CORNWALL COUNCIL
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Council of the ISLES OF SCILLY

Director of Public Health Annual Report 2022-2023

A Life Less Equal

10 tales of Cornwall and the Isles of Scilly

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Contents

Foreword

Almost every aspect of our lives impacts our health and ultimately how long we will live.

Some of these relate to our personal characteristics (i.e. age, gender or genetic make-up) whilst others are related to our living and working conditions (i.e. our housing, employment, education and environment).

Whilst we all hope to live longer and in better health, the opportunities for this are not equal across Cornwall and the Isles of Scilly, and the gap has grown over the last decade. These differences in how long we live, or the age at which we get preventable diseases or health conditions are largely unfair and avoidable. Despite putting reducing health inequalities at the centre of our health and care partnerships and NHS ambitions some groups of people continue to spend more of their lives in poor health and dying sooner than others. We can and should do better.

While these differences in health outcomes have always been present, the COVID-19 pandemic and cost of living crisis have shone a spotlight on these differences. Fundamentally, when we don't have the building blocks of health we need like financial security, warm homes, and healthy food, it impacts on how we develop as young children, how well we live, how we achieve our aspirations and crucially, how long we live.

There are many different factors that affect our health, and groups of people who have poorer health, but the differences are surprisingly consistent.

This year's Director of Public Health Report provides a framework to better understand the factors influencing these differences in health status and wellbeing across 10 lenses:

01. Deprivation

02. Geography

03. Protected characteristics

04. Occupation

05. Lived experiences

06. Housing

07. Community safety

08. Education and work

09. Environment

10. Travel and transport

Learning from successful public policy in the past to reduce health inequalities, there is plenty of evidence of steps we could take summarised by Sir Michael Marmot and the Institute of Health Equity. This report also includes examples of local programmes underway to remind us that action can be taken and change is possible. I have selected a range of these programmes for this report as they demonstrate what can happen when we work together across Cornwall and the Isles of Scilly and in partnership.

In my report I am recommending to system partners and leaders to agree to a set of challenging commitments to address inequity in health outcomes across Cornwall and the Isles of Scilly which could improve the lives of many. This will require endurance, partnership and disruption.

We have an opportunity for change and the future health of our residents in Cornwall and the Isles of Scilly will be influenced by how effectively we work together to reduce health inequalities. It is only through a joint vision and co-ordinated efforts that we will be able to make a significant impact for future generations.

Rachel Wigglesworth,
Director of Public Health

Introduction

Opportunities to be healthy are not the same for everyone.

We all benefit when everyone has the opportunity to live a long, healthy, productive life. However, it is a sad reality that in parts of Cornwall and the Isles of Scilly today people are dying 9 years earlier than they should.

The most recent data on how long we live overall (Life expectancy), and the period of people's working lives spent active and healthy (years lived in good health - Healthy Life expectancy), are actually falling across Cornwall and the Isles of Scilly, with life expectancy stalling relative to long-run trends. The slowdown in life expectancy improvement has struck all age groups and disproportionately affected those in less affluent households and communities.

If you travel just seven miles from Shortlanesend near Truro to Perranporth, **life expectancy for women falls by 9 years, from 88 to 79**

Almost every aspect of our lives impacts our health and ultimately how long we will live. This includes our jobs and homes, access to education and public transport and whether we experience poverty or discrimination.

The differences in how long we live, or the age at which we get preventable diseases or health condition are avoidable and despite the progress that has been made over the decades, the benefits of this have not been felt equally across the population, resulting in some groups or individuals continuing to spend more of their lives in poor health and dying sooner than others.

When we don't have the things we need, like warm homes and healthy food, and are constantly worrying about making ends meet, it puts a strain on our bodies and minds. Factors that increase the risk of poor health, like an unhealthy diet, a lack of physical activity, smoking, alcohol misuse, low educational attainment, poor housing, insecure employment and pollution are disproportionally more common in areas of relative economic deprivation, but not exclusively so.

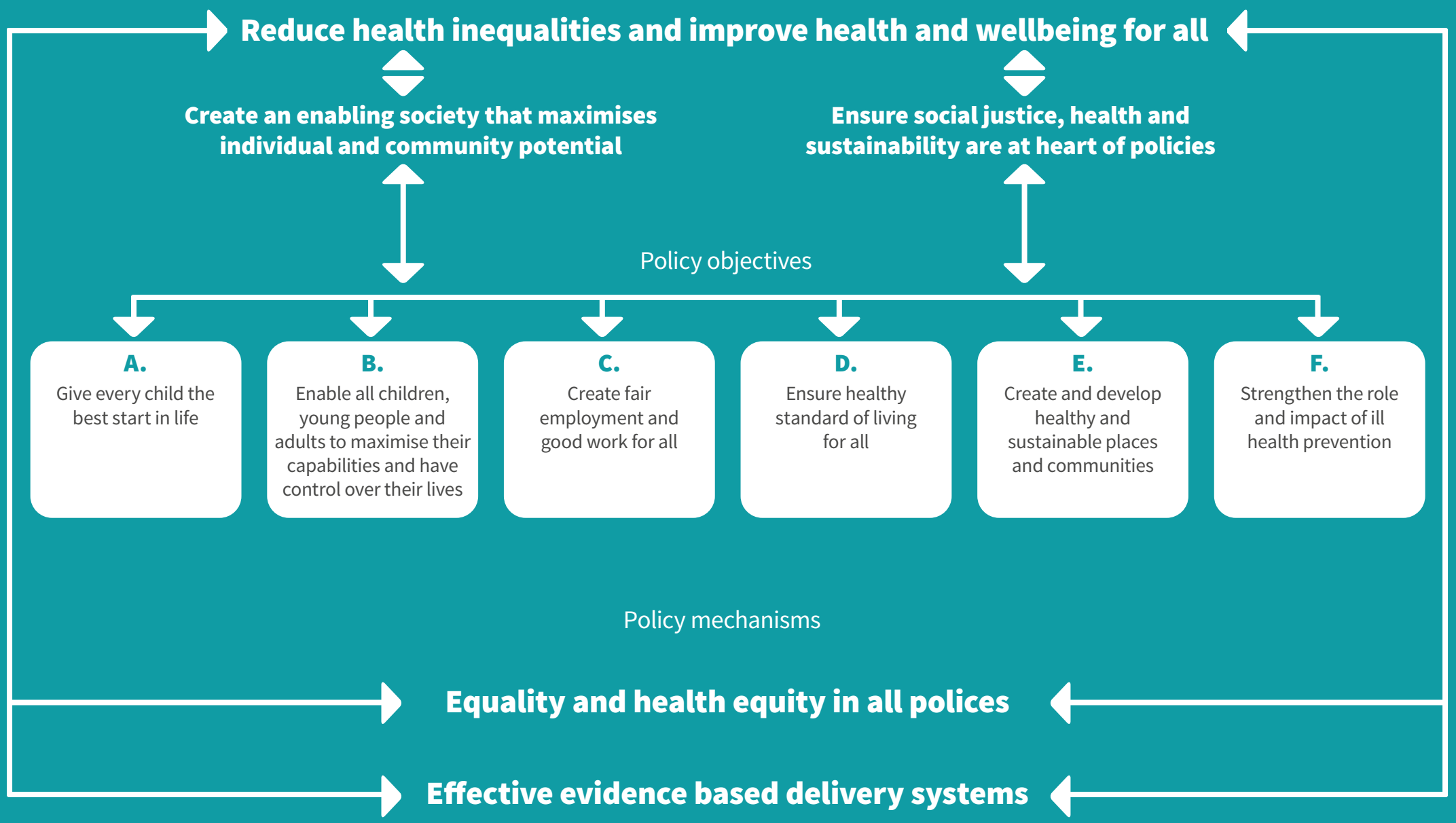
The reality is, almost anyone can experience poverty. Unexpected events such as bereavement, illness, redundancy or relationship breakdown are sometimes all it can take to push us into circumstances that then become difficult to escape.

Many across our communities continue to face barriers that impact on their ability to fulfil their potential because of their race or ethnic group, religion, financial situation, education, sex, age, or because of where they live, such as in a rural or coastal area. As a result, some parts of our community are falling behind and can expect poorer life chances than their neighbours.

Tackling the barriers that prevent or limit health bring positive results for the individual, the economy and society. It enables our population to live healthier, longer lives. In turn, a healthier population will increase the country's prosperity.

> We have to stop seeing health as this enormous hole into which we pour resources and realise that a healthier population is a more productive, economically active population.
>
> **Matthew Taylor, chief executive of the NHS Confederation**

This year's report take a look at some of the key elements which impact on our health and wellbeing which, depending on individual circumstance, can either build and enhance peoples life chances or conversely act as a barrier and prevent an individual achieving their full potential. The report also highlights examples of projects which are seeking to support communities and address the disparities and challenges people across Cornwall and the Isles of Scilly face.



Source: Fair Society, Healthy Lives, 2010

Executive summary

Recommendations

Strategic and partnership opportunities:

01. All partners should **adopt a Health in all policies approach** to that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. Councils and other public bodies should require that financial and business planning has regard for this evidence on health inequalities and should report annually on specific groups affected by their decisions.

02. The Joint Health and Wellbeing Board for Cornwall and the Isles of Scilly should **review the Health and Wellbeing Strategy** (2020) in light of this update on health inequalities by the end of 23/24. This should include development of a specific delivery plan to tackle inequalities in health with clear accountability, resourcing and governance arrangements.

03. **Engage actively in the South West Marmot Region approach** to develop a health equity system involving regional authorities, NHS, local authorities, business and economic sector and voluntary and community sector. This will include 'making the case' tools and a common indicator set.

Give every child the best start in life:

04. There should be **a greater focus on reducing inequalities in maternal health and early years** development as this best life stage to improve future health. Whilst support is needed for all families and young people, it needs to be proportionately greater in more deprived areas, educational settings and groups identified in this report to ensure fairness and wellbeing for future generations.

Ensure a healthy standard of living, fair work and good employment for all:

05. A sustainable and fair economy should focus on creating well-being for all. The employment and skills strategy, and adult education should increase opportunities for those in the most deprived communities in Cornwall and Isles of Scilly. In addition, the Councils and economic partners should develop a policy approach which explicitly outlines **how an inclusive economy will be achieved for our most excluded groups.**

06. Support a movement for Cornwall **to become a Living Wage Foundation Place** promoting Living Wage accreditation to address in work poverty. This will require collaboration between leaders and local anchor institutions to create and action group, understand low pay in Cornwall and develop a Low Pay Action Plan.

Create and develop healthy and sustainable places and communities:

07. We should all seek to **change attitudes, systems and behaviours** that perpetuate discrimination and disadvantage. Collectively we should all be knowledgeable and confident in equality, diversity and inclusion matters. Our provision of services and facilities need to be accessible to all, which includes better consideration of geographical, physical, communication and digital access and barriers.

08. Councils should consider new solutions to **address the inequity driven by the second home housing market** to improve access to affordable, secure and good quality housing in Cornwall and Isles of Scilly. New housing is only part of the solution, and we need to better use existing stock, and improve its warmth and quality to meet housing need, reduce homelessness and improve health.

09. Use the opportunity of devolution and Cornwall and Isles of Scilly place leadership to **explore and apply evidence based policy decisions and market interventions which can reduce health inequality.** These might include innovative approaches to tobacco, alcohol or foods by learning from devolved nations and challenging national policies which are exacerbating local inequalities.

Understand and engage with our communities:

10. Commit to working together in a coordinated way to develop **a better understanding of community voices, lived experiences** and stories from different sections of our residents to inform and help design our approach to tackling health inequalities and understanding of health need.

11. Ensure local engagement structures such as **Community Area Partnerships** of elected members, and **Integrated Care Areas are aware of health inequalities and can address area based inequality** via their working including investment of levelling up or Shared Prosperity Funds.

12. **Establish an annual Public Health Lecture** aimed at sharing knowledge on key health issues, bringing together the general public, our public sector and voluntary sector partners, community groups and our academic partners who have an interest in medicine and public health. This should begin with an outline of local health inequalities.

Strengthen the role and impact of ill health prevention:

13. The integrated care system should agree a coordinated and **long term joint investment in prevention,** with a focus on those groups identified in this report as at risk of health inequalities in Cornwall and the Isles of Scilly across all ages. This should include a focus on the illnesses that lead to early deaths and reduced quality of life such as circulatory diseases, cancer, and respiratory diseases. All Trusts and Primary Care Networks should have a plan to address health inequalities.

14. All sectors should strive to ensure that **the data used for inequality monitoring are reliable,** of high-quality, and comparable across settings and over time to measure progress. This inequality data should be routinely reported to Boards alongside performance reports, and under the Equality Act 2010, but should be accompanied **with regular deep dive reporting** into specific topics or equality groups.

Executive summary

Introduction

We all benefit when everyone has the opportunity to live a long, healthy, productive life. However, it is a sad reality that in parts of Cornwall and the Isles of Scilly today people are dying years earlier than they should. Differences between groups in our society have been present in our population for generations and regardless of how we measure these unfair and avoidable differences – by risk factors, use of services or outcomes – we find that particular groups within our society are consistently disadvantaged.

It's widely accepted that the COVID-19 pandemic has exacerbated existing socioeconomic inequalities, compounded more recently by the cost-of-living crisis which has hit some groups of people harder than others. Extreme divisions can have far reaching consequences and so it is important at this time to question whether this variation in our socioeconomic situation, how long we live and how long we remain healthy, has risen too far? How we can collectively work to reverse it and how we prevent the development of any extreme variation for future generations?

These inequalities affect us all. Whatever our socioeconomic position, we are likely to be experiencing worse health than the group who is a little better off than we are – in terms of education, occupation, income or deprivation. Action to reduce inequalities, therefore, has the potential to improve the health and life chances of everyone across Cornwall and the Isles of Scilly.

The complex interaction of multiple factors ranging from individual hereditary factors and behaviours to the communities we live in and the wider socioeconomic, cultural and environmental factors have a significant role in our health outcomes is widely accepted. As a result, the solutions and preventive measures we can take to impact positively on our health and reducing health inequalities will involve the communities and organisations across Cornwall. No individual person or organisation can solve these issues but collectively we can work to improve health an inequalities resident in Cornwall experience.

Life expectancy

Life expectancy is an important indicator of overall population health, and inequalities in health. After decades of progress, since 2011 the improvement in life expectancy has stalled.

The most recent data on how long we live overall (Life expectancy), and the period of people's working lives spent active and healthy (years lived in good health - Healthy Life expectancy), are actually falling across Cornwall and the Isles of Scilly, with life expectancy stalling relative to long-run trends. The slowdown in life expectancy improvement has struck all age groups and disproportionately affected those in less affluent households and communities.

In 2001–2003, period male life expectancy at birth (a measure of current health) was 77.3 years across Cornwall and the Isles of Scilly. By 2015–17 it had reached 79.8 years, but there has been no improvement after 2015-17 with life expectancy remaining at 79.8 years in 2018–20.

The persistence of low life expectancy in some our most deprived areas means that despite fragmented efforts, we have not tackled inequalities in health adequately across Cornwall and the Isles of Scilly. There is no simple solution to reducing these inequalities in health. However, there is good evidence of what works from previous approaches that we can use together to build back fairer.

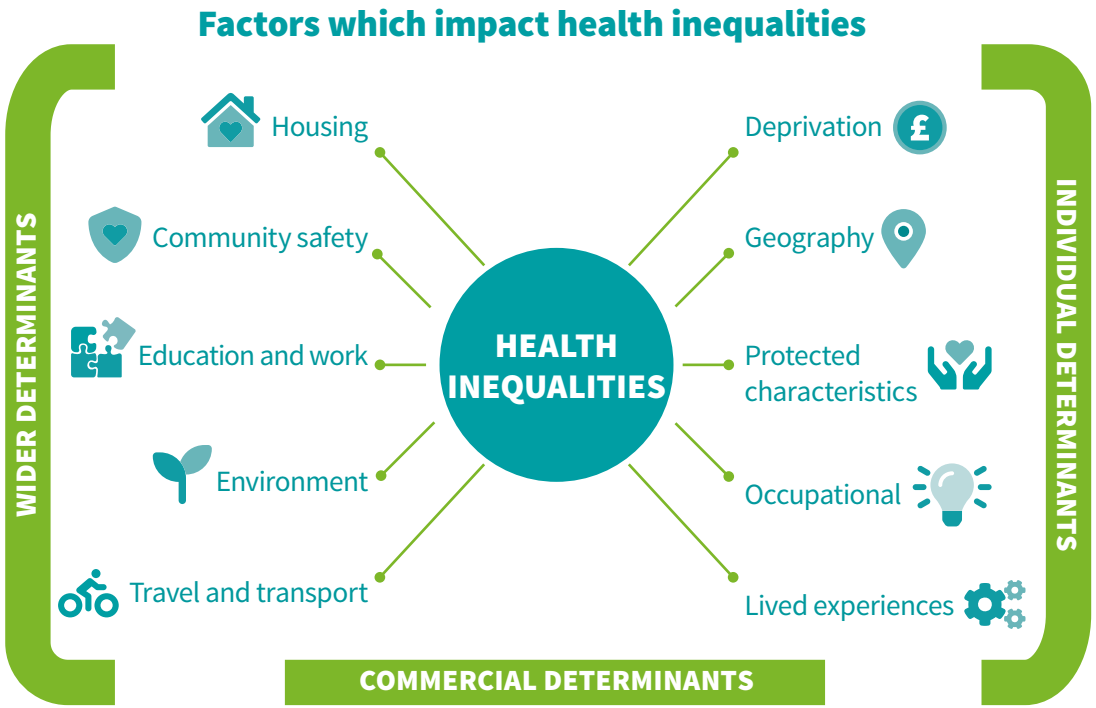
Prevention

Prevention is not new. There are many examples of successful preventative work that have already helped achieve major improvements in health. Early work to improve sanitation, housing and social conditions contributed to improvements in life expectancy in the nineteenth and early part of the twentieth century. Vaccination to prevent disease is commonplace today and has led to a significant reduction in communicable diseases such as measles. It has been instrumental in reducing the harm from COVID-19. National screening programmes for pregnant women, new-born babies and for certain cancers have helped identify issues early, improve health and prevent severe disability or death. Actions to reduce smoking and dietary risk factors have contributed to decline in cardiovascular diseases.

We need to lay the foundations for good health by pushing for a stronger focus on prevention. Everyone has a part to play to enable us to move from dealing with the consequences of poor health to promoting the conditions for good health and designing services that support individuals and communities to achieve better outcomes.

Factors which impact health inequalities

Many people are familiar with the association of deprivation and the impact it has on communities and the resulting inequalities in health and life expectancy. However, similar to the complex nature of the impact of wider determinants on our health, there is more to inequalities and health than the impact of deprivation. This report reflects on ten different factors that have an impact on inequalities, shown in the diagram below.



Deprivation and poverty

People living in more deprived communities live shorter lives with more chronic illness at an earlier age than in more affluent areas in Cornwall.

Children and young people in poorer areas (the under 20s) are much more likely to be living with conditions such as asthma, epilepsy, and to experience alcohol problems.

People in their 20s living in more deprived communities see diagnosed more chronic pain, alcohol problems and anxiety and depression than in less deprived communities.

From 30 onwards, disparities in diabetes, COPD and cardiovascular disease (CVD) rates grow and overtake anxiety and depression, although there is still growing inequality in chronic pain and alcohol problems.

In older age, these health inequalities manifest through inequalities in chronic pain, COPD, diabetes, cardiovascular disease, and dementia.

Geography and access

The typography, settlement pattern and remote nature also brings challenges for many of our communities. Examples of these geographical barriers include:

- Living in a rural area where facilities are limited.
- Living in a rural area where transport is not available when the services are open.
- A long bus/train/boat/plane journey may not be practical because of certain medical complications.

The rural and coastal geography of Cornwall results in higher costs of accessing services owing to higher fuel costs (reduced choice and availability of fuelling and transport options) combined with longer travel distances.

Digital and Online services can help in improving access, however people living in rural areas often have less access to reliable and fast internet. Older people who live in rural communities often have less access to internet or good mobile coverage to access digital services

People living in rural areas can experience social isolation, this is exacerbated in migrant residents who may also experience language and cultural barriers.

Protected characteristics

People living in Cornwall have the right to live life free of discrimination and prejudice. There are a range of protected characteristics which need to be considered when looking at inequalities including

- Age
- Gender
- Ethnicity
- Religion
- Disability
- Sexual Orientation
- Pregnancy and Maternity
- Gender Identity and reassignment
- Marital Status

Adverse impact on health and inequalities for people with a protected characteristic is commonly seen both nationally and in Cornwall. Understanding the nature of inequalities observed in people with protected characteristics living in Cornwall is the foundation of working to address the barriers and challenges that others in Cornwall do not experience.

Occupational

People's occupations are strongly related to multiple dimensions of inequality, such as inequalities in wages, health, and risk of temporary or seasonal employment. Poorer general health and higher rates of illnesses or disabilities are prevalent in some occupation compared to others and this extends beyond workplace accidents and fatality.

Across Cornwall and the Isles of Scilly there are 4 occupations that have been identified as facing greater inequality in health, namely

- Farming and Agricultural workers
- Seafarers
- Carers
- Migrant Workers

Lived experiences

Adults with multiple complex needs are amongst the most excluded people in society. People facing multiple disadvantages experience a combination of problems. For many, their current circumstances are shaped by long-term experiences of poverty, deprivation, trauma, abuse and neglect. Many also face racism, sexism and homophobia.

This presence of overlapping vulnerabilities is associated with extreme health and social inequalities manifesting in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health .

People facing Multiple Complex Needs will be much more likely than the general population to have other needs too, such as long-term health conditions or disability and have significantly higher rates of all-cause mortality than people who have experienced one type of deprivation.

People facing Multiple Complex Needs are often not well supported by mainstream services and as result end up being 'stuck in a revolving door' around different support systems. They fall through the gaps between services and systems because they are assessed on specific issues, rather than their overall need.

Housing

Housing can influence health directly through condition, security of tenure, overcrowding and suitability for inhabitants' needs. Wider aspects of housing that influence health indirectly include affordability and poverty, housing satisfaction, choice and control, social isolation, access to key services such as health care, and environmental sustainability.

To improve physical and mental wellbeing and tackle health inequalities across Cornwall and the Isles of Scilly we need to ensure everyone has access to a warm, dry, safe, affordable home which meets their needs.

Community safety

Community Safety is about communities feeling safe, whether at home, in the street or at work. Perceptions of community safety, whether they are real or perceived, impact on the way people feel and interact in their community with crime and anti-social behaviour (ASB) rates being key factors for local residents in determining a good place to live. The impact of crime on wellbeing is significant and negatively affects ill-health, hospital admissions, new business start-ups and community cohesion.

Social risk factors for involvement in criminal activity, including family factors, community factors, education, financial deprivation, alcohol and drug misuse overlap as important factors for general health and wellbeing. There are conditions, characteristics and influences that can both increase reduce the chances of people coming in contact with the criminal justice system and encourage positive, healthy living.

Education and work

Education is truly one of the most powerful instruments for reducing poverty and inequality and it sets the foundation for sustained economic growth. Educational inequalities emerge in very early childhood and the effects continue throughout a person's life, affecting entry into higher education, future employment and lifetime earnings. Even prior to beginning school, there are differences in children's cognitive and socio-emotional skills. During the school years, these educational inequalities can become more evident and the gap in attainment can widen; nationally it was found that only 8% of young people who were not meeting expectations in reading, writing and maths at the end of primary school went on to achieve pass grades in GCSE English and maths.

Work and income are two of the most important determinants of health and wellbeing. Evidence suggests that (good quality, healthy and safe) work has beneficial long-term physical and mental health effects, and correlates positively with higher healthy life expectancy rates. Conversely, unemployment is consistently seen to have a negative effect on a range of physical and mental health and wellbeing outcomes, including through increased stress and reduced self-esteem, and as a result of financial hardship and insecurity. Furthermore, the health consequences of unemployment have been shown to increase with duration – for mental health and life satisfaction as well as for physical health – and commonly extend beyond the individual to impact on family units. Families without a working member are more likely to suffer persistent low income and poverty.

As the population ages, and the state pension age increases, supporting people with long-term conditions in the workplace will become increasingly important. Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice.

Work and income are two of the most important determinants of health and wellbeing.

Environment

Environmental problems overwhelmingly affect people living in the most deprived areas of the UK. There is a strong correlation between poor environmental quality and economic poverty with ethnic minorities being disproportionately affected. They also have higher rates of underlying health conditions that may make them more vulnerable to the effects of pollution.

The impacts of environmental degradation are concentrated among vulnerable groups and households. Those living in the most deprived parts of England experience the worst air quality and have less access to green space and adequate housing. These problems can affect people's health and wellbeing and can add to the burden of social and economic deprivation which in tun can lower ability to invest in defensive measures (e.g. air filtration and better housing quality) increasing the vulnerability of lower socio-economic households to air pollution and climate change.

Whilst there have been moves in government policies to help address climate change and protect the environment it is important to recognise that the benefits and costs of wider environmental policies are also likely to be unevenly distributed across households. The improvements may be experienced by different social groups in different ways, and it is these distributional differences that can exacerbate inequality if not acknowledged and mitigated.

Travel and transport

Mobility is key to a socially and economically connected society and a good transport system enables residents and visitors across Cornwall and the Isles of Scilly to live their lives. Transport makes it possible to go to work or school, see friends, visit the shops, and get access to welfare provision, hospital services, leisure facilities, financial support and housing. Unfortunately, lack of access, unfair barriers and disproportionate negative impacts can restrict certain groups' ability to move around and travel – thereby affecting their wellbeing and life chances, specifically:

- People may not be able to access services as a result of social exclusion. For example, they may be restricted in their use of transport by low incomes, or because bus routes do not run to the right places. Age and disability can also stop people driving and using public transport.
- Problems with transport provision and the location of services can reinforce social exclusion. They can prevent people from accessing key local services or activities, such as jobs, learning, healthcare, food shopping or leisure. Problems can vary by type of area (for example urban or rural) and for different groups of people, such as disabled people, older people or families with children.
- The effects of road traffic also disproportionately impact on socially excluded areas and individuals through pedestrian accidents, air pollution, noise and the effect on local communities of busy roads cutting through residential areas.

What is the challenge?

Differences between groups in our society have been present in our population for generations and regardless of how we measure these unfair and avoidable differences – by risk factors, use of services or outcomes – we find that particular groups within our society are consistently disadvantaged.

Socioeconomic position, ethnic identity and gender, disability, occupation and lived experience are all related to significant variation in health. The underlying causes of these inequalities often cluster together, with people experiencing 'multiple disadvantage' and arise because of the conditions in which we are born, grow, live, work and age.

Its widely accepted that the COVID-19 pandemic has exacerbated these existing socioeconomic inequalities, compounded more recently by the cost-of-living crisis which has hit some groups of people harder than others. Extreme divisions can have far reaching consequences and so it is important at this time to question whether this variation in our socioeconomic situation, how long we live and how long we remain healthy, has risen too far? How we can collectively work to reverse it and how we prevent the development of any extreme variation for future generations.

These inequalities affect us all. Whatever our socioeconomic position, we are likely to be experiencing worse health than the group who is a little better off than we are – in terms of education, occupation, income or deprivation.

Action to reduce inequalities, therefore, has the potential to improve the health and life chances of everyone across Cornwall and the Isles of Scilly.

The model below simplifies the complex system that causes health inequalities.

It shows the different factors that impact our health; where they stem from; and how – both in sequence and simultaneously – they interact, multiply and re-enforce each other.

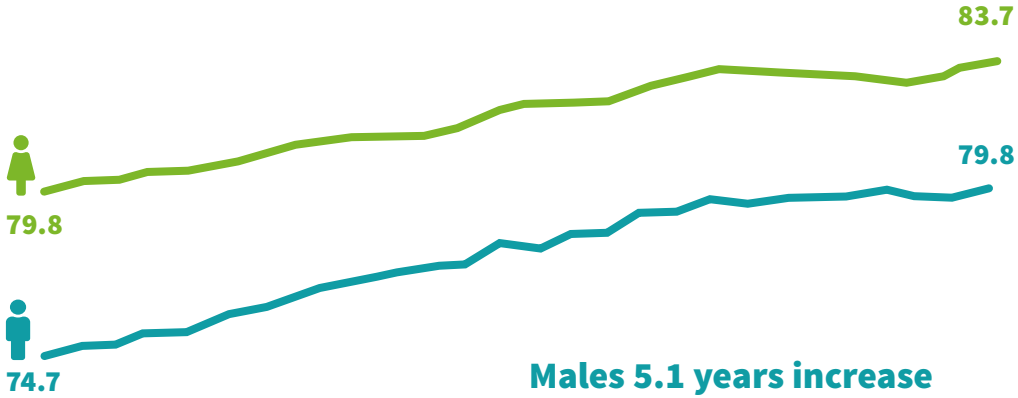
The main determinants of health

Differences in health and life chances are unfair and often avoidable

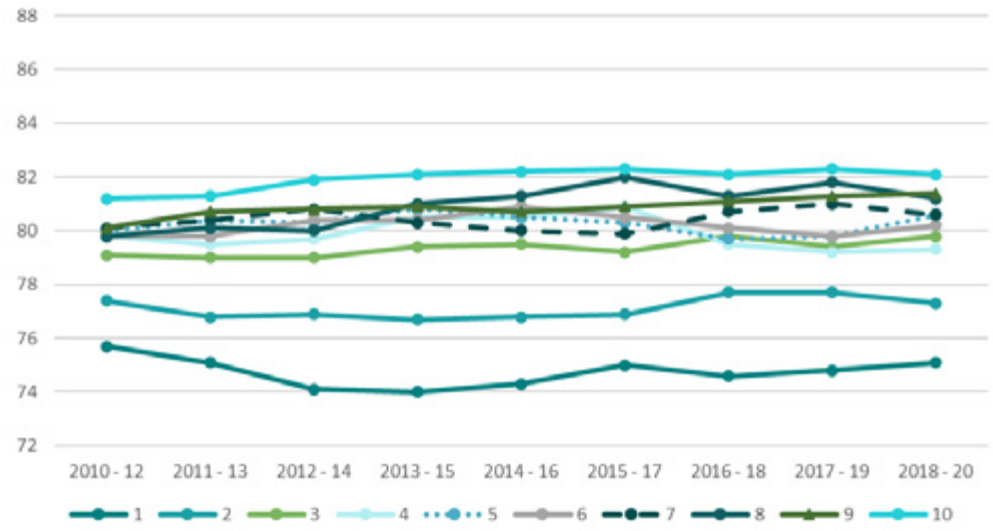
Life expectancy is an important indicator of overall population health, and inequalities in health. After decades of progress, since 2011 the improvement in life expectancy has stalled.

In 2001–2003, period male life expectancy at birth (a measure of current health)* was 77.3 years across Cornwall and the Isles of Scilly. By 2015–17 it had reached 79.8 years, but there has been no improvement after 2015-17 with life expectancy remaining at 79.8 years in 2018–20. The reasons for the slow down and stalling of improvements in life expectancy over the last decade have been well documented by Sir Michael Marmot and the Institute for Health Equity. We will explore this throughout the report. Since 2011-13 there has only been a 0.5 year growth up to the period 2018-20 and with only 2 reporting periods left to complete the 10 year comparison it looks likely that the growth in this last decade will fall far short of those seen previously.

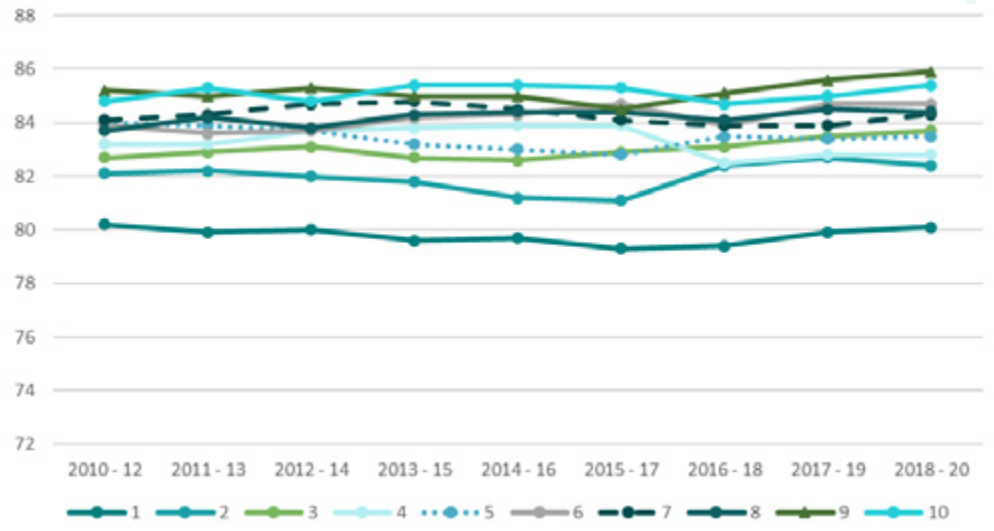
Females 3.9 years increase



Life expectancy at birth - male, deprivation decile Cornwall 2010-2012 to 2018-2020



Life expectancy at birth - female, deprivation decile Cornwall 2010-2012 to 2018-2020



The link between disadvantage and life expectancy is well documented. People living in more affluent areas of Cornwall and the Isles of Scilly live longer than people living in deprived areas with low employment, housing deprivation and smoking among the factors that distinguish these deprived areas with persistently low life expectancy over time.

In 2018 to 2020 **the difference in life expectancy (LE) at birth between the least and most deprived areas of Cornwall and the Isles of Scilly, is 7.0 years for males and 5.3 years for females.**

This variation is stark enough but when you consider that this gap is now wider than 2010 to 2012, where the difference was 5.5 for males and 4.6 for females this emphasises how for many in our communities the situation is worsening.

Males in the most deprived areas of Cornwall and the Isles of Scilly in 2020 are now expected to live for 0.6 years less than in 2010

The persistence of low life expectancy in some our most deprived areas means that despite fragmented efforts, we have not tackled inequalities in health adequately across Cornwall and the Isles of Scilly. There is no simple solution to reducing these inequalities in health. However, there is good evidence of what works from previous approaches that we can use together to build back fairer.

Low socioeconomic position is consistently associated with increased risk of premature death. A child born in England today can expect to live a longer, healthier life than ever before, yet for those growing up in deprivation they still have a one in three chance of dying before they reach 75. How long we live depends greatly on where we live.

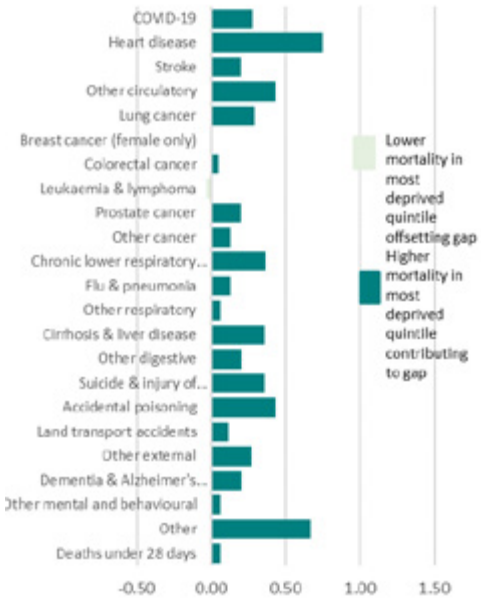
There are some causes of death that drive inequalities in life expectancy more than others. The charts below show, for each detailed cause of death, the contribution in years that it makes to the overall life expectancy gap. Targeting these causes would have the biggest impact on reducing inequalities.

The largest contributors towards the life expectancy gap between the most and least deprived populations across Cornwall and the Isles of Scilly are circulatory diseases, cancer, and respiratory diseases.

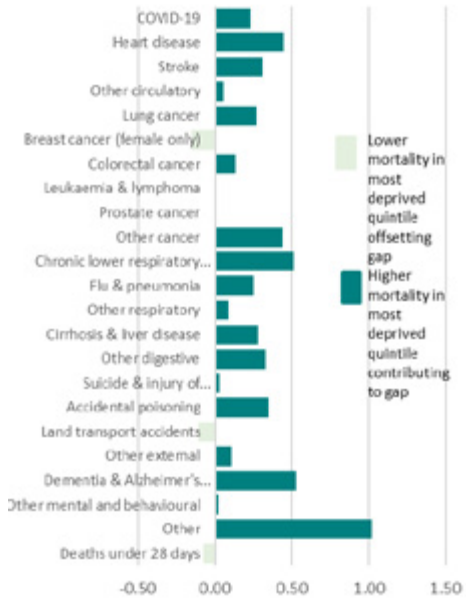
If the death rate from circulatory disease was the same in the most deprived areas as in the least deprived the difference in life expectancy between these groups would be reduced by around 24% for males and 16% for females.

The biggest gap in life expectancy between the least and most deprived is seen in the 60-74 age group. Early deaths are largely driven by cancer, other (inc. COPD and COVID) and ischaemic heart disease. If the death rate for those aged 60-74 was the same in the most deprived areas as in the least deprived the difference in life expectancy between these groups would be reduced by over 40% for males and females.

Male: contribution (years)



Female: contribution (years)



Prevention

There's nothing new about the concept of prevention being better than cure. Focusing on what matters to individuals to promote better health and well-being and stopping them from becoming ill.

Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible. **Prevention is as important at seventy years old as it is at age seven.**

Prevention is not new. There are many examples of successful preventative work that have already helped achieve major improvements in health. Early work to improve sanitation, housing and social conditions contributed to improvements in life expectancy in the nineteenth and early part of the twentieth century. Vaccination to prevent disease is commonplace today and has led to a significant reduction in communicable diseases such as measles. It has been instrumental in reducing the harm from COVID-19. National screening programmes for pregnant women, new-born babies and for certain cancers have helped identify issues early, improve health and prevent severe disability or death. Actions to reduce smoking and dietary risk factors have contributed to decline in cardiovascular diseases.

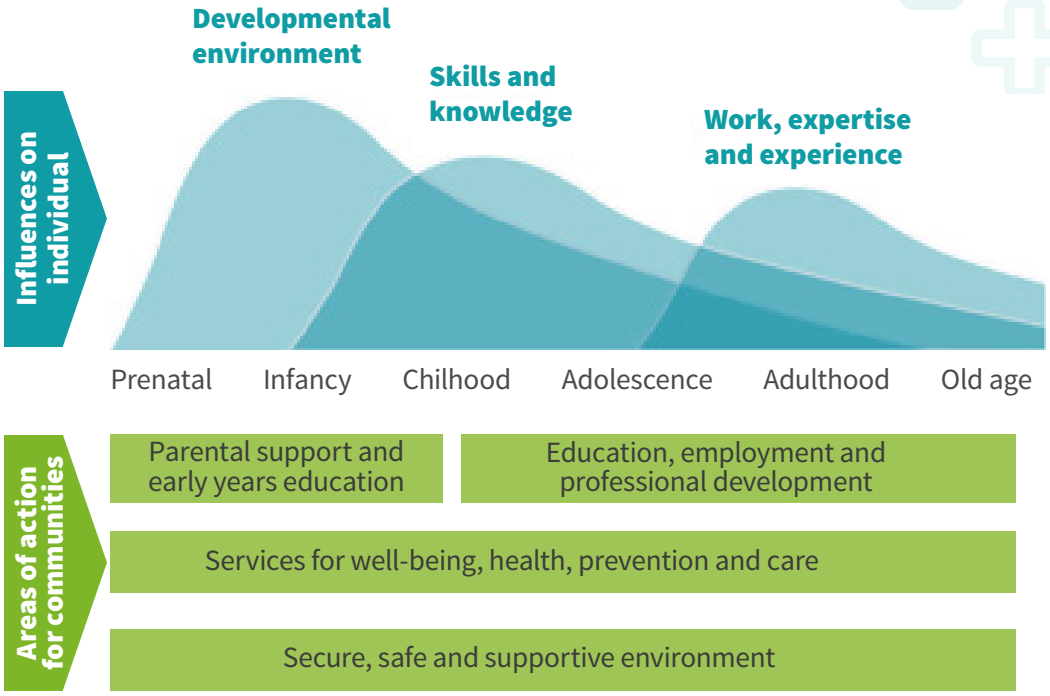
We need to lay the foundations for good health by pushing for a stronger focus on prevention. Everyone has a part to play to enable us to move from dealing with the consequences of poor health to promoting the conditions for good health and designing services that support individuals and communities to achieve better outcomes.

Three types of prevention

- Primary prevention - universal approaches which tackle the causes of ill-health and prevent health problems from developing
- Secondary prevention - early intervention aimed at reducing the progression of health problems
- Tertiary prevention - treatment aimed at reducing and delaying the impacts of ill-health

Collectively, we need to help create a more level playing field to enable and realise the potential of community-led, assets-based preventative approaches to improve heath, life chances and create a more equal society where everyone has the chance to thrive.

A life course approach to prevention



The NHS Five Year Forward View, published in October 2014, gave a very clear message on prevention:

> If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

Opportunities for prevention

One way of describing the opportunities for prevention across our population is in terms of health loss. The concept of health loss captures both the quantity and quality of life lost due to physical and mental ill-health and is measured in disability adjusted life years or DALYs. One DALY represents one year of life that a person in full health has lost.

The Global Burden of Diseases study identifies cancers, cardiovascular diseases, musculoskeletal disorders, neurological disorders and mental health disorders as the leading causes of ill-health and disability, otherwise known as Disability Adjusted life Years (DALYS) across Cornwall and the Isles of Scilly. They represent thousands of avoidable deaths and preventable health conditions every year.

Disability Adjusted life Years (DALYS) represent the number of life years our residents lose, through either premature death or living with disease or disability and across Cornwall and the Isles of Scilly these are increasing faster than England.

The leading conditions that result in people loosing years of life change over the life course i.e. mental health is the leading cause of health loss in those aged 15-49. As such prevention needs to follow a life course approach considering the critical stages, transitions, and settings where large differences can be made by prevention interventions.

DALY Cause (All Age) 2019

01. Cancers
02. Cardiovascular disease
03. Musculoskeletal disorder
04. Neurological disorder
05. Mental disorder
06. Chronic respiratory
07. Other non-communicable
08. Diabetes and CKD
09. Unintentional injuries
10. Digestive diseases

DALY Cause (15-49) 2019

01. Mental disorders
02. Musculoskeletal disorder
03. Substance use
04. Other non-communicable
05. Neurological disorder
06. Cancers
07. Unintentional injuries
08. Self harm and violence
09. Cardiovascular disease
10. Digestive diseases

DALY Cause (70+) 2019

01. Cardiovascular disease
02. Cancers
03. Chronic respiratory
04. Neurological disorder
05. Musculoskeletal disorder
06. Diabetes and CKD
07. Respiratory infections and TB
08. Unintentional injuries
09. Digestive diseases
10. Other non-communicable

What works?

Office for Health Improvement and Disparities (OHID) identified six preventative interventions that could deliver cost savings to the NHS and care system within five years:

- ✓ **Alcohol brief interventions**
- ✓ **Alcohol care teams in secondary care**
- ✓ **Tobacco screening, advice and referral in secondary care**
- ✓ **Improved management of hypertension in primary care**
- ✓ **Increased uptake of long-acting reversible contraceptives**
- ✓ **Implementing a fracture liaison service in secondary care**

Prevention is about helping people stay healthy, happy and independent for as long as possible.

Characteristics of effective prevention work

- Partnership working across sectors
- Multi-component programmes rather than single issue activities
- Programmes that reduce income and employment inequalities
- Widening access by offering prevention in communities and using a variety of methods
- Systematic and individually tailored processes for identifying people at risk and encouraging access to support
- Targeting population groups using appropriate and culturally sensitive language and materials
- Initial approach made by a familiar person, for example, GP or link worker
- Training health and care staff and partners to support prevention

The need for coordinated action

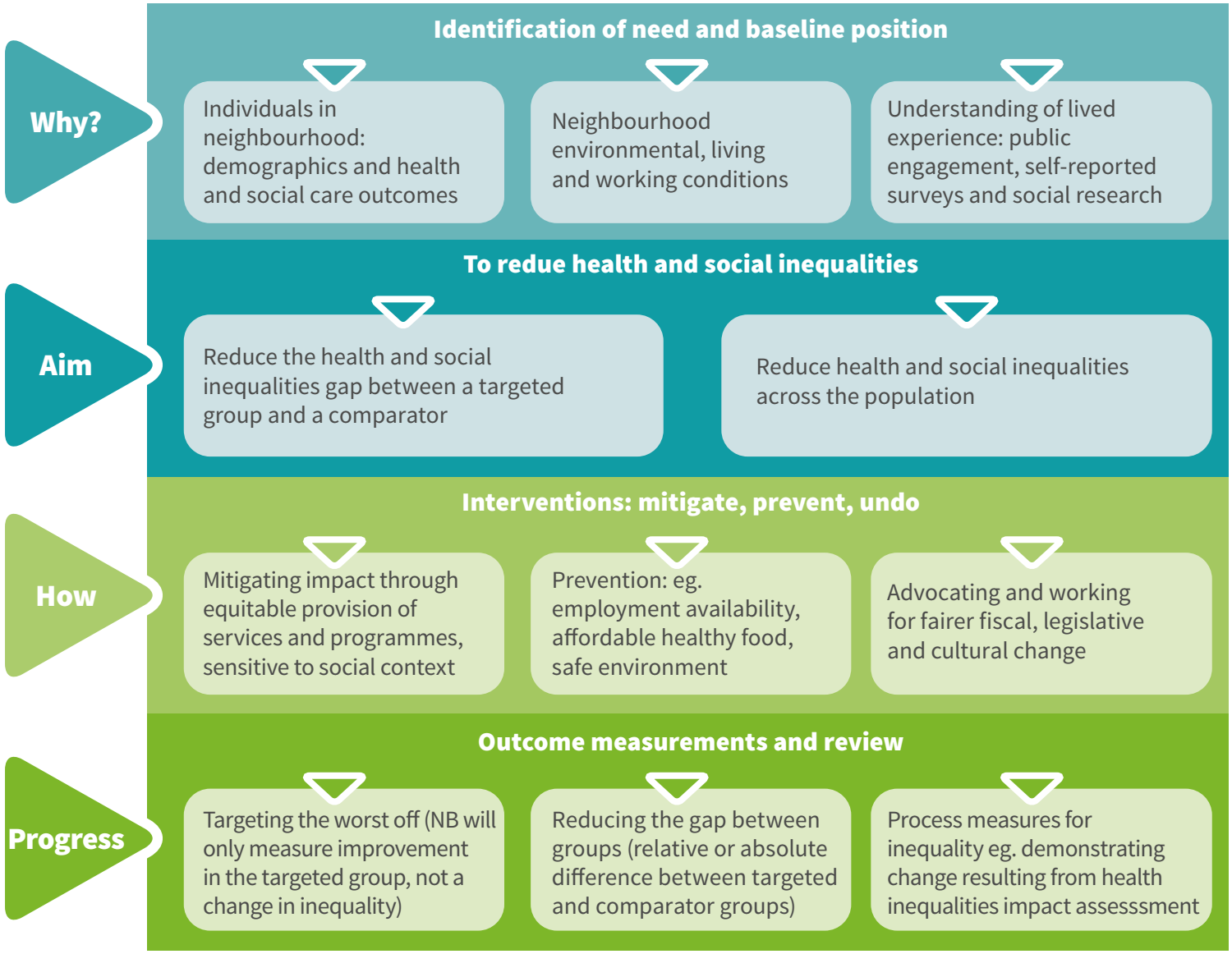
Not everyone will live to the same age and not everyone will enjoy equally good health throughout their life. However, where differences occur because of the circumstances into which we are born, our sex or our ethnicity these are unfair. The Pandemic has highlighted where some of these challenges already occurred and have worsened but it also proved the momentum that can be achieved when agencies work together to tackle a common issue.

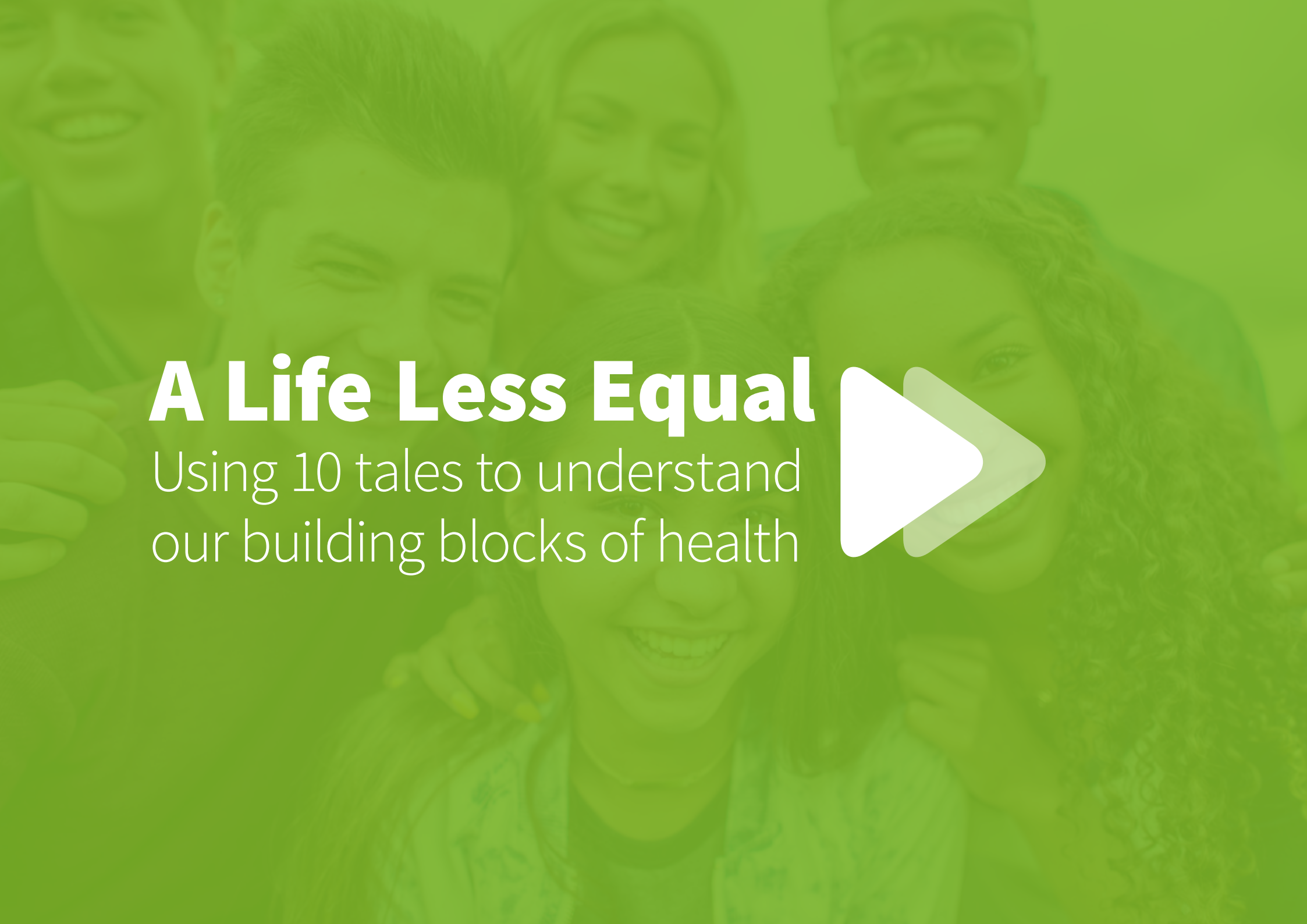
Tackling the widening gaps and divisions across our population is our new emergency and the opportunity needs to be matched by action.

The King's Fund identifies three key aspects which need a fundamental focus in the implementation of any approach to addressing health inequalities.

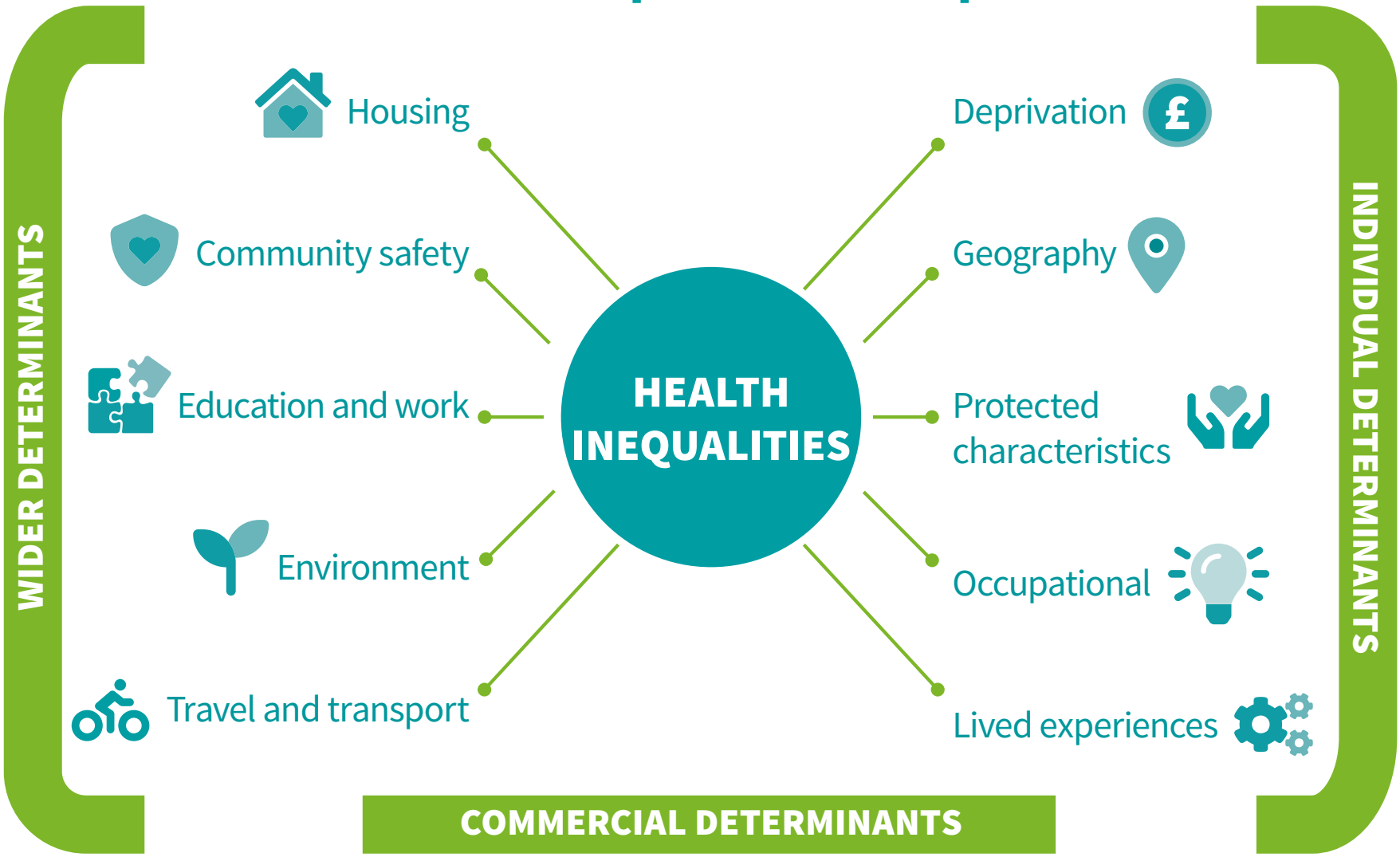
- ✓ **Endurance:** inequality reduction needs a long-term programme that takes it beyond planning cycles, political attention spans and leadership tenure. Its scale requires a balancing of short-, medium- and long-term actions, and a belief that brave changes are being built to last.
- ✓ **Partnership:** tackling inequalities is a multi-agency effort. It cannot be achieved by one part of the system acting alone. Central government, the NHS and local government need to work in close partnership, harnessing the contribution of the voluntary, statutory and private sectors.
- ✓ **Disruption:** to make intervening in care upstream a mainstream model is not an add-on project but a re-invention of the status quo, with all the innovation that this demands. It disrupts patterns of public service delivery that fail to tackle inequalities and which, in some cases, reinforces them.

Framework to review action on health and social inequalities




A Life Less Equal
Using 10 tales to understand
our building blocks of health

Factors which impact health inequalities



Deprivation and poverty

The relationship between deprivation and health is well documented. Poverty damages health and poor health increases the risks of poverty.

Evidence shows that those living in the most deprived areas of England face the worst healthcare inequalities in relation to healthcare access, experience and outcomes - People who live in poorer areas in Cornwall and the Isles of Scilly are therefore more likely to die early from disease and have more years of ill health.

The relationship between deprivation and life-expectancy is systemic – the more deprived an area a person is from, the shorter their life expectancy on average. This relationship holds true across the whole population and is known as the social gradient in health. It is evident in higher mortality from heart and respiratory disease, and lung cancer in more deprived areas. It also manifests itself in a higher prevalence of unhealthy behaviours such as smoking, excess alcohol consumption, poor diet and lack of exercise, which are strongly related to higher mortality and higher rates of obesity in more deprived areas. The gap in healthy life expectancy (the length of time people spend in 'good' health) is even greater than for life expectancy – about 19 years for both males and females – between the least and most deprived areas.

Inequalities can also be observed in people's ability to access care and how they use services. For example, the most deprived parts of England have the fewest number of GPs per head and see lower rates of admission for elective care but have the highest rates of emergency admissions and attendances at A&E.

A recent study 'Quantifying health inequalities in England' [Aug 2022] found that for most of their lives, people in the poorest areas of England, on average, have more diagnosed illness over 10 years earlier than those in the richest areas. **Specifically:**

- Children and young people in poorer areas (the under 20s) are much more likely to be living with conditions such as asthma, epilepsy, and to experience alcohol problems
- People in their 20s see diagnosed chronic pain, alcohol problems and anxiety and depression
- From 30 onwards, disparities in diabetes, COPD and cardiovascular disease (CVD) rates grow and overtake anxiety and depression, although there is still growing inequality in chronic pain and alcohol problems.
- In older age, these health inequalities manifest through inequalities in chronic pain, COPD, diabetes, cardiovascular disease, and dementia.

Reducing deprivation and poverty is a long game. That's why we must make choices now that will give us the platform from which to make progress in the years and decades ahead.

It has been proven that social and economic disadvantages in early life, and the childhood experiences that may come with these disadvantages, have a detrimental effect not only on the children themselves but also future generations. These lead to the children running the risk of having lower incomes, lower skills and lower standards of health in adult life affecting their opportunities and prospects.

What works?

Involve people with first-hand experience of poverty as experts and partners in solving poverty, shaping actions and achieving change.

- ✓ **Organise locally and strategically around a shared goal to reduce poverty, building on what is already there and taking action together.**
- ✓ **Use awareness raising and advice so people can maximise their resources, for example increasing benefit take-up, signposting to affordable credit, or enabling people to get better deals from providers.**
- ✓ **Strengthen community relationships and address barriers such as loneliness, isolation and stigma.**
- ✓ **Facilitate ways to share or reduce living costs, learn or trade skills, for example volunteering, community currencies, or social and neighbourhood enterprise.**
- ✓ **Co-ordinate local advice and service provision, fostering links with community groups, so people can access the support they need when they need it, and not be passed from pillar to post.**
- ✓ **Galvanise community-led approaches and social action to build pressure for change.**

CASE STUDY: Healthy Cornwall and Treneere Team Spirit

Healthy Cornwall aims to support people to lead happier and healthier lives. Since January 2022, Healthy Cornwall have been working alongside Treneere Team Spirit residents' association in Penzance, where 52% of the children are affected by income deprivation. The team have attended Treneere Team Spirt community events, including their Queen's Jubilee event, summer fun day and Christmas party! By attending these events and residents' meetings, the team have been able to build trusted relationships with the community, allowing conversations around health and wellbeing to happen.

"By working together and attending events which we have been able to offer our residents, it breaks down barriers between Healthy Cornwall and residents - hopefully they can then explain their offer and get residents involved, as often it is very difficult for them to make the first step in making contact." Debbie Sims – Treneere Residents' Association.

Alongside community engagement, Healthy Cornwall have made sure that their programmes are accessible for Treneere residents. The Argyle Fit Men's weight loss football at Mounts Bay School, Children's Activity Club at Humphry Davy School and 0-5 swim and adult's free swim at Penzance Leisure Centre, are all within walking distance from Treneere.

"We have been really grateful for the support over the past year and are very much looking forward to continuing to work with them in the future, to build up relationships and get more residents involved in their activities." Debbie Sims – Treneere Residents' Association.

Geography and access

The location in which a person lives, or accesses services as well as the way in which a service is accessed has the potential to exacerbate disadvantage, isolation and poor access to services.

Rural and dispersed settlements

Equitable access to essential services across our communities is essential in tackling persistent inequality and it is in all our interests to ensure those in rural and remote communities can easily access services, employment and education and participate in wider community activities if our rural communities and the individuals within them are to sustain and thrive.

The natural environments of Cornwall and the Isles of Scilly and their peripheral and rural locations are some of the key elements that unite people in their love for the Duchy and Isles of Scilly. However, the typography, settlement pattern and remote nature also brings challenges for many of our communities. Examples of these geographical barriers include:

- Living in a rural area where facilities are limited.
- Living in a rural area where transport is not available when the services are open.
- A long bus/train/boat/plane journey may not be practical because of certain medical complications.
- Higher costs of accessing services owing to higher fuel costs (reduced choice and availability of fuelling and transport options) combined with longer travel distances.

40% of the Cornwall and Isles of Scilly population live in settlements and communities which have under 3,000 residents.

Naturally occurring geographic barriers are evident, the clearest example of this being the Isles of Scilly with 28 miles of sea between it and the mainland but also the archipelago formation also separates communities. Likewise, Cornwall itself has a distinctive peninsular form and the sea forms the northern, southern and western boundaries, with the River Tamar forming the eastern border with Devon. The numerous coastal inlets along its long coastal boundaries alongside large swathes of moorland (e.g. Bodmin Moor) also present challenges in accessing and delivering services.

Overall health comparisons suggest that rural communities often experience better health than urban residents. There are, however, persistent problems that put the focus on rural areas. Examples include the ageing population, road traffic accidents and fuel poverty. Equally, it is no secret that it becomes more costly to deliver the same level of services to rural areas as in urban areas. Population sparsity leads to higher delivery costs and can make it more difficult for commercial providers to recruit and retain staff. So very rural communities may have to travel further to secure services or may receive health care in a different manner (for example through greater use of telemedicine).

It is in nobody's interests, least of all those who live there, for rural and coastal communities to become home only to a narrow cross section of society who can afford the house price and additional costs of access. Some argue that people living in rural and coastal communities have a greater choice than is, in reality, available. A choice is only a choice if it can be taken.

For rural people to exercise a choice to achieve better access to services then they would have to be able to relocate somewhere else. Many have little option due to being 'locked into' accommodation or lack the means to move. Others have limited choice due to their age e.g. a fifteen-year-old choosing their educational progression or local obligations e.g. someone combining local work with care for a relative.

Likewise, for those from minority backgrounds or whom have a distinct cultural identity - barriers to services can have more or less of an impact depending on where you live, for example, in areas where many people of the same ethnicity live, there are more likely to be specialist services available. In places where people are dispersed including many rural areas and coastal areas, barriers can be exacerbated and access to culturally appropriate services can be even more difficult.

Digital / online services

Digital inequalities are becoming one of the social determinants of our health. The trend towards digital access to care has been rapidly accelerated by the pandemic and the internet is being used increasingly across all areas of life.

Digital technology offers a number of benefits to the individual, but the pace of change brings with it an increased risk that some people will be left behind. What's more, it's those already at a disadvantage – through age, education, income, disability, or unemployment – who are most likely to be missing out, further widening the social inequality gap. People living in rural areas have less access to, and slower, internet infrastructure, older people are less likely to own smartphones or connect to the internet, and people with lower incomes are less likely to have access to smartphones in their household and more likely to be on pay-as-you-go mobile phone contracts and data plans which can make it more expensive to access the internet.

A lack of digital skills and access can mean paying more for essentials and financial exclusion. Those who are digitally excluded also lack a voice and visibility in the modern world, as services and democracy increasingly move online.

Inclusion is about making sure that everyone – regardless of age, income, or ability – has the same opportunities, helping to level the playing field for all and digital inequalities do warrant attention if everyone is to benefit from 'digital by default' services.

This is not an insurmountable challenge, and certainly not a reason to stymie digitalisation, but the fact that people remain digitally excluded highlights the importance of ensuring that non-digital alternatives continue to be made available to enable everyone to participate fully in society.

Language and culture barriers

There are a number of barriers to accessing services, but barriers around language and culture are challenges that disproportionately affect people from minority ethnic groups, migrant workers, refugees and asylum seekers. Individuals with limited English language or literacy can find it difficult to engage with services which can prevent or impede access to services, widening pre-existing health inequalities.

A lack of cultural inclusivity - Cultural identity or heritage can cover a range of things. For example, it might be based on ethnicity, nationality or religion. Or it might be to do with the person's sexuality or gender identity. Lesbian, gay, bisexual and transgender people have a particular culture. So do Deaf people who use British Sign Language.

While different groups can have different cultural values, there may be differences within groups as well. It is easy to make assumptions or stereotype and as such it is important that individuals are asked about their specific preferences.

Language and communication - lack of access to necessary translation services acts as a barrier when attempting to access services. This includes face-to-face consultations, as well as accessing information resources, such as written leaflets and appointment letters.

- Across Cornwall and the Isles of Scilly the highest numbers of people who identified their main language is not English were Polish (1,853), Romanian (1,128), Lithuanian (870), Portuguese (678) and Spanish (424)
- In the 2021 Census there were 180 people across Cornwall and the Isles of Scilly where sign language (British Sign Language and other) was identified as their first language.

1 in 6 adults in England have very poor literacy skills

Intellectual barriers

The issue of inequalities for people with a learning disability or other intellectual disability is complex, and it is known that this population experience a range of barriers when seeking access to services appropriate to their needs.

Reasonable adjustments are a requirement of the Equality Act 2010 and evidence suggests that making reasonable adjustments is one major solution in getting the right access to healthcare. Support to communicate for those who may have difficulties in communicating and understanding information is also critical and having the right person there to provide support and assist with communication can mean the difference between a successful intervention and a distressing, or even life-endangering event.

A number of barriers to accessing services have been identified for people with a learning disability or other intellectual disability which include:

- a lack of accessible transport links
- individuals not being identified as having a learning disability
- staff having little understanding about learning disability
- lack of joint working from different services/ providers
- not enough involvement allowed from carers
- inadequate aftercare or follow-up care.

The experience of inequalities across our population is heavily intertwined with place and so tackling issues at the right level is paramount. The following table sets out some of the key considerations that need to be made to reduce access inequality and provide inclusive services:

Universal Barriers Framework

		Inequality/ Excluded Groups – examples	Impact on wider population
Awareness	Users need to be made aware that the service exists, and that they are eligible to use it. They also need to be aware of the service through a range of channels	Refugees and asylum seekers can be unaware of their entitlements to health services in the UK	Anyone new to the UK who may not be aware of their entitlements. Anyone given misinformation about eligibility
Time	Users need to be able access at times that suit their life, and options need to be available to all users to access the service outside of standard hours	Migrant workers often have long working hours or are on zero hour contracts without flexibility to attend appointments during the day	Anyone who is unable to take time off work during the day. Anyone with an insecure or unsupportive workplace
Finance	Users need to be able to afford our services in proportion to the service being offered. It's also good to consider whether users need to pay for evidence, travel or take time off work to complete the service	Gypsy, Roma and Traveller communities often live in remote rural areas and experience economic deprivation	Anyone experiencing poverty with no access to transport
Access	Users who do not have access to internet and digital devices need to be access our services and support they need	The passenger locator form for international travel is not accessible for blind / partially sighted people. No text to speech option available	Anyone who cannot access our services through the available channels or find the right support to access them
Interface/ interaction skills	Users who do not have the ability to use a computer need available options for them to user the service. We also need to consider users verbal ability and dexterity when designing services.	Online booking systems for services can be complicated and stressful for people with cognitive diversity and requires fine motor skills	Anyone unable to use available channels due to permanent, situational or temporary reasons

		Inequality/ Excluded Groups – examples	Impact on wider population
Self confidence	Some users will not have belief in their ability to interact with the service, or to complete tasks, or deal with uncertainty	People with cognitive diversity report excessive worry due to not knowing what to expect before going to receive a service	Anyone who needs to know what to expect of a service in advance so they can plan their available time and resources
Comprehension	Anyone who fears that their data and personal information may be misused in the future	Anyone who fears that their data and personal information may be misused in the future	Anyone who fears that their data and personal information may be misused in the future
Emotional state	Users might not always feel psychologically well enough to take on a task	People with drug or alcohol dependencies report anxiety over having to self isolate	Anyone who fears that they will not be able to self isolate without harming their emotional wellbeing
Trust	Users must have confidence that the people and technology involved will be reliable. The must believe their data will be safe, and not shared without their permission.	Black males are less likely to share their data and personal information with the government due to low trust	Anyone who fears that their data and personal information may be misused in the future
Evidence	Users might not have the ability to provide specific documents, such as passports, driving licence, bank statements, home address or immigration status.	Refugee, asylum seekers and the homeless community report being refused access to register at a GP due to lack of permanent address	Anyone without a permanent address given misinformation about their entitlements to health services
Enthusiasm	Users might not have the enthusiasm to going through a long process, or ask for help, or agree to a request if they are unsure or demotivated to do so.	Repeating LFT tests is an additional barrier to digitally excluded groups	Anyone who finds repeatedly entering personal details to provide LFT results a long-time consuming process

Place based inequalities

Differences in opportunities and outcomes between broad geographic regions – such as between the North and South – are often the focus of attention nationally when debating geographical inequalities.

This has led to the Levelling Up White Paper which states:

> The UK has larger geographical differences than many other developed countries on multiple measures, including productivity, pay, educational attainment and health. Urban areas and coastal towns suffer disproportionately from crime, while places with particularly high levels of deprivation, such as former mining communities, outlying urban estates and seaside towns have the highest levels of community need and poor opportunities for the people who grow up there.

This recognises that areas are not homogeneous entities and can contain pockets of both deprivation and affluence, as well as both areas that are struggling and areas that are growing rapidly.

These spatial inequalities are sometimes referred to as a "postcode lottery" where people living in different communities have very different life outcomes These disparities are even more acute when we look locally across our towns and settlements and where pockets of affluence and deprivation can exist on adjoining streets. Understanding the factors driving these issues and how they could be tackled is therefore vital but there is no one-size-fits-all solution.

We have used three very different communities across Cornwall and the Isles of Scilly to help illustrate how these differences exist here on our doorstep.

Camborne, Pool, Illogan and Redruth


Looe

Isles of Scilly

AN EXAMPLE OF COASTAL HIDDEN DEPRIVATION: Looe

The picturesque fishing harbour of Looe, can be found on the south coast of Cornwall. The town centres around a small harbour and along the steep-sided valley of the River Looe which flows between East and West Looe.

Today, Looe is known as a successful fishing port and tourism destination, but along with its beautiful location comes the frequency of flooding. This impacts not only on residents and businesses but also key services such as the doctor's surgery and police station which are located in the flood zone.

As with many of Cornwall's picturesque coastal towns and villages, the beauty masks some of the deep rooted challenges residents face. Looe is challenged by an ageing population and pockets of considerable deprivation. As a result, on average local people have more complex health and care needs, with a high prevalence of mental health needs. Meeting those more complex needs is challenged by the geographical isolation of coastal communities. Many of the factors contributing to health risks in coastal communities relate to the wider social determinants of health as well as access to services, so working together with partners across all sectors is especially important.

Watch our film on the challenges Looe faces here

Key challenges

- High inward migration of older adults, the economically inactive and people in poorer health, coupled with outward migration of young adults, many of whom leave the area to go to college, university, or for work, and do not return.
- The employment market is dominated by low paid, low skilled, seasonal work, leading to low income and poor long-term career prospects and progression. This contributes to a vicious cycle with educational attainment, leading to significantly lower levels of qualifications, impacting opportunities for higher skilled employment.
- Coastal communities present a unique challenge in relation to housing. Houses of multiple occupation and temporary accommodation (e.g. static caravans) are common. Whilst more affordable, these units are usually the worst type of accommodation for energy efficiency, contributing to fuel poverty. As static caravans are not meant for permanent living, they are exempt from regulations to control their condition meaning many older, vulnerable people are living in substandard shelter. Additionally, the popularity of coastal areas has driven up local house prices.
- Recruiting and retaining skilled and experienced workers across health and social care (e.g. GPs, experienced practice nurses, dentists and health visitors) is a significant challenge. Delivery of health services is becoming ever-more challenging in coastal areas where they struggle to reach the critical mass needed to be sustainable.
- The health services infrastructure, pharmacies, hospitals, and GPs are put under extra strain during peak holiday season, due to the influx of tourists.

Protected characteristics

Age

Age is one of the protected characteristics within the Equality Act 2010 and refers to a person of a particular age (i.e. 18 or 65) or age group (i.e. 16-64).

Why age matters

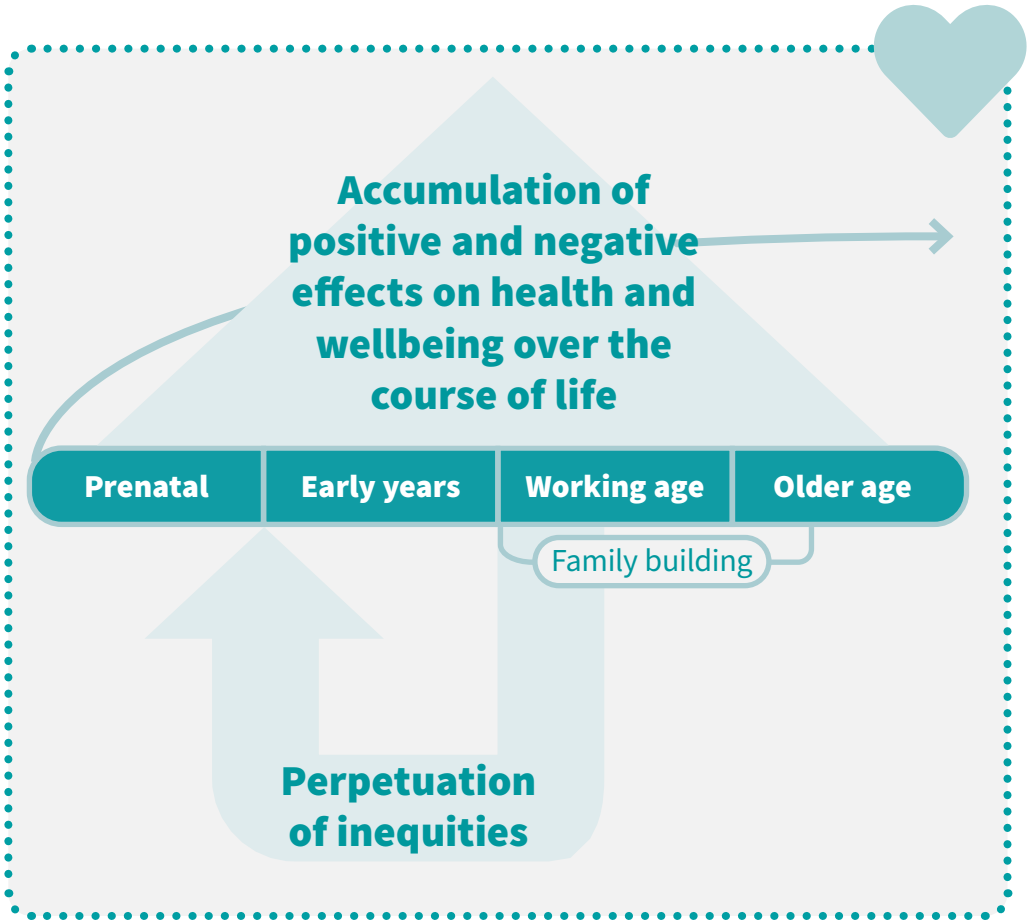
Inequality can affect people of all ages; however, there are some stages of the life-course at which inequality can have a particularly significant impact. Children and young people are often more affected by, and subject to, inequality than adults and they are often the least able to defend themselves against it. What is more, the negative impact of inequalities experienced in childhood can have a long term effect across the life-course, often being perpetuated and exacerbated such that their life chances are significantly reduced.

The ongoing challenge is to break the generational cycle of disadvantage that drives health inequalities. Taking a life course approach values the health and wellbeing of both current and future generations and reinforces efforts to tackle this challenge.

Inequalities compound over the life course

Inequalities accrue and get reinforced over a person's life. They come home to roost in later years, often exacerbating each other and causing greater disadvantage. Poverty, poor health, discrimination and marginalisation are all-too common realities for many older people in both developing and developed countries. As women are the ones with longer life expectancy and more often suffer discrimination than men, many older women can expect to be most affected, living with more years of scarcity and strain.

Negative experiences from previous phases can have an important compounding effect, with the risk that an individual may fall to a lower level on the social ladder. This has special relevance for transitions during mid-life, such as becoming parents, entering and staying in the workforce and preparing for active and healthy ageing. These transitions offer opportunities to proactively intervene to stop the intergenerational cycle of inequality.



Interventions across the life course

This approach attempts to address multiple risk factors in a more comprehensive way, delivering coordinated support for different risk factor-related behaviours, targeting more deprived communities, and reflecting the real-life context of people's lives.

Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

Positive and negative influences across the life course

Protective factors	Risk factors
Having a healthy and balanced diet	Smoking
An environment that enables physical activity	Adverse childhood experiences
Good educational attainment	Crime and violence
Being in stable employment with a good income	Drug and alcohol dependency
Living in a good quality housing	Poor educational attainment

Protected characteristics

Gender

Your gender should not define or limit the choices you make about what you study, where you work, your career ambitions and how you care for others.

Why gender matters

Gender inequality and discrimination are argued to cause and perpetuate poverty and vulnerability in society as a whole . Gender inequality is still a big issue in the UK today and impacts across the course of every person's life. Gender norms, roles and relations, can influence a person's experiences, life chances, exposure to risk of harm and disease and access to services.

Gender inequalities generally affect women and girls more often than men and boys and have led to controversy and activism since the 19th century.
As the government's Gender Equality Roadmap reveals, women in the UK are, on average:

- more likely to enter the workforce with higher qualifications than men, but earn less per hour
- less likely to be employed full time
- more likely to take on unpaid work, such as unpaid care.
- three times as likely to work part time, and
- likely to save less into their private pensions.

Women also have a higher probability of living in disability than men and women with lower socio-economic status are likely to spend longer living with a disability than women with higher economic status, as well as dying earlier. The greater risk of dementia in women, particularly poorer women, requires particular focus including strategies throughout life

Although women live longer than men, they do so in poorer health.

Women and girls also often face multiple and intersecting forms of discrimination and inequalities between genders can be additionally compounded due to factors based on:

- Race
- Ethnicity
- Geography
- Income
- Education
- Religion
- Language
- Sexual orientation
- Gender identity
- Age
- Disability
- Migrant or refugee status

Gender inequalities also exist for men

Harmful gender norms – including those related to rigid notions of masculinity – affect the health and well-being of boys and men. For example, notions of masculinity encourage boys and men to smoke, take sexual and other health risks, misuse alcohol, increase the risks of being involved in or perpetrating violence and not seek help or health care.

Harmful notions and societal norms around masculinity also have grave implications for men's mental health. While women are often encouraged to share their feelings from a young age, men can find themselves programmed be 'strong and silent' and to try and cope alone about problems or worries that may be affecting them – so much so that as many as 40 per cent of men wouldn't talk about their mental health until their struggles had escalated to thoughts of suicide or self-harm.

Thankfully these norms and values are changing but the impact of these can be clearly seen in the inequality across suicide statistics where:

68% of suicide cases across Cornwall and the Isles of Scilly are men

Gender identity

Gender identity describes how a person feels about their gender. For many people, their gender identity corresponds to the sex they were registered at birth. For others, it does not.

Terms used to describe gender identity include:

- **Trans or transgender:** this is when someone feels their gender is different from, or doesn't sit comfortably with, the sex they were registered at birth.
- **Non-binary, gender diverse and genderqueer:** these are umbrella terms for people whose gender identity doesn't sit comfortably as man or woman. Instead, they may identify with some aspects of one or both of these identities or identify with neither. Additionally, some people may identify as genderfluid and see their gender as flexible, rather than a fixed identity.
- **Cisgender:** this is when someone's gender identity is the same as the sex they were registered at birth.

Gender diverse people are more likely to experience violence and coercion, stigma and discrimination, including from health workers. Data suggests that transgender individuals experience high levels of mental health illness – linked to the discrimination and stigma they face in day to life and interactions with services. However, the evidence base for inequalities by gender identity still has major gaps with a lack of data relating to these communities derived from population-based studies and statistical datasets.

Protected characteristics

Ethnicity

Understanding our ethnic populations and their needs are key to reducing inequalities. Policies and interventions should be 'universal' but developed to be more intense where needs differ –proportionate to need.

Why ethnicity matters

Ethnicity is a complex, multidimensional concept, defined by features such as a shared history, origins, language, and cultural traditions. Although often used to describe distinct populations, it is a subjective identity based on how individuals define themselves.

Health is largely shaped by the social circumstances in which people are born, grow, learn and live. Ethnicity also reflects and influences these social circumstances and as such, incorporating an explicit focus on ethnicity is important when examining inequalities.

However, there is significant diversity within, as well as between, groups of people with particular ethnic identities. Different ethnic groups, therefore, have different needs. The UK has long been recognised as a multi-ethnic society and the diversity of the population of Cornwall and the Isles of Scilly continues to increase. In the 2021 census:

6 per cent of people across Cornwall and the Isles of Scilly identified themselves as belonging to an ethnic minority group. Cornish is also a minority group with 16.9% of residents identifying as Cornish in 2021.

Without explicit consideration of ethnicity within inequalities work, there is a risk of partial understanding of the factors leading to poor outcomes.

Ethnicity may impact on outcomes at many levels, acting through factors such as:

- Differences in service uptake
- Communication issues
- Culture and attitudes
- Socio-economic factors
- Differences in disease prevalence

These differences affect access to services and can act as barriers.

How people promote or seek assistance from services reflects a range of social factors and experiences all of which can be influenced by ethnicity. Low health literacy, potentially exacerbated by language barriers, can lead to unhealthy behaviours and poorer uptake of preventive services and there is strong evidence that people from ethnically diverse backgrounds – particularly those with low English language proficiency – can receive poorer quality services compared to others and are more likely to experience adverse events in their journey through the system.

Evidence shows that people who are socially excluded underuse some services, such as primary and preventative care, and often rely on emergency services such as A&E when their health needs become acute. This results in missed opportunities for preventive interventions, serious illness and inefficiencies, and further exacerbates existing health inequalities.

Experiences of discrimination and exclusion, as well as the fear of such negative incidents, have been shown to have a significant impact on mental and physical health across all ethnic minority groups but there are also significant differences in health between ethnic groups, for example:

People from the White Gypsy or Irish Traveller, Bangladeshi and Pakistani communities **have the poorest health outcomes across a range of indicators**

Rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes **are higher among Black and South Asian groups than white groups**

Mortality from cancer, and dementia and Alzheimer's disease is highest among white groups.

Smoking prevalence is substantially higher amongst migrants from East European countries compared with most other non-UK-born groups and rates are highest in the Gypsy or Irish Traveller group.

Protected characteristics

Religion

"No one is born hating another person because of the colour of his skin, or his background, or his religion."

- Nelson Mandela

Why religion matters

The UK is a diverse society with people of many beliefs and some with none. Some practise religious observances outside the boundaries of traditional world religions (e.g. pagans). Others abide by sets of beliefs that are not religious in nature, for example secularists and humanists.

Across Cornwall and the Isles of Scilly more than 60% of people identify as having religious beliefs – most are Christian (46.3%), Buddhist (0.4%) Muslim (0.2%) encompassing a broad cross section of society - young, old, economically well off or worse off.

Religious inequalities often arise through the way in which individuals and groups suffer from systemic marginalisation, exclusion and, in extreme cases, genocide on account of their religious beliefs and affiliation. This may overlap with national or ethnic origin, race and culture where a particular religion is strongly associated with or perceived to be associated with a particular racial or other group. The inter-relationship between these protected characteristics can be complex.

- Ethnic groups are often multi-religious. Indians, for example, may be Hindus, Muslims, Sikhs, Christians or members of other belief systems or may have no religion or belief.
- Religious practice can cut across ethnic groups, for example Muslims can be Albanian, Bangladeshi, Bosnian, Chinese, Indian, Indonesian, Iraqi, Malaysian, Nigerian, Pakistani, Somali, Turkish, English, Irish, Scottish or Welsh.
- Ethnic and religious identities can also coincide: both Jews and Sikhs are recognised as ethnic groups under the Equality Act 2010.
- A large minority of British people of all ethnic groups have no religious belief. Some adopt non-religious life stances, such as humanism or secularism.

No one should experience discrimination for exercising their right to freedom of religion or belief.

However, discrimination on the basis of belief or non-belief still occurs and contributes to social exclusion of groups and individuals. Discrimination ranges from violence and bullying to prejudice against a person because of their actual or perceived belief or non-belief. Prejudice also manifests itself in the signals sent out, intentionally or not, in the way in which the needs of a person are ignored or overlooked, for example when accessing services.

Examples of cultural, spiritual, religious and attitudinal differences which may impact on health outcomes and service delivery include:

- The patient's expectations
- The expression of symptoms which have cultural or linguistic influences.
- Family roles and relationship differences between cultures.
- Different attitudes to sex and marriage between cultures and religions.
- Different attitudes to clinical examination, diagnostic procedures, medications and treatment programmes and what is acceptable to the patient.
- Adherence to medication and treatment plans (for example, periods of religious fasting)
- Patients' preferences for doctors or nurses of particular gender.
- Beliefs, rites and rituals around specific milestones like pregnancy and birth, 'coming of age', menstruation, marriage, and death
- Different significance attached to issues such as the gender of a baby or the presence of serious abnormality detected antenatally.
- Rules around death and the timing of burial or cremation.
- Cultural and/or religious views on organ transplantation and blood transfusion.
- Use of alternative traditional medicine and healing practices
- Assumptions regarding lack of need for immunisation or antimalarial medication when visiting relatives in at-risk countries.
- Problems of culture and religion may make it difficult for patients to admit to such matters as homosexuality, premarital sex, infidelity leading to disease or unplanned pregnancy, alcohol abuse or even depression.

Protected characteristics

Disability

"Impairment is, and always will be, present in every known society, and therefore the only logical position to take, is to plan and organise society in a way that includes, rather than excludes, disabled people."

- Barbara Lisicki, 2013

Why disability matters

Almost everyone will temporarily or permanently experience disability at some point in their life and numbers are set to rise. As our population ages so will the number of people with disabilities, as such, understanding the diversity of disabled people is vital.

The most commonly used definition of disability in the UK is from the Equality Act 2010, which states:

You have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

In national datasets, the definition used is:

...a person who has a physical or mental health condition or illness that has lasted or is expected to last 12 months or more, that reduces their ability to carry-out day-to-day activities.

Disabled people make up approximately 22 per cent of the British population, and up to 45 per cent of those of state pension age. People from all ages, genders and ethnicities, and all walks of life experience disability. 11 million people in the UK live with a limiting long-term illness or disability, and they face far greater barriers to living a long and healthy life than non- disabled people.

Disabled people experience vast and varied barriers. If you are a disabled person or have a learning disability, you are statistically less likely to have access to a good education and qualifications, decent housing or a secure job. You could be cut off from your local environment, if it is difficult to use public transport or access public spaces. That could also mean you miss out on the chance to get involved in your community or to feel you have control over your daily life. Key disabling barriers from a Social Model approach include:

Attitudinal barriers: These are social and cultural attitudes and assumptions about people with impairments that explain, justify and perpetuate prejudice, discrimination and exclusion in society; for example, assumptions that people with certain impairments can't work, can't be independent, can't have sex, shouldn't have children, need protecting, are "child-like" etc.

Physical barriers: These are barriers linked to the physical and built environment and cover a huge range of barriers that prevent equal access, such as stairs/steps, narrow corridors and doorways, kerbs, inaccessible toilets, inaccessible housing, poor lighting, poor seating, broken lifts or poorly managed street and public spaces.

Information/communication barriers: These are barriers linked to information and communication, such as lack of British Sign Language interpreters for deaf people, lack of provision of hearing induction loops, lack of information in different accessible formats such as Easy Read, plain English and large font.

A person's disabilities don't make them less relevant in the workplace, in the home, or anywhere else but sometimes people with disabilities face judgment and a lack of support, especially if their disability is invisible or is seen to be somehow their fault.

Health inequalities often start early in life. Difficulties in getting effective and appropriate healthcare when it is needed can make a person's health worse and affect their quality of life. **The World Health Organisation (WHO) has summarised some of the barriers that can result in health inequalities experienced by disabled people. These include:**

- Limited availability of accessible services
- Access barriers
- Inadequate skills and knowledge of health workers
- Poverty
- Inaccessible transport
- Poor communication
- Negative attitudes
- Diagnostic overshadowing and under-shadowing[1]

[1] Diagnostic overshadowing is a term used to describe the under-diagnosis of mental illness in people with a general learning disability. The term has also been used when physical illnesses are overlooked in people with mental illness. Diagnostic overshadowing can lead to delays in treatment for physical health conditions in people with mental illnesses, leading to increased mortality and poorer treatment outcomes

During the first year of the Covid-19 pandemic in England, 60 per cent of those who died from Covid-19 were disabled. People with learning disabilities were eight times more likely to die of Covid-19 than the general population.

Disabled people continue to die avoidable deaths, and many more experience unfair, poor outcomes. Behind these statistics are our family members, our friends, ourselves. Disability inevitably touches all our lives – we all have a stake in ensuring that things improve.

Protected characteristics

Sexual orientation

People around the world face violence and inequality—and sometimes torture, even execution—because of who they love, how they look, or who they are.

Why sexual orientation matters

Sexual orientation is an umbrella term covering sexual identity, attraction, and behaviour. However, these may not be the same; for example, someone in an opposite-sex relationship may also experience same-sex attraction, and vice versa.

For decades now, we have seen a steady increase in social acceptance of lesbian, gay and bi relationships, and steady increase in the percentage of the population who identify as lesbian, gay or bi.

Around 2.95% percent of the population aged 16 years and over across Cornwall and the Isles of Scilly identified with an LGB+ orientation in the 2021 Census, compared with 3.2% across England and Wales.

The LGB+ population in the UK represent a very diverse population who face different challenges. This diverse population continues to experience significant inequalities relating to health, wellbeing and broader social and economic circumstances despite the significant improvement in social attitudes and laws that protect and uphold the rights of gay, lesbian, bisexual and transgender people. Many face multiple disadvantage due to their sexual orientation and/or gender identity combined with mental health problems, ethnicity, age, physical or sensory impairments, economic background and sometimes asylum-status.

Collectively, the community experiences significant physical and mental health inequalities compared to the general population. LGBTQ+ (the acronym for lesbian, gay, bi, trans, queer, questioning and ace) people are at higher risk than heterosexual people of bullying, abuse, discrimination and exclusion. LGB+ people are also at greater risk of mental disorder, substance misuse and dependence, self harm and suicidal behaviour/ideation than heterosexual people.

Notable research reports on the inequalities faced by the LGBTQ+ community include:

LGBT in Britain – Health report (2017 survey)

In 2017 Stonewall commissioned YouGov to administer a survey of LGBTQ+ people about their life in Britain. There were 5,375 responses from people across England, Scotland and Wales.

The following key findings have been extracted from the full report:

- **Half of LGBTQ+ people** (52 per cent) said they've **experienced depression** in the last year.
- **One in eight LGBTQ+ people** aged 18-24 (13 per cent) said they've **attempted to take their own life in the last year.**
- **Almost half of trans people** (46 per cent) **have thought about taking their own life** in the last year, 31 per cent of LGB people who aren't trans said the same.
- **Forty-one per cent of non-binary people said they harmed themselves** in the last year compared to 20 per cent of LGBTQ+ women and 12 per cent of GBTQ+ men.
- **One in six LGBTQ+ people** (16 per cent) said **they drank alcohol almost every day over the last year.**
- **One in eight** LGBTQ+ people aged 18-24 (13 per cent) **took drugs** at least once a month.
- **One in eight** LGBTQ+ people (13 per cent) **have experienced some form of unequal treatment** from healthcare staff because they're LGBTQ+ .
- **Almost one in four** LGBTQ+ people (23 per cent) have **witnessed discriminatory or negative remarks against LGBT people by healthcare staff.** In the last year alone, six per cent of LGBTQ+ people – including 20 per cent of trans people – have witnessed these remarks.
- **One in twenty** LGBTQ+ people (five per cent) **have been pressured to question or change their sexual orientation** when accessing healthcare services.
- **One in five** LGBTQ+ people (19 per cent) **aren't out to any healthcare professional about their sexual orientation** when seeking general medical care. This number rises to 40 per cent of bi men and 29 per cent of bi women.
- **One in seven** LGBTQ+ people (14 per cent) **have avoided treatment for fear of discrimination** because they're LGBTQ+

LGBT+ mental health

Rethink updated their LGBT+ mental health worksheet in September 2020 which explains why LGBT+ people are more likely to have a mental illness and where help can be accessed. The following summary has been extracted from the worksheet:

Being LGBT+ does not automatically mean you will have mental health issues. But you may be more likely to develop mental health issues. A review of studies on mental health issues in the LGBT+ community found the following:

- **LGBT+ people are at more risk of suicidal behaviour** and **self-harm** than non-LGBT+ people.
- **Gay and bisexual men are 4 times more likely to attempt suicide** across their lifetime than the rest of the population.
- **LGBT+ people are 1½ times more likely to develop depression** and **anxiety** compared to the rest of the population.
- **67% of trans people had experienced depression** in the previous year. And 46% had thought of ending their life.
- Stonewall's 'Prescription for Change' report found **lesbian and bisexual women had higher rates of suicidal thoughts** and **self-harm** compared to women in general.
- Of all the common sexual identity groups, **bisexual people most frequently have mental health problems,** including depression, anxiety, self-harm and suicidality.
- The **reasons why there are higher rates of mental health issues among LGBT+ people are complex.** There are many experiences that LGBT+ people will often have to deal with as a minority community, such as stigma, prejudice and discrimination.

In order to help improve outcomes across the LGB+ population, the way services are commissioned, designed and delivered must take into account the diverse needs and challenges faced. **The NHS Confederation has identified Six Overarching Recommendations to help support delivery of more inclusive services:**

01. Create visible leadership and confident staff

02. Create a strong knowledge base

03. Be non-heteronormative and non-cisnormative in everything you do

04. Take responsibility for collecting and reporting data

05. Listen to your service users

06. Proactively seek out partners to co-deliver services

The following seeks to provide definitions of differing types of sexuality, recognising that for some people their sexuality is fluid and can change over time:

Aromantic or aro - Someone who has little or no romantic attraction to other people, or who doesn't have the desire to have a romantic relationship

Ace or asexual - Someone who experiences little to no sexual attraction to other people

Bicurious - People who don't see themselves as either heterosexual or gay, but may also sometimes be curious about the gender they're not normally attracted to.

Bi or bisexual - Someone who is emotionally and physically attracted to more than one gender.

Demiromantic - Someone who doesn't feel any romantic attraction unless they have a strong emotional connection with someone first.

Demisexual - Someone who doesn't have any sexual attraction unless they have a strong emotional connection with someone first.

Gay - Someone who is romantically and sexually attracted to people of the same gender.

Greyromantic - Someone who doesn't experience feel romantic attraction very often, or doesn't experience strong romantic attraction to other people.

Greysexual - Someone who doesn't experience sexual attraction very often, or who doesn't have strong feelings of sexual attraction.

Heterosexual or straight - Feeling emotionally and physically attracted to people of the opposite gender.

Homosexual - Feeling emotionally and physically attracted to someone of the same gender.

Homoflexible – Someone who mostly identifies as gay or homosexual, but who is sometimes attracted to someone of a different gender.

Lesbian – Girls/ women who are emotionally and physically attracted to someone of the same gender.

Mixed orientation - People who experience a romantic or emotional attraction that is different from their sexual attraction. For example, someone may feel emotionally attracted to girls but sexually attracted to boys.

Omni or omnisexual - Someone who is sexually attracted towards people of any gender.

Omniromantic - Someone who experiences romantic attraction towards people of any gender.

Pansexual - Someone who is sexually attracted to someone else regardless of their gender.

Panromantic - Someone who experiences romantic attraction towards someone else regardless of their gender.

Polyamory (or poly) - Someone who can have multiple romantic relationships at the same time. People in polyamorous relationships are all aware of each other and consent to any new relationships that start.

Polysexual - Someone who is romantically and sexually attracted to some genders, but not all.

Queer - Some LGBTQ+ people use queer to describe not fitting into other labels or sexualities, or feel more comfortable using it to describe themselves. Some LGBTQ+ people also use it to describe the community as a whole. Queer has been used as an insult or slur against LGBTQ+ people, which is a form of bullying and discrimination. Because of this, some people don't like to use the term at all.

Questioning - This describes someone who is going through the process of understanding their sexuality, or who's unsure about it. This can also describe someone who is questioning their gender because it doesn't sit comfortably with the sex that was recorded at birth.

Protected characteristics

Pregnancy and maternity

Pregnancy, the birth and the early weeks of a child's life are a crucial period for the mother, future of the family and of the child.

Why pregnancy and maternity matters

Pregnancy and maternity are usually portrayed as happy events, but sadly this is not every person's experience. Socioeconomic inequalities disproportionately affect women, which impacts on their own health and the life chances of their children.

Having a healthy pregnancy is vital to improve the life chances of future generations, to prevent perinatal and infant mortality and to give every child the best start in life. Pregnancy and the first few weeks of life affect health, well-being and educational outcomes across the whole life course (Source: Department of Health). During pregnancy and the first few weeks of life, risks to mother and baby can include communicable diseases, physical and mental health problems.

A growing body of evidence suggests that women who experience severe and multiple disadvantage during pregnancy are more likely to experience poor maternity outcomes . For example, in 2019, the Saving Lives, Improving Mothers Care report found that women who experienced severe and multiple disadvantage were overrepresented among the women who died during pregnancy or shortly after birth.

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and includes treating a woman unfavourably because she is breastfeeding.

What is Severe Multiple Disadvantage?

There is no consistently accepted definition of severe and multiple disadvantage . However, it is broadly understood to refer to the co-occurrence of 'serious social problems', which often appear in the lives of people facing inherent disadvantage and which act in a mutually reinforcing manner leading to their further enrichment.

There is considerable divergence in the literature as to which serious problems fall within SMD. A broad list typically includes: adverse childhood experiences (ACEs), poverty, inadequate housing or homelessness, mental health problems, substance misuse, irregular immigration status, history of domestic abuse and or violence, and involvement with the criminal justice or social care systems. This list in not exhaustive.

Across Cornwall and the Isles of Scilly poverty and deprivation contribute increased risks for women during pregnancy and risk factors which are more prevalent in deprived areas generally increase risks during pregnancy. **These modifiable risk factors in pregnancy can have health impacts on both mother and child and can increase the risk of stillbirth, complications in pregnancy, low birthweight and of the child developing conditions in later life. These include:**

Behavioural risk factors

- Smoking during and after pregnancy
- Obesity during and after pregnancy
- Alcohol and substance misuse
- Nutrition, physical activity and body weight

Pre-existing and pregnancy related maternal morbidity

- Diabetes
- High blood pressure
- Mental illness
- Infectious diseases

Maternity care is a key determinant in the outcomes of a pregnancy and delivery. Nationally, research has identified that Disabled women perceived greater problems regarding their maternity care, communication and involvement in decision making than non-disabled women. A specific example of this is women with learning disabilities who experience poorer maternal wellbeing and pregnancy outcomes compared to the general population. **Studies have reported poorer outcomes for women with learning disabilities including:**

- increased rates of pre-eclampsia
- venous thromboembolism
- pre-term birth
- delivery by caesarean section
- low birth weight
- low Apgar scores

Teenage pregnancy provides a further example of where outcomes can be worse for both child and mother and is both a cause and consequence of inequalities.

Research has shown that teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of mental health problems than older mothers. Infant mortality rates are 60% higher for babies born to teenage mothers and as children they have an increased risk of living in poverty and are more likely to have accidents and behavioural problems.

Adverse childhood experiences, financial hardship, attention, behaviour, and conduct difficulties, low educational performance and engagement, and a family history of teenage pregnancy are some individual and social risk factors for teenage pregnancy.

Key evidence-based interventions to promote maternal health and good outcomes of pregnancy include:

Addressing social factors:

- Improving educational attainment and access to employment and income for disadvantaged groups, particularly women
- Ensuring adequate housing for vulnerable pregnant women, including teenagers
- Identification and support for women experiencing domestic violence, including FGM

Maternal health promotion:

- Health education for young people and women of child bearing age including: sex and relationships education, awareness of factors affecting maternal health and outcome of pregnancy and understanding of how to access antenatal services
- Reduce the number of unplanned teenage conceptions
- Access to preconception information and care e.g. preconceptual intake of folic acid
- Support for smoking cessation during pregnancy
- Promoting healthy weight during and after pregnancy

Improving access to high quality, patient centred care:

- Early access to maternal care i.e. booking by 12+6 weeks
- Woman-centred care and informed decision making, including access to antenatal classes
- Access to specialist care for high risk women, e.g. those with mental health problems, alcohol and substance misuse, teenage mothers, vulnerable first time mothers
- Advocacy and translation services for women who have difficulties with reading or speaking English
- Identification and control of existing and pregnancy associated clinical conditions e.g. mental illness, diabetes and hypertension
- Informed access to antenatal screening for foetal anomalies, sickle cell and thalassaemia and infectious diseases
- Access to home births or midwife led birthing centres for low risk women
- Reduce number and percentage of C-sections
- Infection control

Protected characteristics

Gender reassignment

For some anatomy doesn't determine their gender identity and neither does the "gender binary".

Why gender reassignment matters

Gender identity refers to each person's deeply felt internal and individual experience of gender. A decision to undertake gender reassignment is made when an individual feels that his or her gender at birth does not match their gender identity. This may involve, if freely chosen modification of bodily appearance or function by medical, surgical or other means and other expressions of gender, including dress, speech and mannerisms . **Gender reassignment refers to individuals who either:**

- Have undergone, intend to undergo or are currently undergoing gender reassignment (medical and surgical treatment to alter the body).
- Do not intend to undergo medical treatment but wish to live permanently in a different gender from their gender at birth.

'Transition' refers to the process and/or the period of time during which gender reassignment occurs (with or without medical intervention). Not all people who undertake gender reassignment decide to undergo medical or surgical treatment to alter the body. However, some do and this process may take several years.

Trans people have long endured high levels of prejudice (referred to as "transphobia") and misunderstanding. This is manifested in numerous forms, including discrimination in a wide range of settings (including public services), hostile portrayal in the media, abuse and violence (including, in some cases, sexual assault and murder). This can undermine trans people's career opportunities, incomes, living standards, access to social capital, quality of life, and physical and mental health.

There remains a lack of statistical data regarding the health and wellbeing of trans people in the UK alongside experiences of service usage. However, despite the lack of large-scale studies, the studies that have been conducted are both compelling and consistent in pointing to disproportionately worse health outcomes and experiences of services.

The 2021 Census is the first census across England and Wales that has asked people about their gender identity which showed that across Cornwall and the Isles of Scilly:

1 in every 433 people across Cornwall and the Isles of Scilly (1,106 people) had a gender identity different from sex registered at birth or identified as a Trans Woman or Man

The ways in which inequalities can impact a trans person's life are interconnected, stigma and transphobia drive isolation, poverty, violence, lack of social and economic support systems, and compromised health outcomes. Each circumstance relates to and often exacerbates the other

Inequality when accessing services is a significant issue for trans people and national research reveals significant inequalities in health and wellbeing faced by trans people including an increased risk of mental ill health. It shows more trans people experience problems with their mental health, including depression and thoughts of suicide. Unsurprisingly, this is linked to higher use of mental health services. The evidence of poorer health outcomes is not however, limited to mental health. The GP Patient Survey identifies that younger trans and non-binary patients (aged 16 to 44) are more likely to report a long-term condition, disability (including physical mobility) or illness compared with other patients of the same age.

Trans people with other protected characteristics often face multiple barriers. For example, **the Race Equality Foundation report** that trans people of colour experience higher rates of discrimination when trying to access mental health support, access to substance abuse treatment and domestic violence support.

Protected characteristics

Marriage and civil partnership

Why marriage and civil partnership matters

The quality of personal relationships is essential in the promotion of health and overall quality of life and this has long been recognised with poor mental health and well-being linked to weaker personal and social connections for individuals, families, and society.

Marriage and Civil Partnerships form a fundamental part of these relationships for many and this status is protected from discrimination as one of the 9 protected characteristics of the Equality Act 2010.

The law on marriage and civil partnerships, for both opposite and same sex couples, is equal – both same sex and opposite sex couples can become civil partners, or they can marry.

47.1% of usual residents aged 16 years and over in Cornwall and the Isles of Scilly were married or in a civil partnership at the time of the 2021 Census

The proportion of households married or in a same-sex civil partnership across Cornwall and the Isles of Scilly was above the rate for England and Wales as a whole. At the time of the Census 2021 there were 224,698 married individuals, 99.4% opposite sex couples and 0.6% same sex. 1,212 people were in a civil partnership,67.5% registered same-sex and 32.5% opposite sex.

Unlike the other 8 protected characteristics, marriage and civil partnerships are not necessarily linked as strongly to poorer outcomes and inequalities. **In fact, there is some evidence from studies around marriage and civil partnerships that suggests many positive outcomes from a quality relationship namely:**

- Marriage makes people far less likely to suffer psychological illness
- Marriage makes people live much longer
- Marriage makes people healthier and happier
- Both men and women benefit, though some investigators have found that men gain more

This doesn't mean that just being married automatically provides these health benefits. These finding are predicated on the fact that the relationship within the marriage or civil partnership is healthy and based on commitment, trust, respect and responsibility/ support. People in stressful, unhappy marriages or facing the negative effects of marital disruptions (divorce, widowhood) may be worse off than a single person who is surrounded by supportive and caring friends, family, and loved ones.

There are also specific elements relating to marriage and civil partnerships which are known to have harmful and long-lasting consequences for those involved namely:

Forced marriage

Government guidance on recognising a forced marriage states:

A forced marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) **consent to the marriage** as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights.

The criminal law on forced marriage (as it applies in England and Wales) is set out in section 121 of the Anti-social Behaviour, Crime and Policing Act 2014. Section 121 makes it an offence for a person to use violence, threats, or any other form of coercion for the purpose of causing another person to enter into a marriage, and they believe (or ought reasonably to believe) that their conduct may cause the other person to enter into the marriage without free and full consent.

It is also an offence to pursue conduct for the purpose of causing a victim who lacks capacity (by reference to the Mental Capacity Act 2005) to consent to marriage, whether or not that conduct amounts to violence, threats or any other form of coercion.

In 2022, the Forced Marriage Unit gave advice or support in **302 cases** across the UK related to a possible forced marriage and/or possible female genital mutilation (FGM). 4% (9) of these cases were from the South West region.

Of the cases in which the FMU provided advice or support in 2022:

88 cases (29%)
involved victims aged 17 years and under

119 cases (39%
involved victims aged 18 to 25

62 cases (19%)
involved victims with mental capacity concerns

235 cases (78%)
involved female victims and **67 cases** (22%) involved male victims

Occupation

Adults in employment spend a large proportion of their time in work, our jobs and our workplaces can have a big impact on our health and wellbeing.

Why occupation matters

People's occupations are strongly related to multiple dimensions of inequality, such as inequalities in wages, health, and risk of temporary or seasonal employment.

Poorer general health and higher rates of illnesses or disabilities are prevalent in some occupation compared to others and this extends beyond workplace accidents and fatality.

Across Cornwall and the Isles of Scilly there are 5 occupations that have been identified as facing greater inequality in health, namely:

- **Farming**
- **Seafarers**
- **Carers**
- **Migrant workers**
- **Veterans**

What are the issues - Farming

It's no secret that farming is a very hard job characterised by long hours, dangerous working conditions and modest financial rewards. But less visible are high rates of mental ill-health and poor quality of life.

Farmers' physical and mental health and wellbeing are often pushed to one side as the important tasks of managing a busy arable or livestock farm take over.

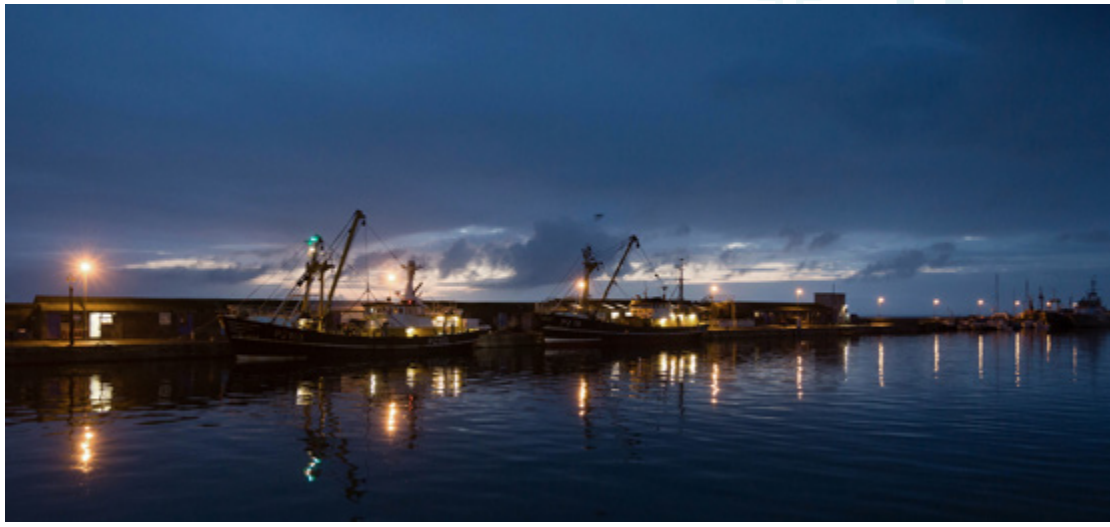
On average farmers work a 65-hour week – far exceeding the UK national average of 37 hours. Some growers and livestock producers work in excess of 100 hours – with many rarely taking a day off, let alone an annual holiday.

Given isolated conditions, long working hours and many hazards faced by farmers, it's no surprise that they experience poorer health outcomes. Lots of moving machinery, unpredictable livestock, chemicals, silos and a noisy environment all contribute to this result. Farmers and agricultural contractors work in a sector with a rate of accidents 20 times higher than the all-industry rate. In addition, farmers and farm workers can often face physical health challenges: musculoskeletal injury, for example, is over three times the rate for all industries. Less visible are the high rates of mental health issues among farmers and agricultural workers which is of growing concern and are having a direct impact on safety on farms and more importantly farmers themselves – **nationally more than one farmer a week takes their own life.**

Over 70% of the land mass of Cornwall and the Isles of Scilly is farmed and **there are over 1,980 farms with 4,400 holdings and a workforce of nearly 11,800.** Of the 254,188 hectares of farmland, 72% is grassland and 21% arable. 60% of the farms specialise in livestock (315k cattle, 487k sheep, 52k pigs and 1.085m poultry).

Specific inequalities facing the farming communities:

- Farmers may consider themselves to be healthier than the general population but **are at increased risk of a range of physical health problems**, including asthma and musculoskeletal conditions.
- Farmers **are more likely to commit suicide than the general population** and to have symptoms of depression. This may be linked with a range of factors including financial hardship, "red-tape" and experiences of disease outbreaks or natural disasters.
- Farming is inherently isolated, with many farmers and farm workers living in rural areas with low access to amenities, poor internet access and a lack of social mobility and opportunities. While isolation is not always a negative thing, **there are many occupational, physical and psychological risks associated with lone working,** long working hours and a lack of social interaction.
- The farming community can be "stoic" about their health, sometimes **leaving health problems unchecked for long periods of time.** This appears to be more common in older male farmers.
- People living in rural areas are more **likely to experience longer travel times to services** which can mean reduced uptake of services and late presentation.
- Farmers may be less likely to access health care in traditional settings but **do utilise and value "farming specific" clinics in non-health settings.**



What are the issues - Seafarers

Seafaring is widely recognised as an inherently dangerous occupation. Historically, high rates of injury and mortality among fishers have been documented globally. Despite efforts to improve health and safety, fishers remain more vulnerable to accidents and injuries than other occupational groups because of persistent risks such as unpredictable weather conditions and operation of heavy machinery.

Beyond physical accident and injury, seafarers, both small-scale and large-scale are exposed to a range of health risks:

- chronic musculo-skeletal problems associated with heavy physical labour
- work-related health risks such as fatigue, exposure to contaminants and noise
- lifestyle factors such as high levels of alcohol consumption, smoking, and poor diet
- mental health problems such as anxiety and depression exacerbated by long periods away from home, long hours - typically seven days per week and as shipping is a 24 hour per day business, seafarers must also work at night which in and of itself can lead to increased levels of stress.

Furthermore, anecdotal evidence suggests that fishers are less likely than other occupational groups to access healthcare, for example because of organisation constraints and prevalent social norms that discourage help-seeking.

In Cornwall the latest figures from 2021 show that there were 535 fishing vessels and 780 people employed on fishing vessels

Specific inequalities facing the seafaring communities:

Health and wellbeing issues identified from a review of literature undertaken on Seafarers Health identified the following specific issues:

Physical:

- Overweight/obesity
- High blood pressure
- Metabolic syndrome
- Peptic ulcers
- Gastritis
- Joint/back pain
- Cardiovascular disease
- Rheumatological conditions due to accidents/external causes
- High prevalence of communicable diseases
- Sleepiness
- Poor quality of sleep
- Fatigue
- Cognitive dysfunction (from fatigue)

Psychological:

- Burnout
- Anxiety
- General psychiatric disorders
- Suicide
- Depression

Personal/lifestyle:

- Smoking
- Alcohol abuse
- Drug abuse
- Unhealthy eating habits/poor dietary
- Reluctance to obtain professional help

What are the issues – Carers

Providing unpaid care often impacts negatively on health and wellbeing, increasing the likelihood of poor health compared to non-carers . COVID-19 has had a significant impact on the number of people providing care, according to the State of Caring 2021 report . Being a Carer also impacts other aspects of life, such as relationships, finances and emotional wellbeing.

10% of residents (54,757 people) look after, or give any help or support to family members, friends, neighbours or others because they have long-term physical or mental ill-health or disability, or problems related to old age [2021 Census]

Specific inequalities facing carer communities:

A report by Carers UK looked closer at the health of carers compared to non-carers. The key findings from the survey relating to inequality are presented below.

Long-term conditions, disability and illness

- 60% of carers stated they had a long-term condition, disability or illness compared to 50% of those who weren't caring. The most likely were arthritis, back or joint problems and high blood pressure.
- 69% of those providing 50 hours or more reported having a long-term condition compared to 58% providing less than 35 hours.
- Older and retired carers were also most likely to report having a long-term condition, 79% and 76% respectively.

Mental health

- 27% of carers not in work declared they had a mental health condition compared to 12% of working carers and 5% of retired carers.
- 26% of carers under the age of 25 had a mental health condition, compared to 5% of carers over 65.
- 36% of lesbian, gay and bisexual carers had a mental health condition compared to 13% of heterosexual carers.

Social isolation

- 18% of carers reported feeling isolated compared to 14% of those who weren't caring.
- Feeling isolated increased during COVID-19, from 8% in 2019, 9% in 2020 and 18% in 2021.
- 32% of carers aged under 25 reported feeling isolated over the last 12 months, compared to 12% over 65.

Physical activity

- Overall, Carers have significantly lower levels of physical activity. The greatest barriers were limited time, lack of motivation, affordability and not having anyone to go with. Many Carers do not feel that they can do as much physical activity as they'd like to do particularly for Carers who are disabled, lonely or struggling financially.

Financial

- Research has consistently found that a significant proportion of carers are struggling financially, and that caring comes with a financial penalty that can impact on carers' finances now and in the future. Providing significant amounts of care is clearly linked to higher levels of financial stress and decreased financial resilience.

What are the issues – migrant workers

Migration is not new. For hundreds of years, people have left their place of origin to live in other countries and cultures, and in the last 100 years this trend has increased. Migrants are widely described as people who belong to (or have an allegiance) to one state/country, but move into another for the purpose of settlement.

> A migrant "should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor"
>
> **(UNHCR, 2017)**

Migrant populations are diverse, and migrant populations have different health and wellbeing issues depending on lifestyle risk factors, cultural practices, country of origin, genetic and hereditary factors and wider determinants (poor housing, lower economic opportunities, unemployment and living in deprived areas).

As a consequence, the health of migrants is influenced by many complex factors. These factors can be grouped into four broad themes:

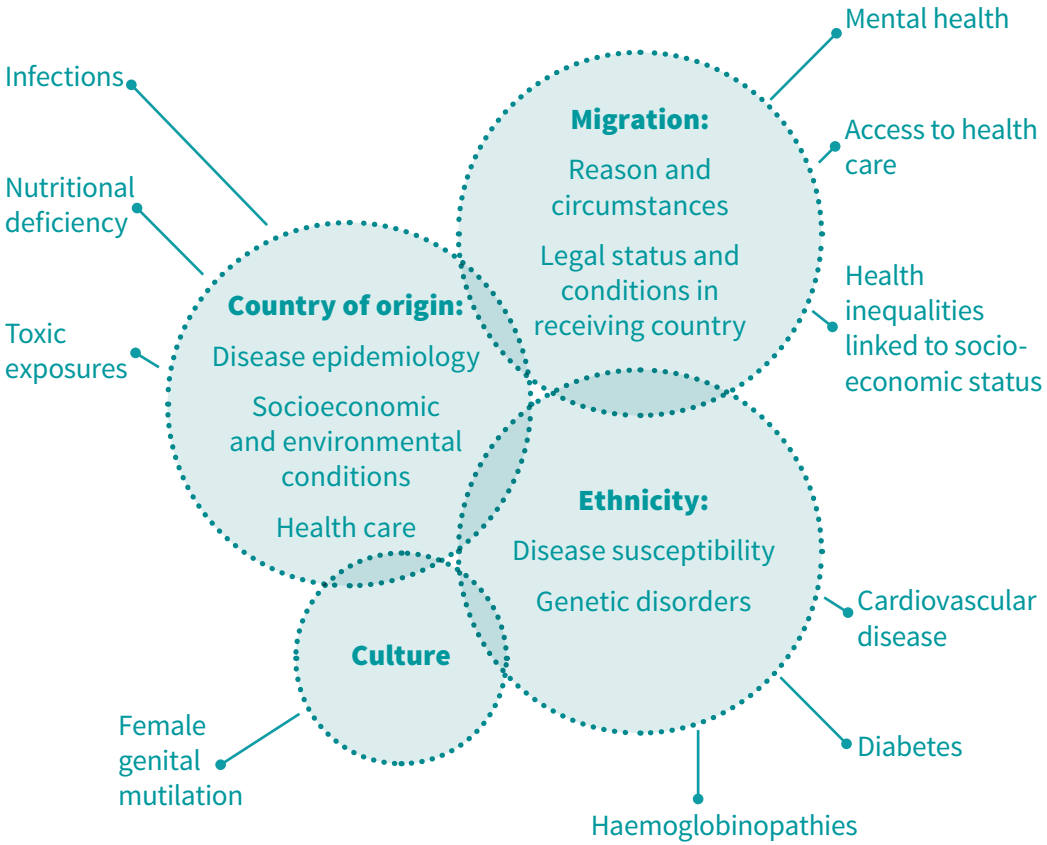
- Country of origin
- Migration
- Culture
- Ethnicity

Evidence also suggests that whilst there are specific health conditions that affect some groups of migrants, the main issue common to them all is one of accessing health services. **A number of factors leading to low uptake of services by migrants include:**

- Limited understanding of the UK health system, and in particular the role of the GP
- Differing health seeking behaviours and expectations of healthcare services
- Returning home for medical care amongst some groups of migrants
- Language barriers and cultural differences
- Changing entitlements to healthcare services
- Some migrants are not able to access healthcare services due to poverty and destitution; particularly migrants with No Recourse to Public Funds (NRPF)

Importantly, some of these barriers cut across length of residence in the UK, thus having an impact on both recent migrants and established residents (Jayaweera et al., 2005). Such evidence suggests that social determinants of health play as important a part in explaining health outcomes for migrants as for minority ethnic groups.

Most migrants are young an healthy



Specific inequalities facing migrant worker communities:

Own characteristics
Age, gender, ethnic group, past and current medical history

Behaviour/lifestyle factors
Smoking, drug and alcohol use, diet, exercise

Ability to communicate
Language(s) spoken, access to appropriate interpretation, cultural differences such as gender

Country of origin
Burden of disease and prevalence of infectious diseases. Socioeconomic status (macro – country's position in global economy, micro – personal circumstances in own country prior to migration).

Arrival and 'settling' process, living in the UK
Poverty, grief, isolation, home sickness, racial harassment, anxiety about family members (present and absent). Denial of right to work, loss of identity, status and means to provide for self and family, loss of hope, despair at own story not believed, limited access to healthy food choices, different expectations of health services, entitlement confusion.

Housing issues
The quality of accommodation and landlord practice. Poorly maintained or inappropriate housing (including problems such as damp and mould, leaks, draughts, vermin, fuel poverty, inadequate food storage and hygiene facilities, increase risk of ill-health). Overcrowding and houses of multiple occupation. Sharing space with strangers (can have a negative impact on mental health as well as increasing risk of physical ill-health such as food-borne and other communicable diseases). Destitution – has significant negative physical and mental health effects.

Employment factors: no access to legal employment (asylum seekers)
Worklessness impacts on mental wellbeing. Poverty impacts on physical and mental wellbeing.

Employment factors: illegal/ unregulated employment
Exploitation, long hours, less than minimum wage, surrendered documents (if have any), little or no job security. Accommodation may be linked to employment: poor quality, houses of multiple occupation. Risk to physical and mental wellbeing: mental distress from circumstances of employment such as trafficking (intimidation threats to family members at home). Direct physical hazards such as sexually transmitted infections (in sex workers). Musculoskeletal injuries such as via exposure to heavy machinery, manual labour in agriculture

Employment factors: legal employment
Low skill, low paid: poverty impacts on physical and mental wellbeing. Potentially unaware of rights and open to exploitation.

Access to services
Lack of understanding or awareness of service options, unfamiliar systems and language, different previous experiences, for instance of health care and different expectations.

What are the issues – veterans

A Veteran is anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve), or Merchant Mariners who have seen duty on legally defined military operations. In this context, Veterans are those who have already left the Armed Forces.

The veteran community is a population with specific health and wellbeing needs based on its demographics, occupation and conditions in which they live and have served. In general, the veteran population are likely to suffer the same range of health and welfare issues as the general population and most make a successful transition to civilian life, although a small percentage struggle. This minority experience complex mental and physical issues that are often compounded by wider determinants of health such as social isolation, crime, housing and income.

Specific inequalities facing veteran community include:

Loneliness and social isolation
Integrating into civilian life represents a health risk with 65% of veterans reporting feelings of loneliness and social isolation. 31% of veterans have one or no close friend and 53% are unlikely to discuss feelings of loneliness with a family member or close friend. Risk factors include losing touch with friends (41%). Physical and mental health issue (33%) and relating to civilian life.

Housing/homelessness
Military lifestyles can reduce someone's ability to cope post service (e.g. housing) While homelessness is risk factor, there is limited evidence to support this is a result of military life.

Employment
Whilst employment rates are similar with non-veterans (79%), veterans are more likely to work as process, plant and machine operatives' (18%) and less likely to work in professional occupations' (11%).

Education
The number of veterans with a qualification was similar to non-veterans (92%). Less veterans had a degree (21%) and more have gained a qualification through work (60%).

Domestic abuse
Combat can result in post deployment physical aggression and violence in around 13% of military personnel.

Mental health issues
Such as PTSD increases risk of developing cardiovascular diseases (circulatory diseases, including hypertension), elevated heart rate, tobacco use, dyslipidaemia and obesity.

Early Service leavers
More early leavers experience mental health problems (46%) than other military leavers (27%), and may have increased heavy drinking, self harm and suicidal thoughts.

Hearing problems
Veterans aged <75 are around three and a half times more likely than the general population to report hearing problems (7% and 2% respectively).

Smoking
Veterans of a working age and retirement age were more likely to have ever smoked (55% and 66% respectively). Smoking rates increase in those suffering from PTSD.

Alcohol
Veterans may have higher rates of hazardous drinking in both men (67%) and women (49%) than non-veterans (33% and 16% respectively) (Fear et al, 2007). While the severity of alcohol misuse and hospital admissions are similar, veterans are more likely to be referred for support with alcohol at an older age and to be admitted for longer periods of time.

Access to healthcare
Lack of access to services such as dentists. Read codes are able to identify veterans registered with GP practices and support programmes to access health needs. However, there is an unwillingness for veterans to identify themselves and lack of awareness of appropriate read codes.

Criminal justice system
Whilst a risk factor, veterans may be less likely to be incarcerated than the general public.

Lived experiences

The more complex a person's needs, the more likely they are to fall through the gaps in the services society provides.

Why lived experiences matters

Adults with multiple complex needs are amongst the most excluded people in society. People facing multiple disadvantages experience a combination of problems. For many, their current circumstances are shaped by long-term experiences of poverty, deprivation, trauma, abuse and neglect. Many also face racism, sexism and homophobia.

This presence of overlapping vulnerabilities is associated with extreme health and social inequalities manifesting in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health . This is sometimes referred to as 'multiple complex needs' and 'Severe multiple disadvantage (SMD)'.

Multiple Complex Needs is generally considered to be an experience of two or more of the following sources of disadvantage simultaneously:

- Mental health issues
- Homelessness
- Offending
- Domestic violence
- Substance misuse

People facing Multiple Complex Needs will be much more likely than the general population to have other needs too, such as long-term health conditions or disability and have significantly higher rates of all-cause mortality than people who have experienced one type of deprivation.

People facing Multiple Complex Needs are often not well supported by mainstream services and as result end up being 'stuck in a revolving door' around different support systems. They fall through the gaps between services and systems because they are assessed on specific issues, rather than their overall need. Whilst they may not meet the threshold for one service, their overall need can be severe. This makes it harder for them to address their problems and escape chaotic lives.

A lack of co-ordination between services can means that:

- People risk being turned away from services because their needs are judged either too mild to meet a threshold, or because of their other needs. For example, counselling services turn away those with substance misuse issues. However, without the counselling, the individual may not be able to address their substance misuse issues.
- Organisations may not communicate with each other to ensure that an individual's full range of needs are met.
- Risk of failure to manage crucial transitions, for example from the youth to adult estates, or as people leave the care system or prison.

As a result, people experiencing Multiple Complex Needs often have high levels of service use, with one estimate stating that this accounts to over £28,000 of public service use per person each year:

* Average annual cost to public services of beneficiaries of the Fulfilling Lives programme, which supports people with SMD. Source: Fulfilling Lives

With on-going rises in homeless, prolonged austerity, recession and significantly reduced local authority budgets, the number of people affected by multiple complex needs across Cornwall and the Isles of Scilly is likely to rise.

The Making Every Adult Matter (MEAM) approach is a framework used to develop a coordinated approach to tackling multiple disadvantage which can help identify and act on solutions to support those facing complex multiple needs.

It focuses on creating long-term, sustainable change to the way that complex problems and systems are approached and understood in order to directly improve the lives of people facing multiple disadvantage. The tool includes four key elements – Build, Explore, Act and Learn – supporting local areas to build effective partnerships for change; explore a systemic problem from a range of perspectives; take action to make a change in the system; and to learn from and reflect on the impact to determine next steps.

MEAM system intervention tool

Build

Build focused intervention group including people with lived experience

Agree a clear vision for change

Promote and practice systems leadership skills

Explore

Explore problem from a range of perspectives

Develop shared understanding of the issue

Prioritise actions to focus on

Learn

Develop a culture of listening, learning and challenge

Reflect on changes made

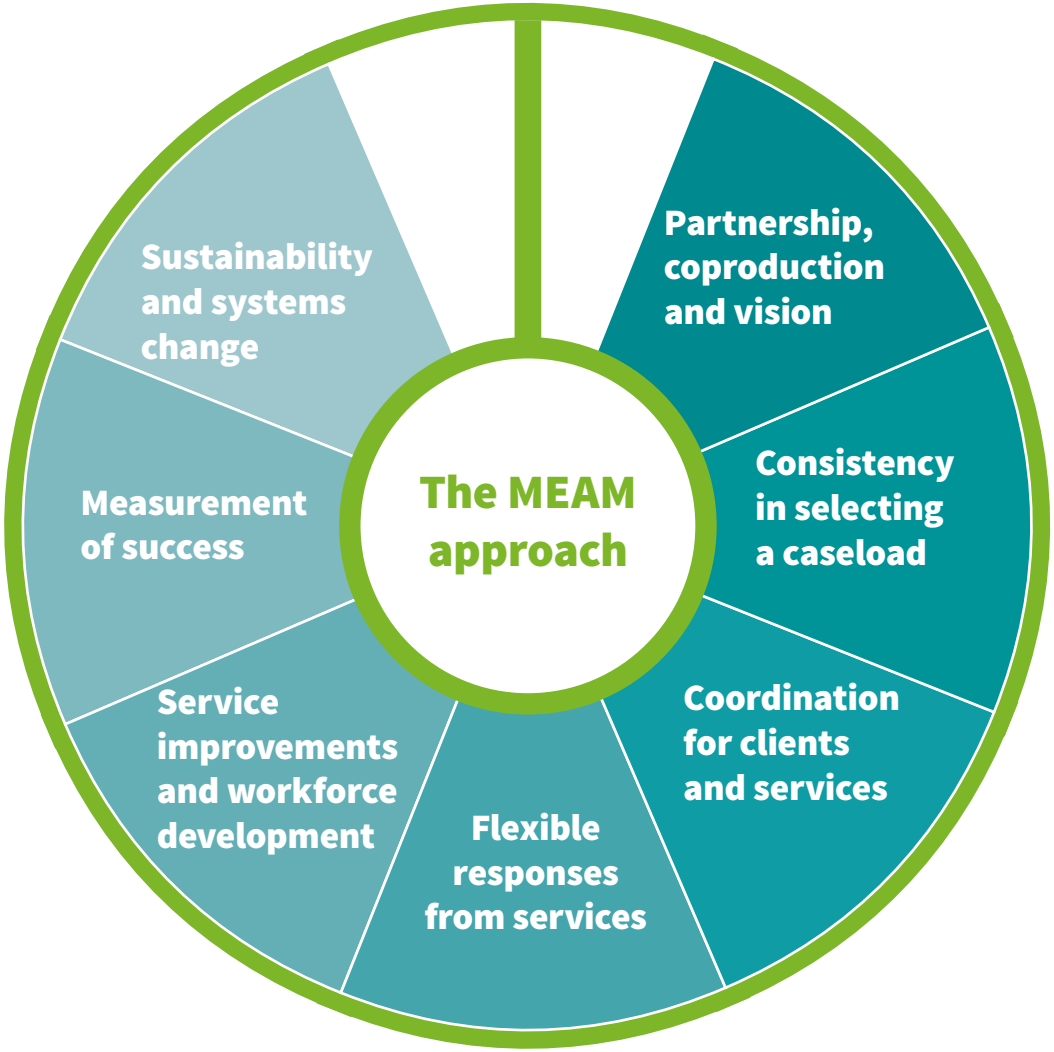
Use data to learn

Act

Trial a change in the system

Deliver for people

Review and record feedback



Housing

The right home environment protects and improves health and wellbeing. A warm, dry and secure home is associated with better health and prevents physical and mental ill health.

It is estimated that we spend around 90% of our time indoors, with 65% of this spent at home. If we want to improve the health and wellbeing of individuals, families and communities, there can hardly be a more important place to start than the home: it is where most people spend most of their life.

Housing can influence health directly through condition, security of tenure, overcrowding and suitability for inhabitants' needs. Wider aspects of housing that influence health indirectly include affordability and poverty, housing satisfaction, choice and control, social isolation, access to key services such as health care, and environmental sustainability. To improve physical and mental wellbeing and tackle health inequalities across Cornwall and the Isles of Scilly we need to ensure everyone has access to a warm, dry, safe, affordable home which meets their needs.

As we enter a period of the highest inflation seen in a generation there is a real risk that housing-related health inequalities will widen: this includes a particular risk of affordability, growing rates of fuel poverty, higher costs of maintenance and repairs, and greater insecurity of tenure leading to rising homelessness, especially for those

A healthy home is...

- Affordable and offers a stable and secure base
- Able to provide for all the household needs
- A place where we feel safe and comfortable
- Connected to community, work and services

Why housing matters

Housing across all tenures and its affordability, influences where people live and work and affects the quality of housing, poverty and community cohesion. Cornwall and the Isles of Scilly face some fundamental housing challenges related to high house costs to earnings, reduced housing stock through second homes and holiday rentals, and reductions in the supply of social housing since the 1980s.

Housing affects inequality in a number of important ways. Differences in house prices across our communities' and limit where people on lower incomes can live. Higher demand for houses in the most desirable neighbourhoods will tend to push up prices in locations with access to good schooling, low crime, access to transport, abundant employment opportunities, and pleasant physical environment. This means that the housing market has a key role in "sorting" less affluent households into areas with poorer housing stock, worse pollution, crime and employment opportunities.

There are a number of housing attributes that can affect our health and wellbeing:

Hazard	Physical health effect		Mental health and wellbeing effect	
General substandard housing			Mental health - anxiety, depression Socio-emotional development	Disruption to education and impact on academic achievement
Damp and mould growth	Increase in heart rate, increased hygiene risk Increased risk of accidents	Spread of contagious disease	Depression, anxiety, feelings of shame	
Excess Cold	Hypothermia Respiratory conditions Cardiovascular	Heart attacks, strokes Infections Death	Depression and anxiety	Slower physical growth and cognitive development in children
Excess Heat	Thermal stress Cardiovascular strain and trauma	Strokes Dehydration Death		
Lead	Lead when ingested accumulates in the body and has toxic effects on the nervous system, cognitive development and blood production		Continual exposure at low levels has been shown to cause impaired cognitive development and behavioural problems in children	
Asbestos	Pleural plaques, Fibrosis, Lung cancer, Mesothelioma			
Carbon Monoxide and fuel combustion products	High Concentrations - unconsciousness and death Lower Concentrations - headaches, dizziness, weakness, nausea, confusion, disorientation, fatigue			
Crowding and Space	Increase in heart rate Increased hygiene risks	Increased risk of accidents Spread of contagious diseases		
Noise	Headaches Sleep disturbance		Stress responses; Sleep disorders; Lack of concentration; Anxiety and irritability	

What works?

Where we live can promote equity if it is:

- ✔ **Available** - ensuring an adequate supply of housing for our current and future residents, with consideration to size and tenure to prevent and reduce household crowding
- ✔ **Affordable** - affordable and provides a stable and secure base
- ✔ **Quality** – new stock is designed and built to high standards and existing stock provides decent homes with improved energy and thermal efficiency to protect the health of the general population
- ✔ **Safe** - a place where we feel safe and comfortable as well as equipped with appropriate safety devices such as smoke and carbon monoxide alarms
- ✔ **Accessible** - able to provide for all the household's requirements including an aging population and those with functional impairments and disabilities
- ✔ **Connected** - connected to community, work and services
- ✔ **Outdoor space** – creates environments that support and encourage healthy behaviours

CASE STUDY: Supportmatch Homeshare

Cornwall's Supportmatch Homeshare Service is an award-winning partnership between Cornwall Council, Cornwall's Voluntary Sector Forum and Supportmatch Homeshare. The service matches people who need affordable support at home with tasks such as cooking, cleaning and shopping, with people needing affordable accommodation.

The service innovatively helps to decrease demand on the health and social care system and the housing system in Cornwall. It also supports 'anticipatory care', supporting people before they require acute health and social care such as needing the hospital. Homesharing also reduces loneliness and social isolation by offering companionship and an overnight presence.

> "Mum's more content to be in her own home. If there's a way we can keep her in her own home for as long as we possibly can then it's got to be a win-win."

> "I have been immeasurably grateful for not only the affordable housing, but also the opportunity to experience a different part of the country and be welcomed into a new home, family, and community."

Over 30 Homeshare matches have been made across Cornwall, with many more applications coming in. In 2022, the service won a South West Personalised Care Award for the 'Choice and Control' category for the support one Householder, Graham, received during his final moments. Graham had terminal cancer and his choice was to die at home, but this was going to be impossible because he lived by himself. The service mobilised quickly to identify someone who needed somewhere to live that was willing to support Graham, meaning that Graham was able to die peacefully at home.

www.supportmatch.co.uk

Community safety

Community safety is an area of work concerned with protecting people, individually and collectively, and their quality of life, from hazards or threats that result from the criminal or anti-social behaviour of others.

Although community safety as an area of work can be defined in a single paragraph, the range of problems and behaviours that it covers is incredibly varied and complex, and community safety is not just an issue for police and fire and rescue services - Community Safety is a shared issue.

Community Safety is about communities feeling safe, whether at home, in the street or at work. Perceptions of community safety, whether they are real or perceived, impact on the way people feel and interact in their community with crime and anti-social behaviour (ASB) rates being key factors for local residents in determining a good place to live. The impact of crime on wellbeing is significant and negatively affects ill-health, hospital admissions, new business start-ups and community cohesion.

Inequalities experienced by those known to the criminal justice system

The links between inequalities, social exclusion and involvement in the criminal justice system are complex. Addressing inequalities, including health inequalities, as well as directly addressing offending behaviour can improve public safety, prevent offending and reoffending, and reduce crime .

The health, economic and social inequalities faced by the population in contact with the criminal justice system are stark and striking. People in contact with the criminal justice system face significant health inequalities :

- mortality rate for prisoners is 50% higher than the rest of the population
- people in and out of the criminal justice system are four times more likely to be smokers
- 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population
- 42% of men and women in prison and 17.3% on probation suffered from depression, compared to just over 10% of the rest of the population
- it is broadly recognised that many prisoners have the biological characteristics of those who are 10 years older than them

While evidence is of variable quality, the picture that emerges is one of a population characterised by multiple and complex health and social care needs, housing problems, not being in employment, training or education, and psychological trauma.

Social risk factors for involvement in criminal activity, including family factors, community factors, education, financial deprivation, alcohol and drug misuse overlap as important factors for general health and wellbeing. There are conditions, characteristics and influences that can both increase reduce the chances of people coming in contact with the criminal justice system and encourage positive, healthy living.

Risk factors usually occur in clusters and interact with each other, and protective factors act against risk factors. Protective factors can go some way to explaining explain why those who face the same level of risk are affected differently.

Risk factors

Individual

- Genetic or biological perinatal trauma
- Early malnutrition
- Poor educational attainment
- Behaviour and learning difficulties
- Poor communications skills
- Alcohol and substance misuse
- Traumatic brain injury
- Gender

Relationships

- Low family income
- Poor parenting and inconsistent discipline
- Family size
- Abuse (emotional, physical, sexual)
- Emotional or physical neglect
- Household alcohol or substance misuse
- Household mental illness
- Family violence
- Family breakdown
- Household offending behaviour

Community

- Unsafe or violent communities
- Low social integration and poor social mobility
- Lack of possibilities for recreation
- Insufficient infrastructure for the satisfaction of needs and interests of young people
- Racism

Society

- Socio-economically deprived communities
- High unemployment
- Homelessness or poor housing
- Culture of violence - norms and values which accept, normalise or glorify violence
- Discrimination
- Difficulties in accessing services

Protective factors

Individual

- Healthy problem solving and emotional regulation skills
- School readiness
- Good communication skills
- Healthy social relationships

Relationships

- Stable home environments
- Nurturing and responsive relationships
- Strong and consistent parenting
- Frequent shared activities with parents
- Financial security and economic opportunities

Community

- Sense of belonging and connectedness
- Safe community environments
- Community cohesion
- Opportunities for sports and hobbies
- Positive social interactions and friendship groups

Society

- Good housing
- High standards of living
- Opportunities for valued social roles

Inequalities experienced by victims of crime

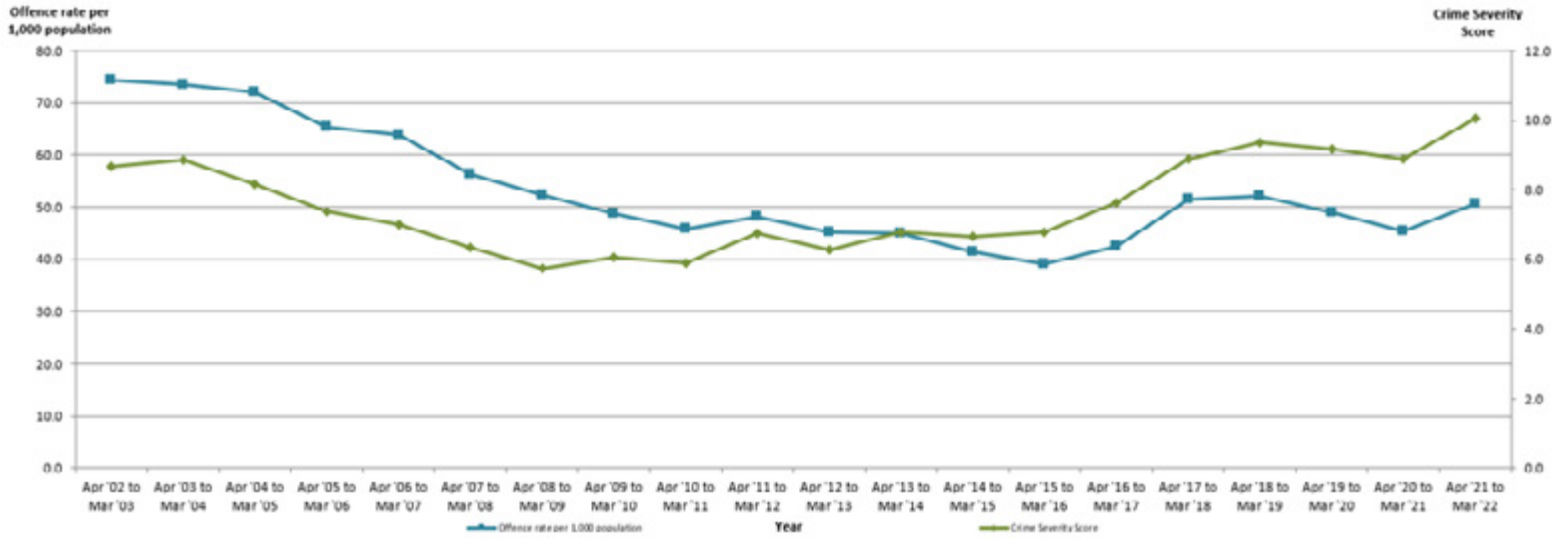
Crime harm refers to the negative impacts of crime on individuals and society. While crime is often seen as a harm in its own right, the negative impacts related to any one incident will differ by the type of crime experienced as well as the perspective of the victim. These harms include a wide range of outcomes for both individuals, such as financial loss and physical harm, and for communities and wider society, such as fear of crime and increased use of health and victim services .

However, crime does not affect people in the same way; the extent of the impact on the victim is influenced by many factors and some evidence indicates that aspects of the crime and the seriousness of the incident do not solely account for this variation . Additional factors include the victim's characteristics and financial circumstances and the support available. This again, points to the interplay between socio-demographic inequalities and how those with less resources are likely to be those most impacted by crimes committed against them.

The Crime Severity Score (CSS) data tool was developed to complement police recorded crime count data by providing a single value for crime severity to measure change over time and between geographical areas.

Whilst recording changes account for much of the increase in the CSS across Cornwall from 2014, **the latest year is highlighting a rise** since the end of the pandemic **suggesting an increase in the severity of crime reported** and whilst the extent of the impact on the victim is influenced by many factors this indicates an increasing risk of impact on victims and wider communities across Cornwall.

Crime Severity Score compared with offence rate per 1,000 population,
year ending March 2003 to year ending March 2022: Total Recorded Crime*

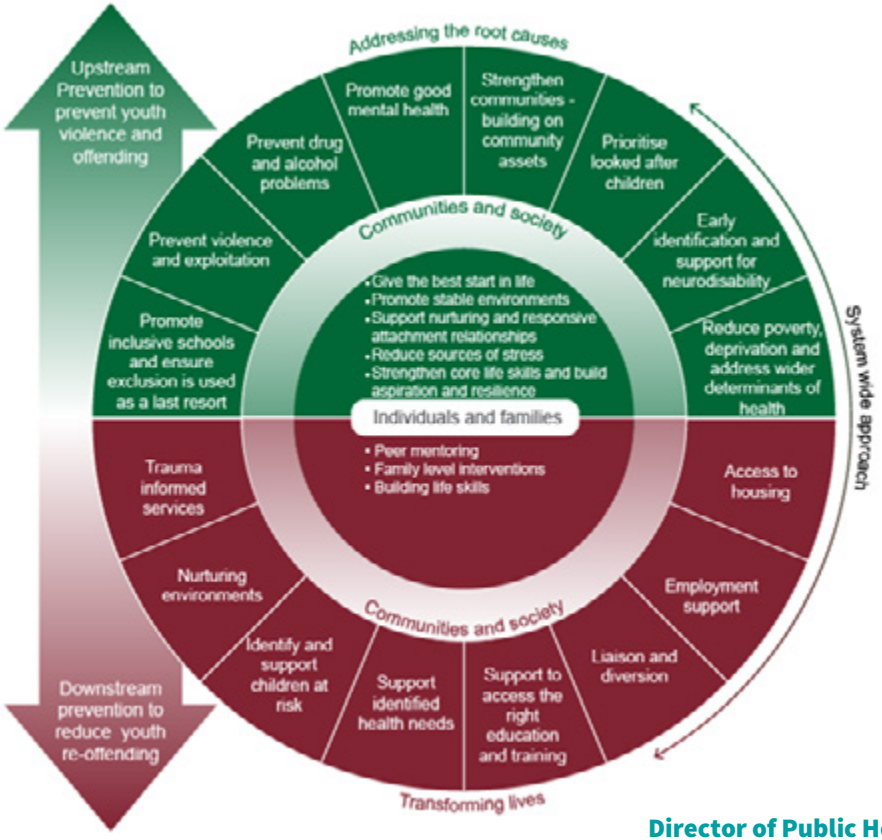


* The increases in the Crime Severity Score were more pronounced than the police recorded crime rate between year ending March 2014 and year ending March 2019 because of rises in more serious violent and sexual offences, which have a larger weight. Various improvements to recording processes and practices by the police made substantial contributions to rises in these offences during this period. Decreases from year ending March 2020 to year ending March 2021 reflect the impact of the coronavirus (COVID-19) pandemic.

What works?

✔ **Community safety is a shared issue,** which must be delivered collaboratively and in partnership to provide solutions at strategic, tactical, and operational levels. The delivery of services is much more effective with a holistic approach, and reduces duplication, silo working; but provides a mechanism for information sharing and the sharing of ideas.

✔ **The CAPRICORN diagram illustrates** how important it is to start with upstream prevention and early intervention. It illustrates areas to focus upstream and downstream prevention that can be undertaken at individual, family and community levels. Strong, cohesive communities are part of the solution and form the underlying support structures of a place-based, whole system approach.



CASE STUDY: Tri-Service Safety Officers

The Tri-Service Safety Officers (TSSOs) focus on engagement, early intervention and prevention to reduce risk and vulnerability in our communities. The role complements existing services and reduces frontline demand, whilst also providing an operational emergency response for Fire and Ambulance services.

First piloted with just one officer in 2014, the innovative model has proven a huge success and there are now 13 TSSOs located across Cornwall. The role is a vocation in its own right and provides a unique approach to resolving community safety matters by targeting and identifying issues jointly. TSSOs also provide the three emergency services with a visibility and presence in otherwise hard to reach rural communities.

In 22/23 the team of TSSOs made 486 domestic premise risk reduction visits and responded to over 604 Police Logs, 493 Ambulance calls and provided 1207 hours of fire availability. They also delivered over 3000 hours of community engagement and training, including distributing over 200 Raizer Chairs to care homes in Cornwall and providing training in their use to reduce frontline demand on our emergency services for slips trips and falls and supporting Junior Life Skills and engaging with over 1500 children.

> They are looking after some of the most vulnerable people; going into their homes, keeping them safe, keeping them well. They are ensuring that the communities they serve are as vibrant as they can be, as safe as they can be and as resilient and connected as they can be.

Kathryn Billing, Chief Fire Officer at CFRS

CASE STUDY: Safer Towns Programme, Truro Community Football Youth Football Sessions

Safer Towns is Safer Cornwall's flagship programme, celebrating its fifth anniversary in 2023. Ten town-based partnerships provide intensive support to the towns that experience the most crime and anti-social behaviour, alongside complex issues around drugs, alcohol, rough sleeping and safeguarding vulnerable people. Truro Safe partnership is co-ordinating a 15-month multi-agency programme of work, with a value of just over £1m, funded by the Home Office Safer Streets Fund.

Anti-social behaviour is identified by Truro Safe as a priority to address in the city, with a particular focus on supporting young people. Issues have escalated in the last year, with significant community impact. Consultation with young people identified the need for diverse and age-appropriate activities out of school time.

Truro City Football Club affiliated Supasport Southwest delivered 8 sessions of football skills, activities and mini games to young people with the aim of promoting teamwork, kindness and respect as well as diverting them away from anti-social behaviour. The sessions were held in green spaces on 3 key housing estates in Truro. The sessions were open to all boys and girls aged 5-15. Stalls on site offered information, advice and guidance to the young people and those attending with them. Services included Young People Cornwall, the Council's ASB Team, Police, Children and Family Services and Truro City Council's Community Development staff.

Project impact:

- It provided a meaningful out of school activity for young people as well as bringing the community together through sport.
- It inspired exercise and wellbeing with a message of kindness and respect for each other.
- Young people were asked about future opportunities for more sessions and/or developing new ideas other sport-based activities.
- Some young people known to local services participated and this is believed to be having a positive impact; local take up of youth services has increased.
- Parents positively engaged with police and Community Safety Team to talk about concerns and help foster good relationships.

Education and work

The link between better health and greater prosperity has long been recognised. Most of us know from our own lives that good health is a prerequisite for learning, finding a good job and working.

Good health has its own value – it is vital to an enjoyable and meaningful life, free from avoidable diseases and, in the worst cases, premature death. But it is also a crucial determinant of our economic prospects determining which people and places share in prosperity. Illness is unequally distributed across geography, social groups, gender and ethnicity and so improving health can also help tackle the interplay between health inequalities and economic disadvantage. Despite this, health is rarely considered as a commonsense economic lever.

Why education is important

Education is truly one of the most powerful instruments for reducing poverty and inequality and it sets the foundation for sustained economic growth. Educational inequalities emerge in very early childhood and the effects continue throughout a person's life, affecting entry into higher education, future employment and lifetime earnings.

Even prior to beginning school, there are differences in children's cognitive and socio-emotional skills. During the school years, these educational inequalities can become more evident and the gap in attainment can widen ; nationally it was found that only 8% of young people who were not meeting expectations in reading, writing and maths at the end of primary school went on to achieve pass grades in GCSE English and maths.

The overall outcome measure of school readiness across Cornwall and the Isles of Scilly is the same as England however this is 66% of all children who have expected level of development at end of Reception. **So still 1 in 3 children are not school ready.**

Socio-demographic characteristics, such as economic disadvantage, ethnicity, disability, gender, whether a child has been in care or has special educational needs and disability (SEND) status, are related to educational inequality and attainment gaps, and the long-term implications for the individual and society.

The COVID-19 pandemic has led to increased attention on educational inequalities and attainment gaps in the short-, medium- and long-term as the pandemic has significantly worsened overall outcomes as well as widening inequalities. Higher levels of qualification are strongly associated with better prospects in the labour market conversely those with lower levels of qualifications are also more exposed to slow earnings growth over their lives, with less opportunity for pay progression throughout their careers. The long-term impacts of the pandemic on our children and young people – our future working age population - is significant and should not be a concern just for those in education. The impacts are far reaching and require a concerted and co-ordinated effort by the public and private sector to ensure our children and young people are supported to reach their full potential.

It is also important to remember that the health of the current working age population will affect the potential of the next generation too. When parents are prevented from working because of a health condition or find themselves unemployed, the risk is not just that their children may end up in poverty, but that those children may experience worse health outcomes and face an increased likelihood that they themselves will be workless in the future. The effect of unemployment does not just affect individuals. Children growing up in workless households are almost twice as likely to fail at all stages of education compared with children growing up in working families.

Between 2018/19 and 2021/22 the number of children in absolute low-income families* across Cornwall and the Isles of Scilly increased by 21% - and additional 3,500 children

* Absolute low-income is defined as a family whose equivalised income is below 60 per cent of the 2010/11 median income adjusted for inflation. Gross income measure is Before Housing Costs (BHC) and includes contributions from earnings, state support and pensions

Why work is important

Employment and work are linked to the fundamental causes of health inequality – the unequal distribution of income, wealth and power. Increasing the quality and quantity of work can help reduce health inequalities. The availability of good jobs lies at the heart of inclusive economic growth and the alleviation of poverty.

Work and income are two of the most important determinants of health and wellbeing. Evidence suggests that (good quality, healthy and safe) work has beneficial long-term physical and mental health effects, and correlates positively with higher healthy life expectancy rates. Conversely, unemployment is consistently seen to have a negative effect on a range of physical and mental health and wellbeing outcomes, including through increased stress and reduced self-esteem, and as a result of financial hardship and insecurity. Furthermore, the health consequences of unemployment have been shown to increase with duration – for mental health and life satisfaction as well as for physical health – and commonly extend beyond the individual to impact on family units. Families without a working member are more likely to suffer persistent low income and poverty.

21.3% (1 in 5) of those aged 16-64 are Economically inactive* across Cornwall and the Isles of Scilly

* people aged 16 and over without a job who have not sought work in the last four weeks and/or are not available to start work in the next two weeks. The main economically inactive groups are students, people looking after family and home, long-term sick and disabled, temporarily sick and disabled, retired people and discouraged workers.

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Work has the potential to improve health. However, jobs which don't protect against poverty, offer limited autonomy and increase the risks to mental or physical health are as bad for health as unemployment. **The Marmot Review (2010) argued to reduce health inequalities:**

> "jobs need to be sustainable and offer a minimum level of quality…getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option."

Paid employment is not a guaranteed route out of poverty. Whilst the poverty risk of part-time workers is dependent on the overall household context and varies widely across individuals, part-time work is naturally linked to limited earnings and therefore presents a greater poverty risk for certain groups such as single working adult households and where part-time work is involuntary (i.e. a worker would like to work more hours).

Some groups also face additional barriers to get and keep work. For example:

- Lone parents are often restricted in the overall hours and timing of work they can reasonably do, because of a lack of available, affordable, appropriate childcare
- People with fluctuating health conditions or disabilities who may benefit from flexible employment that recognises their needs
- People with complex or multiple needs, such as those who are homeless or those with addictions, need extra help to overcome non-work related problems
- Black and Minority Ethnic (BME) groups, and some migrants, may face language barriers, while others (who may well be bilingual and highly skilled) may not have their qualifications or work experience gained overseas recognised by employers or employability services

As the population ages, and the state pension age increases, supporting people with long-term conditions in the workplace will become increasingly important. Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice.

The links between health, employment, productivity and poverty underline the critical importance of improving the health of the working age population in achieving both greater social justice and higher economic growth. Promoting health and well-being for all will raise employment, reduce child poverty and poverty later in life, and raise the growth in productivity of our economy. Similarly, increasing employment and opportunity of employment will directly promote better health and well-being for all. Thus, the health of the working age population is important for everyone:

- **for individuals and their families,** because it impacts on the quality and length of life people lead, affecting their capacity to work and provide for their family;
- **for employers,** because a healthier workforce is a more productive workforce; having healthier workers also provides an incentive to invest in their training and development, as such investment will yield a higher return; and
- **for society as a whole,** because the consequences of ill-health lead to social exclusion, lower output and reduced tax revenues. Higher costs in terms of healthcare and social security benefits add to the burden on the taxpayer.

A healthier population can be more prosperous. This could be achievable through more prevention, better treatment, faster access to care, and more effective employment support services and workplace interventions for people with existing long-term conditions, mental health problems or other impairments.

Achieving fair employment and good work for all will involve a holistic, sustained, long-term approach, proportionate to need. Action will be needed across a number of policy areas. However, a shift in attitudes is necessary to ensure that employers and employees recognise not only the importance of preventing ill-

health, but also the key role the workplace can play in promoting health and well-being .We need a shift from apathy on actively pursuing good health to one where policy implementation, innovation and strategic investment is the norm.

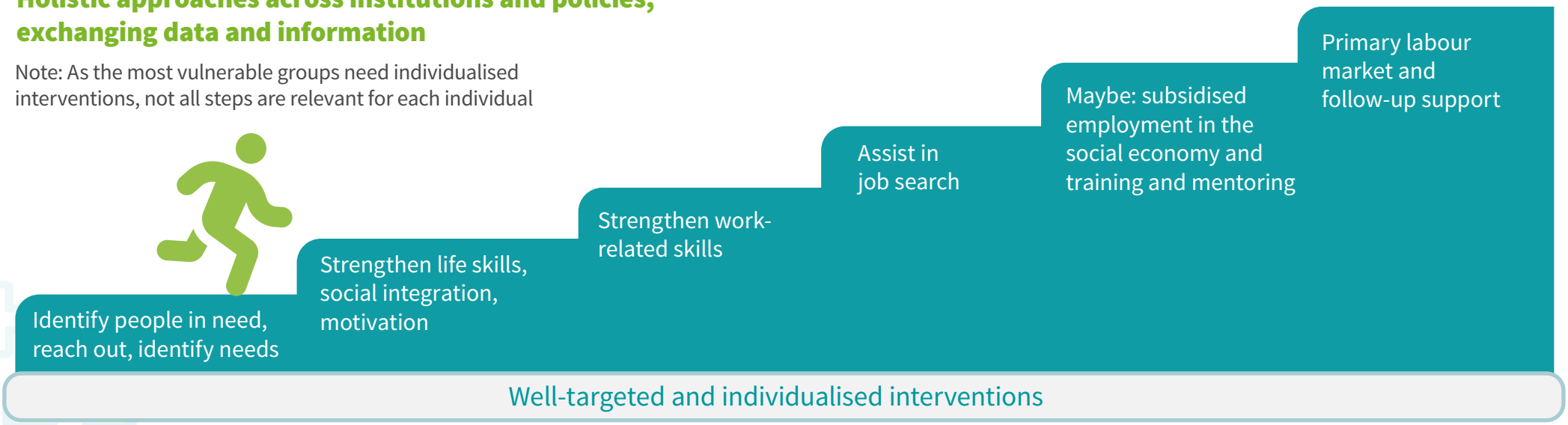
What works?

To reduce health inequalities through employment it is important to:

- ✔ **Increase the availability of work (jobs and hours)**
- ✔ **Increase the wages of low-paid workers**
- ✔ **Support people with health and social issues into work**
- ✔ **Promote lifelong learning and skills development opportunities**
- ✔ **Increase the quality of available work by increasing worker autonomy and investing in in-work training**
- ✔ **Improve the quality of work, by increasing wages and in-work benefits, improving employee control at work and minimising health and safety risks in the work environment, including through NHS and local government procurement policies**
- ✔ **Provide better practical support, on issues such as childcare and long-term health conditions, to help people to get and keep jobs**
- ✔ **Supporting the most vulnerable groups through pro active outreach and a good understanding of their needs**

Holistic approaches across institutions and policies, exchanging data and information

Note: As the most vulnerable groups need individualised interventions, not all steps are relevant for each individual



Source: Organisation for Economic Co-operation and Development (OECD)

CASE STUDY: PROPER JOB

PROPER JOB is a new Enterprise and Employment Service that, through innovation, passion and commitment, creates high quality, work-related outcomes for people with learning disabilities and/or autism, enabling them to access greater opportunities and live active, better lives.

Since launching in June 2022, the PROPER JOB Café enterprise has supported 98 clients and delivered 658 hours of paid employment, 1035 hours of training, 854 hours of work experience, 45 hours of work tasters and 555 client volunteer hours. 27 clients have since secured employment.

Jason's Story

Jason joined PROPER JOB following a referral from a Department for Work and Pensions (DWP) Employment Advisor. Jason met with Phillip Silvio (one of PROPER JOB's Opportunity Coaches) and decided to focus on preparing and looking for work, whilst gaining work experience in PROPER JOB's Café Enterprise which he attended for 4 hours on a weekly basis. Jason began to develop his communication skills and was soon supporting other clients with their tasks.

Following several unsuccessful job applications Jason applied for the post of Trainer with the Royal Cornwall Hospital Trust, delivering Oliver McGowan training to doctors and specialist hospital staff. Phillip helped Jason prepare for his interview, this was going to be Jason's first ever paid job interview and so it was important that he was well prepared, and this included a mock interview. The interview panel at the Cornwall Hospital Trust were extremely impressed by Jason and were delighted to offer him employment!

Jason said:

> "I cannot quite believe it; I feel so happy now. I am also feeling nervous as I do not know what to expect but know that you will be there to help me"

Feedback from Jason's mum: "I would like to provide you with some feedback about my son, Jason, who has been working with you for over 6 months now. Firstly, I would like you to know how much more confident he is, both in his physical demeanour and his mental attitude. He tells me that he feels so much better about himself and believes in his own abilities now. Secondly, the process of working with you has provided a step-by-step approach to the workplace. This has taken the fear away from the idea of paid work and allowed him to understand how the job market works. Trying out interview questions and scenarios has been extremely helpful, especially recently when you arranged for a colleague to give JP a practice interview with constructive feedback prior to the actual interview. This increased his confidence hugely and prepared him to cope with the interview process. In addition, you arranged a place for him to work at the Proper Job Cafe. Hands on experience of working individually, as a member of the team and with real customers has been invaluable to his confidence and progression. The Proper Job trainers found the best of Jason and allowed him to flourish."

Phillip Silvio, Jason's Opportunity Coach, said;

> "I am so proud of him and proud that PROPER JOB has been able to make such a difference to someone's life as well as the impact that it has on his family at home"

www.cornwall.gov.uk/properjob

CASE STUDY: Trelya

Trelya is a registered charity working with children, young people and families in West Cornwall's most under resourced communities. Their overriding aim is to ensure fair and equal access to positive health, education and employment opportunities for families facing the most significant and complex barriers.

Trelya's work takes a multi-generational, asset-based approach, working with the entire family to build on strengths, as well as addressing the challenges they face. Children and adults access up to 15 hours (and sometimes more) of face-to-face, direct support each week through the following three Trelya services:

- ✔ **Skylar** - Trelya's 'Outstanding' Ofsted registered Early Years Service provides individualised support to children and families from pre-birth - 4.
- ✔ **Gallos** - Trelya's award-winning youth work programme provides 12+ years of support for young people from the age of 5 and their families. Gallos delivers a diverse and individually tailored weekly programme of asset-based activities that combine sports, arts, community engagement and travel to develop essential life and social skills.
- ✔ **Gul Skills Development Programme** - A 6-month holistic, asset-based programme that enables those aged 18+ to meaningfully progress towards employment. This is Cornwall Community Led Local Development Fund's most successful employment project, with 77% of participants progressing onto employment, training or further education.

Woven into all the above 3 services is crises intervention through which the Trelya team works with families to avert or navigate crisis, providing immediate solutions to challenges such as homelessness and food poverty.

Trelya is open 50 weeks a year and over 800 individuals access their centre (The Lescudjack Centre) annually.

https://trelya.com

Environment

Addressing inequalities in environmental risk will help to mitigate health inequalities and contribute to fairer and more socially cohesive societies.

Why the environment is important

Clean air, unpolluted water and access to nature are vital ingredients for healthy lives. The Marmot Review identified that environmental factors, such as air quality, access to green space and housing are crucial in driving health inequalities in the UK. **The government's Chief Medical Officer stated in 2018 that if**

> everyone had the type of environment currently only available to the most affluent sections of society, people would live longer, healthier, more productive lives with fewer years of ill health.

Environmental problems overwhelmingly affect people living in the most deprived areas of the UK. There is a strong correlation between poor environmental quality and economic poverty with ethnic minorities being disproportionately affected. They also have higher rates of underlying health conditions that may make them more vulnerable to the effects of pollution. A 2003 study for the Environment Agency found strong evidence that a greater burden of tidal flooding, air quality and pollution from industrial sites is borne by deprived areas. A Friends of the Earth study in 2001 found that 66% of UK carcinogen emissions were present in the 10% most deprived wards. In contrast, the economically better off often enjoy a healthier, cleaner environment with the 50% least deprived wards suffered only 8% of these polluting emissions.

The impacts of environmental degradation are concentrated among vulnerable groups and households. Those living in the most deprived parts of England experience the worst air quality and have less access to green space and adequate housing. These problems can affect people's health and wellbeing and can add to the burden of social and economic deprivation which in tun can lower ability to invest in defensive measures (e.g. air filtration and better housing quality) increasing the vulnerability of lower socio-economic households to air pollution and climate change.

The following list presents some possible explanations for the emergence of environmental challenges within communities:

- **Discrimination** (e.g. in siting decision over hazards)
- **Protest evasion** (e.g. hazard developers targets minority communities having low perceived collective resistance)
- **Risk** - perception and acceptance of environmental risk varies by social characteristics
- **Commercial rent** – hazardous activities locate where land and labour is cheaper, but minority and deprived groups are more prevalent
- **Invasion succession theory** - minorities locate near a hazard, do well, and attract others creating a concentration of minorities next to the hazard
- **Location choice** – minority households locate in areas of low environmental quality as other area features, such as home size, compensate (Tiebout theory)
- **Neighbourhood transition theory** – development repels the affluent whose properties are occupied by lower income groups
- **Property rent seeking** - housing developers build higher value homes in high environmental quality areas; private rented and social housing is more concentrated in lower quality areas
- **Conservation policy** – protection of high-quality environments directs new housing to areas that are already degraded, concentrating lower income households.

Whilst there have been moves in government policies to help address climate change and protect the environment it is important to recognise that the benefits and costs of wider environmental policies are also likely to be unevenly distributed across households. The improvements may be experienced by different social groups in different ways and it is these distributional differences that can exacerbate inequality if not acknowledged and mitigated.

Overall, vulnerable groups may have a considerable stake in the success of green polices as direct beneficiaries since they bear a disproportionate share of the health costs of air pollution and climate change. Examples of unintended consequence include higher taxes on road transport fuels may affect rural residents more than urban dwellers, since the former tend to rely more on private cars and have limited access to viable public transport alternatives.

At the same time, households that are owner-occupiers may benefit more from environmental policy measures that increase home and land values than home-renters, such as subsidies for improving the energy efficiency improvements or creation of green areas.

In 2019 Cornwall Council declared a Climate Emergency and the impacts and risks to our environment through climate change and its impacts are clearly identified through **the Cornwall Council Climate Risk Assessment Report. It details how Cornwall will be affected by climate change. It highlights key potential changes for Cornwall, including:**

- The highest potential sea level rises around the UK by the end of the century
- The possibility of more high impact flooding. For example, like the floods in Boscastle (2004) and Coverack (2017)
- Stronger storms and higher wind speeds
- Faster coastal erosion
- More heatwaves and severe droughts.

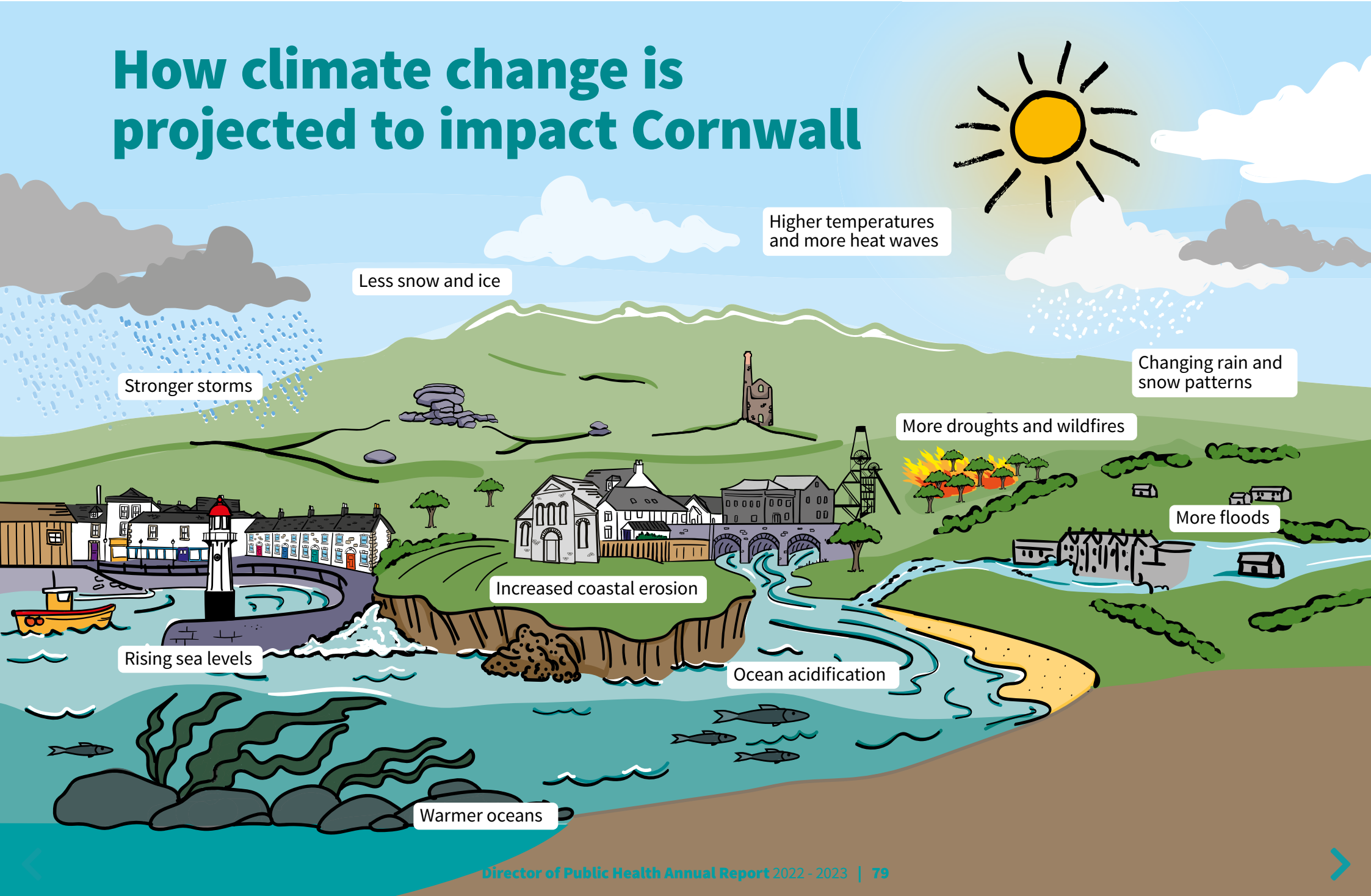
These themes are echoed by another significant report the **'State of Nature in Cornwall ' report** which states that Cornwall's natural environment which faces a plethora of different – but interconnected – climate change pressures.

wAs our population changes and grows we must seize opportunities for strategic design and planning of communities that will address inequality and enable people to live healthy, fulfilling lives, while protecting our natural environment. It is our responsibility, whether as residents, community leaders or policy makers to meet the challenge of ensuring that future generations will inherit a healthy, biodiverse natural environment, which benefits their health and wellbeing.

Causes of environmental and socio-demographic inequalities are often complex and long-standing. Some problems are due to the historical location of industry and communities; others are the result of the impacts of new developments such as traffic. It is argued that environmental inequalities are entrenched due to the fact that the vulnerable communities exposed to environmental burdens lack the means necessary to change their situation due to factors such as limited economic means and exclusion from decision-making processes.

Reviewing our policies and implementation plans is crucial to ensure we don't leave our more vulnerable and deprived neighbourhoods behind viii through improving our environment whether built or natural. It is therefore crucial that local communities are involved in decision-making to promote engagement and the sustainability of initiatives and policies.

How climate change is projected to impact Cornwall



What works

Inequality evidence: Evidence on societal structures and mechanisms leading to environmental inequalities

Policy actions:

- ✓ Review and learn from examples of good/equitable societal practices.
- ✓ Formulate equitable policy options on environmental protection.
- ✓ Improve public participation in planning and decision-making processes affecting people's local environment.
- ✓ Incorporate environmental and health equity issues into economic, social and infrastructural regulations, strategies and plans.

Inequality evidence: Evidence on differential exposure to environmental health risks

Policy actions:

- ✓ Enforce environmental standards where they are exceeded.
- ✓ Implement appropriate interventions to improve environmental conditions for the whole population.
- ✓ Target action on pollution hot spots and population subgroups with the highest exposures.
- ✓ Shift attention to policies that assure environmental protection and population health.
- ✓ Support intersectoral action and extend Health in all Policies approaches.
- ✓ Review the equity impacts of regulations directly or indirectly affecting environmental conditions (such as urban and infrastructure planning, taxation and social welfare) and their implementation.

Inequality evidence: Evidence on differential vulnerability to environmental health risks

Policy actions:

- ✓ Ensure that adequate environmental and infrastructural services and conditions are accessible for all.
- ✓ Provide environmental resources and social benefits to compensate for the influence of environmental risks or social stressors.
- ✓ Increase targeted protection measures in areas or settings with a high density of vulnerable, sensitive or disproportionately affected populations.
- ✓ Improve environmental standards in the vicinity of child care centres, schools, hospitals, nursing homes and similar.

The benefits of a healthy natural environment for our populations mental and physical health and economy are clear.

CASE STUDY: Cornwall Area of Outstanding Natural Beauty, Mental Health Training in Cornwall's Farming in Protected Landscapes (FiPL) programme

Cornwall AONB's Farming in Protected Landscapes (FiPL) programme has been working with farmers and land managers across the 12 Sections of Cornwall AONB since the programme began in early 2022. These relationships are integral to the success of the programme and delivering for people, place, nature and climate.

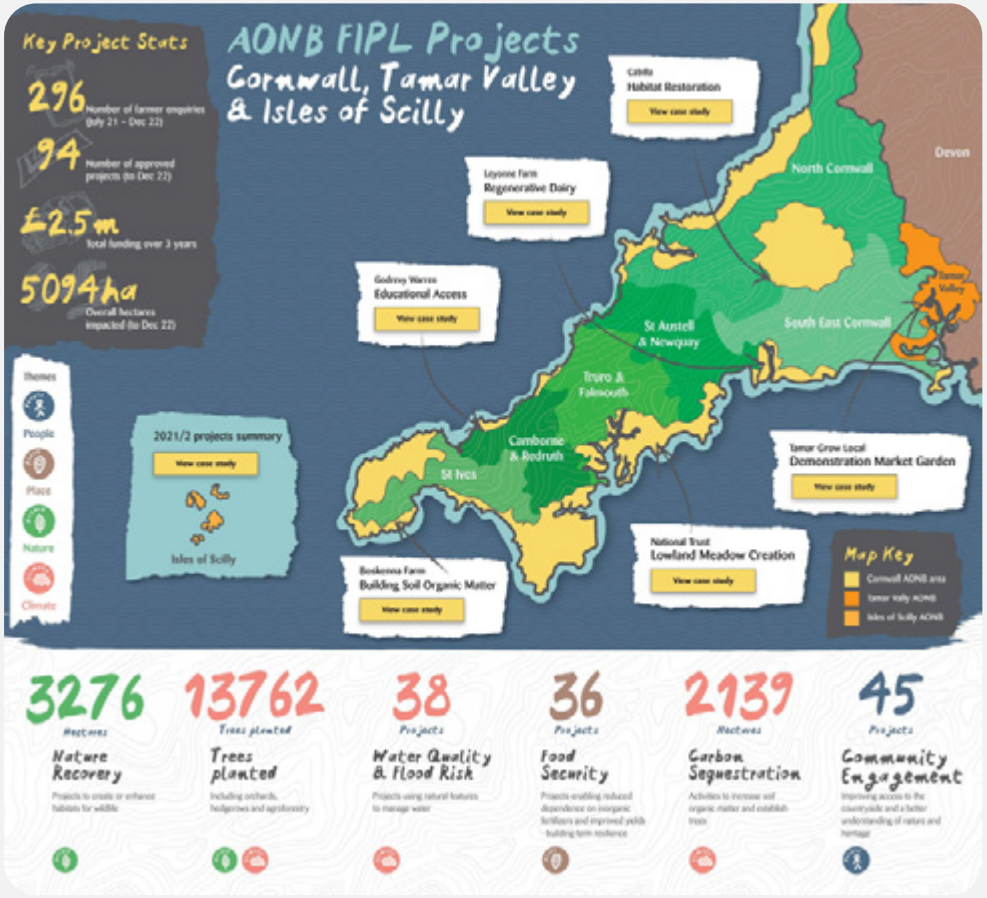
Delivering for people also includes the farmers themselves. Poor mental health in the farming community is widely recognised and the FiPL team were keen to help support them in this aspect. The Cornwall AONB team have benefitted hugely from the Mental Health First Aid Training, becoming Orange Button holders, and identified a need for more Mental Health First Aiders in this particular sector.

Working with Cornwall Council's Wellbeing & Public Health team, the Cornwall AONB team have been able to offer six Mental Health First Aid courses with an aim to have a minimum of one Mental Health First Aider from the farming community in each Section of the protected landscape. Farmers which are considered 'Hard to Reach' are often the most vulnerable. Those keen to become a Mental Health First Aider in this community are most likely to be in contact with hard-to-reach farmers and by providing training and support may be able to reduce this risk factor.

The project has had a great amount of interest when presented across the Sections across a range of ages, from Young Farmers upwards.

> I would recommend this excellent course to anybody/organisation. Thank you for bringing it to my attention.

- A farmer in Section 07 West Penwith who completed the free Mental health first aid course and is now a certificated Mental Health First Aider.



Travel and transport

Inequalities in the provision of transport services are strongly linked with where people live, and the associated differences in access to employment, healthcare, education, and local services.

Why travel and transport is important

Mobility is key to a socially and economically connected society and a good transport system enables residents and visitors across Cornwall and the Isles of Scilly to live their lives. Transport makes it possible to go to work or school, see friends, visit the shops, and get access to welfare provision, hospital services, leisure facilities, financial support and housing. Unfortunately, lack of access, unfair barriers and disproportionate negative impacts can restrict certain groups' ability to move around and travel – thereby affecting their wellbeing and life chances, specifically:

- People may not be able to access services as a result of social exclusion. For example, they may be restricted in their use of transport by low incomes, or because bus routes do not run to the right places. Age and disability can also stop people driving and using public transport.
- Problems with transport provision and the location of services can reinforce social exclusion. They can prevent people from accessing key local services or activities, such as jobs, learning, healthcare, food shopping or leisure. Problems can vary by type of area (for example urban or rural) and for different groups of people, such as disabled people, older people or families with children.
- The effects of road traffic also disproportionately impact on socially excluded areas and individuals through pedestrian accidents, air pollution, noise and the effect on local communities of busy roads cutting through residential areas.

Determinants of transport inequality

Geographical: How the transport infrastructure connects communities (particularly rural) to promote inclusion

Physical: Barriers that may limit people's access i.e. physical design of infrastructure (bus and rail design including stations)

Economic: Costs of transport and share of household budget impact on key journeys - social, work and healthcare

Time-based: Competing time pressures and varying availability of transport at different times of the day or days of the week

Spatial: Fear of using transport options due to experiences of harassment, anti-social behaviour or violence

Impacts of transport inequality

Social exclusion: Insufficient access options can prevent people from participating in economic, political and social life of communities

Inactivity: Lack of available options and car dependency can lead to inactivity affecting physical and mental health

Air pollution: Reliance on cars rather than an integrated transport network impacts air pollution impacting users and residents

Access to services: Where basic level of mobility is not available to individuals their ability to access key services to protect their health and wellbeing is compromised

Crime and road danger: Different road users have varying risk of injury from accidents or crime and antisocial behaviour on roads and public transport

Specific socioeconomic and demographic groups are disproportionately impacted by transport related inequalities. **The groups most commonly highlighted through research on the issue include:**

Gender: differences in caring responsibilities mean that women are disproportionately impacted by time-based constraints, and by physical constraints linked to caring. This is exacerbated by women being more likely to be in part time employment and requiring travel outside of defined peak commuter periods. Women were also found to be more likely to be exposed to spatial exclusion – particularly in public transport spaces and when travelling actively .

Ethnicity: the fear of discrimination or harassment on modes of public transport can impact those from ethnic minority communities. There is also evidence nationally, of lower car ownership levels among ethnic minority communities that can lead to greater exposure to social isolation where transport infrastructure is lacking alongside time-based limitations.

Disability: the inaccessibility of transport infrastructure for people with physical and sensory disabilities and reduced physical mobility – particularly for wheelchair users – is perhaps the most visible manifestation of transport related inequality. This includes inaccessible bus and rail carriages, road crossings that are unusable or unsafe, and a lack of adapted ticketing services. Transport information and the design of transport access points can exclude those with a range of less visible disabilities and health conditions, including those who are neurodiverse. Alongside this, higher levels of poverty among those with disabilities means that this population is also more at risk of transport inequality through economic factors.

Making use of public and community transport infrastructure requires knowledge and skills of finding information about the services that are available, and how to access and use them. Particular vulnerable groups have been identified by the Department for Transport who may benefit from 'travel training': training that aims to help people travel independently and without fear to work, to education, to other key services, or simply for leisure:

- People with learning difficulties of all ages, requiring individualised training appropriate to their situation for specific journeys or the whole network
- People with disabilities, ranging from physical or cognitive disabilities to mental impairments, reduced sensorial abilities, again people of all ages
- Children and young adults with Special Educational Needs (SEN)
- Children (often at/or approaching transitional stages)
- People who do not know how to and/or do not feel safe or confident using public transport
- Older people who find themselves without the use of a car for the first time in many years, either through their own deteriorating health or the death of a spouse/partner that drove them
- Ethnic minority groups, particularly when English is not the first language
- Unemployed people who might not, for a number of reasons, be able to access and/or remain in employment
- People who have started to use specialist transport services such as dial-a-ride

Age: In addition to effects associated with greater exposure to disability and reduced mobility for older people, transport inequality can impact across life stages. For those outside of working age, travel times and patterns diverge from those of peak time commuters, and there are greater levels of reliance on public transport. In addition, fear of anti-social behaviour and harassment, play a greater role in inequalities in younger age cohorts .

Income: While heavily overlapping with gender, disability, and ethnicity, those with lower incomes, and those in working class communities experience disproportionate exposure to transport inequality. This can reflect the greater prevalence of shift working and casual employment in peripheral locations among these groups, and through this, the challenges of accessing transport on the right route at the right time

LGBTQ: LGBTQ people are more likely to be exposed to anti-social behaviour, violence, and harassment in public transport spaces, and with this fear and reluctance to use these services where they are available. Those who are or are perceived to be transgender are particularly likely to face direct harassment ,

What works:

The way we get around affects others, and the way we work, and travel have changed significantly since the Covid pandemic. These changes present an important opportunity to adapt to new habits and to invest in a greener, higher quality, more active transport system that enables healthier lives for all and in doing so will help to reduce inequalities for communities across Cornwall and the Isles of Scilly.

To do this effectively, it will be essential to incorporate the following priorities into local planning:

- ✓ **Greater coordination of new infrastructure projects with transport policies**, to reduce car dependency and improve community connectedness.
- ✓ **Increased safe cycling and walking facilities** (such as segregated cycle lanes and secure bicycle parking facilities).
- ✓ **Increasing the availability, reliability and affordability of public transport** to improve wellbeing and shift travel behaviour away from cars.

What can we do...?

... as individuals

- ✓ **Use Public transport:** Buses have lower emissions per head than cars, and a good bus service means those without access to private cars can still travel easily. This reduces social isolation and enables people to find and keep jobs.
- ✓ **Active travel:** You don't need to wear lycra to cycle! Cycling has positive effects on the local economy, improves wellbeing, costs less, and reduces emissions – a mile by bike uses about 100g of CO2 compared to 700g by car. And it's fun!
- ✓ **Think about your driving:** Keep within speed limits and avoid sharp braking and accelerating (this reduces air pollution too). Keep your tyres at the right pressure and if you have a choice, don't drive: for your and the planet's health.
- ✓ **Reducing vehicle emissions:** Turning engines off, switching to electric/hybrid cars, or to more fuel-efficient models, driving at the speed limit and avoiding rush hour all reduce emissions. Consider car sharing – find a friend or colleague to share journeys – you'll save money too.
- ✓ **Fly less:** Take fewer flights each year and think about alternatives, especially for short haul flights. If you have to fly, go direct and fly economy.

... in the workplace

- ✓ **Reducing car travel:** Support staff via promoting home working, video conferencing, attending meetings via public transport, encouraging and co-ordinating car sharing, cycling, walking.
- ✓ **Enabling active travel:** Workplaces should provide secure places to keep bikes and also places to dry clothes.
- ✓ **Reducing emissions:** Ensure vehicles are fuel efficient and up to date, provide electric vehicle charging points, offer eco-driving training to staff, encourage non-road freight services.

CASE STUDY: Transport for Freedom Campaign

In 2019 to 2021, Barnardos and Carefree teamed up to pilot free bus travel for care-experienced young people. They provided free bus passes for local care leavers for a year and carried out monthly research and interviews with the young people to gather evidence about the difference free bus passes could make to their lives. From 2021 to 2022 the pilot formed part of Barnardo's national 'Transport for freedom' campaign.

Care-experienced young people often live independently, and without support networks that other young people may have such as family support with travel. Bus fare can often be prohibitively expensive to their quality of life. The pilot aimed to provide care-experienced young people with equitable access to basic health and life experiences.

Without access to transport, care leavers face a whole host of challenges. These include:

- struggling to meet with friends and family and negative experiences of prolonged isolation.
- difficulties accessing education, employment or training
- limited opportunities to take part in hobbies
- difficulties in going food shopping
- barriers to attending medical appointments

Free bus travel improved the mental and physical health of the participants. During the campaign it granted emergency access to GPs for the children of care leavers, and pregnant care leavers who would struggle to access it otherwise. It reduced social isolation increased wellbeing and improved socio-economic security and aspirations and increased uptake of community resources in the population in the study.

In February 2023, Cornwall Council, Carefree and young people met with Richard Holden, the Under Secretary of State at the Department for Transport. This led to all departments being around the table and supporting and as a result, in April 2023 the Council's cabinet approved plans for free travel for all care leavers up to the age of 25.

> "The bus pass made me feel free, it's about getting out there. It gave me hope."

> "If I pay for the bus, I haven't got enough money for food shopping or to put gas and electric on so I can't really afford to get the bus."

> "In care I couldn't have the relationship that I wanted with my dad and I want to be that network for my son that I didn't have."

> "[As care leavers] we're independent from a young age and need to be able to get out and about to places."

Find the transport for freedom report **here** and **here.**

CASE STUDY: Bus Fares Pilot

The Bus Fares pilot project entails working with local bus operators to develop a scheme to test the impact on patronage through offering better value fares. The Pilot is part of Transport for Cornwall's integrated public transport project. The aim is to initiate and sustain modal shift by creating an environment where lower fares can be introduced, patronage increased, and financial sustainability achieved.

Research of both non-users and bus users show that the biggest perception by people is that bus travel is too expensive. Bus usage nationally is still below pre-pandemic levels, although Cornwall is doing better than some areas. The Bus Fares Pilot aims to address this major barrier.

The bus fares pilot is marketed through a series of comprehensive media campaigns. Each campaign comprises of a strong overarching primary message which heads up all collateral. We then have a suite of secondary messaging which the partnership has agreed, promoting the excellent value currently on offer though specific ticketing pricing. This also compliments the new way to pay message, through Tap and Cap.

Early indications are that Cornwall's patronage has returned to pre pandemic levels and further analysis is underway to determine the specific impacts of the pilot and associated messaging and products.

> Shortly after arriving in Falmouth to start a new job, I made the best of my free time and set off to explore this stunning region that I instantly fell in love with. I soon discovered the great offers available on public transport, particularly the £5 day bus pass for the whole of Cornwall! Being a keen walker, the opportunity to combine some travel by bus and/or train and a long walk is particularly appealing to me. From my experience the local public transport is very reliable, and its network allows me to get easily to most places on my expandable wish list

- Cecile Franckinioulle

> My experience of the new bus pilot in Falmouth and Penryn has been positive. Journeys by bus have become an attractive, convenient and viable alternative to car use, replacing the majority of short trips I would have previously undertaken by car for both work and leisure purposes. Time savings and avoiding the hassle of finding a parking space are two the big plus points.

- Robin Watson

More information on Transport for Cornwall please visit:
www.transportforcornwall.co.uk

Commercial determinants of health

Commercial determinants of health are the private sector activities that affect people's health, directly or indirectly, positively or negatively.

The private sector has a major influence on health through its products and practices. They shape the physical and social environments in which people are born, grow, work, live and age – and significantly impact on people's lives, whether as employees, consumers, suppliers, as part of society as a whole.

The influence on health is both varied and complex. The private sector has been fundamental in developing and delivering essential health goods and services, but some of their products and practices are responsible for escalating ill-health and health inequity worldwide.

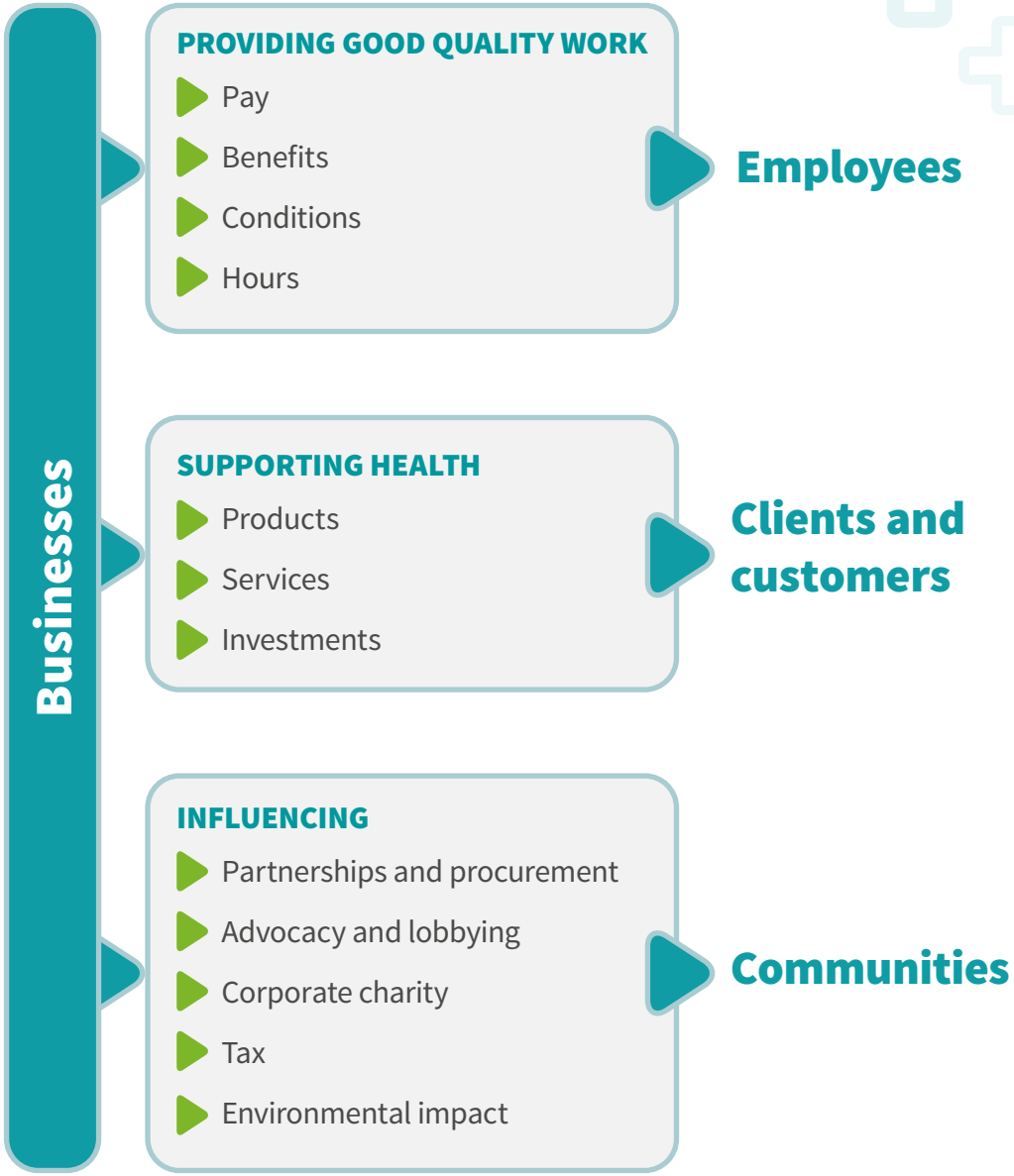
The main causes of chronic diseases i.e., cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes as well as hypertension and obesity include consumption of unhealthy goods such as tobacco, alcohol, or foods high in fat, salt and/or sugar.

Exposure to these is preventable but requires consideration across three key areas:

Availability –the supply as well as the physical location of sale that impacts on our exposure to goods through our environment and neighbourhoods that we move between on a day-to-day basis

Promotion – the targeted marketing and advertising of products as well as discounts and offers inc. loyalty schemes used to target and sell goods across a range of media and in-store

Price – the pricing and required need for profits which includes price reductions to stimulate greater demand and market share, premium pricing aligning to brand or product marketing, increased/ high pricing of products in demand, or where product supply isn't sufficient to meet demand.



There are four main ways that corporate influence is exerted: marketing and advertising; corporate political activities (i.e. lobbying); corporate social responsibility strategies; and supply chains.

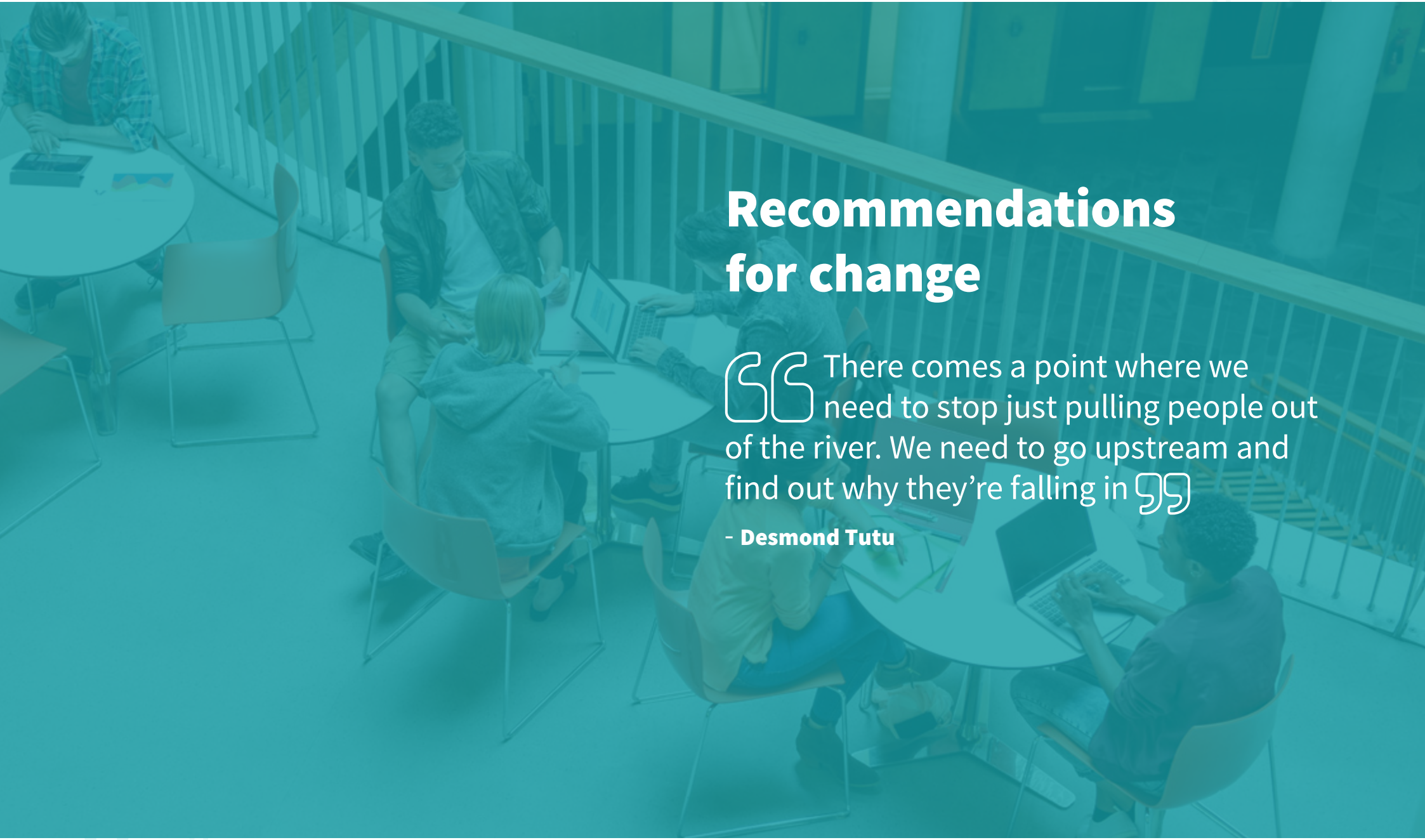
Consideration of the commercial determinants of health is critical to establishing effective approaches to preventive health, as individuals have limited control over their circumstances and what they are exposed to in their everyday life.

The success of public policy such as the smoking ban in public places and plain packaging of cigarettes; and recent evidence of the positive effects of Minimum Unit Alcohol pricing in Scotland (increasing cost of high strength alcohol which reduces consumption) demonstrates that market interventions for health can create large benefits.

> Today's food environments exploit people's biological, psychological, social, and economic vulnerabilities, making it easier for them to eat unhealthy foods.
>
> **- The Lancet Series on Obesity (2015)**

The effect of commercial determinants on health:

Commercial element	Protective	Adverse
Marketing and advertising	• Social marketing promotes public health and health promotion messaging	• Promotion of unhealthy products – end of aisle promotions, BOGOF encouraging to buy more • Enhances desirability and acceptability of unhealthy products
Corporate political activities	• The provision of goods and services such as health facilities, schools or other collective goods, especially in political environments where these goods are under-provided	• Lobbying • Political donations • Barrier to public health policy • Shapes the social environment
Corporate social responsibility strategies	• Add meaningful benefit to society by addressing a need	• Enhances public perception and credibility of organisations who don't have health at the heart of their products or services
Supply chains	• Development of health-enhancing products	• Resistance of inclusion of features that enhance health due to cost • Development of products that are detrimental to health



Recommendations for change

> There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in

- **Desmond Tutu**

Recommendations

Strategic and partnership opportunities:

01. All partners should **adopt a Health in all policies approach** to that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. Councils and other public bodies should require that financial and business planning has regard for this evidence on health inequalities and should report annually on specific groups affected by their decisions.

02. The Joint Health and Wellbeing Board for Cornwall and the Isles of Scilly should **review the Health and Wellbeing Strategy** (2020) in light of this update on health inequalities by the end of 23/24. This should include development of a specific delivery plan to tackle inequalities in health with clear accountability, resourcing and governance arrangements.

03. **Engage actively in the South West Marmot Region approach** to develop a health equity system involving regional authorities, NHS, local authorities, business and economic sector and voluntary and community sector. This will include 'making the case' tools and a common indicator set.

Give every child the best start in life:

04. There should be **a greater focus on reducing inequalities in maternal health and early years** development as this best life stage to improve future health. Whilst support is needed for all families and young people, it needs to be proportionately greater in more deprived areas, educational settings and groups identified in this report to ensure fairness and wellbeing for future generations.

Ensure a healthy standard of living, fair work and good employment for all:

05. A sustainable and fair economy should focus on creating well-being for all. The employment and skills strategy, and adult education should increase opportunities for those in the most deprived communities in Cornwall and Isles of Scilly. In addition, the Councils and economic partners should develop a policy approach which explicitly outlines **how an inclusive economy will be achieved for our most excluded groups.**

06. Support a movement for Cornwall **to become a Living Wage Foundation Place** promoting Living Wage accreditation to address in work poverty. This will require collaboration between leaders and local anchor institutions to create and action group, understand low pay in Cornwall and develop a Low Pay Action Plan.

Create and develop healthy and sustainable places and communities:

07. We should all seek to **change attitudes, systems and behaviours** that perpetuate discrimination and disadvantage. Collectively we should all be knowledgeable and confident in equality, diversity and inclusion matters. Our provision of services and facilities need to be accessible to all, which includes better consideration of geographical, physical, communication and digital access and barriers.

08. Councils should consider new solutions to **address the inequity driven by the second home housing market** to improve access to affordable, secure and good quality housing in Cornwall and Isles of Scilly. New housing is only part of the solution, and we need to better use existing stock, and improve its warmth and quality to meet housing need, reduce homelessness and improve health.

09. Use the opportunity of devolution and Cornwall and Isles of Scilly place leadership to **explore and apply evidence based policy decisions and market interventions which can reduce health inequality.** These might include innovative approaches to tobacco, alcohol or foods by learning from devolved nations and challenging national policies which are exacerbating local inequalities.

Understand and engage with our communities:

10. Commit to working together in a coordinated way to develop **a better understanding of community voices, lived experiences** and stories from different sections of our residents to inform and help design our approach to tackling health inequalities and understanding of health need.

11. Ensure local engagement structures such as **Community Area Partnerships** of elected members, and **Integrated Care Areas are aware of health inequalities and can address area based inequality** via their working including investment of levelling up or Shared Prosperity Funds.

12. **Establish an annual Public Health Lecture** aimed at sharing knowledge on key health issues, bringing together the general public, our public sector and voluntary sector partners, community groups and our academic partners who have an interest in medicine and public health. This should begin with an outline of local health inequalities.

Strengthen the role and impact of ill health prevention:

13. The integrated care system should agree a coordinated and **long term joint investment in prevention,** with a focus on those groups identified in this report as at risk of health inequalities in Cornwall and the Isles of Scilly across all ages. This should include a focus on the illnesses that lead to early deaths and reduced quality of life such as circulatory diseases, cancer, and respiratory diseases. All Trusts and Primary Care Networks should have a plan to address health inequalities.

14. All sectors should strive to ensure that **the data used for inequality monitoring are reliable,** of high-quality, and comparable across settings and over time to measure progress. This inequality data should be routinely reported to Boards alongside performance reports, and under the Equality Act 2010, but should be accompanied **with regular deep dive reporting** into specific topics or equality groups.

Annual Report 2021-2022 update

Recommendation 1 - Co-production

- ✔ Suicide prevention innovation projects are informed by people with lived experiences alongside close working with the voluntary sector who support people with poor mental health.
- ✔ Mental Health and Suicide Prevention programme has co-production at the centre of the service design and people with lived experience will co-design the final programme.
- ✔ People with lived experience of drug and alcohol use are employed as experts to both support others and design services for people with complex needs.
- ✔ A range of NHS health inequalities work at Integrated care area level is being co-produced with voluntary sector organisations who already have reach into our most deprived localities and is employing staff from within the communities
- ✔ Healthy Cornwall works closely with the residents association at Treneere in Penzance using voices and intelligence picked up from engaging with the community to shape the local offer.

Recommendation 2 - Communication

- ✔ Ongoing campaigns to increase uptake of immunisation programmes via range of media and targeted outreach work.
- ✔ Annual Winter Wellbeing Guide made available in easy read for Cornwall and Isles of Scilly https://www.cornwall.gov.uk/media/2pcbvtxc/easy-read_winter-wellbeing-guide_web.pdf
- ✔ Integration of voluntary and community sector support via creation of Community Hubs across Cornwall as a one stop shop for variety of support and activities.
- ✔ Close collaboration with NHS health partners on all mental health and suicide prevention communications to ensure same/consistent messaging
- ✔ Healthy Cornwall services are accessible and will be converted to Easy Read in order that all communication needs are met. The FRESH and Accessible healthy weight courses adapt content to meet the needs of individuals accessing the courses.
- ✔ The SafePlaces scheme ensures that people with a learning disability are supported by local organisations and businesses at times of crisis.
- ✔ Healthy Cornwall target our Outreach Health Checks at individuals who do not routinely access health services in order to help address inequalities and to pick up any cardiovascular issues early.

Recommendation 3 - Commissioning

- ✔ Mental Health and Suicide Prevention Innovation Collaborative programme was commissioned in partnership with ICB to support the VCSE sector to deliver upstream, preventative mental health support. This is an innovative style of utilising a collaborative of Voluntary Sector organisations to deliver better outcomes for people over a sustainable five year funding period.
- ✔ Collaborative commissioning cultures being established within the Integrated Care System to reduce competition and improve outcomes e.g. Provider Collaboratives for mental health and learning disability in the SW Peninsula.

Recommendation 4 - Culture and language

- ✔ The voluntary sector increasingly valued and treated as equal partners alongside the statutory sector in health and care partnerships.
- ✔ Healthy Cornwall has responded to changing needs within schools providing a vaping pilot at Liskeard school which worked with students based on the needs that they identified as important. A survey response by over 800 students gave insight as to how delivery should be shaped in the future.
- ✔ Experience of working with refugees and asylum seekers living in Cornwall has raised awareness of the health and wellbeing challenges and diversity of cultures amongst our staff and residents. Creation of a dedicated team to support refugees and asylum seekers will increase local expertise.
- ✔ Healthy Cornwall have taken time to embed a culture within the team that includes how we communicate with our communities. This is achieved by two way communication that reflects the needs of the audiences worked with including absolutely no jargon.

Recommendation 5 - Workforce

- ✔ The Kernow Workforce Wellbeing Hub supports health and social care, voluntary sector, police and ambulance service staff to consider their own wellbeing needs in order that they can continue to support others.
- ✔ The maternity Treating Tobacco Dependency programme is an extremely good example of NHS and Local Authority sharing resources and delivering as one partnership in the best interest of pregnant. All referrals processed in one place, shared across the two teams with a single evaluation to avoid duplication.
- ✔ Joint development of a draft Integrated Care System Work and Health Strategy which aims to support people with a disability and long term condition to remain in work or increase access to good work in Cornwall and the Isles of Scilly.
- ✔ The Treating Tobacco Dependency in people with severe mental illness which is a smoking cessation programme, whilst in its infancy, is increasing skills and awareness across the workforce to address health inequalities due to tobacco.

Recommendation 6 - Outcomes and impact

- ✔ The Integrated Care Partnership is working towards a single outcomes framework to measure the impact of their joint 5 years strategy to improve health in Cornwall and the IoS.
- ✔ Mental Health and Suicide Prevention Innovation Collaborative programme is using a suite of patient outcome and experience measures to evaluate the efficacy of this new service.
- ✔ TTD maternity programme of work that collaborate with shared outcomes with one agreed reporting schedule through NHS systems which is shared to the LA reporting needs.
- ✔ To achieve longer term sustainability, Healthy Cornwall partner with small local groups and organisations based on their priorities. We then aim to build capacity and resilience among these partners to influence longer term organisational and behaviour change so that local groups lead on some health improvement priority for their communities.
- ✔ The Voluntary Sector Forum alongside wide range of partners are increasing skills and capacity within small local community groups and organisations which support health and wellbeing. This includes use of logic frameworks to evidence impact of their work.

What are community assets?

People

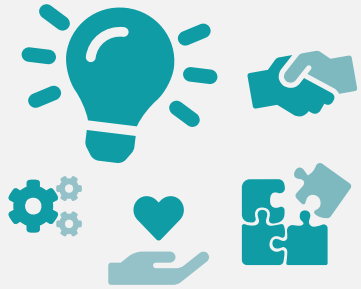
- Skills, knowledge and experience of people in communities
- Neighbours, friends, family
- Volunteers and local community groups who give time as a resource
- Our local workforce – VCSE, statutory sector, local businesses

Places

- Community buildings e.g. village halls
- Local facilities e.g. youth clubs, churches
- Organisational buildings and offices
- Green/blue spaces and the natural environment
- Schools and colleges
- GP surgeries
- Cultural and historic spaces

Resources

- Skills and expertise in public, private and third sectors
- Shared training and development opportunities across VCSE, Council and Health
- Local transport resources e.g. electric scooters, bikes, cars and minibuses
- Services and support e.g. food banks, community hubs, community groups
- Police, housing and wider social and community support



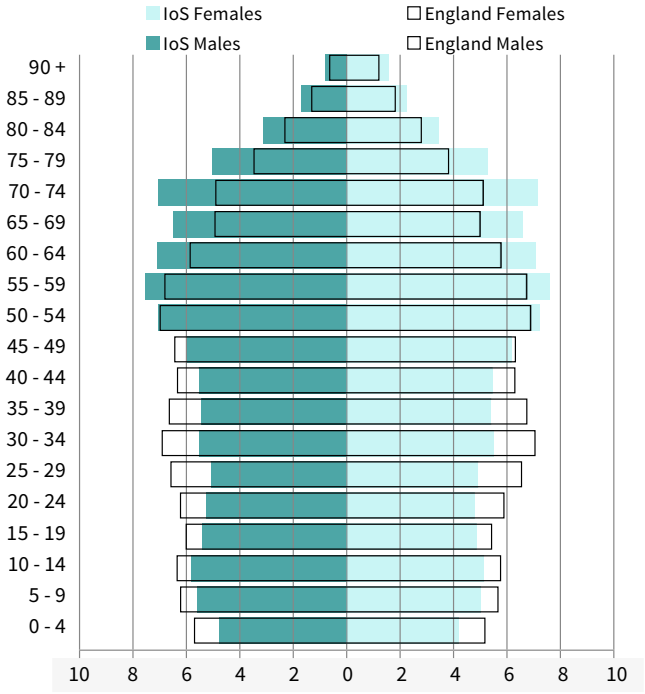
Vital statistics

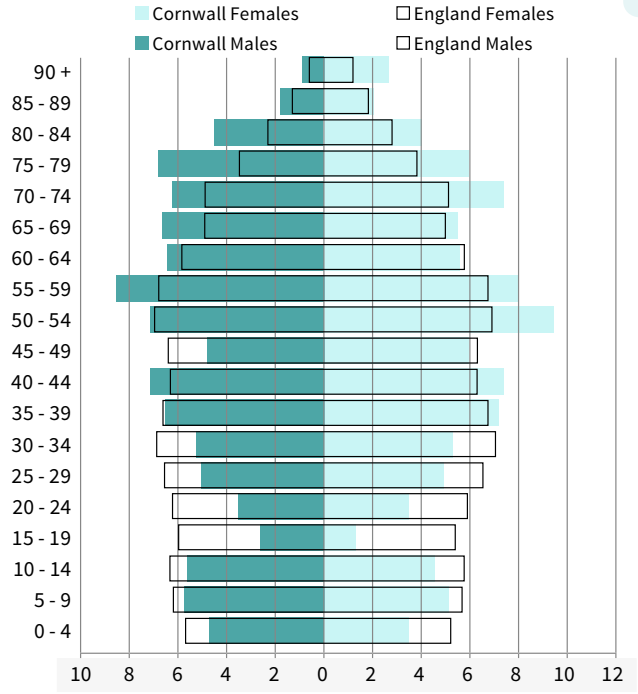
Estimates of population

The population of Cornwall and the Isles of Scilly is estimated to be 574,281 people. Cornwall is the largest unitary authority in England (572,010) whilst the Isles of Scilly at 2,271 is the smallest. Both however, fall within the lowest 20% of authorities for population density with Cornwall at 161 people per square kilometre (2021) and the Isles of Scilly 129 people per square kilometre.

Population pyramids for both Cornwall and the Isles of Scilly (2021 Mid Year Estimates) are set out in the charts below compared against the profile for England. Both Cornwall and the Isles of Scilly have an older age profile; the median age of people living in Cornwall (2020) was 48 years old (Isles of Scilly 49 years), compared to 40 years in England and Wales.

Population pyramids for Cornwall and the Isles of Scilly compared to England

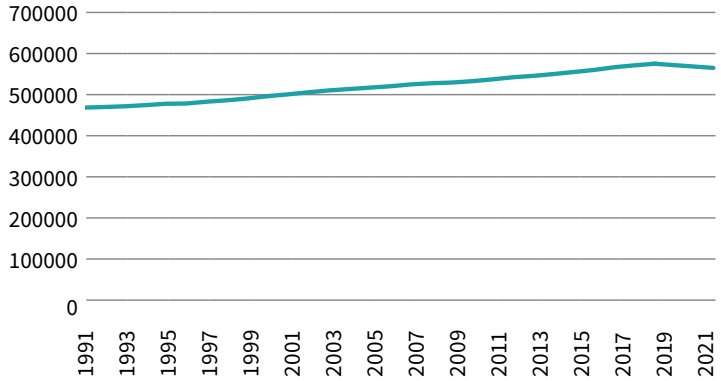


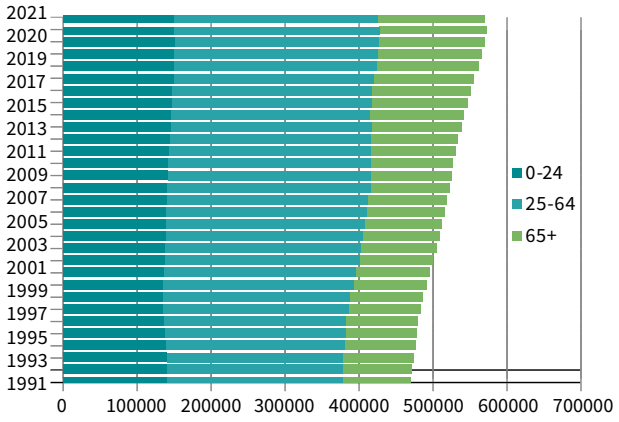


Population trend

Since 1991 the population of Cornwall and the Isles of Scilly has increased from 471,549 to 572,010, an increase of 21%. The 65+ age group has increased by over 50%, whilst the 0-24 by 6% and 25-64 by 18%.

Population tend of Cornwall and the Isles of Scilly

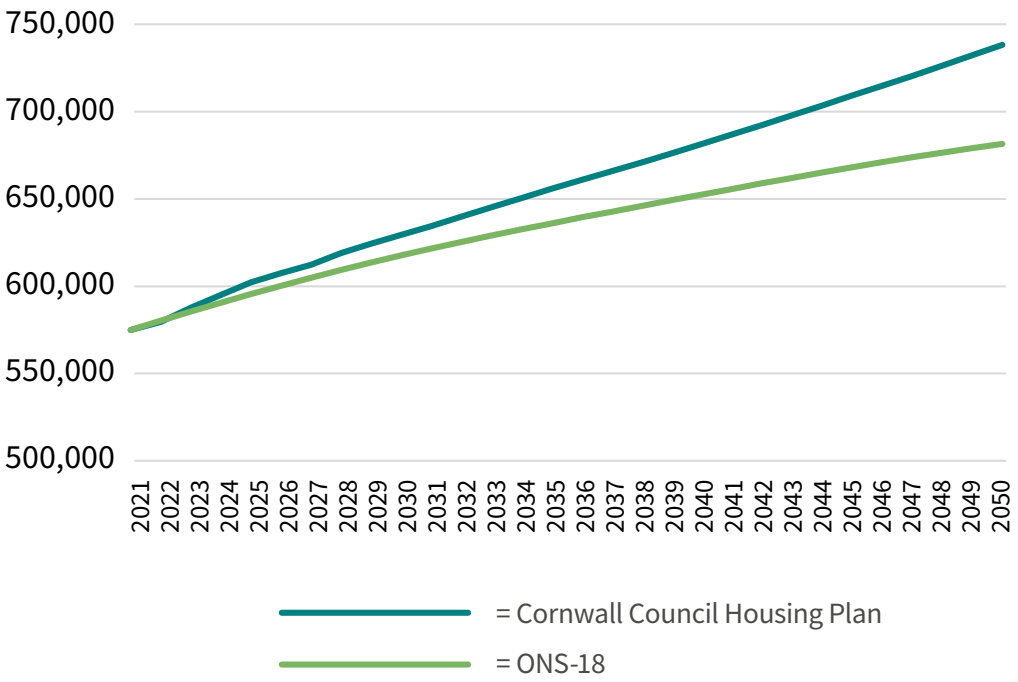




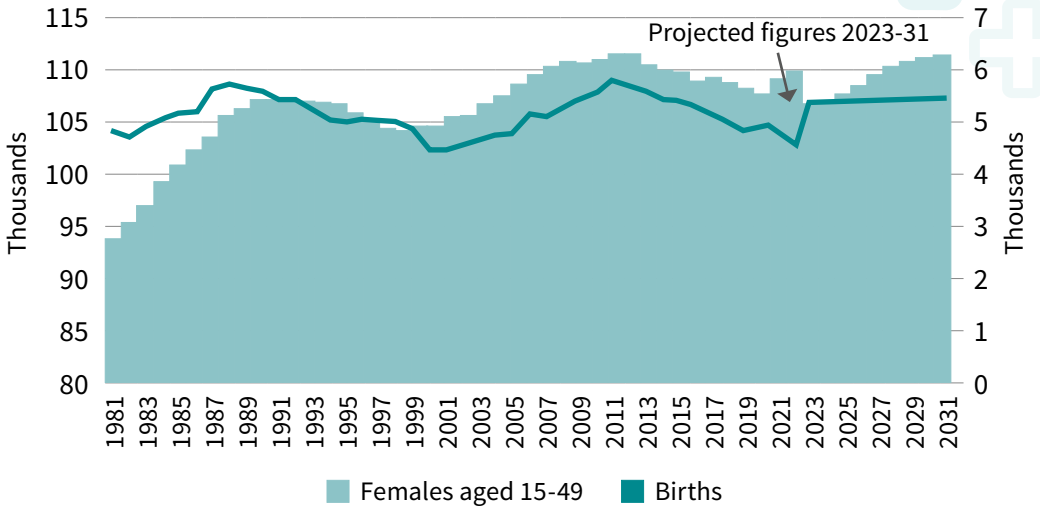
Population projections

There is a predicted population growth of between 14.1% and 19.5% (depending on the projection scenario) between 2021-41 across Cornwall and the Isles of Scilly. Population projections show that the population in Cornwall will continue to have an older profile than that of England over this period.

Population projections for Cornwall and the Isles of Scilly



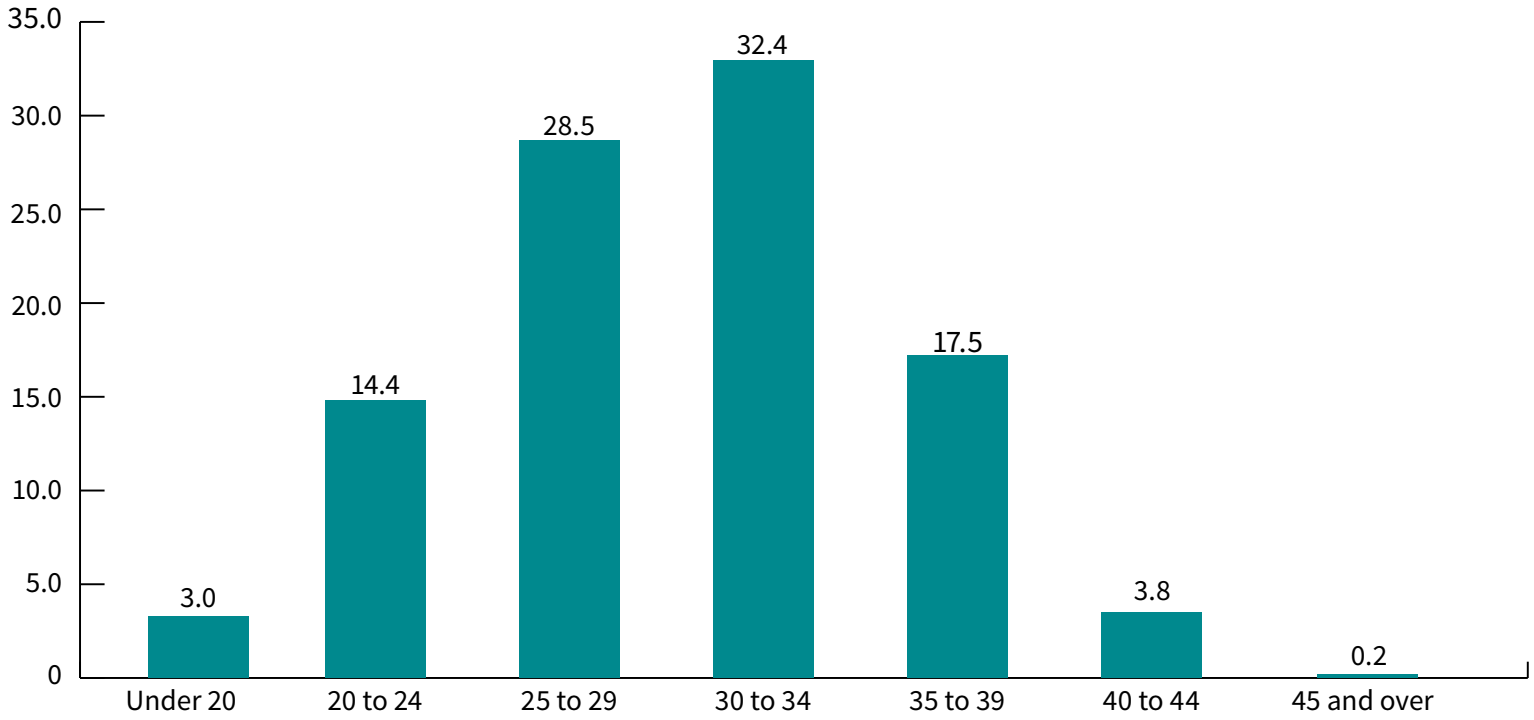
Projected live births by maternal age



Live births by maternal age in Cornwall and the Isles of Scilly 2018-2022

Age of mother	2018	2019	2020	2021	2022
Mother aged under 20	169	145	133	121	136
Mother aged 20 to 24	823	734	671	614	584
Mother aged 25 to 29	1,427	1,404	1,392	1,345	1,219
Mother aged 30 to 34	1,548	1,543	1,526	1,634	1,456
Mother aged 35 to 39	850	812	830	869	801
Mother aged 40 to 44	172	182	170	199	189
Mother aged 45 and over	11	8	7	10	19
Age of mother unknown or not stated	-	-	-	33	21
Total	**5,000**	**4,828**	**4,729**	**4,825**	**4,425**

Age of mother % of all births in Cornwall and Isles of Scilly (2018-2022)



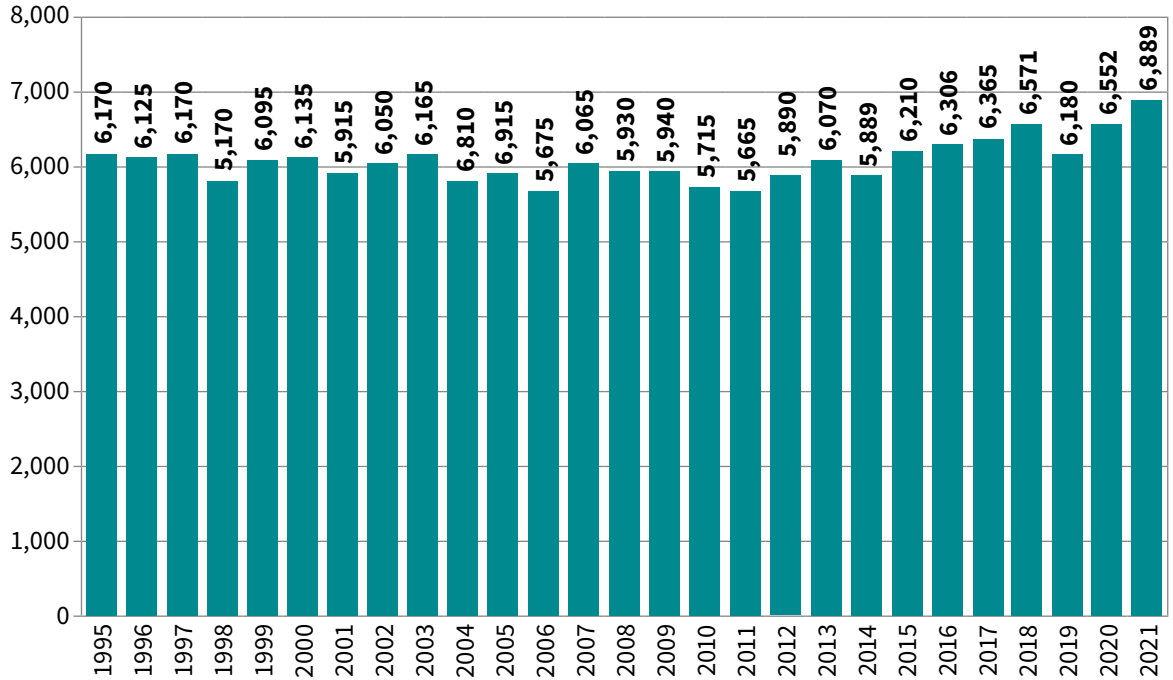
Live births, stillbirths, and infant deaths (2021)

Area of usual residence	Numbers						Rates (per 1000)				
	Births			Deaths							
	Live birth	Stillbirth	Peri-natal	Neo-natal	Post neo-natal	Infant	Stillbirths	Perinatal	Neonatal	Post neo-natal	Infant
England	595,948	2,451	3,737	1,633	576	2,209	4.1	6.3	2.7	1.0	3.7
South West	52,278	176	252	97	32	129	3.4	4.8	1.9	0.6	2.5
Cornwall UA and Isles of Scilly UA	4,834	15	21	9	4	13	3.1	4.3	1.9	0.8	2.7

Deaths

In 2021, there were 6,889 deaths registered in Cornwall and the Isles of Scilly, this is a significant reduction and the lowest for four years. However, when taking the age and size of the population into account, death rates have remained more or less stable since 2013.

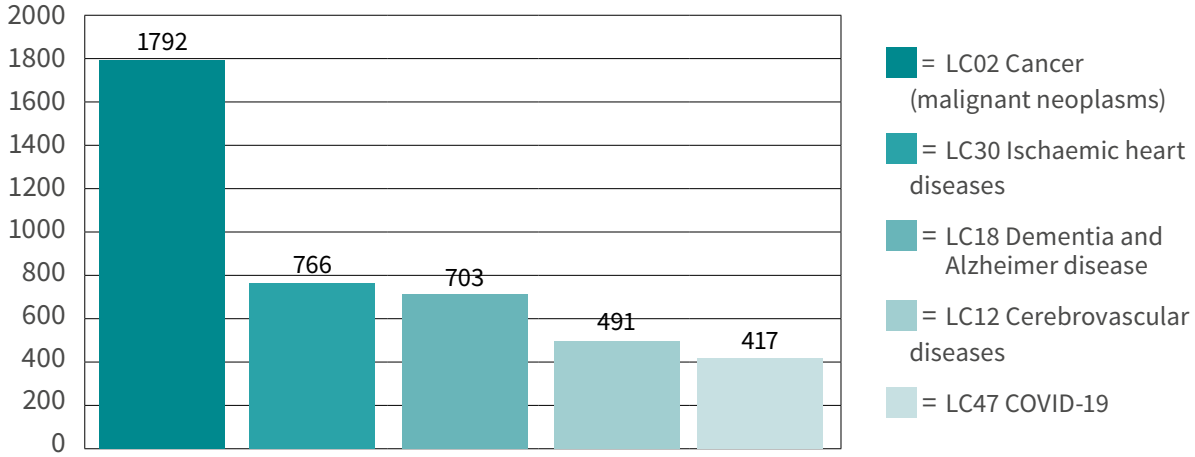
Cornwall and Isles of Scilly annual deaths (1995-2021)



Deaths from selected causes

In 2021, there were 6,865 registered deaths for Cornwall and Isles of Scilly. Most of these deaths (4,291 or 62.5%) were caused by; cancers (1,839, 26.8%), diseases of the circulatory system (1,794, 26.1%), and diseases of the respiratory system (658, 9.6%). Disease of the circulatory system includes deaths from cardiovascular diseases such as coronary heart disease, stroke and heart failure.

Number of deaths from the top 5 leading causes in Cornwall and Isles of Scilly (2021)

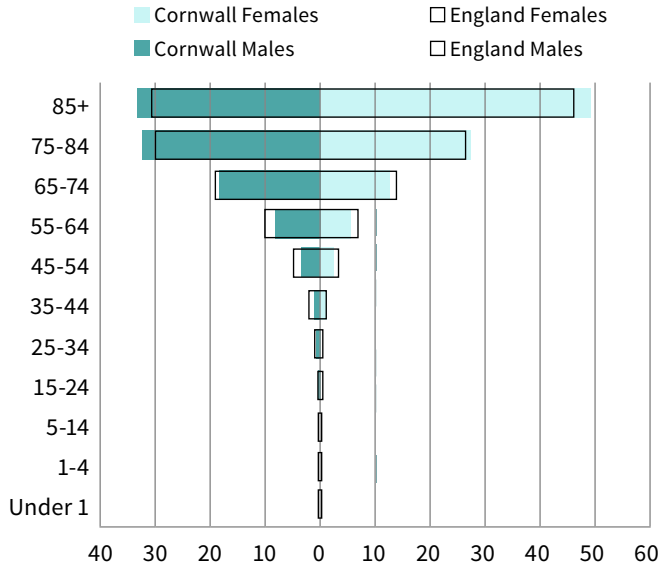


Deaths by underlying cause and age, 2021	1 to 4	5 to 14	15 to 34	35 to 64	65 to 74	75 +	All
A00-R99,U00-Y89 All causes, all ages	0	10	66	768	1,083	4,947	6,889
LC01 Accidents	0	0	25	47	25	164	260
LC01a Accidental drowning and submersion	0	0	0	0	0	0	0
LC01b Accidental falls	0	0	0	5	15	139	159
LC01c Accidental poisoning	0	0	15	29	5	0	48
LC01d Accidental threats to breathing	0	0	0	0	0	0	6
LC01e Land transport accidents	0	0	5	0	5	5	26
LC01f Non-intentional firearm discharge	0	0	0	0	0	0	0
LC02 Cancer (malignant neoplasms)	0	0	10	249	463	1,064	1,792
LC02a Malignant neoplasm of bladder	0	0	0	5	10	48	64
LC02b Malignant neoplasm of brain	0	0	0	11	13	16	39
LC02c Malignant neoplasm of colon, sigmoid, rectum and anus	0	0	0	30	43	116	188
LC02d Malignant neoplasm of gallbladder and other parts of biliary tract	0	0	0	0	0	5	13
LC02e Malignant neoplasm of kidney, except renal pelvis	0	0	0	5	11	29	47
LC02f Malignant neoplasm of larynx	0	0	0	0	5	5	10
LC02g Malignant neoplasm of liver and intraheptic bile ducts	0	0	0	10	19	34	61
LC02h Malignant neoplasm of oesophagus	0	0	0	12	22	49	81
LC02i Malignant neoplasm of ovary	0	0	0	6	12	24	44
LC02j Malignant neoplasm of pancreas	0	0	0	19	35	55	111
LC02k Malignant neoplasm of prostate	0	0	0	10	15	107	129
LC02l Malignant neoplasm of stomach	0	0	0	5	13	14	38
LC02m Malignant neoplasm of trachea, bronchus and lung	0	0	0	50	122	182	355
LC02n Malignant neoplasm of uterus	0	0	0	5	10	15	28
LC02o Malignant neoplasms of bone and articular cartilage	0	0	0	0	0	0	5
LC02p Malignant neoplasm of breast	0	0	0	20	32	60	119
LC02q Malignant neoplasms, stated or presumed to be primary of lymphoid, haematopoietic and related tissue	0	0	0	10	37	116	167
LC02r Melanoma and other malignant neoplasms of skin	0	0	0	0	12	18	39
LC03 Acute respiratory diseases other than influenza and pneumonia	0	0	0	0	0	50	48
LC12 Cerebrovascular diseases	0	0	0	25	49	407	491
LC14 Chronic lower respiratory diseases	0	0	0	24	58	189	271
LC16 Cirrhosis and other diseases of liver	0	0	5	58	30	25	112
LC18 Dementia and Alzheimer disease	0	0	0	0	19	681	703
LC19 Diabetes	0	0	0	5	17	50	74
LC28 Influenza and pneumonia	0	0	0	7	17	208	236
LC30 Ischaemic heart diseases	0	0	0	101	131	528	766
LC40 Septicaemia	0	0	0	0	5	45	51
LC41 Suicide and injury/poisoning of undetermined intent	0	0	17	47	5	5	73
LC47 COVID-19	0	0	0	45	48	324	417

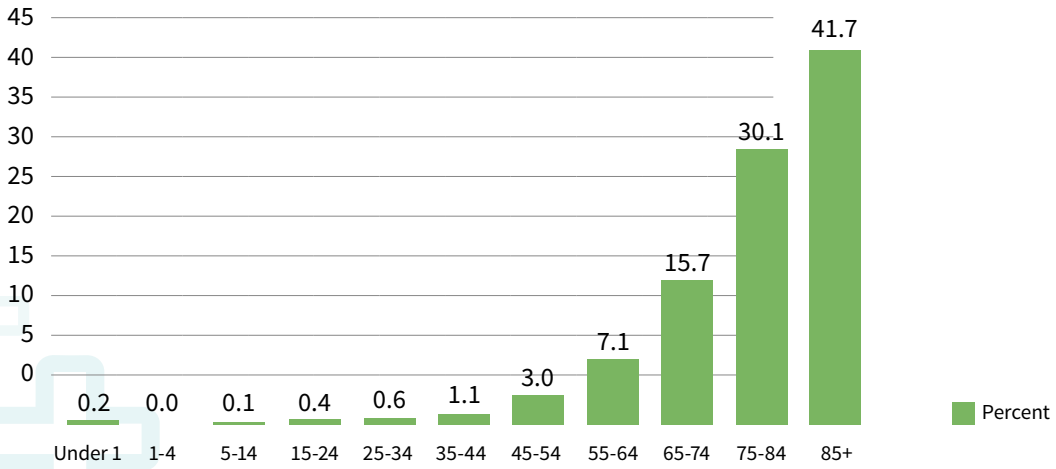
Deaths by age group and sex

Number of deaths by age group and sex in Cornwall and Isles of Scilly (2021)

	Males	Females
Under 1	9	7
1-4	-	-
5-14	5	5
15-24	16	10
25-34	23	18
35-44	45	31
45-54	127	77
55-64	293	195
65-74	651	432
75-84	1,139	941
85+	1,169	1,694
Total	**3,479**	**3,410**



Percentage of deaths per broad age group in Cornwall and Isles of Scilly (2021)



Indices of Multiple Deprivation (2019)

The Indices of Multiple Deprivation is an important tool for identifying the most deprived areas in England. They are used by national and local organisations to identify places for prioritising resources and more effective targeting of funding.

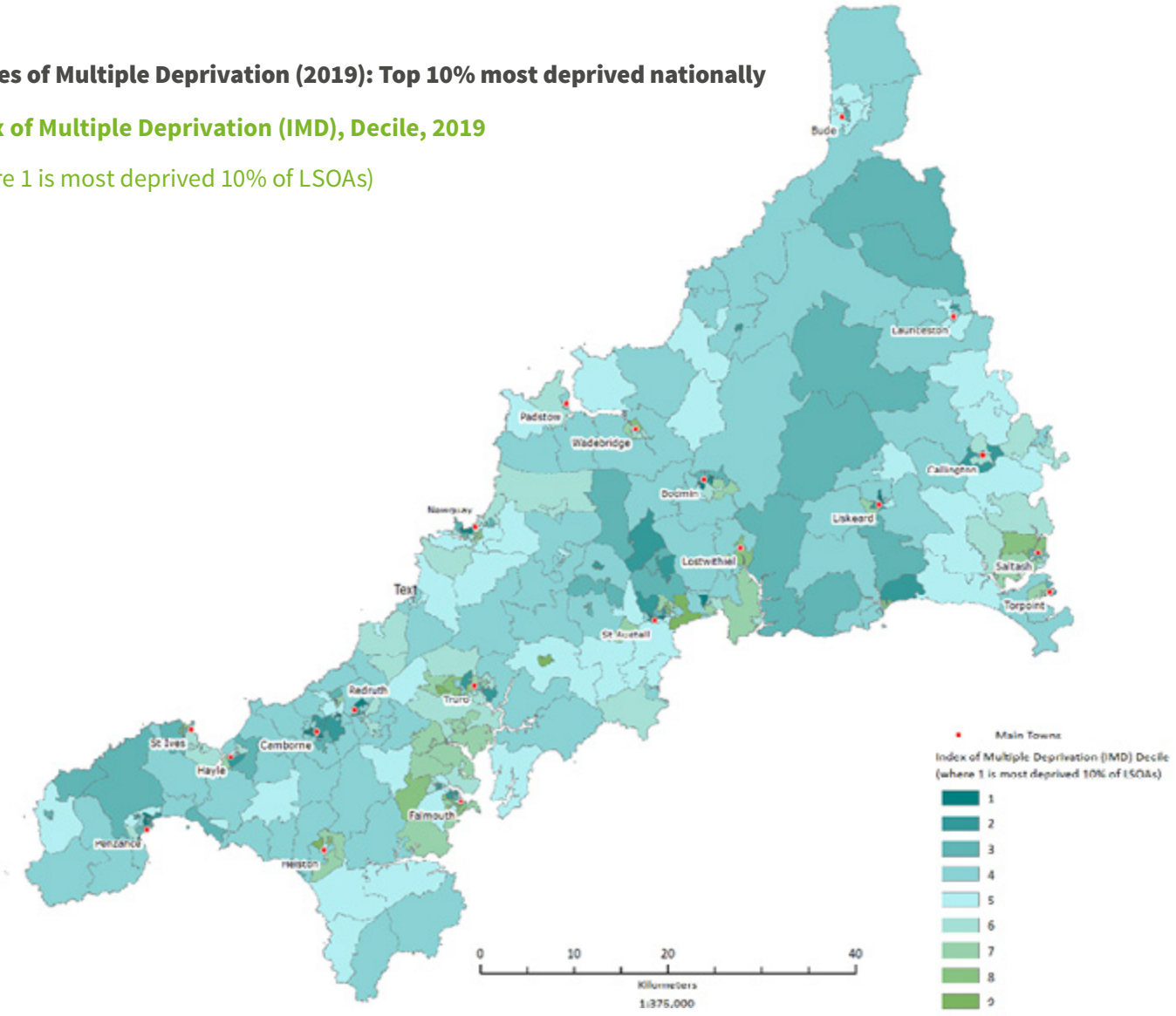
The indices measure a number of factors (income, employment, health, education, barriers to services, the environment and crime) which, when combined, provide small-area measures of relative deprivation.

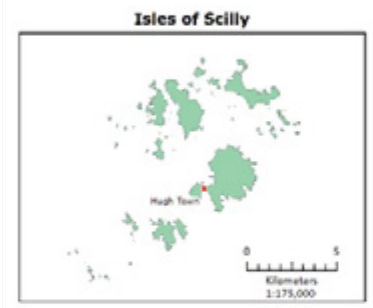
The latest figures (2019) identify 17 neighbourhoods (LSOAs) across Cornwall as being within the top 10% most deprived areas in England. 16 of these 17 neighbourhoods were also present in the top 10% in 2015.

Indices of Multiple Deprivation (2019): Top 10% most deprived nationally

Index of Multiple Deprivation (IMD), Decile, 2019

(where 1 is most deprived 10% of LSOAs)





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