable learning experiences.
The Liverpool Learning Partnership (LLP) was established to lead collaborative work between schools and other learning establishments in Liverpool, as part of the school improvement agenda, and was tasked with taking forward the Commission's recommendations. The LLP's strategic aims include:

- To develop inclusive learning to ensure that all learners in Liverpool, including the most vulnerable, are given opportunity to achieve.
- To provide opportunities within the city to ensure lifelong learning for all children and adults.
- To keep the achievement of all children at the forefront of educational planning across the city.
- To shape provision across the city, ensuring that new learning opportunities are co-ordinated and meet the individual needs for all learners in Liverpool.

The partnership has two strategic groups focusing on: the quality of provision for all learners; and targeted provision for learners who need more, including vulnerable learners.

The three most visible projects are: Liverpool 'City of Readers' which aims to transform Liverpool into the UK's foremost reading city; the numeracy project 'Liverpool Counts'; and the Liverpool Cultural Education Partnership (LCEP) developed in response to the Arts Council England's Cultural Education Challenge.

Another Challenge was launched in January 2016. The 'Liverpool Challenge' is an initiative which will run for at least the next four years to drive up education standards in the city further, particularly in school readiness, improving literacy and numeracy in primary schools, transition from primary school to secondary school and employability, ensuring that the necessary skills are taught in schools for jobs that are expected to come to the city over the next decades but may not yet be specified. The Liverpool Challenge and LLP will work in partnership.

**Next steps**

The two most likely routes after secondary education are continuing to learn or work. There are also options to combine the two such as apprenticeships.

Good workplace health and wellbeing is positive for both employees and employers and helps to make the experience of work attractive to young people entering work for the first time. Good workplace communication, a positive organisational culture and good leadership are the foundations for good workplace health and wellbeing. A workplace that supports good mental and physical health will enable its staff to be productive and motivated to achieving the organisational goals and helps to minimise sickness absence and 'presenteeism' which refers to coming to work while unwell and then being unproductive. Prevention and early intervention can offer solutions including health promoting activities and services such as confidential conversations with a trained colleague.
For those who go into further or higher education, there will also be health and wellbeing issues. Student life offers the opportunity for another round of exploratory behaviours, with the same possible adverse consequences. Mental health can be more fragile, both at starting a new, more independent phase of life, and also at pressure points such as exams. Prevention and early intervention approaches can also be helpful in these circumstances. Students should particularly be aware and take part in any offered vaccination programmes, as they are a risk population who may have missed being immunised previously. It is important to register with GPs and dentists so that the correct route through health services is followed.

Young people who find themselves not in education, employment or training (NEETs) are also at risk of depression and continued unemployment at the beginning of working life can have an impact on long term employment chances after only six months. Risk factors for poor health linked to unemployment include reductions in income or low income, increased social exclusion, and a lack of social support. Unhealthy behaviours such as drinking and smoking may increase, and healthy behaviours such as physical activity decrease. Positive actions will include health improving behaviours, goal setting, and exploring all available help to achieve potential, even if in another direction.

A few will find themselves becoming young parents. This may be a life choice or due to circumstance. Either way, the mother and child will be in one of the highest risk groups for physical, mental and emotional health, as shown in this report. Learning as much as possible about pregnancy, birth and caring for the baby is the best preventive action. Making best use of support, whether from family or friends, or professional services such as the Family Nurse Partnership, can help in managing the process of bringing new life into the world.
While there has been much work done in 2015-2016 and previously to improve the health, wellbeing and life chances of children and young people, some of which is highlighted here, there is much yet to do.

All partners will need to take serious action to enable us to reduce health inequalities both within Liverpool and in comparison with other areas. It is our continuing responsibility to lobby those who have the power to make whole system changes to improve the health and wellbeing of all our citizens. Locally, we will need to do as much as we can, across all sectors, organisations, communities and families, to provide the environment that allows our children to make the best start in life.

Never too early, never too late, invest in early lives, invest in prevention for a stronger, healthier future for us all.

References and links

1 Dickson K, Sutcliffe K, and Gough D. 2009 The experiences, views and preferences of Looked After children and young people and their families and carers about the care system Institute of Education London
3 Fresh CAMHS http://www.freshcamhs.org
**Recommendations**

1. That all public service commissioners and policy makers should consider the wider determinants of health and wellbeing as a foundation for their actions and take account of the rights and needs of children, young people and families, ensuring that their voices can be heard in all service developments.

2. That public service commissioners should develop an integrated commissioning model for children and young people’s services that places prevention and early intervention at the centre of service delivery, including the development of a pre-birth to 19 Service that meets the needs of the Liverpool population.

3. That partners work together to promote vaccination and immunisation at every stage of childhood and adolescence to ensure high levels of uptake for the protection of population health.

4. That the LSCB and its partners continue to work together to further strengthen safeguarding support and delivery across agencies.

5. That public service commissioners and policy makers work to deliver parity of esteem for mental health across pre-birth, infancy, childhood and adolescence, ensuring seamless service transitions.

6. That all partners continue to work to promote healthy eating for children, young people and families using successful approaches such as the Sugar Cubes Campaign.

7. That all partners continue to work together to address the known risks associated with tobacco use and potential harms associated with the use of e cigarettes.

8. That all partners encourage greater levels of physical activity for everyone in the city.

9. That public service commissioners and policy makers continue to develop their understanding of addictions and alcohol misuse in young people to support the reshaping of services.

10. That Public Health and partners work to improve data concerning children and young people to provide intelligence for evidence based action and demonstrate change more transparently.
Liverpool City Council 2016
Further information on topics in this report and many others together with current statistics can be found on the Liverpool Joint Strategic Needs Assessment webpages:
www.liverpool.gov.uk/jsna

This report can be accessed from the following webpage:
www.liverpool.gov.uk/phar

We welcome any comments or feedback on the Annual Report of the Director of Public Health for Liverpool
Contact: healthandwellbeing@liverpool.gov.uk