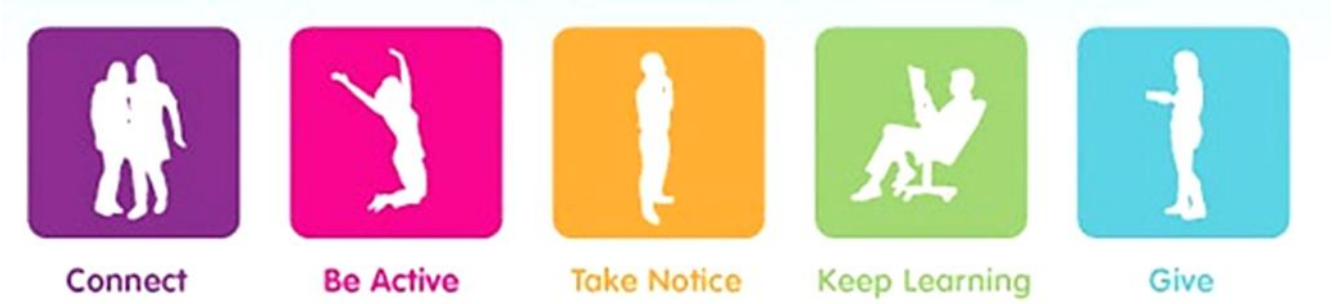
Liverpool City Council

Liverpool's Joint Strategic Needs Assessment
Safeguarding Children

April 2016



READER INFORMATION	
Title	**Liverpool's Joint Strategic Needs Assessment - Safeguarding Children**
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Description	This document aims to provide a comprehensive overview of issues relating to the safeguarding of children and young people in Liverpool. As part of the Joint Strategic Needs Assessment (JSNA), its purpose is to provide an evidence base to support policy makers and commissioners within the City Council, local NHS, Liverpool Safeguarding Children Board and Liverpool Children's Trust Board. Whilst the document is primarily aimed at policy makers and commissioners, it is also available to members of the public and other organisations.
Related Documents	Liverpool's Joint Strategic Needs Assessment – Statement of Need 2014
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Summary of Key Findings

Demographics

- There are just over 89,900 children and young people in Liverpool and this is projected to grow by a further 5.4% over the next decade. This would equate to an additional 4,870 children and young people by 2024. Projections indicate the growth will be particularly substantial among the 8 to 13 age groups.

- The ethnic diversity of children and young people in the city is slightly higher than for the overall population, standing at 18.3%. The largest minority groups among those aged under 18 are: Black African, Arab, and White Other.

- Liverpool is one of the most deprived Local Authorities in England, ranked 7th out of 326. A substantial proportion of our local residents live in areas of high deprivation, with almost 45% of our population live within communities ranked within the 10% most deprived in England. Around a third of children in the city live in poverty. The high levels of deprivation and poverty in the city mean that our children face a greater risk of poor health, being exposed to crime, and failing to achieve their full potential.

Safeguarding Risks: Compromised Ability to Care

- There is increasing evidence that negative experiences in childhood can have a significant impact on health and wellbeing of the individual in the longer term. So called 'adverse childhood experiences' (ACEs), such as abuse, neglect and domestic violence, are known to be associated with a range of health harming behaviours in adulthood, such as alcohol and substance misuse, risky sexual behaviour and crime. Almost 1 in 10 children in England have experienced 4 or more adverse experiences in childhood, and local levels are expected to be higher.

- Domestic violence and abuse between parents is the most frequently reported form of trauma for children, with 1 in 4 young people nationally reporting that they experience domestic violence and abuse during their childhood. There is no actual offence of domestic abuse although it is recorded as a contributory factor to an offence. In 2014/15, there were 2,857 domestic abuse related crimes recorded by Merseyside Police, which was a 32% increase on the previous year's figure.

- Figures for September 2013 to August 2014 show that there has been a 25% reduction in the number cases reviewed at the Liverpool MARAC when compared with the previous 12 months.

- Perinatal mental ill health (most commonly depression, but also anxiety, and postnatal psychotic disorders) affects at least 10% of women. As a minimum, this would equate to between 500 and 600 women each year in Liverpool. Research indicates that the prevalence

of depression among women increases during the antenatal period, rising from 7.4% in the first trimester, 11.4 to 12.8% in the second trimester and 13.1 to 14.8% in the third.

- Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least a third of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings. Local intelligence shows that roughly one in three adults being treated for substance misuse has a child living with them at least some of the time, equating to almost 1,500 parents in the city.

- Children living within households where there are multiple risk factors are a particular concern as co-morbidities are associated with less effective treatment and additional difficulties in parenting. Applying this research to our local population estimates suggests almost 850 children in the city may live in such situations. It should be noted that there are limitations to extrapolating local prevalence from national research. These figures are likely to underestimate the true extent of the issue locally.

- There are over 5,100 people in Liverpool aged under-25 who identify themselves as providing unpaid care, the highest level among the eight core cities in England, and significantly above both national and regional levels. Local information shows that the primary illness or disability of the person being cared for was mental illness, mirroring the national pattern. Mental ill-health was also a factor identified in caring for people with drug & alcohol issues and physical disabilities.

- During the period 1st April 2014 to 31st March 2015, 88 child deaths were notified to the Merseyside Child Death Overview Panel (CDOP) across the five LSCB areas, with the number relatively stable over the past 5 years. There were 38 notifications from Liverpool during the year, and the city has the highest rate amongst the Merseyside Local Authorities. Around half of child deaths in the city occur within the first 28days of life.

- Locally, there has been a rise in the number of active caseloads of FGM at Liverpool Women's Hospital since September 2014, though this may relate to improved recording. By March 2015 there were 54 active caseloads of female genital mutilation at the hospital i.e.: women and girls being actively seen/treated for FGM-related conditions.

- Between 2012-13 and 2013-14, the NSPCC report that there was a 39% increase in police recorded sexual offences against children in England. The research suggests part of this increase will relate to the media focus on child sexual exploitation in recent years, which has led to more people willing to come forward to the police and report abuse. However, the NSPCC suggest there is a significant national shortfall in therapeutic support available to those who have suffered child sexual abuse. In the 6-month period between October 2014 and March 2015, there were 163 CSE referrals made from the Liverpool area to the MACSE meeting of children considered at risk of, or experiencing sexual exploitation.

Safeguarding Risks: Behavioural & Environmental Risk Factors

- Long term trends suggest there has been a substantial fall in the use of illegal drugs among young people in England. Figures for 2013 show that 16% of pupils in England had ever taken drugs, 11% had taken them in the last year and 6% in the last month.

- Young people between 15 and 24 years old experience the highest rates of sexually transmitted infection (STIs). 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 259 under-18 conceptions in Liverpool in 2013, with 6 in 10 leading to an abortion. Latest annual figures indicate a continued fall in the under-18 conception rate, both locally and nationally.

- Children and young people with additional needs may be more vulnerable to safeguarding risks for a variety of reasons including variations in their perceptions of risk and danger, their ability to articulate concerns, and their ability to recognise inappropriate behaviour. Local information shows that in 2015 around one in five children and young people in Liverpool have Special Educational Needs and/or disabilities, equating to almost 13,000 children.

- Around 1 in 10 children aged under 16 will have some form of mental disorder, with the prevalence increasing with age. Research indicates the most prevalent condition is emotional disorders, with up to 1 in 27 young people aged 5 to 16 having the condition. Lack of robust local information makes it difficult to obtain a true picture of the extent of mental ill-health affecting children and young people.

- Results from the 2014 bullying audit in Liverpool indicate there has been a significant increase in the number of pupils stating they have been bullied in the previous 12 months. However, it is important to acknowledge that the long term trend is a positive one, with levels of bullying substantially below those reported in 2006. National research by the London School of Economics in 2010 and 2013 indicates that cyber-bullying is now more common than face-to-face bullying.

- The number of suicide cases among children and young people in Liverpool is comparatively low. Over the 10 year period 2004 to 2013 there were 28 confirmed cases of suicide among those aged under25, with an average of less than 3 per year.

- There is difficulty in obtaining accurate figures on the extent of self-harm due to underreporting of cases, and the various definitions that may be used for those that do seek help and support. Locally, data suggests the rate of hospitals admissions for self-harm among young people has remained relatively stable, with 744 cases over the three year period 2010-11 to 2012-13. Admission rates for Liverpool are significantly lower

than England, however this may relate to methods of recording rather than a true difference.

- Admission to hospital can represent the more severe cases of accidental injury among young people, and while there were 1,159 admissions in 2014-15, there were significantly more attendances at A&E caused by accidents. In the 12 month period there were just under 11,200 A&E attendances by children and young people in Liverpool caused by accidents.

- Results from the Crime Survey 2013/14 indicate that 6.5% of 10 to 15 year olds in England & Wales were victims of violent crimes within the previous 12months. As an indication, this is more than three times the proportion of adults who were victims of violent crime in 2013/14, though direct comparisons are problematic due to methodological differences. The 2015 Health Related Behaviour Survey of Year 8 pupils in Liverpool showed that 7% of children taking part in the survey responded that they were the victim of crime in the last 12 months, with school being the most common location for both boys and girls.

- Figures for 2014 indicate that Liverpool has the highest rate of NEET among the eight Core Cities in England, with 8.2% of young people not in education, employment or training. This compares to a national average of 4.7%. In addition, the status of almost 1 in 4 young people is unknown, significantly above the national average of 9%.

- As of October 2015, Liverpool has identified 1,695 families who meet two or more problem areas in the first year of the extended Families programme. Currently 940 are engaged within a family intervention programme. Complex families cross all socio-economic boundaries and are not confined to one particular group of individuals. However, seven of the top ten wards are located in the north of the city.

Profile of Local Need

- In April 2015 there were 4,287 children and young people in Liverpool identified as being in need. While levels of need are higher than those in England, they are comparable to other Core Cities. The largest cohort of children in need are aged 10 to 15 years, accounting for just over 30% of cases. Abuse or neglect is the most common cause of children assessed as being in need, accounting for four in ten cases.

- In April 2015 there were 455 child protection plans in place in Liverpool, and the latest figures indicate levels in the city are comparable to the national and core city averages. The largest cohort of children subject to a CPP are aged 10 to 15 years, accounting for just over 30% of cases. Latest figures for Liverpool indicate that neglect is the primary reason for a child protection plan in the city, accounting for more than four in every ten cases. This is an increase on the previous year when neglect accounted for just under a

third of cases. There has also been an increase in the proportion of CPPs due to emotional abuse.

- There are no robust projections available relating to the number of children and families that might need support in the future, due to the multitude of influencing factors and social pressures. However, we know that the number of people under-18 is projected to increase by over 5% over the next decade. If the prevalence of children and young people in need stays the same, then the demand for early help and support would also increase.

- At the 31st March 2015 there were just under 1,000 looked after children in Liverpool, with rates increasing by 18% between March 2009 and March 2014. The rate of looked after children in the city is almost double national levels.

- The latest information indicates that around two thirds of looked after children placements are within the city, with the majority of other placements in the neighbouring local authorities of Sefton (10%), Knowsley (5%) and Wirral (5%).

- It is crucial that the voice of young people is at the centre of any strategy that seeks to improve their outcomes, and the City Council is required to take into account the views and wishes of the children within its' care when making decisions. Research clearly shows that where children and young people are involved in the development and delivery of services, provision is more likely to meet their needs and be welcomed.

1. Introduction

This report forms part of Liverpool's Joint Strategic Needs Assessment (JSNA), and focuses on safeguarding issues relating to children and young people in the city. Safeguarding children is defined as the action we take to promote the welfare of children and protect them from harm.

As part of the JSNA, the purpose of this report is to provide an overview of the health and wellbeing issues, and an evidence base to support the Liverpool Safeguarding Children Board (LSCB). Whilst the document is primarily aimed at policy makers and commissioners, it is also available to members of the public and other organisations.

2. Policy Context

2.1 National Strategic & Policy Context

2.1.1 Working Together to Safeguard Children 2015[1]

This statutory guidance was released in March 2015, to update and replace previous statutory guidance regarding safeguarding children, such as *Working together to safeguard children (2013)* and *Framework for the assessment of children in need and their families (2000*). It clarifies the core legal requirements placed on individuals and organisations to keep children safe. The guidance identified four key elements of safeguarding and promoting the welfare of children:

> "*….protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes*."

Safeguarding arrangements identified within the guidance are underpinned by two key principles that should be used in local planning, notably:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part.
- A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

2.1.2 Children Act 2004[2]

The Children Act aims to improve effective local working to safeguard and promote children's wellbeing. The Act takes a child-centred approach and includes universal as well as targeted and specialist services. Part of the aim of the integration of services, plans and information is to enable young people's needs to be identified early to allow timely and appropriate intervention before needs become more acute.

The Children Act established:

- a basis for better integrated planning, commissioning and delivery of children's services;
- clearer accountability for councils' children's services, by requiring that a Director of Children's Services is appointed and designating a lead councillor for children's services;
- a legislative basis for better sharing of information;
- statutory Local Safeguarding Children Boards to replace non-statutory Area Child Protection Committees; and
- a Children's Commissioner for England, to ensure a voice for children and young people at a national level.

Under the Act, a new duty was placed on agencies to cooperate to improve the health and wellbeing of children and young people. Wellbeing includes: physical and mental health and emotional wellbeing; protection from harm and neglect; education training and recreation; contribution to society and social and economic wellbeing.

2.2 Local Strategic & Policy Context

2.2.1 LSCB Business Plan 2014-16[3]

The Liverpool Safeguarding Children Board (LSCB) Business Plan outlines seven priorities that the Board will focus on during the three year period, 2014-16.

Priority 1: Neglect linked to: Domestic Abuse, Alcohol and Drug Use and Low Level Adult Mental Health Issues;

Priority 2: Early Help and Support for Families;

Priority 3: Child Sexual Exploitation linked to: Children Missing from Care; Children Missing from Home; Children Missing from Education; Excluded Children and Children subject to Elective Home Education;

Priority 4: Child Mental and Emotional Health (including that addressed at child and adolescent mental health services (CAMHS) Tier 2/3) Self-Harm and Attempted Suicide;

Priority 5: Children Affected by Criminality including; Children Involved in, or impacted by, Gang Crime or Serious Organised Crime; Children in Families with Known Adult Criminal Behaviour; and Young Victims of Crime;

Priority 6: Front Door, including; Multi-Agency Safeguarding Hub (MASH); Referral Pathways; Thresholds and Assessments;

Priority 7: Performance Monitoring and Management Processes including; Data Collection, Sharing, Analysis and Hypothesis Formation; Single Agency, Thematic and Multi-Agency Audit; Case Review Learning Methodology and Follow up; Embedding the Voice of the Child at all Levels.

These priorities have been developed using a wide range of evidence including: performance data; audit of children's cases; the experiences and views of children and young people and the observations and experiences of front line staff.

2.2.2 Liverpool Children & Young People's Plan (CYPP) 2013-17[4]

The Children and Young People's Plan (CYPP) is the single strategic and overarching five year plan for all services that affect children and young people across the city. It sets out how the City Council, with its strategic partners, intends to achieve improvements with specific reference to:

- The integration of services provided by partners to improve the health and wellbeing of children and young people across the city;
- Arrangements made to safeguard and promote the welfare of children and young people;
- Arrangements for early help and intervention to prevent problems from escalating or becoming entrenched.

The CYPP is focused around five key themes:

- Families at risk
- Early help / intervention
- Children in care and those leaving Care
- Children and young people with special educational needs, including those who are disabled.
- Learning and achieving

Monitoring of the plan and its objectives is undertaken by the Children's Trust Board and its sub-groups.

2.2.3 Liverpool Children & Young People's Joint Commissioning Strategy 2014-17[5]

The Joint Commissioning Strategy for Children & Young People outlines the agreed strategic commissioning arrangements for the city. The strategy covers the key life-stages for children and young people and outlines the key commissioning intentions for the three year period, 2014-17. The aim of the strategy is to create a whole-systems approach to health, social care and other welfare services, as well as the broader influences on health. Liverpool's Children's Trust Board is responsible and accountable for the performance and commissioning decisions for children.

2.2.4 Liverpool Multi-Agency Neglect Strategy 2014-16[6]

This strategy outlines the key principles under which work around neglect is undertaken in the city, and identifies key priority areas of work in order to improve Liverpool's response to neglect. Liverpool aims to ensure early recognition of neglect and improve agency responses to children and young people affected by neglect through strong and effective multi-agency leadership.

Neglect is defined in statutory guidance, Working Together to Safeguard Children[1], as:

"*…the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers);*
- *ensure access to appropriate medical care or treatment.*"

2.2.5 Liverpool's Integrated Early Help Strategy 2013[7]

The development of an effective Early Help offer is the responsibility of all partners in the city, a responsibility shared with families and their communities. The Integrated Early Help Strategy for Liverpool has strong links to other key policies and strategies in the city, and is underpinned by the Children & Young People's Plan.

The strategy has six strategic objectives:

- To identify the needs of children, young people and their families across the continuum of need.
- To understand and respond quickly to the needs of children and young people and families across the continuum of need.
- To support the refocusing of resources from crisis intervention to prevention.
- To support families to achieve their full potential and thereby mitigate the impact of issues such as child poverty and health inequalities.
- To support an action learning approach that ensures that learning and evidence informs future service design and delivery. This includes listening to what children and families have to say about what best helps them to prevent problems from occurring or escalating.
- To provide the context for multi-agency partnerships to work together to improve outcomes for children, young people and families for generations to come.

The Early Help sub-group of the Children's Trust Board and the Families Strategic Board will be the main delivery vehicles for the implementation of the strategy. The Children's Trust Board will monitor progress against the strategic objectives on a quarterly basis. The local Safeguarding Children's Board will challenge the Children's Trust Board on the effective delivery of the strategy via regular outcome indicator progress reports.

2.2.6 Liverpool's Special Educational Needs & Disabilities Strategy 2013-16[8]

There is a statutory requirement for all Local Authorities to have a current Special Educational Needs (SEN) Strategy. The SEN Strategy sets out the Local Authority's vision for SEN and the continued development of specialist educational support and educational provision. In this respect, the SEN Strategy focuses only on education but it is recognised that other services outside of education work closely with children with SEN and therefore will play a role in supporting the Strategy.

2.2.7 Liverpool Families Programme[9]

Liverpool Families Programme was established in 2012 and is Liverpool City Council's response to the Department for Communities and Local Government's initiative for working with families with complex and multiple problems.

The Outcomes Plan underpinning the Families Programme highlights a range of issues and indicators that have been identified using the DCLG national recommendations and local profiling to reflect the needs of Liverpool families. Through extensive research and analysis the following local priorities have been identified for Liverpool (in addition to the national recommendations):

- Not in Education Employment or Training (NEET)
- Mental Health
- Transitions (including school transition and transition between services based on need /age)
- Early Years

The programme aims to identify families and proactively target support through the most appropriate family intervention. In order for families to be eligible to join the programme, a minimum of two problem areas will have been identified. Families are then prioritised according to need.

2.2.8 Liverpool's Joint Health & Wellbeing Strategy 2014-17[10]

The Joint Health and Wellbeing Strategy for the city has a vision of creating a "*Fairer, Healthier, Happier Liverpool*". The strategy is the city's overarching approach to improving the health and wellbeing of children and adults, based on the Joint Strategic Needs Assessment and on-going engagement with partners and local communities. The strategy seeks to reduce health inequalities within Liverpool and relative to the rest of the country. It also recognises the needs of those people with protected characteristics who face additional challenges in society for improving their health and wellbeing, over and above their physical and emotional needs.

In responding to the issues identified within the JSNA, the strategy identifies four key health and wellbeing priorities for the city, which all partners on the Health and Wellbeing Board work towards, the first of which is to "***Give all children the best start in life***".

Children and young people are at the centre of Liverpool's future sustainability. There is strong evidence that the foundations for good health and future life chances are built early in childhood, during pregnancy, and even before a baby is conceived. Understanding the importance of key transition points where significant changes occur, such as moving from primary to secondary school, is important in developing policies and interventions that effectively improve health in early years, and give children the best start in life.

2.2.9 Cheshire & Merseyside Child Sexual Exploitation Strategy 2014-17

The Safeguarding Children Boards of Cheshire (Cheshire East, Cheshire West and Chester, Halton and Warrington) and Merseyside (Liverpool, Sefton, Knowsley, St Helens and Wirral) have identified tackling the sexual exploitation of children as a key strategic priority. Together, the LSCBs have developed a multi-agency strategy to tackle child sexual exploitation across the whole of Cheshire and Merseyside[11].

The purpose of the strategy is;

- To focus and co-ordinate multi agency resources in tackling child sexual exploitation
- To ensure that children and young people and the wider community across Cheshire and Merseyside, in particular parents and carers, are aware of child sexual exploitation and its effects
- To enhance training for professionals
- To bring to justice the perpetrators of child sexual exploitation and to ensure that young people are properly safeguarded in the course of any criminal proceedings

2.2.10 Liverpool City Region Child Poverty & Life Chances Commission

The Liverpool City Region Child Poverty and Life Chances Commission first met in 2011, with the purpose of advising the City Region Cabinet on approaches to tackle poverty and making recommendations for action. The Commission is chaired by Frank Field MP, and includes representation from local councillors, academics, and representatives from the voluntary, community, public and private sectors.

The Commission is in the process of developing a revised Child Poverty and Life Chances Strategy for 2015-18, building on previous work. The Commission is maintaining its' long term vision that:

"*Working together as City Region partners we will reduce child and family poverty and maximize opportunities for children and young people in their life chances.*

***We will achieve this through a dual strategy which ensures an ever growing proportion of children and young people are ready for school and life whilst maximising family resources*."**

The revised strategy focuses on two key aims, with five specific priority areas that underpin these. The broad actions contained within the City Region Strategy are designed to be reflected in strategies and plans at the local level.

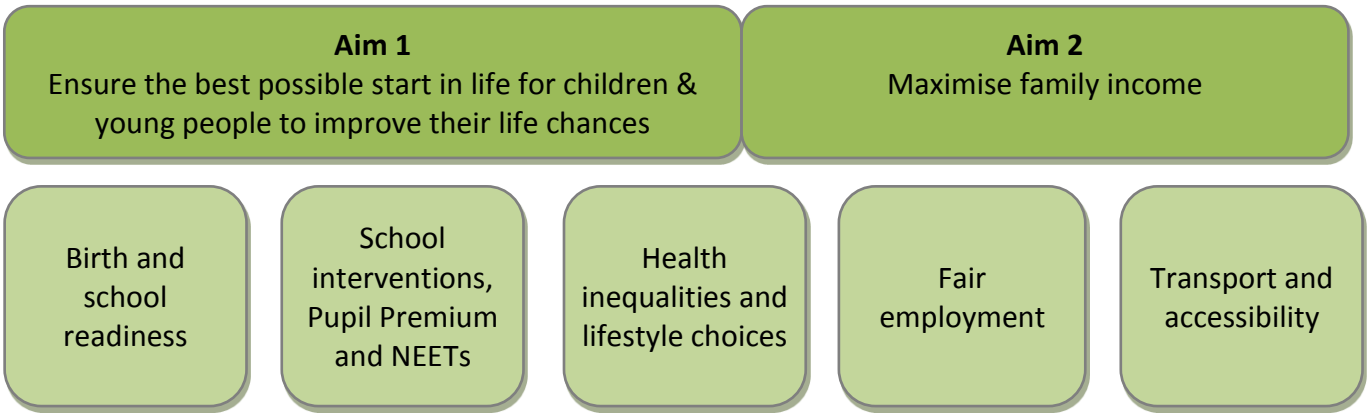


Figure 1: Liverpool City Region Child Poverty and Life Chances priorities 2015-18
Source: Liverpool City Region Child Poverty and Life Chances Strategy 2015-18 refresh

2.2.12 Healthy Liverpool – Prospectus for Change

Liverpool Clinical Commissioning Group (CCG) has set out its vision for a new health and social care system for the city in their Healthy Liverpool Programme. The programme is designed to respond to the challenge of an ageing population and the rise in long term conditions. By 2020 the CCG aim to ensure that all people in Liverpool will be 'enjoying longer, healthier lives', with care delivered closer to home. Within the plan there are a number of transformational programmes that aim to transform the health and social care services in the city, of which children is one.

The Children's Programme aims to develop a holistic, family based model of care, addressing the needs of the family as a whole, rather than just the individual child. This will involve a coordinated, multi-agency approach with prevention and early intervention being key components.

One of the key initiatives that will enable the identification of children with health and care needs is through the establishment of a common assessment framework so that all public service professionals in the city – including health, social services, police, fire and education professionals – are using the same criteria and tool to assess a child's potential needs. The 'Early Help Assessment Tool' (EHAT) was launched across the city in October 2014. This initiative, alongside the development of the early help locality hubs in January 2015, will support earlier intervention[12].

2.2.13 Reducing Domestic Violence and Abuse: Merseyside Partnership Strategy

Domestic violence and abuse is a priority of the Merseyside Criminal Justice Board (MCJB). The Board is currently in the process of revising its strategy for reducing domestic violence and abuse, which will cover all five boroughs across the sub-region and bring together non-criminal justice agencies to build a partnership approach across all sectors.

The draft aims of the strategy are to provide a framework for both statutory and voluntary agencies to work together in order to:

- Focus and co-ordinate multi-agency resources to identify domestic violence and abuse and reduce prevalence through preventative interventions.
- Provide consistent and effective support for victims with standardised risk assessment tools and a minimum threshold for access to statutory services.
- Tackle the perpetrators of domestic violence and abuse and reduce repeat incidents through monitoring, education, support and criminal justice interventions.
- Raise awareness of domestic violence and abuse as an issue for both males and females of any age, religion, belief, race, sexual orientation or disability.

3. Children & Young People in Liverpool

3.1 Demographics

3.1.1 Births

In 2013 there were 5,676 live births in Liverpool. This represents an increase of over a fifth since 2002. While the number of births in the city is increasing, fertility rates remain below national levels. The total period fertility rate (TPFR) measures the average number of children which would be born to a woman if they experienced the same age specific fertility rates throughout her life. Figures for Liverpool show the TPFR in 2013 was 1.56 – a rate considered below replacement level of 2.1.

3.1.2 Population

Population estimates for 2014 indicate that the population of Liverpool is continuing to grow, with 473,070 people now living in the city, up from 470,780 people in 2013. The Office for National Statistics estimates that there are just over 89,900 children and young people in Liverpool and this is projected to grow by a further 5.4% over the next decade. This would equate to an additional 4,870 children and young people by 2024. Projections indicate the growth will be particularly substantial among the 8 to 13 age groups.

Age	2014			2024			Percentage Change		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0	2,960	2,838	5,798	2,945	2,810	5,755	-0.5%	-1.0%	-0.7%
1	2,885	2,771	5,656	2,917	2,774	5,691	1.1%	0.1%	0.6%
2	2,997	2,998	5,995	2,881	2,736	5,617	-3.9%	-8.7%	-6.3%
3	2,868	2,581	5,449	2,854	2,716	5,570	-0.5%	5.2%	2.2%
4	2,654	2,491	5,145	2,824	2,690	5,514	6.4%	8.0%	7.2%
5	2,687	2,578	5,265	2,793	2,670	5,462	3.9%	3.6%	3.7%
6	2,592	2,526	5,118	2,758	2,642	5,400	6.4%	4.6%	5.5%
7	2,581	2,464	5,045	2,745	2,617	5,363	6.4%	6.2%	6.3%
8	2,431	2,292	4,723	2,722	2,601	5,323	12.0%	13.5%	12.7%
9	2,304	2,176	4,480	2,692	2,564	5,256	16.9%	17.8%	17.3%
10	2,216	2,162	4,378	2,663	2,543	5,207	20.2%	17.6%	18.9%
11	2,200	2,208	4,408	2,612	2,497	5,109	18.7%	13.1%	15.9%
12	2,150	2,108	4,258	2,652	2,613	5,265	23.3%	24.0%	23.6%
13	2,283	2,191	4,474	2,610	2,396	5,007	14.3%	9.4%	11.9%
14	2,323	2,302	4,625	2,451	2,331	4,782	5.5%	1.3%	3.4%
15	2,425	2,463	4,888	2,468	2,376	4,844	1.8%	-3.5%	-0.9%
16	2,469	2,425	4,894	2,433	2,395	4,828	-1.5%	-1.2%	-1.4%
17	2,693	2,610	5,303	2,449	2,332	4,782	-9.0%	-10.6%	-9.8%
Under 18	**45,718**	**44,184**	**89,902**	**48,470**	**46,304**	**94,774**	**6.0%**	**4.8%**	**5.4%**

Table 1: Mid-Year Resident Population Estimates for Children & Young People in Liverpool
Source: ONS Mid-Year Resident Population Estimates 2014 & SNPP 2012

3.1.3 Ethnicity

Our local population is becoming increasingly diverse. At the time of the 2001 Census, just under 93% of people in Liverpool identified themselves as being "White - English/Welsh/Scottish/Northern Irish/British". However, by the time of the 2011 Census this had decreased to 84.8%, with around 1 in 7 of the Liverpool population now classing themselves as part of a minority ethnic group, equating to almost 71,000 residents. The ethnic diversity of children and young people in the city is slightly higher than for the overall population, standing at 18.3%. The largest minority groups among those aged under 18 are:

- Black African (2.8%)
- Arab (2.1%)
- White Other (2.1%)
- Mixed - White & Black Caribbean (1.3%)
- Mixed - White & Black African (1.3%)

Ethnic Group	General Population		Under 18's	
	Number	Percentage	Number	Percentage
Total Population	**466,415**	**100.0%**	**88,911**	**100.0%**
White: Total	**414,671**	**88.9%**	**74,856**	**84.2%**
White: English/Welsh/Scottish/Northern Irish/British	*395,485*	*84.8%*	*72,622*	*81.7%*
White: Irish	*6,729*	*1.4%*	*315*	*0.4%*
White: Gypsy or Irish Traveller	*185*	*0.0%*	*40*	*0.0%*
White: Other White	*12,272*	*2.6%*	*1,879*	*2.1%*
Mixed/multiple ethnic group: Total	**11,756**	**2.5%**	**4,138**	**4.7%**
Mixed/multiple ethnic group: White and Black Caribbean	*3,473*	*0.7%*	*1,141*	*1.3%*
Mixed/multiple ethnic group: White and Black African	*3,164*	*0.7%*	*1,173*	*1.3%*
Mixed/multiple ethnic group: White and Asian	*2,283*	*0.5%*	*777*	*0.9%*
Mixed/multiple ethnic group: Other Mixed	*2,836*	*0.6%*	*1,047*	*1.2%*
Asian/Asian British: Total	**19,403**	**4.2%**	**3,765**	**4.2%**
Asian/Asian British: Indian	*4,915*	*1.1%*	*1,089*	*1.2%*
Asian/Asian British: Pakistani	*1,999*	*0.4%*	*483*	*0.5%*
Asian/Asian British: Bangladeshi	*1,075*	*0.2%*	*363*	*0.4%*
Asian/Asian British: Chinese	*7,978*	*1.7%*	*1,043*	*1.2%*
Asian/Asian British: Other Asian	*3,436*	*0.7%*	*787*	*0.9%*
Black/African/Caribbean/Black British: Total	**12,308**	**2.6%**	**3,689**	**4.1%**
Black/African/Caribbean/Black British: African	*8,490*	*1.8%*	*2,521*	*2.8%*
Black/African/Caribbean/Black British: Caribbean	*1,467*	*0.3%*	*202*	*0.2%*
Black/African/Caribbean/Black British: Other Black	*2,351*	*0.5%*	*966*	*1.1%*
Other ethnic group: Total	**8,277**	**1.8%**	**2,463**	**2.8%**
Other ethnic group: Arab	*5,629*	*1.2%*	*1,849*	*2.1%*
Other ethnic group: Any other ethnic group	*2,648*	*0.6%*	*614*	*0.7%*
Total minority population	**70,930**	**15.2%**	**16,289**	**18.3%**

Table 2: Ethnic diversity among children & young people in Liverpool
Source: 2011 Census

3.2 Deprivation & Poverty

3.2.1 Indices of Deprivation

The English Indices of Deprivation 2015 (IMD 2015) combine a range of economic, social and housing indicators to provide the most up to date and comprehensive picture of deprivation in England. They provide a measure of relative deprivation, i.e. they measure the position of areas against each other.

The table below shows the ranking for each Local Authority in the Liverpool City Region for each of the seven domains, in addition to the two sub-domains on income. Results show that Liverpool remains one of the most deprived local authorities in the country, and the City Region is ranked as the most deprived Local Enterprise Partnership areas in England.

Domain	Liverpool	Halton	Knowsley	Sefton	St Helens	Wirral	Liverpool City Region
Overall IMD	**7**	**36**	**5**	**102**	**52**	**106**	**1**
Income	9	51	5	74	50	78	2
Employment	10	28	1	40	18	42	1
Health and Disability	4	17	3	37	13	32	1
Education, Skills and Training	46	83	7	172	127	191	7
Barriers to Housing and Services	291	220	260	323	286	319	38
Crime	46	61	96	154	111	178	7
Living Environment	23	136	106	111	128	115	7
Income Deprivation Affecting Children	14	47	19	115	59	98	2
Income Deprivation Affecting Older People	10	62	8	82	80	100	2

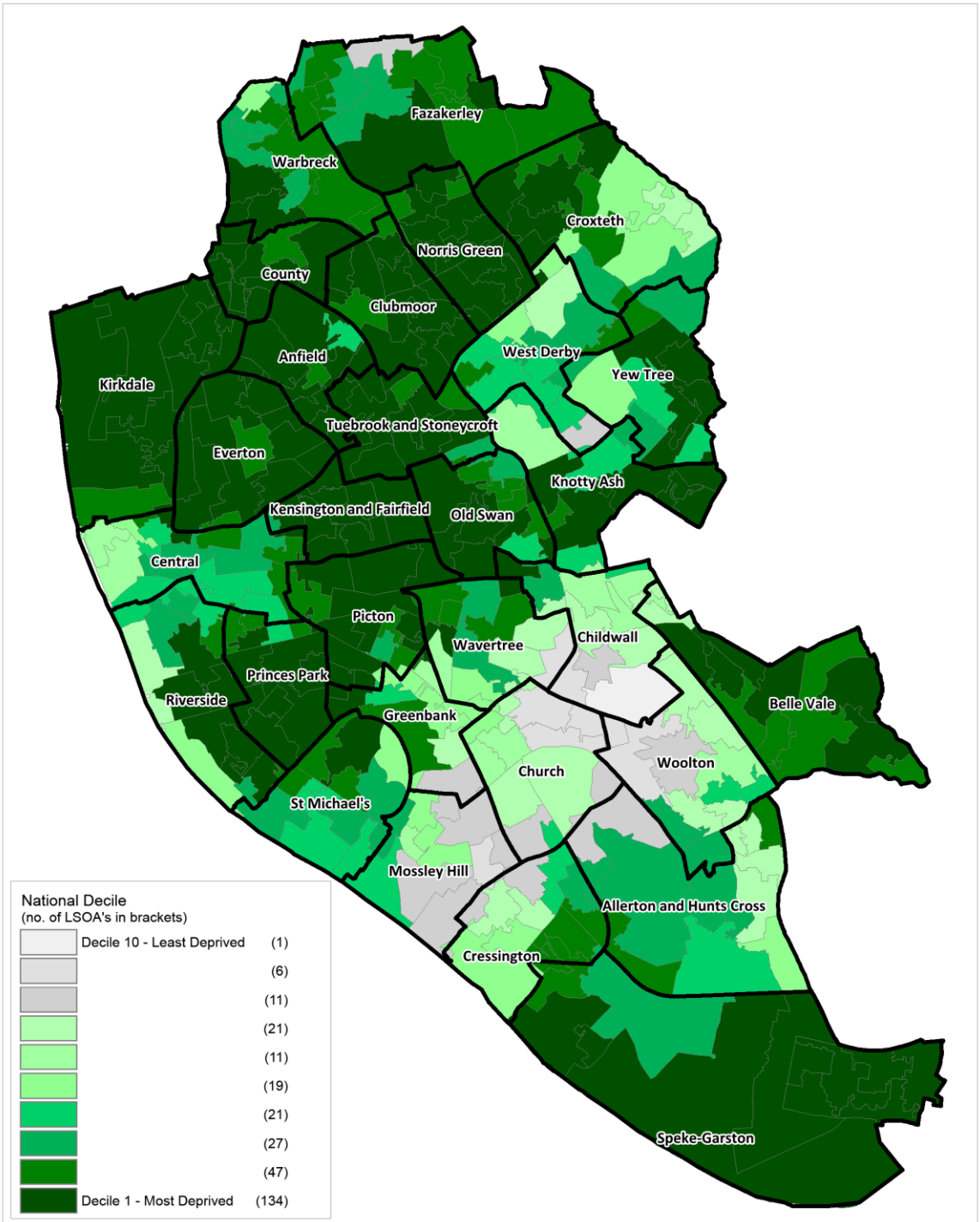
Table 3: Local Authority Rank of Ranks
Source: Indices of Deprivation 2015
Note: Local Authority ranks: 1 = most deprived, 326 = least deprived, Local Enterprise Partnership ranks: 1 = most deprived, 39 = least deprived

A substantial proportion of our local residents live in areas of high deprivation. The table opposite indicates that almost 45% of our population live within communities ranked within the 10% most deprived in England. This compares to less than a third for the Liverpool City Region as a whole. At the other end of the deprivation spectrum, less than 1% of local residents live in communities ranked as the least deprived in England. The severity and extent of deprivation in the city has significant implications for the health and wellbeing of local people, and is strongly associated with poor health outcomes from childhood through to old age.

Area	Liverpool	Halton	Knowsley	Sefton	St. Helens	Wirral	Liverpool City Region
Most Deprived 10%	44.7%	25.5%	44.4%	19.3%	23.4%	21.3%	31.0%
Decile 2	15.8%	23.0%	16.1%	7.7%	16.6%	9.3%	13.7%
Decile 3	9.6%	8.1%	5.7%	8.0%	9.0%	9.8%	8.8%
Decile 4	7.5%	5.3%	5.9%	6.3%	9.7%	8.3%	7.4%
Decile 5	6.4%	4.5%	13.8%	13.0%	9.2%	5.7%	8.3%
Decile 6	3.6%	6.9%	7.9%	15.7%	5.9%	7.6%	7.6%
Decile 7	6.5%	6.8%	4.5%	8.4%	8.0%	11.6%	7.9%
Decile 8	3.7%	9.3%	1.8%	8.0%	8.3%	10.0%	6.6%
Decile 9	1.9%	10.8%	0.0%	8.3%	7.7%	8.1%	5.6%
Least Deprived 10%	0.4%	0.0%	0.0%	5.2%	2.2%	8.2%	3.1%

Table 4: Local population by national deprivation decile
Source: Indices of Deprivation 2015 and ONS LSOA population estimated 2013

The map opposite shows that levels of deprivation within Liverpool are particularly high in the north of the city, where virtually all of the neighbourhoods are ranked in the most deprived one or ten percent nationally. The map below shows that large areas of Everton, Anfield and Kirkdale are particularly deprived. This concentration of high deprivation also encircles the City Centre, this “inner core” area goes from Everton in the north through Kensington and on to Princes Park and Riverside to the south of the City Centre. Outside of the inner core, Speke Garston, Belle Vale, Croxteth and Norris Green also have some of the highest levels of deprivation in the country.



Index of Deprivation 2015 - Overall Index National Rank Deciles (Decile 1 = Most deprived)

Date created: 21/10/2015

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Liverpool City Council

3.2.2 Child Poverty

Broadly speaking, child poverty means growing up in a household with low income. On average throughout the UK, nearly one in six (15.9%) children are classified as below the poverty line before housing costs, while one in four (25.1%) are in poverty once housing costs have been deducted from their household's income. Extensive research and data show that children who grow up in poverty face a greater risk of having poor health, being exposed to crime and failing to reach their full potential.

Figures for 2013 indicate that around a third of children in Liverpool live in poverty, equating to 25,530 children. Child poverty levels in the city are the 4th highest amongst the core cities in England, and significantly above the national rate[13].

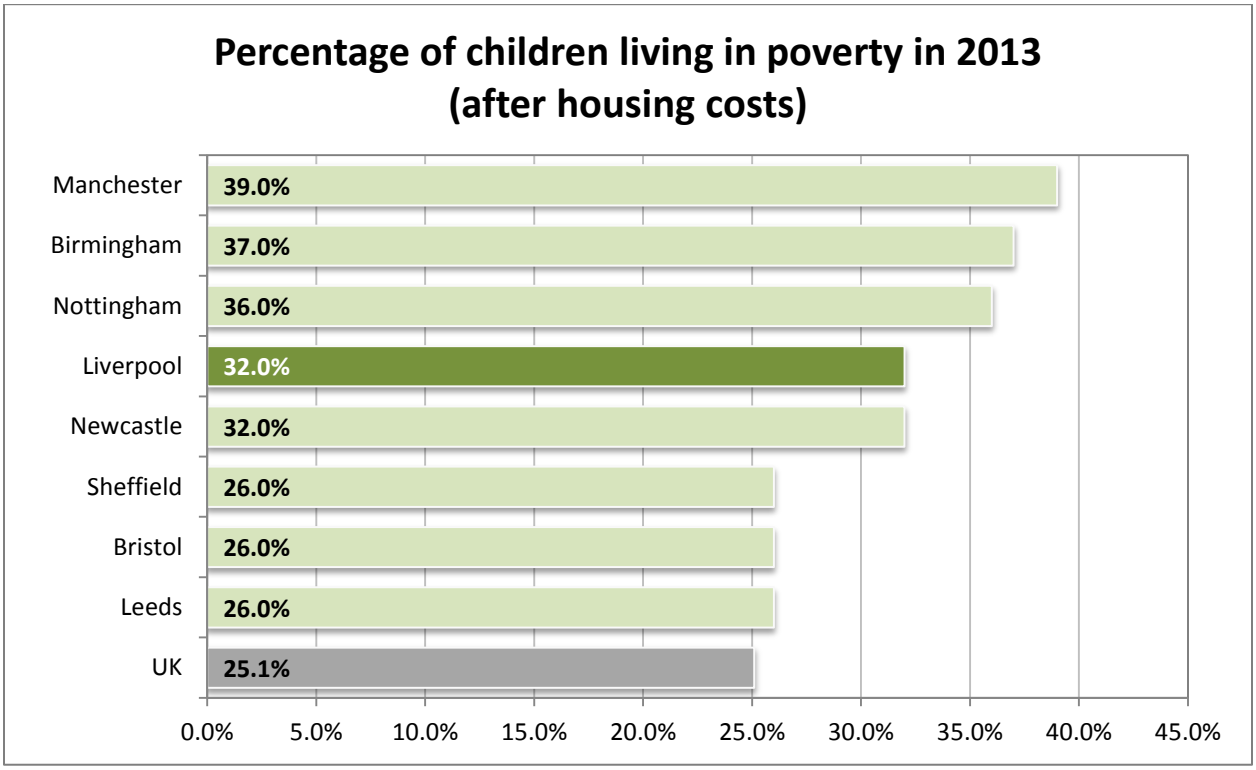


Figure 2: Child Poverty among the Core Cities in England, 2013
Source: Child Poverty Action Group

Within the city there is a large variation in the extent of child poverty, ranging from almost 1 in 2 children in Princes Park ward, to around 1 in 10 children living in Woolton ward.

4. Safeguarding Risks

A wide range of factors can influence the level of risk to the health and welfare of a child, and these often exist in combination with each other, rather than in isolation, magnifying the impact on the child.

The following section of this report outlines some of the key adverse childhood experiences and safeguarding risks and how they affect children in the city, from parental factors through to behaviours of children and young people.

4.1 Compromised Ability to Care

Issues such as domestic abuse, parental mental ill-health, and parental substance misuse are all known to increase the likelihood of children experiencing emotional abuse and neglect, particularly when they appear in combination[1].

4.1.1 Domestic Abuse

Domestic abuse is a significant public health issue, having a major impact not only upon the individuals directly targeted, but also their families. Domestic abuse is defined as; "*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality*"[14].

This encompasses, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Domestic abuse has significant short and long term impacts on survivors, and their children. This includes physical injuries, disfigurement, miscarriage, loss of hearing or vision, severe mental health and behavioural issues, and economic problems. Survivors are more likely to be diagnosed with depression or psychosis, suffer post-traumatic stress disorders, self-harm and it is one of the strongest risk factors for suicide attempts.

Domestic violence and abuse between parents is the most frequently reported form of trauma for children[15]. In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months[16]. In 2002, the Department of Health estimated that nearly

three-quarters of children were on the "at risk" register living in households where domestic violence occurred and 52% of child protection cases involved domestic violence.

There is no actual offence of domestic abuse although it is recorded as a contributory factor to an offence. In 2014/15, there were 2,857 domestic abuse related crimes recorded by Merseyside Police, which was a 32% increase on the previous year's figure (2,167 incidents). According to Merseyside Police data, approximately 4% of all recorded crimes in Liverpool were 'domestic related' offences. The majority (78%) of recorded domestic abuse crimes were related to violence, with some 64% related to Actual Bodily Harm and Common Assault and 4% of crimes were serious violence (Murder, Attempted Murder, GBH and Wounding).

Multi-Agency Risk Assessment Conference (MARAC)

Police recorded crime figures are not the only ways of monitoring levels of domestic abuse. Cases that are sent to a local Multi-Agency Risk Assessment Conference (MARAC) can also be analysed. MARACs were designed as a multi- agency case management process to look at high risk cases of reported domestic violence. In Liverpool, each referral is assessed using the Merseyside Risk Indicator Tool which was rolled out in January 2009 and is the single risk indicator for all services. MARACs are held in both North and South Liverpool on a monthly basis and are designed to deliver complex solutions for survivors.

Between September 2012 and August 2013, 1,180 cases were reviewed at a MARAC in Liverpool, which represented a 2% increase compared with the previous 12 months. These cases involved 1,895 children, with 69% of all cases reviewed at MARAC being referred from within Liverpool North. There were 243 repeat cases in this reporting period which equated to just over a fifth of all cases dealt with. This was an increase on the previous 12 months where 18% of cases dealt with were repeats. For a case to be graded as a repeat, a number of factors have to be in place. The case has to have been seen at the MARAC in the past 12 months and must involve either;

- Violence or threats of violence; and/or
- A pattern of stalking or harassment (the repeated following of, communication with, or other intrusions on the privacy of, a survivor) and/or
- Where rape or sexual abuse is disclosed.

The majority of the referrals to MARAC come from the police (82%), although there are referrals from a significant number of other agencies including the Independent Domestic Violence Adviser (IDVA) Service, the voluntary sector, Clinical Commissioning Groups, the Probation Service and Housing Agencies.

Latest figures for September 2013 to August 2014 show that there has been a 25% reduction in the number cases reviewed at the MARAC when compared with the previous 12 months.

4.1.2 Parental Mental Health

In 2011, the Royal College of Psychiatrists released a report that estimated between 10% and 15% of children in the UK live with parents who have a mental health disorder[17]. The most common conditions are depression and anxiety. The existence of a mental health disorder in a parent can have an impact on the needs of a child in a variety of ways and is strongly associated with poor outcomes in children.

Research by the Social Care Institute for Excellence has outlined the extent of the impact of more severe parental mental ill health on dependents:

- Children of mothers with mental health problems are up to twice as likely to develop emotional disorders.
- Parental mental ill health is a factor in a third of serious case reviews in children's services.
- Up to two thirds of children whose parents have mental health problems will experience mental health difficulties themselves.
- Nearly a third of young carers are estimated to care for a parent with a mental health problem, and are the group least likely to be offered a carer's assessment.

The research by the Social Care Institute for Excellence (SCIE) found that mothers were at higher risk of mental health problems than fathers, and there was some evidence to indicate that younger mothers were more at risk than older mothers. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth[18].

However, it is also important to remember that not all children of parents who experience mental ill-health are at risk and that in any family there may be protective factors at work[14]. Parental mental ill-health is less likely to have an adverse effect on children if it is mild, short lived or not related to family disharmony.

Perinatal Mental Health

Maternal mental health problems in the perinatal period are those that occur or develop during pregnancy or within the first year after childbirth. In 2013, the NSPCC published "Prevention in mind", which examined perinatal mental health in England. They found that perinatal mental ill health (most commonly depression, but also anxiety, and postnatal psychotic disorders) affect at least 10% of women. As a minimum, this would equate to between 500 and 600 women each year in Liverpool. Research indicates that the prevalence of depression among women

increases during the antenatal period, rising from 7.4% in the first trimester, 11.4 to 12.8% in the second trimester and 13.1 to 14.8% in the third[19].

Depression suffered by the mother increases the likelihood that:

- the baby will be premature or have a low birthweight;
- the baby may not develop a secure attachment relationship with the mother;
- the child will experience behavioural, social or learning difficulties and
- the child faces higher risk of depression in adolescence.

In extreme cases, parental mental ill health increase the risk that the child will be abused or neglected. Early identification, support and treatment can prevent the onset and escalation of perinatal mental ill health, or can help to prevent the effect on the family, to improve the wellbeing, health and achievement of the children[20].

Postpartum Depression (PPD) in Fathers

Postpartum depression in men is a significant issue, and research indicates this is closely correlated to levels of maternal postpartum depression i.e. fathers are more likely to experience depression after child birth if the mother does. Evidence regarding the extent of postpartum depression in fathers is scarce, however it is estimated that around 10% of new fathers experience some form of depression[21]. Risk factors for postpartum depression in fathers include:

- Maternal depression – half of fathers suffering PPD live with partners with maternal postnatal depression[22]
- Previous history of mental health problems
- Income – unemployment, an unstable source of income and low levels of income are all associated with PPD
- Poor social networks
- Poor marital relationship
- Unintended pregnancy

4.1.3 Parental Substance Misuse

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings. Parental substance misuse has been found to feature in 25% of serious case reviews[23].

Roughly one in three adults being treated for substance misuse has a child living with them at least some of the time, and data indicates that parents in treatment have similar outcomes to

the rest of the treatment population. While seeking help and support can be a significant protective factor, some children may be at risk of neglect, and in a minority of cases serious harm[15].

The data below shows the number of adults in alcohol and drug treatment services who live with children; users who are parents but do not live with children; and users for whom there is incomplete data. This last item is included to allow commissioners to consider the possible hidden population(s) of drug-dependent parents, or those with childcare responsibilities in contact with local treatment services.

Figures indicate that while the parental status of Liverpool adults accessing drug treatment services is comparable to national levels, the profile of adults in alcohol treatment is substantially different. Far fewer adults in Liverpool using alcohol treatment services are parents compared to the national average (21%, compared to 27%).

Parental Status	Drug Treatment			Alcohol Treatment		
	Liverpool		England	Liverpool		England
	N	%		N	%	
Living with children (own or other)	1,473	33%	32%	354	21%	27%
Parents not living with children	1,159	26%	24%	496	29%	27%
Not a parent / no child contact	1,825	40%	43%	870	50%	44%
Incomplete data	64	1%	2%	3	0%	2%

Table 5: Parental status of adults in drug and alcohol treatment services
Source: PHE JSNA Support Packs 2015-16

Over the past decade there have been substantial improvements in recognising and supporting the needs of children who live with parental substance misuse. However in 2012, the Office of the Children's Commissioner identified three major limitations to progress[24]:

- Greater emphasis has so far been placed on children identified as 'at risk', or who are known to children's services, with much less attention paid to the larger cohort of children that may require support but who are unknown to services.
- While a much larger number of children experience parental alcohol abuse, this is often hidden within a wider drugs agenda.

- While alcohol problems often co-exist with other issues, such as domestic violence and mental health disorders, opportunities are often missed for different policy areas to form an integrated response to support children and their families where there is parental substance misuse.

Public Health England released guidance in 2013 to support the development of local joint protocols between drug and alcohol services and children and family services. The purpose of having a local protocol is to safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by substance misusing parents or carers. The protocols should also promote effective communication between adult drug and alcohol services and children and family services, and to set out good working practice for the services involved[15].

4.1.4 Cumulative Risk

Research published in 2009 showed the cumulative risk of harm based on the National Psychiatric Morbidity Survey (NPMS). This indicated that 3.6% of children in the UK lived with an adult problem drinker (AUDIT score greater than 8) who had also used drugs in the previous year. The research also indicated a greater risk of harm exists for around 1% of children who live with an adult problem drinker who also used drugs and had concurrent mental health problems[25].

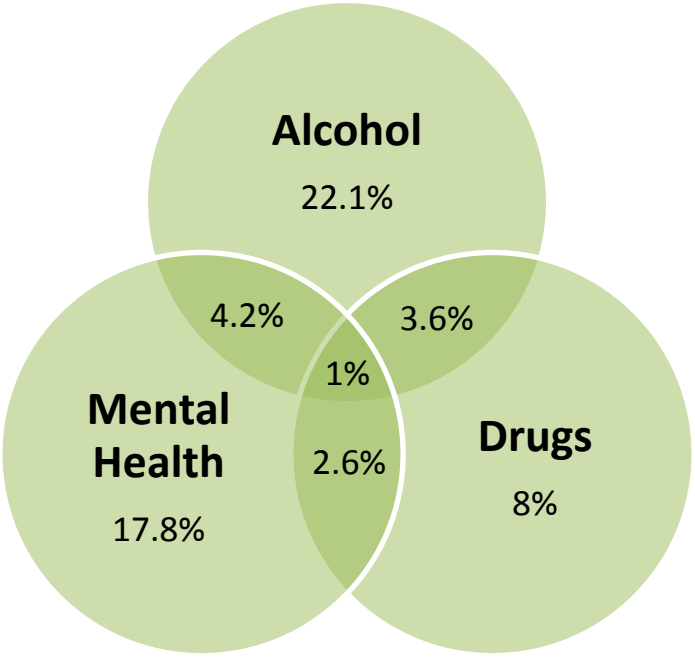


Figure 3: Cumulative risk of harm to children under-16
Source: Manning V; Best D.W; Faulkner N. & Titherington E (2009)

Children living within households where there are multiple risk factors are a particular concern as co-morbidities are associated with less effective treatment and additional difficulties in parenting[14]. Applying this research to our local population estimates suggests almost 850 children in the city may live in such situations. It should be noted that there are limitations to extrapolating local prevalence from national research. These figures are likely to underestimate the true extent of the issue locally.

4.1.5 Young Carers

A young carer is a child or young person under the age of 18 that provides care to another family member usually an adult, who has a physical illness/disability; mental ill health; sensory disability; has problematic use of drugs or alcohol or is HIV positive. The level of care they provide would usually be undertaken by an adult and as a result of this has a significant impact on their normal childhood.

In its report, Hidden from View[26], the Children's Society highlights that:

- One in 12 young carers is caring for more than 15 hours per week.
- Around one in 20 misses school because of their caring responsibilities.
- Young carers are 1.5 times more likely than their peers to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language.
- Young carers are 1.5 times more likely than their peers to have a special educational need or a disability.
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer.
- There is no strong evidence that young carers are more likely than their peers to come into contact with support agencies, despite government recognition that this needs to happen.
- Young carers have significantly lower educational attainment at GCSE level, the equivalent to nine grades lower overall than their peers e.g. the difference between nine B's and nine C's.
- Young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19.

Results from the 2011 Census show that over 5,100 people in Liverpool aged under-25 identified themselves as providing unpaid care, equating to 3.5% of that group. 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 both national and regional levels.

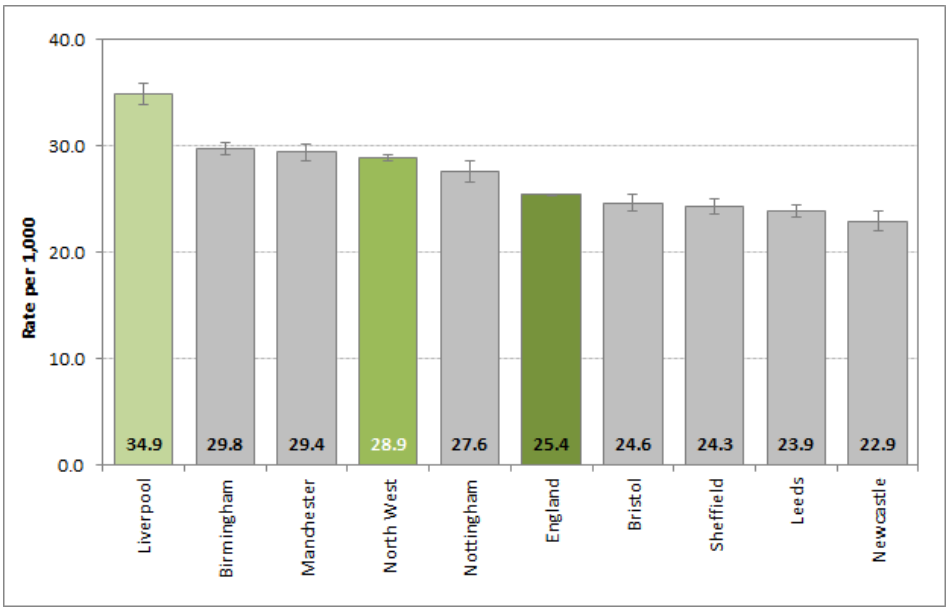


Figure 4: Provision of unpaid care by those aged under-25 among England's Core Cities
Source: 2011 Census

A young carer becomes vulnerable when the level of care and responsibility becomes too great or inappropriate. This can negatively impact on his or her emotional and physical health, along with their future life chances. Results from the Census show that of those young people in Liverpool providing unpaid care, 30% do so for more than 20 hours each week, compared to 25% in England as a whole.

Local information shows that the primary illness or disability of the person being cared for was mental illness, mirroring the national pattern. Mental ill-health was also a factor identified in caring for people with drug & alcohol issues and physical disabilities.

Figures from the Census show that provision of unpaid care is highest in the north of the city. Levels are particularly high in Kirkdale, Everton and County wards, where over 4.5% of young people are providing unpaid care. In these three communities alone, 640 young people stated they were unpaid carers.

In order to maintain and improve health and wellbeing, it is important to identify young carers early. Further work is required locally to improve identification and the quality of data that is available, with opportunities available via the school census. Fundamental to supporting young carers is access to a quality Carers Assessment and Support Plan, that recognises and values the caring role and contribution they make. The Plan should identify the outcomes that each young carer needs to meet to enable them to learn, develop and enjoy a positive childhood.

4.1.6 Child Deaths

Child Death Overview Panels (CDOPs) are a statutory requirement, set out in Chapter 5 of Working Together to Safeguard Children[1]. Their role involves analysing any deaths occurring in children aged from newborn up to eighteen years old, to help identify any modifiable factors that could represent areas for improvement with the aim of avoiding preventable child deaths occurring in the future.

In reviewing the death of each child, the CDOP considers a number of factors, including:

- Factors intrinsic to the child - e.g. health issues, life limiting conditions
- Factors related to care or parenting
- Factors in the environment - e.g. hazards, road safety limits
- The delivery of services - e.g. delayed medical response

The Merseyside CDOP formed in April 2011, and covers Liverpool, St. Helens, Sefton and Wirral. Each year the CDOP produce a report summarising findings of child deaths that have taken place across the area, and relevant issues are referred to the appropriate Local Safeguarding Children's Board / agency as required.

During the period 1st April 2014 to 31st March 2015, 88 child deaths were notified to the Merseyside CDOP across the five LSCB areas, with the number relatively stable over the past 5 years. There were 38 notifications from Liverpool during the year, and the city has the highest rate amongst the Merseyside Local Authorities. Around half of child deaths in the city occur within the first 28days of life, slightly more than the rest of the region.

A number of issues have been identified within the 2014-15 report:

Unsafe Sleeping Practices

Deaths associated with co-sleeping/unsafe sleeping practices continue to be disproportionately represented in the annual figures. For 2014-15, all of the 11 deaths that fell into the 'Sudden unexpected, unexplained death' category were associated with co-sleeping/unsafe sleeping practices. This remains a key focus for the Merseyside panel.

Domestic Abuse

Domestic abuse continues to be fairly regularly associated with deaths to neonates. This has also been highlighted in previous reports. From the 88 child deaths categorised in 2014-15, 37 (42%) had domestic abuse as a feature within the case history. This figure may not be a true

reflection of the incidence, given the lack of adult male information available as checks cannot be pursued.

Domestic abuse is always recorded by the panel within the final categorisation template. However, it is virtually impossible to ever link this directly to the death of the baby owing to uncertainty regarding precise timelines, direct causation etc.

Deprivation

Deaths to children from areas of relative deprivation continue to be higher than those from less deprived areas. This has been consistent over time and reinforces the need to focus greater preventative activity in 'poorer' areas.

Neonatal Deaths

Deaths to babies under 1 month old consistently make up around 30% of the total deaths to under 18s across Merseyside. In the absence of clear-cut clinical conditions where the death of the baby was expected/inevitable, such cases are often associated with a complex family background of instability, domestic violence, unhealthy lifestyles, income deprivation etc.

4.1.7 Female Genital Mutilation

Female Genital Mutilation (FGM) is a serious form of child abuse and violence against women and girls, and a violation of human rights. It has been illegal in this country since 1985 and Local Authorities have a statutory duty to safeguard children and protect and promote the welfare of all women and girls[27].

Female Genital Mutilation (FGM) is defined by the World Health Organisation as "***all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons***." There are four different types of FGM that have been identified by the WHO:

- **Type 1:** Clitoridectomy – Partial or total removal of the clitoris and/or prepuce
- **Type 2:** Excision – Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora
- **Type 3:** Infibulation – Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris
- **Type 4:** All other harmful procedures to female genitalia for non-medical purposes - for example pricking, piercing, incising, scraping and cauterisation

FGM can take place for a variety of reasons, and is often seen as a cultural custom. It can also be seen as a rite of passage in some communities, preparing a girl for adulthood and marriage. Research by *Equality Now* suggests that up to 60,000 women and girls in the UK may be at risk from FGM, with 125,000 already living with the consequences.

FGM can have serious short and long term consequences for women and girls, emotional and psychologically as well as physically. These can include severe pain, infections, damage to other body organs, complications during child birth, depression and post-traumatic stress. In the most severe cases FGM can also result in death.

In 2014, the Government identified a number of risk factors that are associated with FGM with the release of multi-agency practice guidelines[28]

Alongside information about a child's community or country of origin, there are a number of factors that can also be used to determine a child's potential level of risk:

- Communities traditionally affected by FGM and who are less integrated into the UK may be at greater risk of carrying out FGM
- If a child's mother has undergone FGM, then any of her female children could also be risk
- Any child with an older sibling who has had FGM can be considered at risk of the practice
- A child who is withdrawn from personal, social and health education or personal and social education could be at risk as parents may wish to keep her uninformed about the procedure and her rights.

Professionals should also be aware of a number of other risk factors that can indicate that FGM may be about to happen, including:

- Children may talk of having a long holiday to their country of origin where the practice is prevalent, children talk of undergoing a "special procedure" or having a ceremony to "become a woman"
- Parents state that a relative may be taking the child out of the country for an extended visit
- A child may confide in a teacher or another person if she is at immediate risk
- A professional may hear a reference to FGM in children's conversation
- Families may perform FGM when a senior female family member is in the country, particularly if she is visiting from their country of origin.

Source: Multi-Agency Practice Guidelines: Female Genital Mutilation, HM Government 2014
www.gov.uk/government/publications/female-genital-mutilation-guidelines

At the time of the 2011 Census, around 2.5% of the Liverpool population were born in countries with a high prevalence of FGM, equating to over 11,800 people. The most common country of origin was Nigeria (1,951), followed by Somalia (1,249).

The Government has introduced a mandatory requirement for NHS professionals to record incidences of FGM, and all Acute Trusts provide a monthly return to the Health & Social Care Information Centre. The latest figures from the HSCIC indicate that between September 2014 and March 2015 almost 4,000 new cases of FGM were reported nationally, with 60 cases being under the age of 18. Locally, there has been a rise in the number of active caseloads of FGM at Liverpool Women's Hospital since September 2014, though this may relate to improved recording. By March 2015 there were 54 active caseloads of female genital mutilation at the hospital i.e.: women and girls being actively seen/treated for FGM-related conditions.

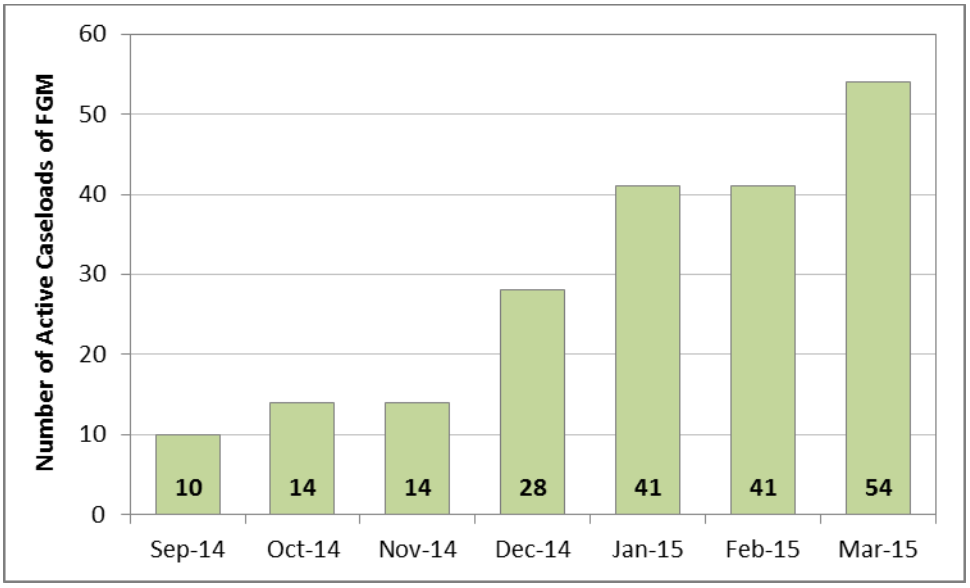


Figure 5: Total number of active caseloads of FGM in Liverpool Women's Hospital
Source: Health & Social Care Information Centre

From summer 2015 the Department of Health are introducing a system that allows a clinician to record on a child's healthcare record that she is potentially at risk of FGM at some point in her childhood/lifetime. This information will be accessible to all healthcare professionals throughout childhood, highlighting that they need to consider the potential risk of FGM as and when they provide care, as well as whether they need to take any action in this regard. The system will be available via the NHS Summary Care Record application[29].

4.1.8 Child Sexual Exploitation

Child Sexual Exploitation (CSE) is child abuse, and children and young people who are targeted face huge risks to their physical, emotional and psychological health and wellbeing. Liverpool has adopted the definition of sexual exploitation that is set out in Safeguarding Children and Young People from Sexual Exploitation, Supplementary Guidance to Working Together to Safeguard Children (2009).

"***Child Sexual Exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, sexual act or activities….***

In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence and coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability." [30]

In 2011, the Inquiry into Child Sexual Exploitation in Gangs and Groups[31] identified thirteen different types of sexual exploitation in addition to that from a single perpetrator. Though this is not considered an exhaustive list, it does identify key types:

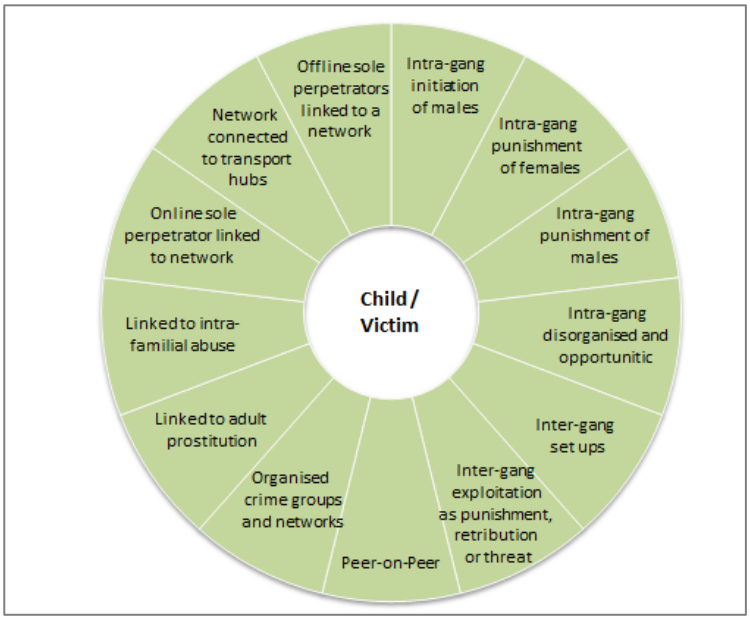


Figure 6: Forms of Child Sexual Exploitation
Source:
www.childrenscommissioner.gov.uk/sites/default/files/publications/If%20it%27s%20not%20better%20Appendices.pdf

In addition to types of child sexual exploitation, the Inquiry identified numerous risk factors and warning signs:

Risk Factors	Warning Signs
Living in a chaotic or dysfunctional household	Missing from home or care
History of abuse	Physical injuries
Recent bereavement or loss	Drug or alcohol misuse
Gang association	Involvement in offending
Attending school with people who are sexually exploited	Repeat STI infections, pregnancy and terminations
Learning Disabilities	Absent from school
Unsure about their sexual orientation or unable to disclose sexual orientation to their family	Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites
Friends with young people who are sexually exploited	Change in physical appearance
Homeless	Estranged from their family
Lacking friends in the same age group	Receipt of gifts from unknown sources
Living in a gang neighbourhood	Recruiting others into exploitative situations
Living in residential care	Poor mental health
Living in a hostel or B&B	Self-harm
Low self-esteem or self-confidence	Thoughts or attempts at suicide
Young carer	

Table 6: Risk Factors & Warning Signs for Child Sexual Exploitation
Source:
www.childrenscommissioner.gov.uk/sites/default/files/publications/If%20it%27s%20not%20better%20Appendices.pdf

Between 2012-13 and 2013-14, the NSPCC report that there was a 39% increase in police recorded sexual offences against children in England[32]. The research suggests part of this increase will relate to the media focus on child sexual exploitation in recent years, which has led to more people willing to come forward to the police and report abuse. However, the increase in reports of CSE has not been matched by an equivalent increase in the available support, and the NSPCC suggest there is a significant national shortfall in therapeutic support available to those who have suffered child sexual abuse.

The primary mechanism for monitoring child sexual exploitation in Liverpool is the Multi-Agency Child Sexual Exploitation (MACSE) meeting. Its purpose is to share concerns and formulate a multi-agency plan to protect children who are experiencing, or at risk of sexual exploitation. Information is collected and monitored to identify any patterns of trends that may emerge across the city.

In the 6-month period between October 2014 and March 2015, there were been 163 CSE referrals made from the Liverpool area to the MACSE meeting of children considered at risk of, or experiencing sexual exploitation. Merseyside Police made just under half of the CSE referrals (46.6%), followed by Social Services (26.4%) and Educational Establishments (schools, colleges, etc) (21.5%). Other organisations that have made referrals include Public Health, sexual health services, drug and alcohol support and a charity (Young Runaways).

Almost 90% of all CSE referrals from Liverpool are for girls, with only a small number of cases involving boys. The most prevalent age groups are for young people aged 15 to 16. Together these account for just over half of all Liverpool referrals.

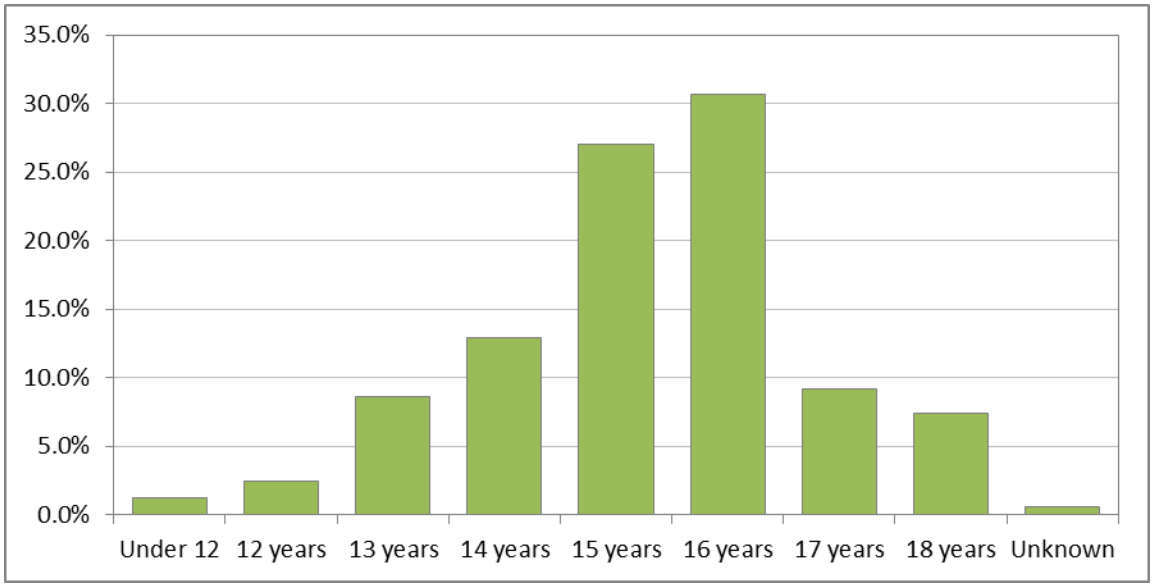


Figure 7: Age profile of CSE referrals between October 2014 and March 2015
Source: Merseyside Police

The majority of suspects identified over the 6month period were males aged between 18 and 24. However, it is worth noting that the quality of information relating to the suspect is poor, with details not listed for three quarters of referrals.

Over half of referrals (58.3%) live with family and have no experience of care. 21.5% of referrals had experience of the care or foster system. It should be noted that on 33 referrals (20.2%) information on care status was unavailable.

4.1.9 Adverse Childhood Experiences

There is increasing evidence that negative experiences in childhood can have a significant impact on health and wellbeing of the individual in the longer term. So called 'adverse childhood experiences' (ACEs), such as abuse, neglect and domestic violence, are known to be associated with a range of health harming behaviours in adulthood, such as alcohol and substance misuse, risky sexual behaviour and crime[33].

Research by the Centre for Public Health at Liverpool John Moores University[34] has shown that just under half of children in England have experienced at least one adverse childhood experience. The most common ACE identified is parental separation (24%), followed by verbal abuse (18%) and physical abuse (15%).

Almost 1 in 10 children in England have experienced 4 or more adverse experiences in childhood. Compared to children with no adverse experience, this cohort were:

- 2 times more likely to currently binge drink and have a poor diet
- 3 times more likely to be a current smoker
- 6 times more likely to have had or caused an unplanned teenage pregnancy
- 7 times more likely to have been involved in violence in the last year
- 11 times more likely to have used heroin/crack or been incarcerated

Research indicates that children growing up in more deprived communities are more likely to be exposed to adverse childhood experiences. Furthermore, the short and longer term outcomes for those exposed to ACEs in more deprived areas tend to be poorer due to increased stress response[35].

Taking action on the causes, prevalence and impacts of ACEs is therefore necessary in order to improve health and wellbeing, and reduce inequalities among not only children, but also adults. Preventative action to tackle ACEs needs to focus on the underlying risk factors identified within this report, and be universal in scope but also proportionate to the level of need.

The Institute of Health Equity has identified three broad level themes for interventions to tackle ACEs:

- ***Improving the context in which families live*** e.g.: tackling social isolation, and improving low pay.
- ***Tackling parental and family risk factors*** e.g.: through parenting programmes
- ***Reducing household adversity*** e.g.: multiagency teams to provide integrated responses to family needs

4.2 Behavioural & Environmental Risk Factors

4.2.1 Substance Misuse among Young People

NatCen Social Research (NatCen) and the National Foundation for Educational Research (NFER) conduct an annual survey on behalf of the Health and Social Care Information Centre (HSCIC) that monitors the extent of smoking, drinking and drug use among children and young people aged 11-15[36].

Results from the 2013 survey indicate that a substantial proportion of young people have tried alcohol and drugs; 39% and 16% respectively. However, this figure falls significantly when asked if they have done so recently, to 9% and 6%.

The prevalence of illegal drug use in England in 2013 was at similar levels to 2011 and 2012, though considerably lower than in 2005. 16% of pupils had ever taken drugs, 11% had taken them in the last year and 6% in the last month.

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Drunk alcohol in the last week	22%	21%	20%	18%	18%	13%	12%	10%	9%
Taken any drugs in the last month	11%	9%	10%	8%	8%	7%	6%	6%	6%
Taken cannabis in the last month	7%	6%	5%	5%	5%	4%	4%	4%	4%
Sniffed volatile substances in the last month	3%	2%	3%	2%	2%	2%	1%	2%	1%
Taken Class A drugs in the last month	2%	2%	2%	2%	2%	1%	1%	1%	1%
Done any of these recently	**29%**	**27%**	**29%**	**25%**	**26%**	**20%**	**19%**	**17%**	**16%**
Done none of these recently	**71%**	**73%**	**71%**	**75%**	**74%**	**80%**	**81%**	**83%**	**84%**

Table 7: Percentage of children aged 11 to 15 who have recently smoked, drunk alcohol, or taken drugs
Source: HSCIC 2013

As might be expected, the prevalence of illegal drug use is higher among older pupils. The prevalence of ever having taken drugs increases from 5% of 11year olds to 30% of 15year olds, with cannabis being the more frequently used substance.

Results from the survey in 2013 show that young people whose circumstances or behaviour already make them the focus of concern also have an increased risk of problematic drug use. This group includes pupils who truant or have been excluded from school.

- 10% of pupils who had played truant or been excluded said they usually take drugs once a month, compared with 1% of pupils who had never truanted or been excluded.
- 8% of pupils who had played truant or been excluded said they had taken Class A drugs in the last year, compared with 1% of pupils who had never truanted or been excluded.

It is worth noting however, that these figures are substantially lower than ten years ago.

4.2.2 Sexual Health, Teenage Pregnancy and Healthy Relationships

Young people need to be able to access sexual health services in order to prevent, diagnose and treat sexually transmitted infections and gain advice to protect against unintended pregnancy. It is essential that these sexual health services are confidential, as this encourages young people to come forward for sexual health care and facilitates disclosure of consensual and non-consensual sexual activity.

Information on the prevalence of sexually transmitted infections is collected by Public Health England, and is available for each Local Authority in the country. The number of cases of STIs diagnosed among under-16s are low, with less than 20 diagnoses in Liverpool a year.

Young people between 15 and 24 years old experience the highest rates of new STIs. In Liverpool, 64% 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.

Re-infection with an STI is a marker of persistent risky behaviour. Young people are more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Liverpool, an estimated 7.9% of 15-19 year old women and 14.1% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became re-infected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate 'safer sex' – i.e. the use of a condom, to minimize the chances of spreading or contracting an STI.

There is a wide body of literature highlighting the importance of tackling teenage pregnancy. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty[19]. Tackling teenage pregnancy can therefore help to reduce health inequalities and tackle social exclusion.

There were 259 under-18 conceptions in Liverpool in 2013, with 6 in 10 leading to an abortion. Latest annual figures indicate a continued fall in the under-18 conception rate, both locally and nationally. The Liverpool rate fell by 41.1% between 1998 and 2013, compared to a national reduction of 47.9% over the same period. The rate in Liverpool is the third highest among the core cities in England, behind Nottingham (37.5) and Manchester (36.5).

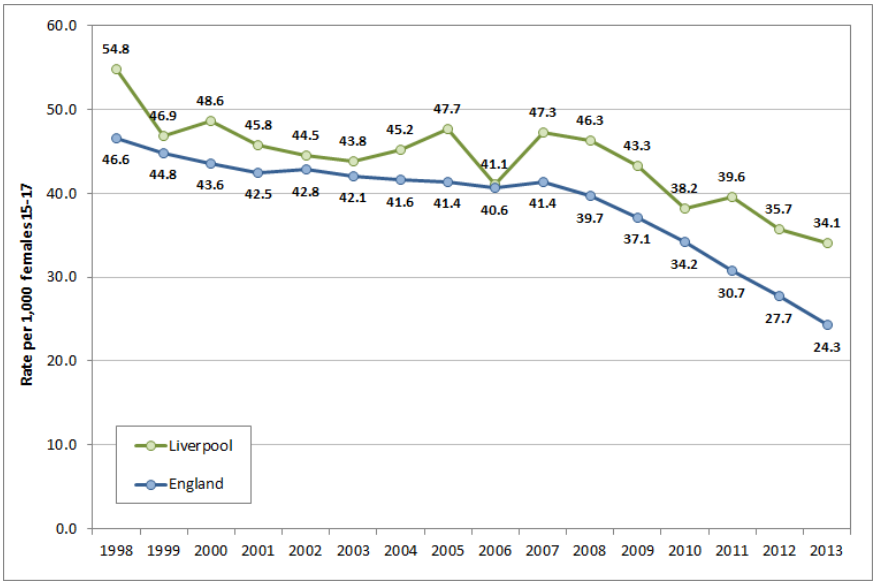


Figure 8: Under-18 conception rate in Liverpool and England, 1998 to 2013
Source: Office for National Statistics

While there has been a substantial reduction in the under-18 conception rate in Liverpool, the conception rate for those aged under-16 has remained relatively stable over the past decade. In the 3 year period 2011-13 there were 193 under-16 conceptions, an average of 64 per year. This is down from 218 conceptions in 2001-03, an average of 73 per year.

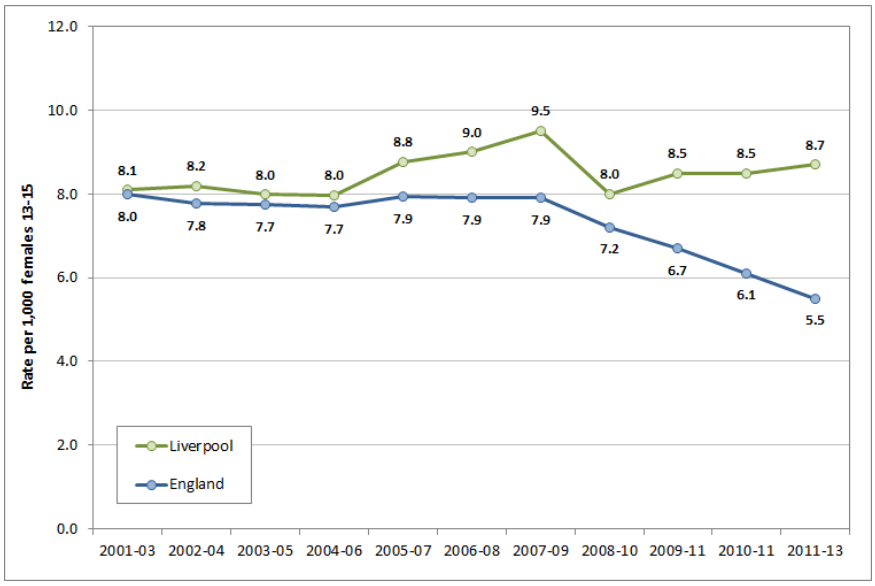


Figure 9: Under-16 conception rate in Liverpool and England, 2001-03 to 2011-13
Source: Office for National Statistics

The implementation of a long-term evidence based, national teenage pregnancy strategy has resulted in a significant reduction in the under-18 conception rate, but for the declining number of young people who become pregnant and choose early parenthood, outcomes remain

disproportionately poor. Higher rates of infant mortality, poor mental health, safeguarding concerns and child poverty place young parents and their children at risk of becoming the most vulnerable citizens of the future requiring the greatest level of health and social care support.

Many young people enjoy mutually consenting sexual relationships. However, young people can also be the victims of sexual abuse or exploitation. They may not recognise that their relationship is abusive, may have been groomed, or they may be too afraid of the consequences to disclose or acknowledge it. The issue of sexual abuse by other young people is often not recognised[37].

In Q4 2014-15, 55 safeguarding and cause for concern forms were completed for young people attending the Brook Sexual Health Service in Liverpool. The majority of cases were not externally referred, but supported by the service in a variety of ways such as 1-1 sessions with Clinical support workers or follow ups with a nurse. Just over a fifth of cases involved some external action being taken, this being with Social services, Merseyside Police/CSE team, individual School nurse and the mental health crisis team at the Royal Liverpool Hospital.

4.2.3 Children with Additional Needs & Disabilities

Children with additional needs are any children or young people up to the age of 18 with a physical, sensory, communication, behavioural or learning disability, or a long-term or life-limiting condition. This may also include children with emotional health and wellbeing needs where there is an impact on their daily life, including those with more significant mental health problems.

Children and young people with additional needs may be more vulnerable to safeguarding risks for a variety of reasons including variations in their perceptions of risk and danger, their ability to articulate concerns, and their ability to recognise inappropriate behaviour. Due to their additional needs they may not be able to articulate whether they are happy and feel safe with the care they are receiving. The most frequently occurring problems for children with additional needs relate to communication, emotional wellbeing and learning.

Local information shows that in 2015 around one in five children and young people in Liverpool have Special Educational Needs and/or disabilities, equating to almost 13,000 children, down from one in four children in 2011.

The proportion of pupils with Statements of special educational needs in Liverpool schools has remained fairly stable in recent years, ranging from 1,268 pupils (1.9%) in 2011 to 1,480 pupils

(2.2%) in 2015. A Statement is a document which sets out a child's special educational needs and any additional help that the child should receive. The aim of the Statement is to make sure that the child gets the right support to enable them to make progress in school. A Statement is normally made when all the educational provision required to meet a child's needs cannot reasonably be met by the resources within a child's school.

From September 2014, Education, Health & Care Plans (EHCPs) began to replace Statements of special educational needs. In 2015 there were 146 pupils in the city with an EHCP, however this is potentially an underestimate due to case backlogs. There are a number of key differences between the Statement process and the new EHCPs[38]:

- A single pathway for 0-25 years within SEN
- A more efficient process with:
    - Improved communication and information sharing
    - Reduced duplication for families
    - Reduced bureaucracy
- A more holistic process
- Increased multi-agency working

Boys account for roughly two thirds of Statemented or EHCP pupils at primary school and nearly three quarters at secondary school. Of pupils with Statements or EHCP in 2015, the most common type of primary need was autistic spectrum disorder (27%) closely followed by severe learning difficulties (26%). The least common was multi-sensory impairment (0.1%).

4.2.4 Mental and Emotional Health & Wellbeing

Poor emotional health has an impact on a wide range of issues, such as physical health, education, employment, parenting, relationships, smoking, substance misuse, unwanted pregnancy, and crime. Research by the Office for National Statistics in 2005 suggested that just under 1 in 10 children aged under 16 will have some form of mental disorder, with the prevalence increasing with age.

The research indicates the most prevalent condition is emotional disorders, with up to 1 in 27 young people aged 5 to 16 having the condition. Lack of robust local information makes it difficult to obtain a true picture of the extent of mental ill-health affecting children and young people; however the table below provides an indication based on national prevalence rates.

Condition	National Prevalence			Local Estimates		
	Boys	Girls	All	Boys	Girls	All
Emotional Disorders	3.1%	4.3%	3.7%	893	1,202	2,100
Conduct Disorders	7.5%	3.9%	5.8%	2,161	1,090	3,292
Hyperkinetic Disorders	2.6%	0.4%	1.5%	749	112	851
Less Common Disorders	1.9%	0.8%	1.3%	547	224	738
Any Disorder	**11.4%**	**7.8%**	**9.6%**	**3,284**	**2,180**	**5,449**

Table 8: Prevalence of emotional disorders among children and young people

Source: ONS, 2005

Note: Figures may not tally due to individuals having more than one condition.

The 2015 Health Related Behaviour Survey of Year 8 pupils in Liverpool incorporated the Stirling Children's Wellbeing Scale. This has been specifically devised by researchers to understand wellbeing among children and young people. Results from the survey indicate that half of Year 8 boys scored highly using the combined wellbeing score, compared to just over a third of Year 8 girls. At the other end of the scale, the prevalence of medium-low wellbeing was twice as high among girls as boys.

The Early Years Foundation Stage (EYFS) is the framework that sets standards for child development. A child is deemed to have reached a 'good level of development' and is 'school ready' if they have achieved at least the expected level of development in early learning in all of the following areas:

- Communication and Language
- Physical Development
- Personal, Social and Emotional Development
- Literacy
- Mathematics

In Liverpool 53% of children achieved a good level of development across all early learning goals in 2013-14, compared to 58% of children nationally. However, there is a significant gender gap (mirroring national patterns), with 62% of girls achieving a good level of development compared to 43% of boys.

When looking specifically at personal, social and emotional development, Liverpool outperforms all of the Core Cities, with levels comparable to England. Overall 80% of children achieve a good level of development in this area, rising to 86% of girls.

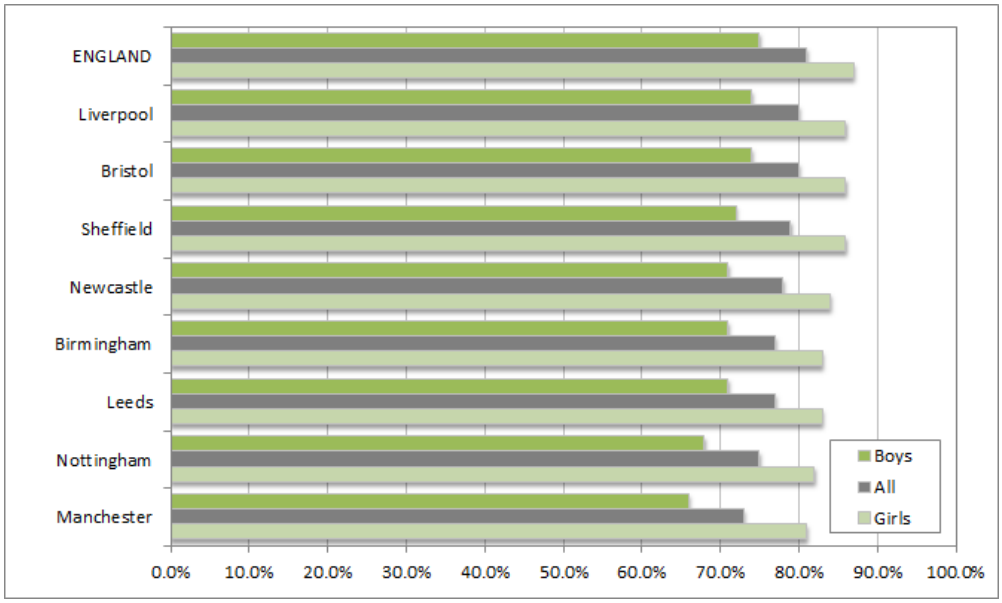


Figure 10: Percentage of children achieving the expected level of personal, social and emotional development in 2013-14, by Core City
Source: Department for Education

4.2.5 Bullying

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the four main types are:

- Physical (e.g. hitting, kicking, theft using physical aggression)
- Verbal (e.g. racist or homophobic remarks, threats, name calling to the young person's face)
- Emotional/Indirect (e.g. isolating an individual from the activities and social acceptance of their peer group, spreading rumours)
- Cyber/Technological (e.g. using technology to hurt an individual, text messages, internet etc.)

Bullying can significantly impact on the health and wellbeing of those people being subjected to it, as well as on educational attainment and academic attendance, and the effects can last into adulthood.

Since 2006, Liverpool has conducted an annual bullying audit across the city. Findings from the audit have informed the development of the city's anti-bullying strategy[39]. In total 6,236 young people between the ages of 7 and 18 took part in the 2014 survey. This is the highest level or participation to date and represents a 12 – 13% response rate of all Liverpool school children in this age range.

Year	7-10 Year olds bullied in the last 12mths	11-15 Year olds bullied in the last 12mths	10-19 Year olds who admit to bullying another person
2006	50%	25%	19%
2007	41%	24%	13%
2008	43%	19%	17%
2009	38%	16%	10%
2010	36%	14%	11%
2011	30%	24%	15%
2012	35%	14%	8%
2013	26%	12%	7%
2014	31.5%	17.8%	7.4%
Significant change between 2013 and 2014?	Yes	Yes	No

Table 9: Key Bullying Indicators 2006 to 2014
Source: Liverpool Children's Services, Schools Bullying Audit 2014

Results from the 2014 audit indicate there has been a significant increase in the number of pupils stating they have been bullied in the previous 12 months. However, it is important to acknowledge that the long term trend is a positive one, with levels of bullying substantially below those reported in 2006.

Key findings from the audit show that:

- Overall, boys are the most frequent perpetrators of bullying. Of those bullied in the last 12 months, boys were involved in 49% of incidents. Pupils being bullied by an adult increases with the age of the pupil.
- Being bullied is directly correlated with age of the pupil. The highest proportion of pupils who said they had been bullied occurred between the ages of 7 and 11, peaking among 8 year olds at over 50%. Bullying fell to a low of 11% amongst 17 year olds.
- Pupils with an Asian, Black or Mixed background reported a marginally higher incidence of bullying than White pupils. Pupils who preferred not to state their ethnicity recorded an even higher level of bullying at 30%.
- Pupils with a disability or with a Statement of Special Educational Need recorded high levels of bullying at 49% and 33% respectively, against an average for all pupils of 20.6%.
- 29% of pupils bullied in the last year were bullied on a single occasion. The same pattern of bullying frequency has been repeated over several years. Of particular note is the fact that 66% of children with a disability have been bullied 'more than four times' in the past year, compared to 39% of pupils who do not have a disability.

- Verbal bullying remains the most common form among both boys and girls. Girls are much less likely to experience physical bullying, but more likely to be subjected to indirect bullying, such as rumour spreading.
- 54% of pupils rated their school as doing 'very well' or 'quite well' in terms of how they dealt with bullying.

National research by the London School of Economics in 2010 and 2013[40] indicates that cyber-bullying is now more common than face-to-face bullying. In 2010, 16% of children reported being bullied face to face, 8% on the internet and 5% via mobile phone. By 2013, this ratio had reversed, making cyber bullying (12%) more common than face-to-face bullying (9%) – most cyber bullying occurs on social networking sites.

4.2.6 Online Safety

The term 'online safety' reflects a widening range of issues associated with technology and a user's access to content, contact with others and behavioural issues.

The rapid pace of development in new technologies provides huge opportunities for society, but also new risks for children and young people. In sharing personal information online through social networking sites and applications, children and young people may expose themselves to harm, either as recipients of abusive messages (i.e. cyber bullying) or by sharing information with those who may seek to harm them (i.e. online grooming).

In 2014, an Ofcom report[41] relating to internet safety identified 4 broad approaches that parents can take to improve their children's online safety and well-being when online:

- **Education & Advice**: Open discussion of the risks the young person might be exposed to, encouraging children to let their parents or carers know if they have an unpleasant or distressing experience.
- **Supervision**: Directly supervise internet use, particularly for younger children.
- **Rules about Internet Use**: Discussing the times and place children can access the internet.
- **Tools & Safety Mechanisms**: Using software to restrict access to certain internet sites.

In Liverpool the aim is for all children to be digitally aware and to understand the risks associated with the online world, rather than being risk averse. In schools we want to give children the knowledge, skills and confidence to deal with online issues, equipping them to be

able to know what they should do, if they encounter any online safety concerns when they are not in school.

The 2015 Health Related Behaviour Survey among Year 8 pupils in Liverpool showed that 96% of pupils had been informed about how to stay safe when chatting online, however the survey also identified a number of areas for concern, with a significant minority of pupils having met people in real life that they first met online.

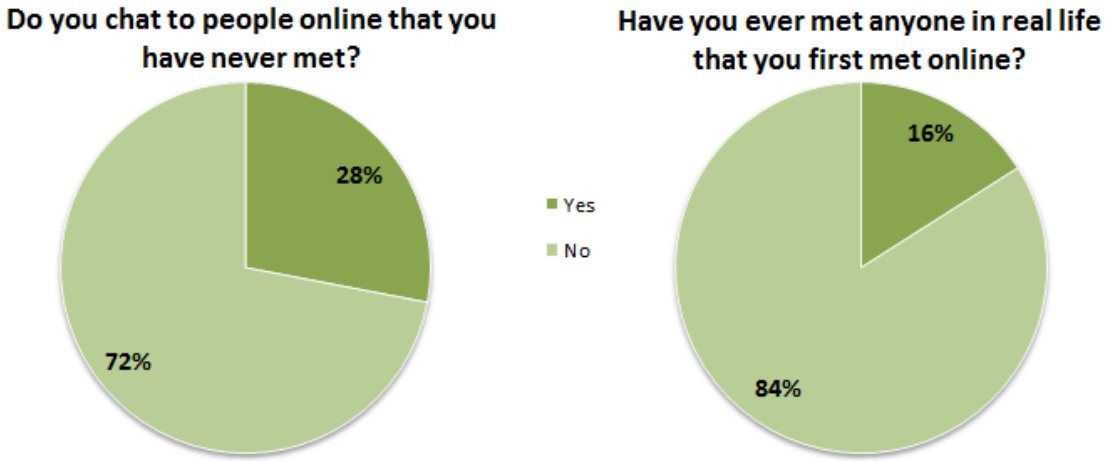


Figure 12: Internet safety among Year 8 pupils in Liverpool
Source: Health Related Behaviour Survey 2015

The results of the survey indicate that almost 1 in 6 pupils aged 12-13 have met someone in real life that they first met online.

4.2.7 Self Harm & Suicide

Information relating to self-harm and suicide is an important measure of child safety, and they are often the result of a variety of underlying factors, such as neglect and abuse. The Children's Commissioner also identified self-harm among children and young people as a potential warning sign for child sexual exploitation.

Thankfully, the number of suicide cases among children and young people in Liverpool is low. Over the 10 year period 2004 to 2013 there were 28 confirmed cases of suicide among those aged under25, with an average of less than 3 per year.

Public Health England has identified a number of methods of self-harm among children and young people, ranging from overdoses to self-mutilation (e.g. cutting behaviours)[42]. They

highlight the difficulty in obtaining accurate figures on the extent of self-harm due to underreporting of cases, and the various definitions that may be used for those that do seek help and support.

The report by PHE highlights the results of a national survey of more than 10,000 children which found that the prevalence of self-harm among 5-10 year-olds was 0.8% among children without any mental health issues, but 6.2% among those diagnosed with an anxiety disorder and 7.5% if the child had a conduct, hyperkinetic or less common mental disorder. The figures increase significantly for 11-15 year-olds, with the prevalence of self-harm at 1.2% among children without any mental health issues, but 9.4% among those diagnosed with an anxiety disorder, and 18.8% if the diagnosis is depression.

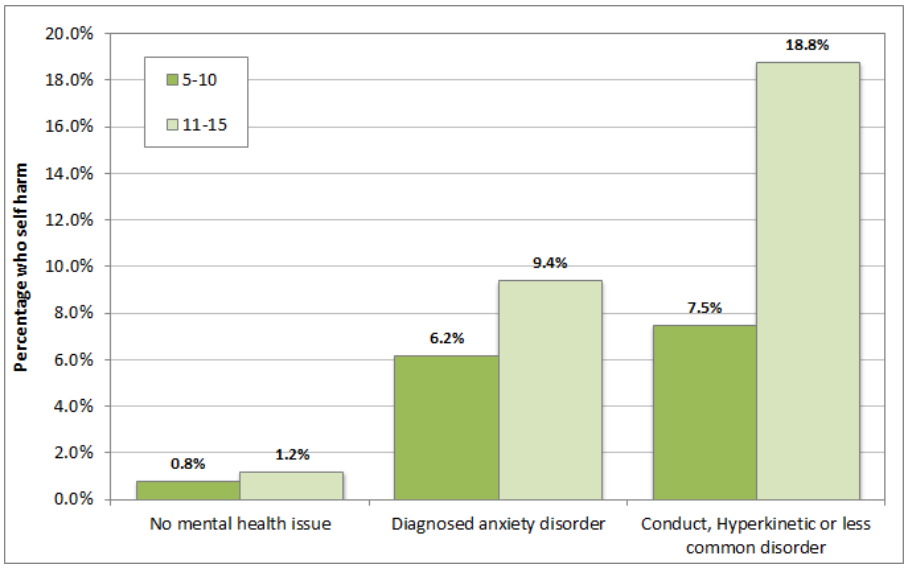


Figure 13: Prevalence of self-harm among children & young people by condition
Source: Public Health England - Self harm in children and young people handbook

Nationally, hospital admissions for self-harm among children aged 10-24 have increased in recent years, with admissions for young women being much higher than admissions for young men. However, locally, data suggests the rate of hospitals admissions has remained relatively stable, with 744 cases in the three year period 2010-11 to 2012-13. Admission rates for Liverpool are significantly lower than England, however this may relate to methods of recording rather than a true difference.

4.2.8 Unintentional & Deliberate Injuries to Children

Accidental injuries are a major health problem throughout the United Kingdom. They are the most common cause of death in children over one year of age, and every year they leave many thousands permanently disabled or disfigured. More than one million children under the age of

15 experience accidents in and around the home every year, for which they are taken to accident and emergency units. Many more are treated by GPs and by parents and carers.

Those most at risk from a home accident are those aged 0-4 years. Falls account for the majority of non-fatal accidents while the highest number of deaths is due to fire. Most of these accidents are preventable through increased awareness, improvements in the home environment and greater product safety[43].

The charts below show the rate of hospital admission caused by unintentional and deliberate injury for children in Liverpool, for those aged 0-4, and the wider age group 0-17. For both population groups there was a large fall in the admission rate between 2010-11 and 2011-12, with levels being relatively stable since that time.

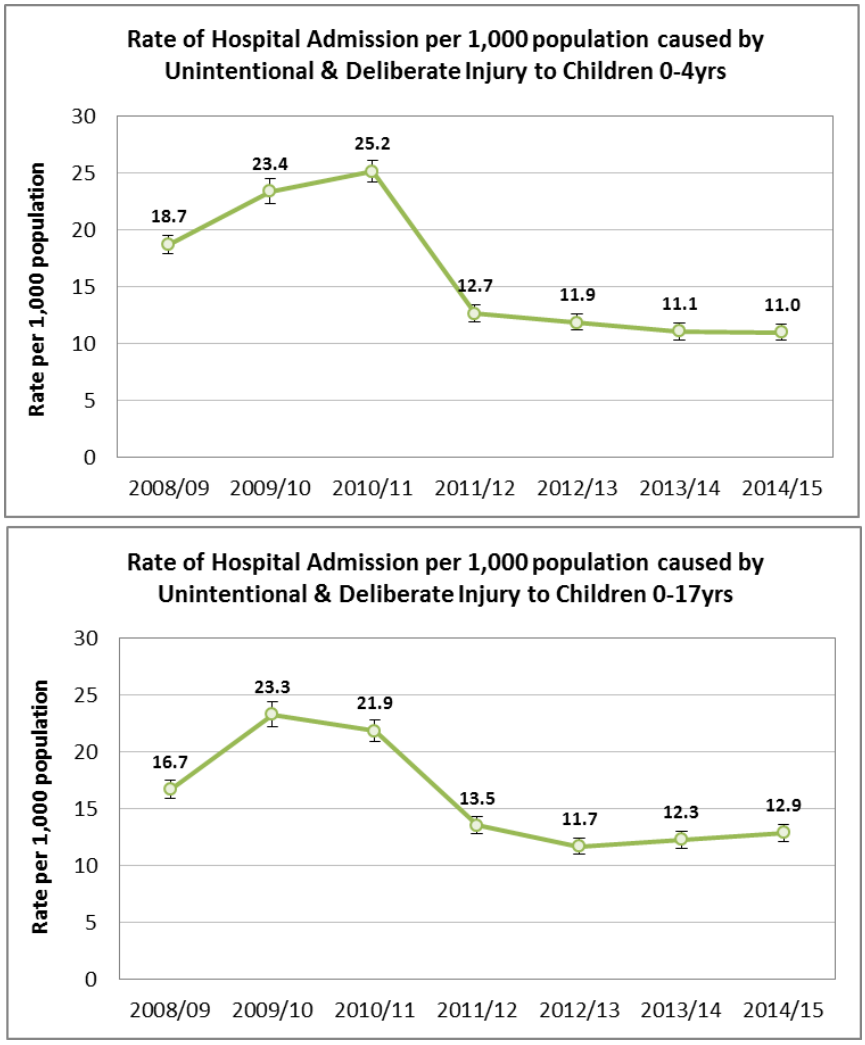


Figure 14: Hospital admissions for Liverpool children caused by unintentional and deliberate injuries
Source: Public Health - SUS

In 2014-15 there were 1,159 hospital admissions for unintentional and deliberate injuries among children and young people (0-17) in Liverpool, almost 100 a month. While high, there has been a statistically significant reduction in the rate of admissions since 2008-09.

The table below illustrates the top 10 causes of accident related admissions in 2014-15. In that year, the main cause of admission was falls (mirroring the national pattern) with 381 admissions. The rate of admission due to falls was more than 4 times greater than the next main cause: transport accidents.

While the number of admissions are comparatively small, there has been a substantial rise in the number of admissions due to being bitten by dogs, foreign body entering into the eye or natural orrifice, assault by bodily force and abnormal reactions to surgical operations or procedures.

Top 10 Causes of Admission in 2014-15	Number of Admissions	Rate per 1,000 Population	% Diff from Previous Year
Falls	381	4.24	0.2%
Transport Accident	95	1.06	-2.6%
Intentional self-poisoning by and exposure to non-opioid analgesics, anti-pyretics and anti-rheumatics	79	0.88	-8.7%
Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	66	0.73	23.8%
Caught crushed jammed or pinched in or between objects	62	0.69	12.1%
Bitten or struck by dog	50	0.56	60.4%
Striking against or struck by other objects	34	0.38	-23.2%
Foreign body entering into or through eye or natural orifice	27	0.30	49.2%
Assault by bodily force	25	0.28	46.2%
Intentional self-harm by sharp object	25	0.28	13.0%

Table 10: Top 10 causes of admission for unintentional & deliberate injury among those aged 0-17
Source: Public Health - SUS

Admission to hospital can represent the more severe cases of injury, and while there were 1,159 admissions in 2014-15, there were significantly more attendances at A&E caused by accidents. In the 12 month period there was just under 11,200 A&E attendances by children and young people in Liverpool caused by accidents. The main reasons identified were:

- Soft tissue inflammation (3,214 attendances)

- Dislocation/fracture/joint injury/amputation (2,163 attendances)
- Head injury (1,911 attendances)
- Laceration (1,124 attendances)

4.2.9 Children affected by Criminality

The Crime Survey for England and Wales (previously the British Crime Survey) is a face-to-face survey in which people resident in households in England and Wales are asked about their experiences of crime in the previous 12 months. The 2013/14 survey was based on face-to-face interviews with 3,000 children aged 10 to 15. Crime Survey estimates are higher than the number of crimes recorded by the police because the survey captures offences that have not been reported to the police. The survey is therefore an important way of filling the gap left by police-recorded crime statistics[18].

Crime	2009/10	2010/11	2011/12	2012/13	2013/14
Wounding	1.8%	1.1%	1.0%	1.0%	1.1%
Assault with minor injury	3.7%	3.7%	3.6%	2.9%	3.3%
Assault without injury	2.4%	1.7%	2.2%	1.4%	1.7%
Robbery	1.3%	0.9%	1.3%	1.0%	0.7%
Violence with injury	5.5%	5.0%	4.8%	4.2%	4.5%
Violence without injury (includes unspecified)	3.4%	2.1%	3.1%	2.2%	2.2%
Any violent incidents	**8.5%**	**6.8%**	**7.7%**	**6.1%**	**6.5%**

Table 11: Estimated percentage of 10 to 15 year olds in England & Wales who were the victim of a violent crime in the past 12 months

Source: Crime Survey for England & Wales

Results from the Crime Survey 2013/14 indicate that 6.5 per cent of 10 to 15 year olds in England & Wales were victims of violent crimes within the previous 12months. As an indication, this is more than three times the proportion of adults who were victims of violent crime in 2013/14 (1.8 per cent), though direct comparisons are problematic due to methodological differences[18]. If these figures are applied to the Liverpool population, it would equate to 1,760 children in the city being a victim of violent crime in 2013/14, with over 1,200 being a victim of violence with injury.

The 2015 Health Related Behaviour Survey of Year 8 pupils in Liverpool showed that 7% of children taking part in the survey responded that they were the victim of crime in the last 12 months, with school being the most common location for both boys and girls. Figures provided by CitySafe show that over 900 young people were recorded by the Police as victims of violence between September 2014 and August 2015, with 345 victims of a sexual offence.

4.2.10 Education

Education is one of the most important wider determinants of health, with poor education associated with poorer health outcomes and lower life expectancy. There is also a large body of evidence which shows that education is linked to health behaviours such as smoking, alcohol and substance abuse, and diet. These links have been shown to exist even when other factors such as income are taken into account. In addition to influencing healthy outcomes, education can impact on broader health issues such as social engagement.

GCSE results for 2013-14 show that half of children (49.9%) in the city achieved 5+ GCSEs A*-C (including English and Maths), up from just over a third of children in 2005 (35.5%). Compared to other areas, attainment levels in Liverpool are slightly below the national and core city averages, however the gap with England has narrowed significantly over the past decade.

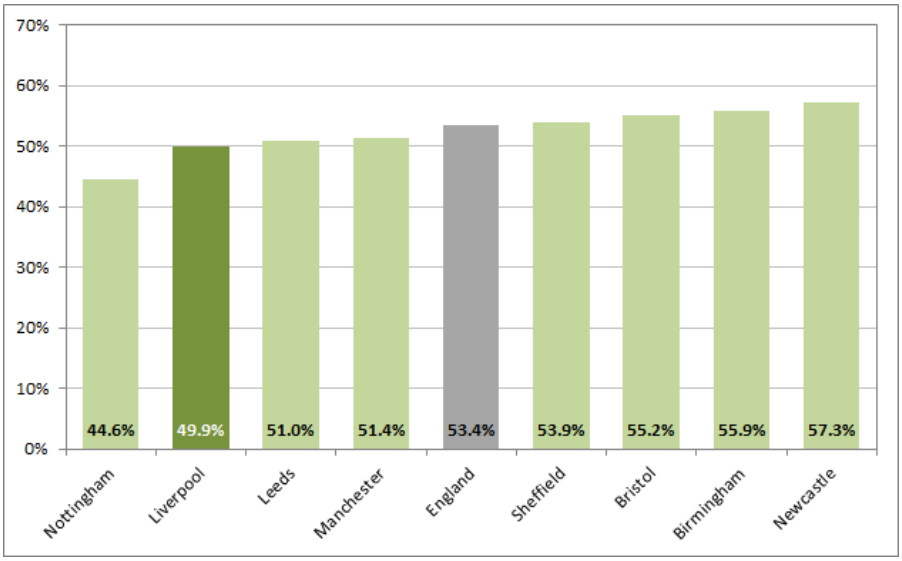


Figure 15: Percentage of children obtaining 5+ GCSEs grade A* to C (inc English & Maths) in 2013-14
Source: Department for Education[44]

Levels of attainment vary markedly within different groups in the city, with less than a third (29.5%) of those eligible for free school meals achieving 5+ GCSEs grade A* to C (including English and Maths). When comparing different ethnic minorities, attainment among those from a Chinese background is 30% higher than those from Black minority groups[45].

Educational attainment of Children in Care is of particular concern; the attainment gap is the widest of any group both locally and nationally. Figures for 2014 show that only 13% of Looked After Children (LAC) in Liverpool gained 5 A*-C GCSEs (including English and Maths), compared with 49.9% of all Liverpool children[46]. Young people who do not achieve five or more GCSEs are more likely to become NEET after leaving school.

4.2.11 Children missing from Education

Children Missing Education (CME) refers to all children of compulsory school age who are not on a school roll, nor being educated otherwise (e.g. privately or in alternative provision) and who have been out of any educational provision for a substantial period of time (usually agreed as four weeks or more). This means all children between the ages of 5 and 16 who are not:

- Named on a school register
- Being Educated at Home
- In any other type of Education (for example college or work experience placement)
- Who have failed to attend for at least four weeks

All parents are required to ensure that their children receive full time education that is suitable to their age, ability and aptitude, either at school or another setting e.g. home schooling. In January 2015, the Department for Education released guidance[47] setting out the key principles Local Authorities should adhere to in fulfilling their duty to identify children at risk of becoming missing from education and ensuring they return. The guidance identified six risk factors that Local Authorities should consider when establishing their own local protocols for tackling the issue:

- Pupils at risk of harm or neglect
- Children of Gypsy, Roma or Traveller (GRT) Families
- Families of Armed Forces
- Missing Children / Runaways
- Children being supervised by the Youth Justice System
- Children who cease to attend school

Each year there are roughly 2,000 referrals in the city for children missing from education, with the overwhelming majority found.

4.2.12 Young People not in education, employment or training (NEET)

Being NEET is often connected to other issues such as teenage pregnancy, substance abuse and Children who are, or have previously been, in Care (LAC). The three most predominant complex characteristics of the NEET cohort in Liverpool are: Teenage Mothers, Learning Difficulties or Disabilities (LDD) and Looked After Children (LAC).

Significant numbers of young people who are not in education, employment or training (NEET) are becoming one of the most serious social problems in the UK. Young people who are NEET often experience a number of long term issues, including:

- **Disconnection from the expectations of the labour market –** particularly employability skills.
- **Wage scarring** – adults who were NEET as a young person tend to earn lower wages than peers who were not.
- **'Churn'** – NEET young people are more likely to be repeatedly unemployed as adults than those who were not.
- **Greater propensity to mental ill health –** NEETs are more likely to suffer from stress and depression.
- **Increased participation in crime –** high numbers of NEETs are particularly involved in property crime.
- **Decreased self-confidence –** which can hamper the likelihood of employment.

Figures for 2014 indicate that Liverpool has the highest rate of NEET among the eight Core Cities in England, with 8.2% of young people not in education, employment or training. This compares to a national average of 4.7%. In addition, the status of almost 1 in 4 young people is unknown, significantly above the national average of 9%.

Core City	Estimated number of 16-18's who are NEETs	Percentage of 16-18's who are NEET	Activity Unknown
England	-	4.7%	9.0%
Liverpool	1,240	8.2%	23.7%
Birmingham	2,790	7.2%	17.3%
Bristol	750	6.3%	11.8%
Leeds	1,460	6.4%	5.8%
Manchester	1,020	6.5%	6.5%
Newcastle	570	6.7%	4.3%
Nottingham	610	6.2%	2.4%
Sheffield	1,020	5.9%	5.8%

Table 12: Estimated number of young people who are not in education, employment or training in 2014
Source: Department for Education

5. Profile of Local Need

5.1 Children in need of support

Families are perhaps the most important factor in children's lives and whilst the vast majority of children can rely on their families to provide them with the care and support they require, some families struggle. The level of need framework in Liverpool follows the 'windscreen model'. The aim of the model is to assist practitioners and managers in assessing and identifying a child's level of need; what type of service/resources may meet those needs; and the process to follow in moving from an identification of need to provision of services.

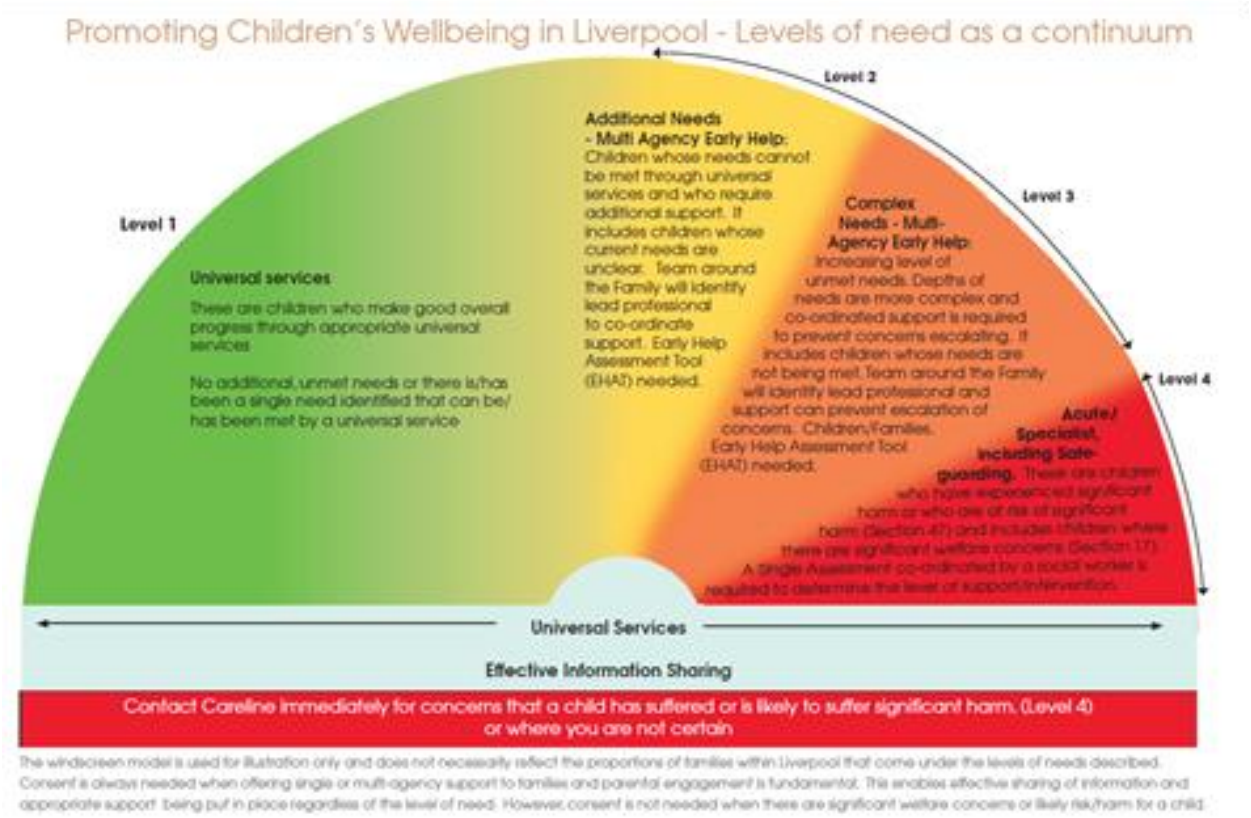


Figure 16: Liverpool level of need continuum
Source: Children's Services

The framework and approach adopted is underpinned by the following principles[48]:

- Children in levels 2-4 also need and use universal services.
- Children's needs can move from one level to another, and it should not be necessary for those needs to be captured more than once.
- Children should be enabled to move quickly and effortlessly to the required service response without necessarily going through each level.

- Where needs appear to have been met, families should be able to choose to keep an open (suspended) Early Help Assessment Tool, (formerly known as CAF) so they can share with services should needs re-emerge at a later stage.
- Children and young people have a right to have their voice heard – and this should have a strong influence on what happens next.

5.1.1 Early Help & Support

Working Together 2015 places the responsibility for Early Help with the Local Safeguarding Children Boards. It emphasises the expectation that collaborative inter agency work will address the needs and improve outcomes for the child/family. As such, the development of an effective Early Help offer is the responsibility of all partners in the city, a responsibility shared with families and their communities. Effective early help (single or multi-agency) can prevent needs and concerns escalating to the stage where statutory social care interventions are required. Early Help is about:

- Identifying needs of children, young people and their family across a continuum of need.
- Understanding and responding quickly to identified needs.
- Listening to children and families so that their views are informing what happens next.
- Supporting and re-focusing resources from crisis to prevention, and helping to avoid concerns repeating over time.
- Supporting families to achieve their full potential and thereby mitigate the impact of issues such as child poverty and health inequalities.

Early Help Assessment Tool

The Early Help Assessment Tool (EHAT) and is a shared assessment tool that is used in Liverpool across all services for children/young people and their families. The EHAT helps practitioners to gather and understand information about the needs and strengths of children and the family. This is based on discussions with children and their family and other practitioners as appropriate.

It is important to note that the aim of the EHAT is to support early intervention and improve joint working and communication between practitioners. Using an EHAT is not an end in itself. The tool is described as a common language for assessment purposes, which gives a consistent view for delivering the most appropriate response.

The actual number of CAFs/EHATs registered between April 2014 and March 2015 was 1,282, compared to 1,211 for the same reporting period in 2013/14 (an increase of 5.9%). However,

the number of children subject to an EHAT has risen substantially over the period, from 1,211 to 1,983 (an increase of 64%). The increase in the number of children subject to an EHAT can be seen as a positive outcome, as more children are being assessed for the help and support they may require.

Measuring Outcomes

The Family Outcomes Star framework is used to help map the journey of a child/family from needs to strengths. This is 'owned' by the child and family who can plot their progress from their initial identification of need across 10 areas.

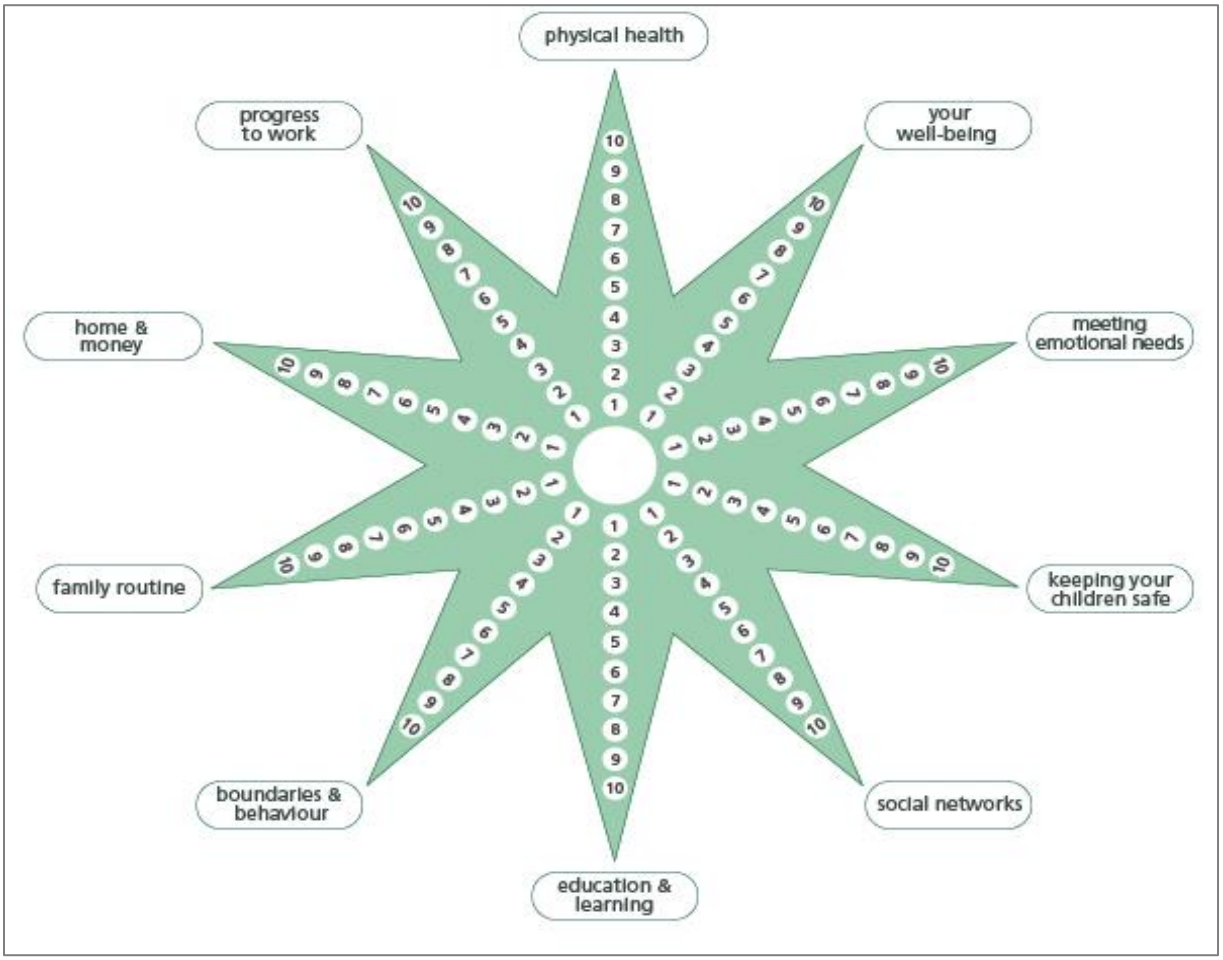
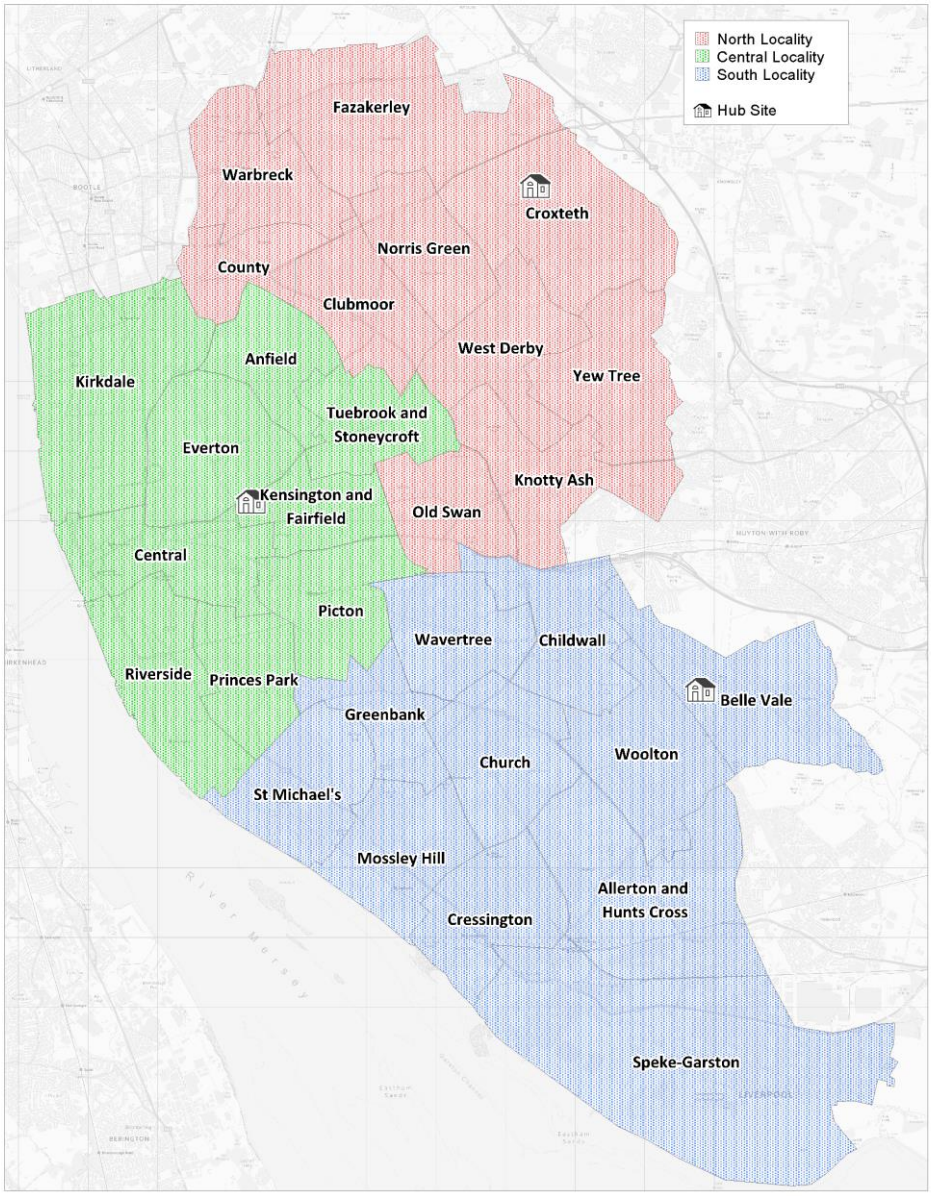


Figure 17: Family Outcomes Star
Source: Children's Services

Information from the Outcome Star is recorded within the EHAT, showing the starting point and points at any review. This identifies where the child/family is becoming self-reliant, or any areas where on-going support is still needed.

Early Help Hubs

There are 3 Locality Early Help Hubs in the City. The locality borders are as co-terminus as possible with other services (e.g. Clinical Commissioning Groups, Adult Services, Social Care Teams, Health Visitor Neighbourhoods) in order to encourages effective multi-agency working.



Liverpool Early Help Hubs & Localities

Date created: September 2015

Liverpool City Council I Millennium House I Victoria Street I Liverpool L1 6JD

Public Health Liverpool I E: chris.williamson@liverpool.gov.uk

Liverpool City Council

Early Help Hubs do not provide a co-location of multi-agency workers, nor does a Hub generally provide a 'case holding' function. Early Help Hubs are facilitators of support to the process and harness existing arrangements to ensure families are receiving the co-ordinated support they need.

Each Locality Hub:

- Receive Pre-EHATs (from agreed services/agencies) and ensure the most appropriate service is engaged to undertake an EHAT and relevant services are contributing to the necessary support.
- Receive "step down" cases from Social Care to ensure relevant support remains in place (using an EHAT) to continue to support families who need this to prevent concerns/needs re-escalating and needing social care interventions again. Step down cases do not necessarily need to be stepped down to an Early Help Hub.
- Provide transitional support (where already engaged with an EHAT) where needs escalate and "step up" is required for social care interventions.
- Receive information from Careline, where safeguarding concerns have been raised, but deemed not to require social care interventions. Services will be advised by Careline that an EHAT is required, and the Early Help Hub will be able to 'track' the registration of the EHAT, or follow up those professionals who have not undertaken an EHAT where one has been recommended by Careline.
- Support practitioners in undertaking EHATs for the first time and taking on the Lead Professional role by administrating Team Around the Family (TAF) meetings and supporting the effective recording of information.
- Support Lead Professionals where EHATs that have become 'stuck' and there is little or no change in progressing needs to strengths and there may be difficulty in engaging services to provide necessary support.
- Provide information, advice and support for Lead Professionals in relation to relevant multi-agency support available in the local Hub footprint.

5.1.2 Families Programme

In Phase One of the Liverpool Families Programme (Troubled Families), the city was tasked by the Department of Communities and Local Government (DCLG) to identify and work with a total of 2,105 families who met at least two of the following criteria:

- A youth who had a proven offence or ASB order,
- Education problems (behaviour and attendance)
- Families claiming out of work benefits.

During the first phase of the programme, a total of 2,316 families were identified, with 2,143 receiving some form of family intervention.

Liverpool was chosen by DCLG in September 2014 as an early adopter area for the Extended National Troubled Families Programme. Between April 2014 and March 2015, Liverpool has a target of identifying and supporting 6,970 families. The criterion for the identification of families has also been expanded to include children who need help, domestic violence and a range of health issues.

As of October 2015, Liverpool has identified 1,695 families who meet two or more problem areas in the first year of the extended programme. Currently 940 engaged with in a family intervention programme. The table below highlights the priority scores for families identified in the Year 1 cohort. Over half of the families identified have met two criteria based on data from partner agencies with 23% of identified families meeting three problem areas.

No. of Problem Criteria Met	Liverpool Phase 2 Year 1 Count	Rate Per 1000 pop	% of problem areas met (Liverpool Total)
6	0	0	0
5	8	0.02	0.5%
4	77	0.16	4.5%
3	396	0.84	23%
2	919	1.94	54%
1	295	0.62	17%

Table 13: Liverpool Phase 2 Year 1 Troubled Families Cohort Problem Areas Met
Source: Liverpool City Council, Families Programme 2015

Complex families cross all socio-economic boundaries and are not confined to one particular group of individuals. However, seven of the top ten wards are located in the north of the city, with Everton (6.3 families per 1,000 population) Anfield (6.2 families per 1,000 population) and Tuebrook & Stoneycroft (5.6 families per 1,000 population) containing the highest number.

5.1.3 Children in Need (CIN)

Children in Need (CIN) are those who have been assessed by children's social care to be in need of services. These services can include, for example, family support (to keep together families who are experiencing difficulties); leaving care support (to help young people who have left local authority care); adoption support; or disabled children's services (including social care, education and health provision).

In April 2015 there were 4,287 children and young people in Liverpool identified as being in need. While levels of need are higher than those in England, they are comparable to other Core Cities. The largest cohort of children in need are aged 10 to 15 years, accounting for just over 30% of cases, followed by 5 to 9 years (28%) and 0 to 4 years (24%).

Abuse or neglect is the most common cause of children assessed as being in need, accounting for four in ten cases, followed by family dysfunction - mirroring the national pattern. Figures for 2015 indicate that the primary cause has not been recorded in one in five cases in Liverpool.

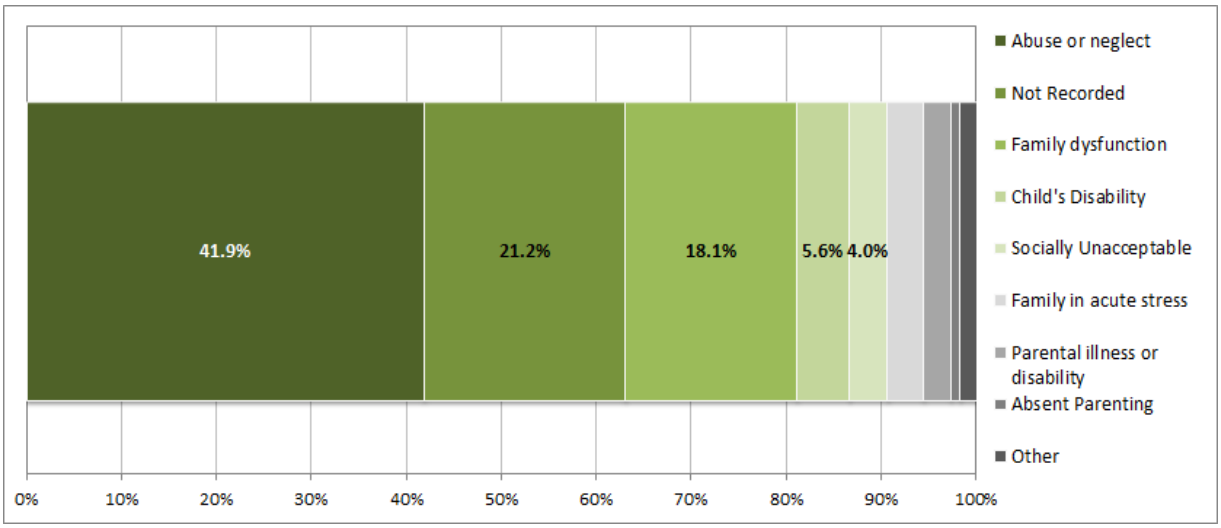


Figure 18: Children in Need – Category of Need in April 2015
Source: Children's Services

There are no robust projections available relating to the number of children and families that might need support in the future, due to the multitude of influencing factors and social pressures. However, we know that the number of people under-18 is projected to increase by over 5% over the next decade. If the prevalence of children and young people in need stays the same, then the demand for early help and support would also increase.

In the longer term, improvements in care are likely to lead to improved survival rates for children with complex needs and disabilities. This could mean that the prevalence of disability within the population could increase leading to higher numbers of children requiring support.

Focusing resources on prevention services and early intervention/support can help to reduce the risk of escalating need and the requirement for more intensive levels of support.

5.2 Children at risk of harm

5.2.1 Child Protection Plans

Children and young people that become subject to child protection plans do so because a child protection conference considers them to be, or likely to be, suffering significant harm. Any child or young person under the age of 18 can be subject to a child protection plan in order to safeguard them from significant harm. Significant harm is where the child's health or development is adversely affected compared to what may be reasonably expected of their peers. In April 2015 there were 455 child protection plans in place in Liverpool, and the latest figures indicate levels in the city are comparable to the national and core city averages. The largest cohort of children subject to a CPP are aged 10 to 15 years, accounting for just over 30% of cases, followed by 5 to 9 years (28%) and 0 to 4 years (24%).

A range of parenting issues may lead to a child suffering harm:

- **Emotional abuse** - persistent emotional maltreatment of a child that is likely to adversely affect their emotional development
- **Physical abuse** - any treatment of a child or young person which causes physical harm to them. It may also be caused when a parent fabricates the symptoms of, or deliberately induces illness of a child
- **Sexual abuse** - involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening
- **Neglect** - persistent failure to meet a child's basic physical and/or psychological needs

Latest figures for Liverpool indicate that neglect is the primary reason for a child protection plan in the city, accounting for more than four in every ten cases. This is an increase on the previous year when neglect accounted for just under a third of cases. There has also been an increase in the proportion of CPPs due to emotional abuse. Conversely, the proportion of child protection plans relating to physical and sexual abuse has declined since 2014-15.

Category of Abuse (Registrations)	2014/15	2015/16
Neglect	32.9%	44.4%
Emotional abuse	35.8%	42.2%
Physical abuse	23.7%	13.3%
Sexual abuse	7.6%	0.0%

Table 14: Child Protection Plans – Category of Abuse in April 2015
Source: Children's Services

As a result of abuse and neglect, children and young people are at risk of a number of poor outcomes. The Government's Working Together to Safeguard Children guidance[1] includes a summary of the known impacts of abuse on children's health and development. These include:

- Poor mental health including disorders such as anxiety, depression, and eating disorders
- Participation in risk-taking behaviours such as substance abuse, youth offending and anti-social behaviour
- Impaired growth, poor emotional and intellectual development and poor social functioning
- Physical injury leading to neurological damage, disability or in extreme cases death

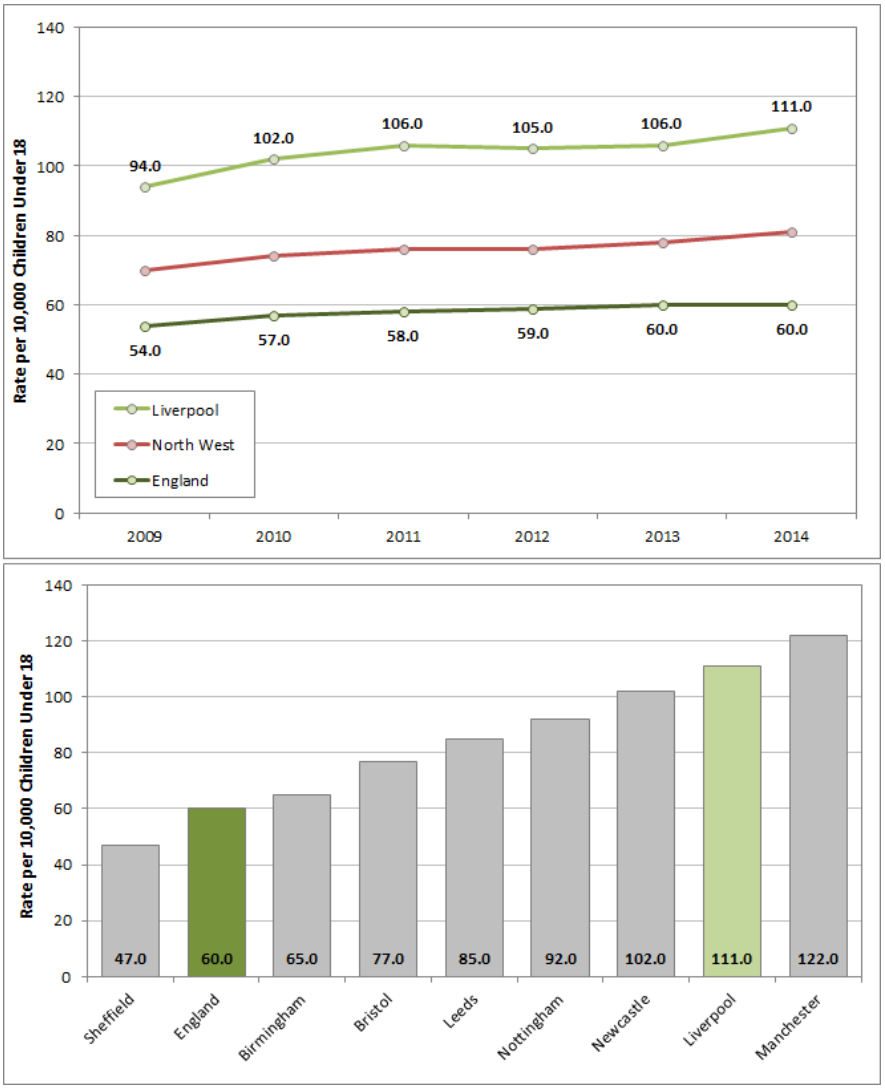
There are no robust projections available relating to the number of children and young people that might be subject to a Protection Plan in the future due to the multitude of influencing factors and social pressures. However, we know that the number of people under-18 is projected to increase by over 5% over the next decade. If the prevalence of children and young people living in circumstances that mean they are at risk of abuse or neglect stays the same, then the number of child protection cases would also increase.

We also know that a large number of families in the city may be subjected to increase financial pressures over the coming years due to changes being implemented within the welfare system. This is in turn may lead to an increase in stresses within the family, and a consequent increase in the risk of abuse.

5.3 Looked after Children / Children In Care

5.3.1 Number of Looked After Children

"Looked after children" are those that are under the age of 18 and within the care of the local authority. Entering care is strongly associated with deprivation and with emotional and mental health problems. In addition, the outcomes for children and young people in care are often poorer than those of the general child population. Local and national evidence shows that the majority of young people that enter the care system do so because of abuse or neglect and family difficulties.



National figures released by the Department for Education indicate that the rate of looked after children in the city is almost double national levels. Between March 2009 and March 2014 the rate of looked after children has increased by 18% in Liverpool, compared to an 11% increase nationally.

While high compared to England, the Liverpool rate is comparable to cities such as Newcastle and Manchester.

Figure 19: Looked After Children – Rate per 10,000 children at March 2014
Source: Department for Education Statistics

At the 31st March 2015 there were just under 1,000 looked after children in Liverpool, and each year the balance between the number of children entering and leaving care has been broadly comparable. During 2014-15 389 children and young people in Liverpool entered care, an 80% increase since 2010-11.

	2010-11	2011-12	2012-13	2013-14	2014-15
	Figures at 31st March 2011	Figures at 31st March 2012	Figures at 31st March 2013	Figures at 31st March 2014	Figures at 31st March 2015
Number of LAC	941	899	957	990	997
Starters	215	270	280	385	389
Leavers	220	290	270	340	385

Table 15: Starters & Leavers
Source: Children's Services and Department for Education Statistics

5.3.2 Demographics of Looked After Children

The profile of looked after children in Liverpool is broadly similar to the national pattern, though slightly younger. Latest figures also show that a higher proportion of Liverpool cases are male.

Area	Sex		Age				
	Male	Female	Under 1	1 to 4	5 to 9	10 to 15	16 to 18
Liverpool	50.9%	49.1%	5.7%	16.3%	24.3%	38.6%	15.1%
England	55.0%	45.0%	6.0%	17.0%	20.0%	37.0%	21.0%

Table 16: Demographics of Looked after Children in Liverpool at April 2015
Source: Children's Services and Department for Education Statistics

Latest figures show that looked after children in the city are more likely to come from an ethnic minority group than the general child population. In March 2014, 80% of looked after children in Liverpool were white, compared to 84% of the general population. Black/Black British and Mixed ethnic groups are particularly overrepresented.

Population	White	Mixed	Black or Black British	Asian or Asian British	Other Ethnic Groups
Liverpool Young People	84%	5%	4%	4%	3%
Liverpool Looked after Children	80%	7%	6%	1%	6%

Table 17: Ethnicity of Looked after Children in Liverpool
Source: Department for Education Statistics & 2011 Census

5.3.3 Category of Need

Mirroring the national picture, the majority of looked after children cases in the city are related to abuse or neglect (6 in 10 cases locally). Parental illness or disability, family in acute stress, and family dysfunction all accounted for just under one in ten cases each.

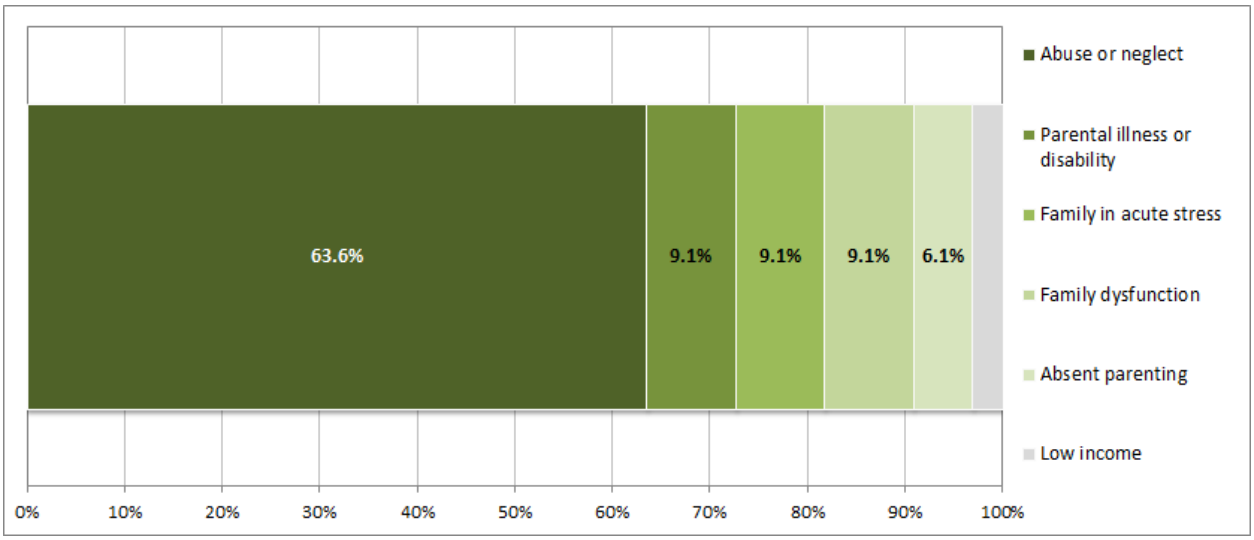


Figure 20: Looked After Children – Category of Need in April 2015
Source: Children's Services

5.3.4 Health & Wellbeing of Looked After Children

Physical Health

As a 'corporate parent' the Local Authority is required to ensure all children they look after for more than 12 months receive annual health assessments, to help identify the health needs of each child. Figures published by the Department for Education suggest that the percentage of looked after children in the city who have had their annual health assessment is comparable to other Core Cities, and above national levels. Uptake in the city is above England for all the various assessments. Maintaining high uptake of health checks is important because it helps to identify issues early, and helps the child develop an understanding of how to look after their health and make healthy choices in future.

Area	Children who had their annual health assessment	Children whose immunisations were up to date	Children who had their teeth checked by a dentist	Children aged 5 or under whose development assessments were up to date
England	***88.4%***	***87.1%***	***84.4%***	***86.8%***
Liverpool	**93.8%**	**94.5%**	**91.8%**	**100.0%**
Newcastle	94.7%	90.8%	72.4%	100.0%
Manchester	93.9%	91.8%	98.5%	72.7%
Leeds	98.0%	98.0%	69.3%	100.0%
Sheffield	80.3%	81.6%	59.2%	85.7%
Nottingham	75.3%	95.1%	82.7%	89.5%
Birmingham	93.4%	98.5%	90.9%	100.0%
Bristol	89.9%	78.8%	91.9%	x

Table 18: Health and care assessments of Looked After Children at March 2014
Source: Department for Education Statistics

Mental Health

Entering care is strongly associated with emotional and mental health problems. Children and young people who are looked after have[49]:

- A five-fold increased risk of mental disorders (42% versus 8% amongst ages 5-10);
- A six to seven-fold increased risk of conduct disorder;
- A four to five-fold increased risk of attempting suicide in adulthood.

Since 2008 all Local Authorities have been required to collect information on the emotional and behavioural health of the children they look after, using the Strengths & Difficulties Questionnaire (SDQ). Use of the SDQ can help in the early identification of emotional and mental health challenges and improve access to appropriate support and treatment. Figures for March 2014 show that 81% of looked after children in the city had completed the SDQ; significantly higher than the national average (68%).

Table 16 below shows the banded scores for each of the Core Cities in England. The latest figures show that Liverpool has the smallest proportion of looked after children whose SDQ score indicate there may be a cause of concern (30%).

Area	Banded Strengths & Difficulties Questionnaire Score		
	Normal	Borderline cause for concern	Cause for concern
England	***50%***	***13%***	***37%***
Liverpool	**59%**	**11%**	**30%**
Newcastle	57%	10%	34%
Manchester	57%	12%	31%
Leeds	51%	16%	34%
Sheffield	41%	14%	45%
Nottingham	41%	18%	41%
Birmingham	57%	11%	32%
Bristol	48%	12%	40%

Table 19: Strengths & Difficulties Questionnaire results at March 2014
Source: Department for Education Statistics

5.3.5 Placement

The Children Act (1989) and the Children and Young Persons Act (2008) place a requirement on Local Authorities to ensure that children within their care are placed near to their homes. However, ensuring children receive a suitable placement may mean that they are located outside Liverpool.

The latest information indicates that around two thirds of looked after children placements are within the city, with the majority of other placements in the neighbouring local authorities of Sefton (10%), Knowsley (5%) and Wirral (5%). There is substantial variation across the Core Cities in England, with a third of looked after children in Nottingham placed within their city boundary compared to 74% of looked after children in Leeds.

The City Council is the largest provider of placements for looked after children in the city, accounting for almost 4 in every 10 cases. Comparatively few children in the city are placed with parents or other adults with parental responsibility.

The type of placements given to looked after children in Liverpool are comparable to the national picture, with around three quarters of children being placed with foster parents. However, the percentage of children placed with a parent is more than double the national average (13%, compared to 5%).

5.3.6 Education

Educational attainment of Children in Care is of particular concern; the attainment gap is the widest of any group both locally and nationally. Figures for 2014 show that only 13% of looked after children in Liverpool gained 5 A*-C GCSEs (including English and Maths), compared with 49.9% of all Liverpool children[50].

5.3.7 Care Leavers

Local Authorities, CCGs and NHS England should ensure that there are effective plans in place to enable looked-after children aged 16 or 17 to make a smooth transition to adulthood, and that they are able to continue to obtain the health advice and services they need[51].

The Liverpool Leaving Care Team provide advice and support to young people aged between 16 and 21 that have been in care but are preparing to, or are, living independently. The team provide a wide range of services and support covering issues such as education, housing, benefits, employment and others. Financial as well as practical support is provided to support and enable young people leaving care to obtain the best start in life.

The City Council has signed a Care Leavers Charter[52] that sets out the principles the Council will follow when making decisions about young people's lives. The charter is designed to raise expectation, aspiration and understanding of what care leavers need and what Government and Liverpool City Council should do to be good Corporate Parents. The principles include promises to:

- Respect and honour your identity
- To believe in you
- To listen to you
- To inform you
- To support you
- To find you a home
- To be your lifelong champion

5.4 Local Authority Designated Officer (LADO)

Each Local Authority is required to have a Local Authority Designated Officer (LADO). The LADO is based within Children's Services and should be alerted to any situation where it is alleged that an adult who works with children (paid, unpaid or volunteer) has:

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against children, or related to a child
- Behaved towards a child or children in a way that indicates they are unsuitable to work with children

The LADO has responsibility for the management and oversight of allegations, providing advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

There have been a number of serious case reviews elsewhere in the country during recent years that have fed into the development of training and continual improvement for LADO arrangements. There is a recurring theme in these serious case reviews: a lack of safe recruitment processes being implemented in organisations which resulted in a failure to prevent and deter the abuser. In Liverpool, links have been made with departments that do not technically have workers in 'regulated activity' with children; but who do have responsibilities around safe working practices. One such area of concern is that there is no specific safeguarding guidance in relation to direct payments. Carers who receive money from the council tend to employ friends, family members or people they know from social groups. This has led to a blurring of boundaries which could leave children at risk[53].

6. Voice of the Child

It is crucial that the voice of young people is at the centre of any strategy that seeks to improve their outcomes, and the City Council is required to take into account the views and wishes of the children within its' care when making decisions. Research clearly shows that where children and young people are involved in the development and delivery of services, provision is more likely to meet their needs and be welcomed.

National surveys have highlighted that the principles young people want Corporate Parents to work to are:

- working in partnership to meet their needs
- put young people before the convenience of the system
- look after those who look after them
- employ only committed, skilled and motivated staff and carers
- accept and value who they are
- prepare them for adulthood

7. Evidence of What Works

There is a wide range of guidance and evidence to support local policy makers and front line staff to improve the outcomes for children and young people who are vulnerable to safeguarding risks or who are looked after. The following section is not intended to be an exhaustive list, only to highlight a number of the key sources of guidance and evidence.

7.1 NICE Guidance

7.1.1 Public Health Guidance 28: Looked After Children & Young People[54]

Joint guidance on looked after children from the National Institute of Health & Care Excellence (NICE) and the Social Care Institute of Excellence (SCIE) emphasises the role of commissioners of health services and local authority children's services. The guidance recommends that commissioners' focus on ensuring services enhance the quality of life of the child or young person by promoting and supporting their relationships with others. Guidance stipulates that service commissioning for looked-after children and young people is informed by:

- The views of children and young people.
- National evidence, guidance and performance data.
- The local corporate parenting strategy.
- Local knowledge and experts (for example, the director of public health).
- Local audits.
- The Joint Strategic Needs Assessment (JSNA).
- Local plans and strategies for children and young people's health and wellbeing.

The guidance also emphasises the importance of commissioned services dedicated to looked-after children and young people that are integrated, preferably on the same site, and have expert resources to address both the physical and emotional health needs.

7.1.2 Public Health Guidance 50: Domestic Violence & Abuse[55]

In 2014 NICE released guidance on domestic violence and abuse. This should be considered when developing the local strategic and operational approach to tackling the issue and its' impact on both the child and wider family.

Recommendation 10 of the guidance relates to the identification and referral of children and young people affected by domestic violence and abuse, and contains the following key actions for providers of services:

- Ensure that staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people.
- Ensure that staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. The violence and abuse may be happening in their own intimate relationships or among adults they know or live with.
- Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs.
- Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse.
- Ensure that staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate.
- Ensure that staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.
- Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse.
- Monitor these policies and services with regard to children's and young people's needs.

7.1.3 Public Health Guidance 40: Social and emotional wellbeing - early years[56]

This guidance aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The term ‘vulnerable’ is used to describe children who are at risk of, or who are already experiencing, social and emotional problems and need additional support.

The guidance is for all those responsible for planning and commissioning children's services in local authorities (including education), the NHS and the community, voluntary and private sectors. Key recommendations include:

- Adoption of a 'life course perspective', recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing.
- Focus on the social and emotional wellbeing of vulnerable children as the foundation for their healthy development and to offset the risks relating to disadvantage. This is in line with the overarching goal of children's services, that is, to ensure all children have the best start in life.

- Ensure universal, as well as more targeted services, provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing. (Key services include maternity, child health, social care, early education and family welfare.)
- The guidance should be used in conjunction with local child safeguarding policies.

7.1.4 Developmental Guidance

In addition to the guidance set out above, NICE are in the process of developing a number of guidance papers that are related to the Safeguarding agenda:

- Preventing unintentional injury among children and young people under 15 (expected publication date: January 2016)
- Early years - promoting health and wellbeing (expected publication date: August 2016)
- Harmful sexual behaviour among children and young people (expected publication date: September 2016)
- Child Abuse & Neglect (expected publication date: September 2017)

7.2 Department for Education Guidance

7.2.1 Promoting the health and well-being of looked-after children[57]

Joint statutory guidance on improving the health and wellbeing for looked after children was released in March 2015 by the Department for Education and Department of Health. Local authorities must comply with this guidance unless there are exceptional reasons that justify a departure. The guidance highlights a number of areas for action that relate not only to placements, but how services and organisations should interact with each other:

- The Local Authority that looks after the child must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010*.
- The initial health assessment must be done by a registered medical practitioner. Reviews may be carried out by a registered nurse or registered midwife.
- The Local Authority must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan.
- When a child starts to be looked after, changes placement or ceases to be looked after, the responsible Local Authority should notify, among others, the CCG – or, in the case of a placement out of authority, both the originating and the receiving CCG (or local health board in the case of a child looked after by a local authority in England but living in

Wales) – and the child's GP. If the child is moved in an emergency, the notifications should happen within five working days. Prompt notifications are essential if initial health assessments are to be completed in good time.

- Looked-after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.
- CCGs and NHS England have a duty to cooperate with requests from Local Authorities to undertake health assessments and help them ensure support and services to looked-after children are provided without undue delay.
- Local Authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area.
- The health needs of looked-after children should be taken into account in developing the local JSNA and the Joint Health and Wellbeing Strategy (JHWS).
- Every Local Authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.
- If a looked-after child or child leaving care moves out of the CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing the child's healthcare and the new providers to ensure continuity of healthcare. CCGs should ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child.
- Local Authorities, CCGs and NHS England should ensure that plans are in place to enable children leaving care to continue to obtain the healthcare they need.
- Looked-after children should be able to participate in decisions about their health care. Arrangements should be in place to promote a culture:
    - where looked-after children are listened to
    - that takes account of their views according to their age and understanding, in identifying and meeting their physical, emotional and mental health needs
    - that helps others, including carers and schools, to understand the importance of listening to and taking account of the child's wishes and feelings about how to be healthy

7.3 Institute of Health Equity

The Institute of Health Equity was established in 2011, to build on the work of the work of Michael Marmot and his team. A key aim of the Institute is to build a strong evidence base to support the design and implementation of policy to tackle health inequalities and improve the social determinants of health.

7.3.1 Why children die: death in infants, children, and young people in the UK[58]

This report outlines the factors behind childhood deaths and actions that can be taken to help prevent them in the future through policy and practice. It highlights five areas for action:

- **Infant Deaths**: The highest mortality occurs within the first year of life. Preventing and reducing the risk of preterm birth, and promoting maternal health can help address this.
- **Acute Illness**: Improvement in the recognition and management of serious illness across all settings of care e.g. General Practice to Community and Hospital care.
- **Injuries and Poisonings**: A concerted and sustained policy response to tackle violence and self-harm among young people is required.
- **Chronic Disease**: Action to improve prevention and care for young people with long term conditions, including mental health.
- **Civil Society & Government**: Children's lives can be protected through supportive social policy and redistributive fiscal measures. The messages are stark and crucial. Poverty kills children. Equity saves lives. Social protection is life-saving medicine for the population[59].

7.3.2 Good Quality Parenting Programmes[60]

Early intervention programmes and strategies are designed to prevent poor outcomes later in life; they may be implemented at any time from conception to the onset of adulthood. This evidence review focuses on two areas of early intervention in childhood: increasing access to parenting programmes and easing children's transition between home and school, with a particular focus on interventions to reduce inequalities in health. Good quality parenting programmes can help mitigate many of the underlying risk factors associated with the Safeguarding agenda.

In addition to providing a review of current evidence and literature, the work by the Institute of Health Equity includes an outline of how local systems can improve parenting through the following actions:

- A strategy that addresses the context in which parents work and live to raise living standards, improve mental health and reduce parental stress through action on poor quality housing, income, debt, skills and education.

- Effective universal programmes that are tailored proportionately to need, that are offered ante-natally and at birth, that improve sensitivity to infants and rates of breastfeeding, and that reduce smoking, alcohol and drug abuse and conflict in the home.

- Promotional interviewing that identifies higher needs through pregnancy and the post-natal period.

- Identification of women at risk of post-natal depression through a universal health visiting service. Programmes to prevent post-natal depression in high risk groups and targeted intervention in mothers with established depression.

- Effective parenting programmes to improve health outcomes, which should be informed by an assessment of need. (Examples of effective programmes are highlighted in the review).

- Good quality affordable early years provision and action on the 21 outcomes identified in 'An equal start', through children's centres and nurseries.

- Use of programmes for older children that address resilience, health and lifestyle behaviours, through parents or schools, the choice of which should be informed by an assessment of need.

7.3.3 Building children and young people's resilience in schools[61]

Resilience is described as the capacity to 'bounce back' from adverse experiences, and succeed despite adversity. Adversity can be defined as a lack of positive circumstances or opportunities, partly brought about by physical, mental or social losses or deprivation, or the experience of trauma.

Building resilience in young people may help to protect against engaging in risky health behaviour, and improve health and health behaviours. Resilience among young people can also help to delay 'transitions' such as parenthood, which can help to avoid the potential negative health consequences of early pregnancy for both parents and babies.

This evidence review focuses on how actions can increase / improve resilience among young people across different spheres, including: individual, interpersonal, and schools & community. It emphasises the need to ensure programmes are accessible to all, but with a need to ensure vulnerable groups receive additional targeted support, i.e. 'proportionate universalism'.

7.3.4 Reducing the number of young people who are NEET[62]

There is good evidence on what works in order to enable and support young people to enter employment, education and training. This paper outlines actions that can be taken at a local level in order to reduce the proportion of young people who are NEET, with recommendations structured around six key themes:

- Act Early
- Tackle barriers and obstacles
- Work across organisational and geographical boundaries
- Work with local employers
- Track people and monitor progress
- Base interventions on features of other successful programmes

7.3.5 Other Publications

The Institute has released a number of other relevant pieces of evidence and guidance that relate to the risks identified earlier in this paper. All of these are available via the Institute website: www.instituteofhealthequity.org

7.4 Other Sources of Evidence & Guidance

7.4.1 The RCGP/NSPCC Safeguarding Children Toolkit for General Practice[63]

In August 2014 the Royal College of General Practitioners and RSPCC released a toolkit to help Practice staff recognise when a child might be at risk of abuse, to know what to do when there are concerns, and to work with other professionals to achieve the best possible outcomes for children by safeguarding and promoting their welfare.

The toolkit is focused on good medical practice and provides a sign-post to the latest safeguarding statutes, policies and tools. It is supported by a strong evidence base for early identification and intervention to improve health outcomes. The toolkit also includes guidance on topical subjects, including: communication with children; looked after children; child sexual exploitation; female genital mutilation; social media; gang abuse; trafficking and radicalisation.

7.4.2 College of Policing – Responding to CSE[64]

In 2015 the College of Policing released guidance to support those responding to child sexual exploitation. It is designed to raise awareness of CSE matters, increase reporting, disrupt offender activity and increase safeguarding measures to help protect children and young people from being sexually exploited.

7.4.3 LGA – Tackling CSE: A Resource Pack for Councils

In 2014 the Local Government Association published a resource pack for Councils that pulled together findings from a number of Inquiries into CSE cases across the country[65]. The recommendations within the resource pack are structured around the following headings:

- Focus on victims
- Engaging with all communities
- Awareness raising and education for professionals and the wider community
- Training for all professionals
- Professional attitudes and use of language
- Leadership, challenge and scrutiny
- Coordinated, strategic responses and performance management
- Disruption and prosecution

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