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In last year’s annual report we emphasised that only around 10% of people’s health is determined by healthcare and we focussed the report on other important factors for health including lifestyle factors. When Duncan Selbie, chief executive of Public Health England, came to visit us in Cornwall at the end of last year he proposed that the fundamentals for health and wellbeing are having a job, having a roof over your head and being part of a community. We decided to focus this year’s annual report on housing as one of those three fundamentals.

I am delighted that in the priorities set by the new Cornwall Council Cabinet the first two are Healthy Cornwall and Homes for Cornwall with some ambitious targets to improve health and increase the supply of good quality homes.

This year we have seen Cornwall Council adopt its Local Plan which sets out the planned development framework across Cornwall through till 2030 and at the time of writing, the Isles of Scilly are consulting on their own development proposals. There is a real opportunity to connect health with the planning process as effective long term design and planning can help improve health and wellbeing. We need to ensure that our communities develop in a way which supports healthy behaviours, providing homes in which to ‘start, live & age well’.

Through this report I am seeking to build an understanding of the circumstances and contributory factors relating to our housing that can impact on our health. Housing can be the source of a wide range of hazards (physical, chemical, and biological). The report therefore highlights where individuals can take action to mitigate some of these issues to protect or improve health.

A focus on housing is an opportunity to improve health, reduce inequalities and to lessen the impact of ill health on local health and care services. I hope we can use this report to inform evidence based decision making over the next four years.

Finally, following the success of the health infographics in last year’s report which were widely used in a variety of settings, we have updated these with current information.

Dr. Caroline Court
(Interim Director of Public Health)
Yn derivas bledhenyek warlena, y poeslevsyn ni bos saw 10% a yeghes tus ervirsyos gans yegheswith hag y fogellyn y fitheg welawch gan an derivas orth elvennow posek erel rag yeghes y’ga mysk elvennow bewedh. Pandeuth Duncan Selbie, pennweythresek Yeghes Poblel Pow Sows, dh’agan vystrya yn Kernow orth penn a’n vledhen eus passyys, y profyas ev bos an traow selenel rag yeghes ha sewena yw kavos soodh, kavos to a-uugh an penn ha bos rann a neb kemeneth. Yth ervirsyn ni fogella an derivas hevlena orth anedhans ha yeghes avel onan a’n tri thra selenel.

Delit a’m beus bos y’n ragwiryow settyos gans Kesva Konsel Kernow an kynsa dew yw Kernow Yagh hag Anedhow rag Kernow gans nebes kostennow ugelwanzek dhe wellhe yeghes ha kressya an provians a anedhow kwalita da.

Henvlena ni re welas Konsel Kernow adoptya y Dowlen Deythyek, a sett an framwewth displayans tewlys a-dreus Kernow bys dhe 2030 hag orth an termyn a skrifà, yma Syllan ow keskussulya a-dro dh’aga frosyans displeglya aga honan. Yma chons gwir dhe juny yeghes gans an argerdh towlennans drefen y hyll desin ha towlennans efeythys hir-dermyn gwellhe yeghes ha sewena. Res yw dhyn surhe aghan kemenethow dhe omdhisplegya yn fordh a skoodh fara yagh ha leheansow yn dibbarderyow yeghes, ow provia anedhow ynna may hyllir ‘dalleth, bewa & kotthe yn ta’.

Der an derivas ma yth assayav drehevel konvedhes a’n kesstudhyow hag achesonyow ow tochya agan anedhow a yll delenwel agan yeghes. Anedhow a yll bos fenten a lies peryl dyffrans (fisegel, kymygiethel, bewoniethel). Rakhenna y hwoolboynt an derivas leow may hallo tus omweytha dhe lehe nebes a’n daldraow ma rag omwth’ha po gwellhe aga yeghes.

Fog orth anedhow yw chons dhe wellhe yeghes, lehe dibbarderyow ha lehe an effeyth a yeghes drog war wonisyow teythek yeghes ha gwit. Govenek a’m beus may hyllynyn ni devndhya an derivas ma rag kedlha ervrinsow selys yn dustuniow dres an nessa peder bledhen.

Wor’twedh, ow sewya sewena an tresennow-kedlha y’n derivas warlena, hag a veu devndhyos yn lies le, ni re’s nowedhas gans kedlhow a-lemmyn.

Dr. Caroline Court
(Kesvarwodhores Servadow Yeghes Poblek)
Housing

Why is housing an important determinant of health?

Our home, both the location and the physical building itself, influences almost every aspect of our lives – from how well we sleep, to how often we see friends, to how safe and secure we feel.

Our home, both the location and the physical building itself, influences almost every aspect of our lives – from how well we sleep, to how often we see friends, to how safe and secure we feel. 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.1

The relationship between housing and health is complex, but creating a physical environment in which people can live healthier lives with a greater sense of wellbeing is hugely important in reducing health inequalities.

There are a number of housing attributes that can affect our health and wellbeing. Poor housing is linked to a variety of conditions such as respiratory diseases (e.g. asthma); depression and anxiety; nausea and diarrhea; infections; allergic symptoms; hypothermia; and physical injury from accidents. It can exacerbate existing health conditions; make treating health conditions difficult as well as having a huge social impact upon the ability of individuals to achieve their potential in education or employment. Those living in poor condition housing also often suffer from a number of other deprivation factors such as low income, high levels of unemployment and social isolation.

Evidence linking human health to poor living and housing conditions dates back centuries to the 1800s with the likes of Friedrich Engels2 and Rudolf Virchow3. More recently, WHO reports, and the 2010 Marmot Review of Health Inequalities in England, has added to our understanding of how psychological, social and environmental factors affect our health.4,5,6,7 These are now commonly referred to as the social determinants of health covering a wide range of issues impacting health and wellbeing ranging from social, lifestyle and environmental to economic factors. These have been portrayed in the “Settlement Health Map” created by Barton and Grant8:

The determinants of health and wellbeing in our neighbourhoods
Who’s at risk and why?

Everyone is potentially at risk from the effects of poor housing, lifestyle and wider environmental conditions. However, those susceptible include the very young, elderly and infirm and those who spend a greater time indoors. The home or housing circumstances present a particular risk to the health and wellbeing of:

- Children (from conception onwards), and their families
- People with long-term conditions and co-morbidity (i.e. having more than one health condition)
- People with mental health issues
- People with learning disabilities and/ or autism
- People recovering from ill health (i.e. a physical or mental health problem)
- Older people with age related fragility or illness
- People who spend a lot of time at home such as carers
- Low income households (e.g. those who have to make stark choices about buying food to eat or to adequately heat their home or those who live in crowded conditions)
- People who experience a number of inequalities (homeless, those who are subject to domestic violence, ex-offenders or offenders living in the community, misusers of drugs and alcohol, gypsies or travellers)

Whilst poor housing conditions, lifestyle and surrounding environment can have a negative impact on health and wellbeing, evidence suggests that the right housing conditions can make a positive contribution towards an individual’s health and wellbeing. Recent evidence suggests that current housing practices need to extend to designing homes that are affordable, of adequate size and affordable to heat. This is required in order to:

- Improve health and wellbeing, and prevent ill-health
- Enable people to manage their health and care needs
- Allow people to return to a safe home following an illness or to remain in their own home, living independently
- Delay and reduce the need for primary care & social care interventions, including admission to long-term care; and
- Improve recovery rates from periods of ill-health or planned admission

Built environment professionals may not have direct control on the wide ranging determinants of health and wellbeing, however, a broad awareness of the interaction between housing and health is extremely important, as risk factors rarely act in isolation. As set out in the diagram opposite:
Addressing these issues requires a joined up approach from multiple departments for example, across local authorities (public health, planning, transport and social care etc.), primary and secondary healthcare and voluntary organisations. This report explores some of the key factors linking our health, housing and the wider environment, some of which pose a serious challenge to the wellbeing of the population and those services that work to address them.
A household consists of one or more people who live in the same dwelling and also share meals or living accommodation, and may consist of a single family or some other grouping of people. **Cornwall’s households are made up of:**

- **14.8%** are people aged 65+, living alone
- **15.2%** are people aged under 65, living alone
- **34%** are married or same-sex civil partnership couples
- **11%** are two or more people aged 65+
- **10%** are co-habiting couples
- **15.2%** are people aged under 65, living alone
- **7%** are classed as ‘other’

**Household Tenure**

- **69.6%** of residents own their homes
- **3.7%** of residents live in rented homes (other)
- **14.7%** of residents rent their homes from private landlords
- **12%** of residents live in Social Housing
- **12%** of residents rent their homes from Social Housing

**Types of Homes**

- **22.8%** terraced houses
- **24.4%** semi-detached houses
- **37.6%** detached houses
- **1.2%** flats (converted houses)
- **1.2%** temporary dwellings
- **12%** purpose built flats

**Housing Stock**

- **4%** of residents live in Social Housing
- **69.6%** of residents own their homes
- **14.7%** of residents rent their homes from private landlords

**Household Tenure**

- **7%** of households lack central heating, compared with 3% across England

**Homes in Cornwall – a statistical overview**

- **553,687** people live in Cornwall
- **270,800** dwellings across Cornwall
- **12%** of residents live in rented homes (other)
- **7%** of residents own their homes
- **14.7%** of residents rent their homes from private landlords
- **11%** of residents live in Social Housing
- **12%** of residents live in rented homes (other)
- **12%** of residents rent their homes from Social Housing
- **12%** of residents live in rented homes (other)
- **7%** of households lack central heating, compared with 3% across England

**The average household size in Cornwall was 2.3 people per household, compared to 2.4 in England.**
A household consists of one or more people who live in the same dwelling and also share meals or living accommodation, and may consist of a single family or some other grouping of people. **Isles of Scilly households are made up of:**

- **11%** are two or more people aged 65+, living alone
- **18.8%** are people aged under 65, living alone
- **18.8%** are people aged 65+, living alone
- **11%** are co-habiting couples
- **3%** are lone parent families
- **3%** are classified as ‘other’
- **10%** are married or same-sex civil partnership couples
- **26%** of households lack central heating, compared with **3%** across England
- **15.2%** of residents rent their homes from private landlords
- **42.5%** of residents live in rented homes (other)
- **18.1%** of residents live in Social Housing
- **18.8%** of residents live in rented homes (other)
- **22.8%** live in semi-detached houses
- **31.8%** of residents own their homes
- **16.3%** of residents live in terraced houses
- **5%** of residents live in flats (converted houses)
- **5%** built between 1900 and 1939
- **42%** built between 1945 and 1999
- **12%** built after 2000
- **40%** built before 1900
- **9.4%** purpose built flats
- **3%** temporary dwellings
- **26%** of households lack central heating, compared with **3%** across England

**Homes on the Isles of Scilly – a statistical overview**

There are **1,410** dwellings on the islands

The average household size on the Isles of Scilly was **2.1 people per household**, compared to **2.4** in England

The Isles of Scilly is **not connected to the mainland gas connection** and so there are no homes with a direct supply of gas on the islands
Lack of loft insulation
Damage to building lets in water/damp
Poor or non-existent damp proofing
Solid concrete floors add to cold/damp
Old gutters and downpipes leak/let water in
Badly maintained roof and/or walls
Single-glazing causes cold/condensation
Asbestos
Damaged chimney adds to damp
Double glazing limits ventilation/air quality
Old paint may contain lead
New furnishings can contain/release toxins
No fire exits or clear escape routes
Overloaded power outlets are a fire risk
Toxic fumes from smoking/e-cigarettes
Pet/other allergies
Poor heating systems add to cold/damp
Damp leads to mould - toxins and allergens
Overcrowding - poor air quality/lack of space
Household chemicals not stored securely
Washing machines and dryers increase moisture levels indoors, adding to damp
Old or inefficient boilers increase risks of cold, fuel poverty and toxins
Fire risk from cooking by-products, ie. fat
Poorly fitted/maintained cookers - fire risk
Paints and chemicals not stored securely
Vehicle fumes, possibly getting into living areas
Trip hazards and steep staircases
Lack of/insufficient extractor fans
Poor sanitation increases levels of damp, mould and bacteria
Bath tub - risk of trips and falls
Poor ventilation if windows don't open
Drying clothes inside adds to condensation
Lack of ventilation via loft/roof space
Old building

Housing - a determinant of health

Key

1. Lack of loft insulation
2. Damage to building lets in water/damp
3. Poor or non-existent damp proofing
4. Solid concrete floors add to cold/damp
5. Old gutters and downpipes leak/let water in
6. Badly maintained roof and/or walls
7. Single-glazing causes cold/condensation
8. Asbestos
9. Damaged chimney adds to damp
10. Double glazing limits ventilation/air quality
11. Old paint may contain lead
12. New furnishings can contain/release toxins
13. No fire exits or clear escape routes
14. Overloaded power outlets are a fire risk
15. Toxic fumes from smoking/e-cigarettes
16. Pet/other allergies
17. Poor heating systems add to cold/damp
18. Damp leads to mould - toxins and allergens
19. Overcrowding - poor air quality/lack of space
20. Household chemicals not stored securely
21. Washing machines and dryers increase moisture levels indoors, adding to damp
22. Old or inefficient boilers increase risks of cold, fuel poverty and toxins
23. Fire risk from cooking by-products, ie. fat
24. Poorly fitted/maintained cookers - fire risk
25. Paints and chemicals not stored securely
26. Vehicle fumes, possibly getting into living areas
27. Trip hazards and steep staircases
28. Lack of/insufficient extractor fans
29. Poor sanitation increases levels of damp, mould and bacteria
30. Bath tub - risk of trips and falls
31. Poor ventilation if windows don't open
32. Drying clothes inside adds to condensation
33. Lack of ventilation via loft/roof space
34. Old building

TRU 540
Housing Conditions

Indoor air quality

While many of the issues associated with 19th century environmental health, such as a basic lack of sanitation, unsafe drinking water and heavily polluted atmosphere have been largely addressed there are still some which persist.

We spend around 90% of our time indoors, with 65% of this spent at home and so indoor air quality is a major factor in an individual’s exposure to a range of pollutants such as damp and mould, allergens (e.g. form pests and pets), a range of chemicals, toxins and particulates. Our total exposure to pollutants found in the home depends on a number of factors, including the use of historic and new building materials, fuel poverty (not able to adequately heat your home), overcrowding and outdoor factors such as noise and air pollution (which can influence the use of ventilation). Consequently, where we live, study and work influences our exposures to air pollutants and overall health and wellbeing from childhood throughout life.

The following sections explore each of these factors and their impacts:

Indoor dampness and mould

PUBLIC HEALTH RISKS: Allergic diseases (e.g. asthma and allergies), respiratory conditions, mental ill health. 17,18,19,20

Indoor dampness is thought to affect around 16% of European homes21. Moisture build-up, mould and bacterial growth can occur as a result of structural building faults (i.e. rising/penetrating damp), inadequate heating, insulation or inadequate ventilation (resulting in condensation). Living in damp and mouldy environments impacts health and wellbeing through increasing the chance of experiencing a range of allergic, respiratory and asthma-related health effects17. There is also increased evidence that these poor living conditions may play a role in the development of diseases such as asthma18.

The levels of dampness within a home depends on a complex interaction between resident behaviours (e.g. overcrowding, inadequate heating and ventilation patterns) and building characteristics (e.g. building age, type and tenure), including the location and orientation of a building22. People unable to adequately heat their home due to the cost of fuel are at a particularly risk of being exposed to damp and mould, and can occur irrespective of a building’s age (old, recently upgraded or new homes).23,24,25 Fuel poverty is a distinct health problem particularly in Cornwall that we come back to further in this report.

Some people are more sensitive to mould than others, and some groups are especially vulnerable including, babies and children, elderly people, those with existing skin problems, such as eczema, or respiratory problems, such as allergies and asthma, and anyone who is immuno-compromised (e.g. chemotherapy patients).
What works? 27,28,29,30

- New builds should incorporate more sustainable construction designs, which include the provision of adequate heating and mechanical or passive ventilation systems, with ideally, heat recovery and adequate system maintenance.
- Adapting older housing stock with energy efficiency improvements such as adequate ventilation, insulation, heating and moisture control helps to prevent the proliferation of bacteria and moulds.
- Older housing which has had retrospective improvements need occupants to adequately heat and ventilate to prevent condensation and mould.
- Properly maintained homes help avoid the build-up of condensation and/or water leaks which lead to damp and mouldy indoor environments.
**Pests, Pets and Micro-organisms**

**PUBLIC HEALTH RISKS: Allergic diseases (e.g. asthma), perennial rhinitis**

Household pests (e.g. mice, rats and cockroaches), all have the potential to create a public health nuisance and affect the health of families and individuals. Research indicates that there is a clear link between exposure to micro-organisms and pests such as house dust mites, rodents and cockroaches, and increased allergic symptoms in those that suffer from allergies and asthma.

Poorly constructed and maintained properties are more susceptible to pest infestation and in addition to the direct health issues, some pests such as rats; mice and birds can also cause damage to a property.

Pets can bring us many health benefits, however pet dander (tiny pieces of skin shed by dogs, cats, and other animals with feathers or fur) poses one of the more significant health risks, in that it is a known allergen and can exacerbate asthma and allergy symptoms.

The development of an allergic disease (e.g. allergy and asthma) often begins in early childhood with increased sensitisation to common allergens such as those from pets, dust mites, animal dander, mould and pollens. While there are strong hereditary links with allergic diseases, these cannot fully explain the rapid rise in the number of people suffering from these complex diseases.

**What works?** 33,34,35,36,37

- Better environmental control of indoor temperature and humidity levels (essential to avoid problems with dampness and allergens) will help lower indoor allergen levels, which is important for people who suffer from allergies.
- Targeting multiple allergens and multiple sites with a range of methods may help lower the amount of indoor allergens, which includes for example, cleaning (bedding, furniture and carpets), restricting movement of pets, repair water leaks and problems with rising damp and removal of damp building materials.
- Like people, all insects and rodents need food, water and shelter to survive. By removing elements needed to sustain insect and rodent populations, infestations can be controlled.

The UK still has some of the highest rates of asthma in Europe and, on average; three people a day still die from asthma.32
Chemicals, toxins, gasses and particulate pollutants

**PUBLIC HEALTH RISKS:** allergic diseases (e.g. asthma), respiratory tract infections, chronic obstructive lung disease, asthma, lung cancer, cardiovascular disease

An increasing number of studies have indicated that the air within homes and other buildings can be more seriously polluted than the outdoor air. Typical pollutants reaching high levels indoors, include common combustible bi-products such as nitrogen dioxide, carbon monoxide and particulates. As people spend around 90% of their time indoors the risks to health from exposure to indoor air pollution may be greater than risks from outdoor pollution.

Many everyday products are designed to make life safer, healthier and more efficient. However, their proper use, storage or maintenance and disposal are important to protect health. The table below sets out some of the most common indoor pollutants and sources:

<table>
<thead>
<tr>
<th>Toxin/ Pollutant</th>
<th>Sources</th>
<th>Known health impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Hand Smoke - from tobacco products</td>
<td>Breathing in other people’s smoke</td>
<td>Respiratory tract infections, chronic obstructive lung disease, asthma, lung cancer, cardiovascular disease</td>
</tr>
<tr>
<td>Particulates – (airborne microscopic dust) from a range of indoor and outdoor sources</td>
<td>Mainly from processes such as manufacturing, construction and mineral extraction activities e.g. mining and road dust.</td>
<td>Respiratory and cardiovascular diseases</td>
</tr>
<tr>
<td>Volatile Organic Carbons (VOCs)</td>
<td>Paints, varnishes, glue for ceiling and carpet tiles, dyes, cleaning products, inks, perfumes, polish removers, pesticides.</td>
<td>Cancer, immune, reproductive and endocrine deficiency</td>
</tr>
<tr>
<td>Formaldehyde</td>
<td>Pressed woods (plywood and chipboards), some fixatives for carpets and tiles, fabrics i.e. new clothing or upholstery and carpets, cosmetics, cleaning products.</td>
<td>Respiratory, lung cancer</td>
</tr>
<tr>
<td>Carbon monoxide - a colourless and odourless gas produced during incomplete burning of carbon fuels</td>
<td>Faulty, incorrectly installed, poorly maintained cooking or heating appliances (which use fossil fuels) or vehicle fumes</td>
<td>Respiratory, at high levels can be fatal</td>
</tr>
<tr>
<td>Nitrogen oxides – nitrogen dioxide, nitrous oxide and nitric oxide</td>
<td>Faulty, incorrectly installed, poorly maintained cooking or heating appliances (which use fossil fuels) or vehicle fumes</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Radon - a colourless, odourless radioactive gas. It is formed by the radioactive decay of the small amounts of uranium that occur naturally in all rocks and soils</td>
<td>Radon is everywhere outdoors as it is formed naturally and in high radon there is a greater chance of a high radon level in a building. However not all buildings, even in the high radon areas, have high levels.</td>
<td>Cancers inc. lung and skin (smoking increases risks if exposed to radon)</td>
</tr>
</tbody>
</table>
What works? 29,44,45

- Improving home safety through face-to-face education can be effective in reducing exposure to pollutants and fire hazards.
- Controlling humidity levels and provision of adequate heating and ventilation helps to prevent the build-up of ozone, ETS, lead, radon.
- Install suitable carbon monoxide and fire detectors on each level of the home and test regularly.
- If you live in an area known to have high levels of radon, then you could contact Public Health England to get your home monitored and remediated if necessary. Details can be found at: http://www.ukradon.org/information/ukmaps
- Avoiding exposure to second hand smoke in the home including, possibly, vaping which can also contribute to poor air quality.
- Correct installation and maintenance of cooking and heating appliances can help lower risk of exposure to hazardous toxins and pollutants.
- Suitable storage and ventilation of household products and chemicals including cleaning and decorating materials etc.

Radon is everywhere but some parts of the country are more likely to have high levels in buildings than others. Much of Cornwall is designated as a radon affected area. This means that dwellings have a 1% chance or more of a house having a radon concentration at or above the Action Level of 200 Bq m and that the levels of radon gas entering properties are such that remedial action is recommended. A large proportion of dwellings across Cornwall have a greater than 30% chance or more of a house having a radon concentration at or above the Action Level. Further details can be found at: http://www.ukradon.org/information/ukmaps

The control of pollutants depends on both tackling their sources and having adequate ventilation with ‘fresh’ outdoor air. There are few regulatory controls on indoor pollution, apart from building regulations. In general, higher energy efficiency is good for health (especially for lower income families that may struggle with fuel bills), but the drive to reduce energy costs, by creating homes with tighter ventilation, means some trade-offs. For example, where energy efficiency means reducing ventilation rates, there may be adverse effects on indoor air quality and occupants health.
Building materials

PUBLIC HEALTH RISKS: asthma, cancer, asbestosis, mental health

The health impacts of many materials previously used in buildings such as lead and asbestos are well-known. But the health effects of many new building materials is poorly understood with comparatively little research to draw on.

Lead is a well-known environmental and industrial toxin found in water (i.e. lead water pipes), paints and fuel. In recent times, there has been an elimination of lead based products and materials due to tighter regulation. With the exception of possible old water pipes and risk of stripping off old lead paint, lead exposure is now thought to be primarily an occupational hazard.

Whilst there is a significant amount of research conducted into the technical performance of building materials, and there are an ever developing range of new materials available. Whilst research is conducted into health impacts of these materials, the true impact on health over the medium and long term will need longer term evaluation. Unintended health consequences of building materials can be clearly evidenced through commonly used products from decades previous with a key example being the use of asbestos. Asbestos was historically commonly used in insulation, roofing, vinyl floor tiles, fireproofing materials and texturised paint until it was found to have significant carcinogenic effects and legislation brought its use and disposal under tight control.

Across Cornwall and areas of Devon there is a unique example of building material failure. Between 1920 and 1950 (up to 1965 in East Cornwall) many properties were built using concrete blocks produced from waste rock worked from mining, quarrying and free supplies of beach gravel. These blocks are commonly referred to as mundic which describes a cause of deterioration in concrete due to the decomposition of mineral constituents within the aggregate. The decomposition of these materials over time can impact on the structural integrity of a building.

There is increasing awareness that the use of new products and materials can affect health, which includes for example increased exposure to volatile organic compounds (VOCs). Where research exists it has been found that many commonly used materials contain VOCs, including formaldehyde which is used in foam insulation installed in the wall cavities of homes as an energy conservation measure. Water damage and/or the degradation of these materials may lead to elevated levels of VOCs in the home. The installation and/or removal of old and new roof insulation material can also emit dust and fibres that can have an impact on health when not wearing appropriate personal protection equipment such as face masks.

What works?

- Specialist removal and remediation of both old (e.g. lead and asbestos) and new potentially hazardous building products and materials
- Adequate home maintenance will help reduce water ingress and the degradation of water damaged building materials and the off-gasing of volatile organic compounds (VOCs).
- The adoption of ‘whole house solutions’ and green building design techniques can make a significant contribution to more sustainable building materials in homes.
Fuel Poverty

PUBLIC HEALTH RISKS: heart attack, stroke, respiratory disease, influenza, falls and injuries, hypothermia, mortality

Cold homes are often also damp homes. Poor energy efficiency in existing homes alongside rapidly rising fuel costs make it unaffordable for low income households to adequately heat and ventilate their homes which can damage their health and quality of life, add to financial problems, and contribute to pressures on the NHS and excess winter mortality. There are also risks of only heating one room within a home to reduce heating costs. For example, moving from a warm room to colder areas of a home affects blood pressure and potentially causes a fall. Additionally, warm moist air from the heat room can migrate to colder areas where condensation forms, promoting mould growth.

Everyone who lives in these conditions is at risk, but there are four particularly vulnerable groups: older people, children, disabled people and those with long-term illnesses. Not only are such people more susceptible to illnesses caused by the cold, but they also tend to spend longer at home.

Fuel poverty is a particular issue across Cornwall and the Isles of Scilly. A household is considered to be fuel poor if it has higher than typical energy costs and would be left with a disposable income below the poverty line if it spent the required money to meet those costs. Fuel poverty is distinct from general poverty: not all poor households are fuel poor, and some households would not normally be considered poor but could be pushed into fuel poverty if they have high energy costs. Fuel poverty is therefore an overlapping problem of households having a low income and facing high energy costs.

14.2% of households affected by fuel poverty in Cornwall rising to 19.4% on the Isles of Scilly.

Housing across Cornwall and the Isles of Scilly contains a significant proportion of ‘hard to treat’ solid wall properties which are more difficult to insulate. Cornwall and the Isles of Scilly are the top 2 county/unitary authority areas for homes without central heating (7.2% and 26.3% of all households) and many homes in more rural locations are not connected to the mains gas supply (42% across Cornwall and 100% on the Isles of Scilly) and are therefore forced to rely on more expensive forms of heating. Low incomes, high heating costs and poorly insulated homes combined with rising energy costs continue to present a real issue for many across Cornwall and the Isles of Scilly.

What works?

- In the UK, sealing homes to prevent heat loss, improved insulation, double glazing and a shift from solid to liquid fuels is being used as a policy for carbon emission reduction targets alleviating fuel poverty and reduce excess winter deaths.
- Grants are available for home energy efficiency measures (e.g. draft proofing, insulation, double glazing and new boilers), but these must be accompanied by adequate heating and ventilation (e.g. installation and use of extractor fans or mechanical ventilation) throughout the entire home to avoid the pitfalls associated with poor air quality.
The diagram below sets out some of the key risk factors associated with cold homes:

**How cold homes affect health...**

**Increased Respiratory Problems**
Worsening asthma and COPD (Chronic Obstructive Pulmonary Disease)

**Accidents**
Increased risk of falls and accidents due to loss of strength and dexterity in the hands, and due to open or free-standing heating

**Adverse Effects**
Homes in fuel poverty have a choice between keeping warm and spending money on other essentials

**Impact on Children**
In many cold homes only one room is heated, which causes difficulties for children doing homework

**Increased Social Isolation**
People may become more socially isolated due to economising and reluctance to invite friends into a cold home

**Increased Blood Pressure**
-Risk of Heart Attacks and Strokes
Blood pressure rises in older people with exposure to temperatures <12°C

**Worsening Arthritis**
Symptoms of arthritis, particularly pain, become worse in cold

**Impaired Mental Health**
Cold housing is associated with increased mental health problems

In Cornwall there are around 300 excess winter deaths each year, indicating that more deaths occur during the colder months of the year. Evidence indicates that living at low temperatures as a result of fuel poverty is likely to be a significant contributor to the excess winter deaths. Around 10% of excess winter deaths could conservatively be attributed directly to fuel poverty.

Source: Adapted from Press.V, Fuel poverty+health: A guide for primary care organisations, and public health and primary care professionals, National Heart Forum, the Eaga Partnership Charitable Trust, the Faculty of Public Health Medicine, Help the Aged and the Met Office, 2003)
Overcrowding

PUBLIC HEALTH RISKS: Mental health, childhood illness, educational attainment, infectious disease

Overcrowding is another factor associated with lower income households. The size of a dwelling relative to the number of people who live there is often influenced by available income and can have a significant impact on people’s health and wellbeing. There is a recognised relationship between overcrowding and aspects of physical health of both children and adults. Overcrowding in childhood is also known to affect aspects of adult health. The relationship between overcrowding and mental health (children and adults) however, is as yet inconclusive.

Those in social or private rented accommodation are more likely to live in an overcrowded household than owner occupiers, where there is a higher prevalence of under-occupancy. Overall, only 3 per cent of households in England live in overcrowded conditions. This figure increases when looking at private rented and social housing where figures rise to around 5.2% and 6.6%. Whilst overall

In 2015-16 there were over 3,700 people on the Council’s waiting lists as a result of insanitary or overcrowded housing or otherwise living in unsatisfactory housing conditions.

those at risk of overcrowding represents a small number of households, the impact on individuals and families living in overcrowded conditions are significant.

Individual residents’ employment status, ethnicity, pre-existing medical history, age, education and role within the household are relevant to their health status and their ability to cope with crowded conditions.

What works?

- Local policies and planning should consider the impact of overcrowding in the allocation of social or public housing opportunities, which should include an assessment of the appropriateness of current criteria for the number of people per home.
- Increasing the number of affordable homes (e.g. rent to buy through to making existing homes more affordable to heat) can make significant impacts on overcrowding.
- For new homes there needs to be a review of ‘space inequality’ issues associated with reducing living and outdoor spaces allocated to individual homes.
Accidents and fire in the home

PUBLIC HEALTH RISKS: Mental health, physical injury

More accidents happen at home than anywhere else. Accidents remain the leading cause of death in people under 39 years old, accounting for more years of life lost in those under-75 years than preventable cancers, suicides or alcohol related causes of deaths.

The likelihood of an unintentional injury/accident is affected by a number of factors, including personal attributes (such as age and any medical conditions), behaviour (such as risk-taking) and the environment (such as poor-quality housing)\(^6^8\). Preventing unintentional injury/accidents is therefore an important component of wider efforts to improve health. Whilst accidents can happen at any age, they occur disproportionately in children and young people and older people\(^6^9\). Falls are the most common accidents, which can cause serious injury at any time of life.

Fire in the home can have devastating consequences and as such fire safety implications should be a key consideration at the design stage of new buildings or other construction or refurbishment.

Building materials along with other common household items can release a number of harmful toxins in the event of a fire such as carbon monoxide, hydrogen chloride and dioxins.

101 hospital admissions per 100,000 resident population due to unintentional and deliberate injuries in children aged 0-14 years (2015/16)

There is a strong correlation between deprivation and accidental injury. Children of parents who have never worked or are long-term unemployed are 13 times more likely to die from accidental injury and 37 times more likely to die as a result of exposure to smoke, fire or flames than children of parents in professional occupations.\(^7^0\)

420 domestic property fires attended across Cornwall and Isles of Scilly during 2016/17.\(^7^1\)

Recent tragic events at Grenfell Tower highlight the need for fire safety design which reflects and understands the interactions between building components such as, fire source, smoke movement, heat transfer to the building structure, detection, human behaviour and toxicity.
Over 12,500 homes across Cornwall received Fire Risk Checks carried out by Cornwall Fire and Rescue Service and partners between 2013/14 and 2015/16. 72

Electrical, gas and oil installation, appliances and equipment all present potential fire hazards that require ongoing management. The risk of fire is reduced if installations are properly designed and installed in the first instance. However, installations may subsequently be modified or extended. These alterations, if not anticipated in the original design, may increase fire hazards. Installations can also deteriorate due to age, misuse or adverse environmental conditions.

Nationally, the main causes of accidental house fires (2015/16) were cooking appliances and misuse or maintenance of electrical systems, equipment/appliances. However, smoking materials resulting in a fire lead to the most deaths.

What works? 73,74

- The most effective means of increasing uptake of smoke alarms includes elements of providing equipment (alarms), home inspection and education. Interventions combining all these elements increased uptake 7 times.
Neighbourhoods and Community

A determinant of health

Just as conditions within our homes have important implications for our health; conditions in the neighbourhood/community surrounding our homes also can have major health effects. The design of the neighbourhood around a home is critical: it provides opportunities for social interaction, exercise, access to nature, local amenities and schools. All of these have a bearing on how much an individual will enjoy living in their community, and therefore on their own personal health and wellbeing.

Outdoor Environments

Planning and urban regeneration have the potential to promote healthier lifestyles (e.g. physical activity rates)\textsuperscript{75}, and improve physical and mental health outcomes\textsuperscript{76,77,78}. The Outdoor and Built Environment infographic identifies a wide range of factors which impact on health and wellbeing. A selection of these issues are set out in more detail here.
Neighbourhoods and Community - a determinant of health
Owner occupied - new builds concealing issues
Social housing (1950s) - regulated/maintained
1970s housing - poorly maintained/regulated
Aging, possibly socially isolated residents
Industrial impact on air/environment/noise
Risk of disruption to power/telecoms
Renewable energy - wind and solar
Access to green spaces, parks and recreation
Access to blue spaces, beaches and leisure
Poorly maintained rural road transport
Busy roads near homes - air/noise pollution
Road safety issues
Tourism/2nd homes - higher property prices
Flooding/extreme weather risks
Homelessness
Fly tipping, dog waste
Social issues inc. crime, substance abuse etc.
Housing/outdoor space inequality
Overcrowding - poor air quality/lack of space
Air/noise pollution from cars
Access to/availability of public transport
Location and design of buildings
Allotments/community gardens
Rural homes at risk of power loss and isolation
Lack of access to mains drainage/sewerage
Climate changes increasing air allergens
Air pollutants/allergens from industry/transport
Individuals responsible for own health habits
Lack of parking/space due to more vehicles
Access to health and care services

Key
35 Owner occupied - new builds concealing issues
36 Social housing (1950s) - regulated/maintained
37 1970s housing - poorly maintained/regulated
38 Aging, possibly socially isolated residents
39 Industrial impact on air/environment/noise
40 Risk of disruption to power/telecoms
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62 Individuals responsible for own health habits
63 Lack of parking/space due to more vehicles
64 Access to health and care services
Noise

PUBLIC HEALTH RISKS: Hypertension, coronary heart disease, ischemic heart disease, diabetes, mental health and wellbeing

Exposure to excessive noise can cause harm. It can interfere with people’s daily activities at school, work, home and during leisure time. It can disturb sleep\textsuperscript{83}, cause cardiovascular and psychophysiological effects, reduce performance and provoke annoyance, responses and changes in social behaviour.\textsuperscript{84} Even lower levels of night time noise can affect sleep, which can have a negative impact on health and should be avoided.

There are many different sources of environmental noise. Sources of noise can be occupational (in the workplace), or in our surrounding environment. Types of exposure include:

- Transport (road, rail and air traffic)
- Construction and industry
- Community sources (neighbours, radio, television, barking dogs, bars and restaurants)
- Anti social behaviour
- Social and leisure sources (portable music players, fireworks, toys, concerts, etc.)

2,820 complaints about noise made in 2014/15 across Cornwall\textsuperscript{85}

Exposure to constant or very loud noise can also cause temporary or permanent damage to hearing.

What works? \textsuperscript{84,86}

- Noise from fixed premises can be reported and dealt with by local authorities.
- Moving living areas to more quiet areas of homes (e.g. on opposite side to a road) and/or sound insulation can be used in the building fabric and windows, although care must be taken to avoid air quality problems associated with reduced ventilation.
- Zoning and improved urban planning and use of urban green spaces can act as a psychological buffer in areas with chronic noise problems
Outdoor air quality

PUBLIC HEALTH RISKS:
Cardiovascular, coronary heart disease, cerebrovascular disease and heart failure and respiratory disease

The average person breathes about seven to eight litres of air per minute, so the quality of the air they are exposed to can have a significant impact on their health and well-being. It is well accepted that ambient air pollution (pollutants in the air ‘outdoors’) can adversely affect health with severity varying depending on several factors including exposure, the amount and duration of exposure.

The effects of both short and long-term exposure to various air pollutants have been comprehensively researched and the links between air pollution exposure and adverse health outcomes are now widely accepted and estimates suggest that poor outdoor air quality results in around 40,000 premature deaths annually in the UK.

The main sources of air pollution include toxic gases and particles from vehicle and industrial emissions, or naturally occurring sources such as ozone. The table below summarises the types of health effects experienced by the most common pollutants at elevated levels:

<table>
<thead>
<tr>
<th>Pollutant</th>
<th>Health Effects at Very High Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrogen Dioxide, Sulphur Dioxide, Ozone</td>
<td>These gases irritate the airways of the lungs, increasing the symptoms of those suffering from lung diseases</td>
</tr>
<tr>
<td>Particles</td>
<td>Fine particles can be carried deep into the lungs where they can cause inflammation and a worsening of heart and lung diseases</td>
</tr>
<tr>
<td>Carbon Monoxide</td>
<td>This gas prevents the uptake of oxygen by the blood. This can lead to a significant reduction in the supply of oxygen to the heart, particularly in people suffering from heart disease</td>
</tr>
</tbody>
</table>

Ambient air quality in the UK has, on the whole, improved steadily over recent decades. For most people, pollution levels in the UK are unlikely to cause any serious health effect. However, during particularly severe pollution episodes, eye irritation or coughing may be triggered and those who are more susceptible to respiratory pollution may feel the effects at lower levels. These include those who suffer from heart and lung disease, including asthma and bronchitis, especially young children and the elderly. For example, being exposed to outdoor air pollution such as particulates in the short and long term has been found to lead to the development and exacerbation of diseases such as asthma and even mortality resulting from many chronic diseases.

Air pollution can also have a negative impact on the environment, both in terms of direct effects on vegetation and indirectly through effects on the acid and nutrient status of soil and waters.

In Cornwall, 4.1% of deaths are estimated to be attributable to long term exposure to particulate air pollution (2.9% on Isles of Scilly).
What works?

There are many examples of successful policies in transport, urban planning, power generation and industry that reduce air pollution:

- **For industry:** clean technologies that reduce industrial smokestack emissions; improved management of urban and agricultural waste, including capture of methane gas emitted from waste sites as an alternative to incineration (for use as biogas)

- **For transport:** traffic management including speed control, utilisation of low pollution vehicles and environmentally-friendly transport systems combined with improved opportunities for walking and cycling networks as well as cleaner improved public and freight transport links

- **For urban planning:** improving the energy efficiency of buildings including the use of mechanical ventilation with filtration and heat recovery (appropriately installed and regularly maintained) alongside restricting and/or diverting the movement of vehicles, particularly heavier polluting vehicles such as diesel Lorries, can help improve air quality.

- **For power generation:** increased use of low-emissions fuels and renewable combustion-free power sources (like solar, wind or hydropower); co-generation of heat and power; and distributed energy generation (e.g. mini-grids and rooftop solar power generation)

- **For municipal and agricultural waste management:** strategies for waste reduction, waste separation, recycling and reuse or waste reprocessing; as well as improved methods of biological waste management such as anaerobic waste digestion to produce biogas, are feasible, low cost alternatives to the open incineration of solid waste. Where incineration is unavoidable, then combustion technologies with strict emission controls are critical.

(Adapted from WHO, Ambient (outdoor) air quality and health, Fact Sheet, September 2016)
Climate change

PUBLIC HEALTH RISKS: Cardiovascular, respiratory disease, allergies, cancers, food and water security

Climate change affects public health in many different ways. There are direct and indirect impacts, as well as those that occur immediately and those that occur over a longer period of time. The changing climate has modified weather patterns, and is predicted to lead to greater seasonal variation in climate patterns, meaning; higher temperatures, milder winters, and wetter summers, with more flooding and severe weather events.

The UK Climate Change Risk Assessment 2017 Evidence Report sets out six areas of inter-related national climate change risk:

- Flooding and coastal change risks to communities, businesses and infrastructure
- Health, well-being and productivity impacts from high temperatures
- Shortages in the public water supply
- Risks to natural capital, ecosystems, soils and biodiversity
- Domestic and international food production and trade risks
- New and emerging pests and diseases, and invasive non-native species, affecting people, plants and animals

As coastal areas, flooding and coastal erosion is a key concern across Cornwall and the Isles of Scilly. Cornwall has experienced two extreme weather events (as identified by the Met Office) in the last 20 years, namely; Boscastle and Crackington Haven (2004), St Blazey, St Austell, Mevagissey and Lostwithiel (2010) and more recently Coverack (2017). Whilst it cannot be said with certainty that these events were a direct consequence of climate change; it is clear that events of this kind are becoming more frequent, and they provide a glimpse of what could become even more severe events in the future.

Across Cornwall there are 24 Multi Agency High Risk Flood Response plans which cover the response to flooding in an area including; shelter locations, roads flooding and human aspects such as identifying care homes children schools /play groups etc. The areas covered include:

- Bodmin
- Bude and Stratton
- Camborne and Redruth
- Flushing
- Hayle and Lelant
- Helston and Porthleven
- Launceston
- Liskeard
- Looe
- Lostwithiel
- Mevagissey
- Millbrook
- Padstow
- Par St Blazey
- Penryn
- Penzance
- Perranporth and Bolingey
- Polperro
- Porthleven
- Rosacraddoc
- St Austell
- St Ives
- Truro
- Wadebridge

In 2015, domestic end-user CO2 emissions in both Cornwall and the Isles of Scilly were 1.6 tonnes per person

Higher temperatures, milder winters, and wetter summers are likely to expand the allergen season, a known trigger for asthma. Prolonged spells of higher temperatures also increase the risk of vegetation and gorse fires. A milder and
wetter climate predicted in the South West may have an impact on housing, indoor air quality and health.

One of the key areas of focus for successive governments, enacted through the Climate Change Act 2008, has been reducing our carbon dioxide emissions. Carbon dioxide belongs to a category of gases known as “greenhouse gases.” These gases absorb warmth from their surroundings and re-radiate some of it back toward Earth’s surface, slowing the rate at which the planet loses heat and have been identified as a key contributor to climate change.

In 2015, Cornwall’s domestic carbon footprint accounts for 29.5% of all carbon emissions, with 31.4% on the Isles of Scilly. Since 2005, domestic end-user emissions have decreased across Cornwall and the Isles of Scilly. This is consistent with the decrease in overall UK emissions from 2005 to 2015. In 2015, about 47.6 percent of domestic end-user emissions came from electricity consumption and 29.5 percent were due to gas use in Cornwall. On the Isles of Scilly, over 71% of domestic end-user emissions came from electricity consumption. This is a marked difference from national figures where 35.5% came from electricity consumption and 54.6 percent were due to gas use. This in part can be explained by the fact that over 42% of households in Cornwall and 100% on the Isles of Scilly are not connected to the mains gas network.

Addressing fuel poverty and providing affordable and cleaner sources of fuel for those unable to access mains gas will be a key factor in improving air quality over the longer term across Cornwall and the Isles of Scilly.

**What works?**

- Lowering the domestic carbon footprint from housing through the promotion and adaption of more ‘greener’ building materials and designs that incorporate renewable energy, energy efficiency measures and water saving measures; all of which help lower the cost of running homes.
**Neighbourhoods and the built environment**

**PUBLIC HEALTH RISKS: incidence of chronic disease, injury, respiratory disease, mortality, and poor mental health**

Neighbourhoods in which residents have close and supporting relationships with one another, can improve physical and mental health by reducing stress and exposure to violence and crime as well as improving school performance and civic engagement. Social relationships are also particularly important in increasing resilience and promoting recovery from illness in socio-economic circumstances that otherwise would be detrimental to health.101

The built environment can have a significant impact on whether or not a person becomes socially isolated. The built environment influences physical access to family and friends, health services, community centres, shops and all the other places and spaces that enable individuals to build and maintain their social relationships. Poor transport links can create barriers to social inclusion, whereas effective transport links can benefit social cohesion.102,103 Safe public spaces, with pavements to walk on and lighting, are also part of the physical infrastructure that helps people to maintain social connections. These factors cut across the whole of the life course as part of sustainable communities and places in which people are born, grow, live, work and age.104

Transport can help people to stay connected; and accessible and affordable transport links are part of the solution to tackling social isolation.105,106 A 2003 report by the Social Exclusion Unit found transport to have a major impact on exclusion. The report found that two in five job seekers say lack of transport is a barrier to getting a job.107 Nearly half of 16- to 18-year-old students experienced difficulty with the cost of transportation.107 Over 1.4 million people say they have missed, turned down, or chosen not to seek medical help over the last 12 months because of transport problems.107 Older people are particularly affected by transport links; a report by the International Longevity Centre found that 12% of older people would like to visit their family more often and of these 76% cite transport or mobility as an issue.108

**What works?**106,109,110,111,112

- Designing the built environment to make the streets conducive to walking and cycling, alongside an integrated public transport system is likely to encourage social connectivity as well as increasing physical activity levels and improving mobility among children, adults and older adults.

- Areas of mixed land use (i.e., neighbourhoods that include green spaces), diverse housing types and high quality public transport were found to be associated with increased physical activity levels, reduced risk of pedestrian injury and road traffic collisions, and increased social participation among older adults, among other positive health outcomes.

- Public participation in designing public spaces that meet community needs is important in building a sense of ownership and belonging.

- Availability of safe public parks, squares, blue and green spaces facilitates social contacts.
Homelessness

PUBLIC HEALTH RISKS: incidence of chronic disease, injury, respiratory disease, mortality, and poor mental health

It is well documented that living without a home has serious impacts on the health and well-being of individuals impacting on their ability to secure or hold onto education, training or paid employment, stay healthy and maintain relationships.113,114

There were 99 rough sleeping individuals identified across Cornwall at the last count in 2016

For some people, homelessness is not just a housing issue but something that is inextricably linked with complex and chaotic life experiences. Traumatic childhood experiences such as abuse, neglect and homelessness are part of most street homeless people’s life histories.115

From a health perspective homelessness often result in marked deteriorations in health and well-being and impact on physical/mental health116. These issues mean that the average life expectancy of someone homeless (47 years old) is lower than the general population, influenced by high rates of infections, traffic accidents, falls, drug and alcohol abuse and suicide117 as well as a range of physical health conditions and lack of health care.

What works?

• Preventive measures are much less expensive than allowing homelessness to be experienced for sustained periods or on a repeated basis. Furthermore, those receiving treatment are more likely to return to the streets and hostels at the end of the treatment programme without assistance in resolving their housing problems.

• Healthcare programmes, peer support and community-based interventions that incorporate the views of homeless people and tailored programmes that include their psychosocial needs and life circumstances can promote health and well-being.

• Appropriate housing solutions play an important role in health people who are homeless. Supported housing can help people to live in more permanent housing or to have less days being homeless than being in accommodation, although housing programmes may not help those chronically homeless.
Older and Vulnerable People

PUBLIC HEALTH RISKS: incidence of chronic disease, falls, injury, respiratory disease, mortality, and poor mental health

Cornwall and the Isles of Scilly have a growing and aging population with 1 in 4 being aged over 65 by 2019. One of the major challenges for housing is to continue to plan and deliver a strategy that meets the needs of our ageing population. Older people are more at risk of developing health issues, falls, and mental health problems as a result of poor housing, inaccessible housing, and social isolation.

Currently 33% of households across Cornwall and the Isles of Scilly are headed by a person over retirement age.

The need for suitable accessible accommodation and adapted properties will become more evident as health and mobility issues increase with the age profile. Those particularly at risk are older people who:

- Live in poor quality housing (as a result of damp, cold, repairs required);
- Have long term conditions (more affected by environmental conditions);
- Have mobility issues and living in housing with poor accessibility (more likely to fall);
- Live alone (social isolation/loneliness);
- Are from less affluent backgrounds and living in more deprived neighbourhoods (statistically more likely to have health problems, and die at an earlier age).

In 2015/16 in Cornwall and the Isles of Scilly there were 2,013 admissions due to injuries caused by falls per 100,000 aged 65+ years.

It is estimated that around nationally, 20% of older people (e.g. aged over 55 years) live in poor quality housing. Unsuitable housing and a lack of adaptations (e.g. grab hand rails, bathing aids and specialised toilet seat) can have a personal (e.g. falling) and economic (e.g. provision of healthcare) cost.

The provision of suitable/adaptable housing has the potential to prevent falls, enable early discharge from hospital and prevent stays in residential care. Falling is a serious and the leading cause of injury and injury-related deaths, affecting around 35% of people aged over 65 years. Falls destroy confidence, increase isolation and reduce independence. For older people, a fall can hasten a move into residential care. After a hip fracture, 50 per cent of people can no longer live independently.
What works? 136,29,137,138,139,140,141,67

- The Lifetime Homes Standard incorporates 16 guiding principles (e.g. parking, access and indoor space) of good housing design, which maximises utility, independence and quality of life. When utilised alongside mixed exercise programmes, education and assistive technology it has been shown to help prevent falls and injury in the general population.

- The World Health Organisations age friendly cities are thought to lead to a number of benefits, which may include speeding up hospital discharge and prevent the escalation of need for example. Essentially age-friendly environments adapt structures and services to be accessible to and inclusive of older people with varying needs and capacities.

- In addition, improving the internal/external fabric of properties (including external fabric works, kitchen and bathroom, and front door upgrades) can have psychosocial benefits (e.g. positive perceptions of internal improvements and home security) and positive physical and mental health outcomes.

- Care and repair schemes are effective in helping people live longer and more independently in their own home. These provide low cost homes improvements such as making repairs to the building fabric through to installation home adaptations to prevent falls for example.

- The provision of supported housing, which usually involves help from family members and informal care can speed up hospital discharge/reduce readmission and prevent escalation of need (e.g. accidents and falls).

- Group exercise has been shown to reduce the rate of falls by 29% and the risk of falling by 15%. Home-based exercise reduced the rate of falls by 32% and the risk of falls by 22%.

- Home hazard assessments and modification carried out by occupational therapists have been found to reduce the rate of falls by 19% and the risk of falling by 12%.
Tenure and Affordability

PUBLIC HEALTH RISKS: asthma, mental health

The affordability of housing has clear implications for health. Housing affordability and its implications for health affect both renters and homeowners and the shortage of affordable housing limits families’ and individuals’ choices about where they live, which can result in lower-income families living in substandard or overcrowded housing.

Families paying excessive amounts of their income for housing often have insufficient resources remaining to meet key needs such as food, heating etc. which can result in negative health outcomes. Research shows emotional strain from housing conditions can directly influence the onset and severity of diseases such as asthma. Insecure housing tenure or living with the threat of eviction has a significant emotional impact that can affect mental wellbeing, sense of belonging and community cohesion. People experiencing housing insecurity are almost three times more likely to be in frequent mental distress than those who have secure housing.

Housing instability has also been shown to have a profound impact on children, resulting in behavioural problems, educational delays, depression, low birth weights, and other health conditions such as asthma.

Housing affordability has, over the last decade, become a well-recognised challenge across Cornwall however; it presents a particular problem in many desirable coastal areas such as St Ives, Padstow, Rock and St Mawes where a high proportion of housing stock are used as second homes and holiday homes.

The average house price across Cornwall is 9 times average earnings

Local buyers or renters, on local incomes and earnings, are therefore priced out of some but certainly not all housing markets.

Across Cornwall Owner occupied 69.6% (owned outright 40%, with a mortgage 28.8%, shared ownership 0.8%), Social rented 12.0% (Council 5.6%, Housing Association or Social Landlord 6.4%), Private Rented 14.7%, Other rented 3.7%

The proportion of people renting their home from private landlords across Cornwall and the Isles of Scilly has increased in recent years and we expect this trend to continue. The private rented sector is meeting the needs of a range of people; however it is not without problems. Whilst a large proportion of private landlords provide good quality accommodation, issues such as high rental costs, security of tenure and housing condition continue to present an issue with some providers.
What works?151

• Effective spatial planning is not an intervention in itself, but an enabler. It is key to shaping the form and structure of housing development, and encouraging a density, quality, and tenure which meets the social and economic aspirations of people within an area.

17% of households in 2011 rented privately across Cornwall and the Isles of Scilly compared with 12% in 2001 150

Changes to the Energy Bill include the introduction of a legal minimum energy efficiency standard for homes rented from a landlord. From 2018, the rental of the very worst performing properties—those rated F and G—will be banned. Whilst work is underway with private landlords across Cornwall and the Isles of Scilly it is likely that these changes will impact on the availability of housing in the short to medium term.

Non-permanent Accommodation – Residential Caravans/ Park Homes

PUBLIC HEALTH RISKS: heart attack, stroke, respiratory disease, influenza, falls and injuries, hypothermia, mortality (see fuel poverty section)

Park homes are residential mobile homes, some resembling bungalows and others closer to traditional caravans. The Oxford Dictionary definition of a Park home states that it is ‘a prefabricated building occupied as a permanent home, located with others in a dedicated area of ground’.

Many residential caravans/ park homes are located in desirable coastal and rural locations. In general, individuals would pay considerably more to buy a traditionally constructed (bricks and mortar) home in these areas which makes this lower cost housing option an attractive form of accommodation for many.

The 2011 Census showed that 1.4 per cent of households were living in caravans or other mobile temporary structures across Cornwall compared to 0.4% across England and Wales.

Whilst representing a small proportion of the housing stock, this type of housing plays a key role in meeting housing...
needs; with 45 residential sites currently identified across Cornwall. Residential caravans/ park homes offer an attractive housing option for many retired people; consequently residents tend to be older. The characteristics of the park home sector suggest that a high proportion of residents are also vulnerable with regard to their health status.

Residential caravans/park homes – especially older homes – can be less energy efficient than other types of properties. It is estimated that ninety-five per cent of park homes were built before 2005, when insulation standards weren’t included in the British Standard for Park Homes. The lack of insulation and poor thermal properties in many of these properties is of particular concern and result in higher heating costs. However, the lifecycle of these properties impacts the ability to access energy efficiency funding in many instances. This increases the risk of cold related morbidity, particularly of older or frail residents.

**What works?**

- External wall insulation for park homes should be coupled with other insulation such as loft and floor treatments where the structure of the dwelling allows for it.
- Behavioural advice should be given alongside the installation of any energy efficiency measures.
- Where residents are vulnerable in terms of age and income, as park home residents often are, it is important to balance the short term well-being must take precedence over the longer term financial savings.
Keeping our housing healthy

Who’s involved?

Public health promotion and protection strategies can be employed to alleviate the impact on resident’s health (e.g. healthy homes programmes, increased energy efficiency with ventilation and affordable housing)\(^{160}\). However, resolving these complex societal, economic and environmental issues influencing health and housing require multi-faceted approaches (e.g. an ecological model) including sustainable building design, community engagement\(^{161}\), social inclusion and public participation. This requires the involvement of diverse stakeholders, joint funding and effective collaboration.

The following lists some of the key partners involved in and responsible for ensuring our homes are healthy now and for future generations:

- Economic development
- Planning
- Transport planners
- Environmental Health
- Landlords and Tenants
- Home owners
- Health Services (GP’s, hospitals and community services)
- The voluntary sector
- Workplaces
- Schools
- Care settings
- Councillors
- Parish Councils
- Housing developers
- Housing Associations and Registered Social Landlords
- Housing and Health commissioners
- Environment Agency
- Local Economic Partnership (LEP)
- Local Nature Partnership (LNP)
Putting Health into Housing

Recommendations

Money spent on dealing with poor housing is money invested in health – when agencies act to improve housing conditions, there is a resulting financial benefit to the health sector. Evidence suggests that good quality housing, environmental factors and support can help reduce demand and support patients through:

- Providing decent homes (lack of excess cold, damp and safety issues) - positive impact on health and wellbeing including a reduction in symptoms and morbidity levels for the chronically ill, a reduction in rates of acute illness and levels of excess winter morbidity and mortality;
- Timely fitment of adaptations or other preventive measures - positive impacts on health and wellbeing for disabled/long term condition recipients, carers and other family members;
- Reduction in home hazards - reductions in injury and acute poisoning via a multiagency approach including health visitors and home safety checks by the Fire and Rescue Service;
- Helping patients discharged from hospital to return home quickly and safely and avoid re-admission
- Supporting those with complex needs to prevent homelessness
- Reducing poverty and fuel poverty
- Awareness of risk factors and modifying behaviours such as varying levels of heating and ventilation patterns through to maintaining heating appliances and smoking indoors

The relationship between housing and health is not just confined to the physical condition of housing stock but also the supply, affordability and the wider built and natural environment. Much of this is routinely addressed by other departments within the Council or partner agencies through our statutory duties.

There is a wealth of work already taking place in the housing and built environment arena in Cornwall such as the Strategic Housing Framework: www.cornwall.gov.uk/media/9631240/strategic-housing-framework_web.pdf and the Local Plan: www.cornwall.gov.uk/localplanchowalcornwall. The recommendations set out below do not look to duplicate this work, but seeks to strengthen the communication and engagement between built environment and health professionals.
1. Collective agreement on a roadmap to promote and disseminate information to residents on healthy homes and supporting residents to make informed choices on issues such as building materials which minimise health risks.

2. Work with the Housing Team to help raise the profile with registered social landlords/private landlords on the need to ensure adequate heating and ventilation in modern new builds and renovations alongside regulated thermal properties.

3. Undertake an assessment of park homes and older housing stock across Cornwall, which are difficult and expensive to retrofit with energy efficiency improvements, and agree key targeted communications which can help support improved health in the home.

4. Develop a clear vision for how diversity and innovation within housing solutions can support/improve health including new technologies and methods of construction which promote healthier environments both in and out.

5. Work with long-term care settings, such as nursing homes, assisted living, or schools to raise awareness of how the environment can create health risks and work with commissioners on building key requirements into future contracts.

6. There are pockets of good practice where collaboration between housing and healthcare organisations works well, however this is by no means a norm. The duty of confidentiality and the need to protect vulnerable people can create real barriers. Developing mechanisms for closer working is needed.
7. Develop communications for land owners, the voluntary sector and local town and parish councils which sets out the important health benefits well maintained local ‘green’ or ‘blue’ spaces can bring to communities.

8. Ensure questions are asked within the planning process of developers on how the development will improve health and wellbeing including improved access to natural spaces that promote health and well-being, as well as age-friendly urban environments that consider the needs of an ageing population.

9. Continue to work with others to promote initiatives to facilitate active travel (for example Healthy Schools Programmes, school travel plans; cycle to work schemes etc.).

10. Preventing unintentional injuries will help the local authority and NHS meet their obligations in other areas; for example preventing falls will reduce pressure on social care budgets and help reduce emergency admissions.

11. Collaborate with all partners to ensure safe good quality, energy efficient homes.

12. Work with partners to identify future health based needs for adapted properties/housing to ensure future stock provides the right mix of house sizes and types to meet demand.
Making Our Own Homes Healthier

Check List

• Providing decent homes (lack of excess cold, damp and safety issues) - positive impact on health and wellbeing including a reduction in symptoms and morbidity levels for the chronically ill, a reduction in rates of acute illness and levels of excess winter morbidity and mortality;

• Timely fitment of adaptations or other preventive measures - positive impacts on health and wellbeing for disabled/long term condition recipients, carers and other family members;

• Reduction in home hazards - reductions in injury and acute poisoning;

• Helping patients discharged from hospital to return home quickly and safely and avoid re-admission

• Supporting those with complex needs to prevent homelessness, domestic abuse etc.

• Poverty and fuel poverty

• Awareness of risk factors and modifying behaviours such as varying levels of heating and ventilation patterns through to maintaining heating appliances and smoking indoors

The relationship between housing and health is not just confined to the physical condition of housing stock but also the supply, affordability and the wider built and natural environment.

Successful prevention of housing-related disease and injuries through healthy homes can be achieved by most householders by incorporating some basic healthy housing knowledge and simple changes simple changes such as:

Improve Air Quality

Keep Warm and Ventilate

✔️ Understanding your heating system and adequately heat the whole property - Cold homes can increase the incidence of respiratory disease, cardiovascular disease, hypothermia, hypertension, accidents and falls, impaired mental function, mental health, rheumatism and arthritis

✔️ Ventilate – an effective way to reduce levels of condensation, mould growth and indoor air pollution is to improve ventilation. This can be achieved by regularly opening windows, using trickle vents and doors for a period of time each day and by using exhaust fans in kitchens and bathrooms.

• Put a lid on saucepans to keep the steam inside.

• Do not leave kettles boiling.

• Dry washing outside if possible. Otherwise, hang it up in the bathroom, close the door and have the window open or a fan working continuously while it dries.

• Try to avoid using paraffin or bottled-gas heaters that do not have an exhaust pipe to the outside. Burning paraffin or gas produces considerable amounts of moisture.

• Ventilate all rooms at regular intervals to remove humid air. Note that tight buildings require more active and/or mechanical ventilation!

• Mechanical ventilation systems should not be stopped and must be maintained.
Cooking, bathing and showering all produce steam. Open the window or put on the fan, and close the door to prevent the damp air circulating into other rooms.

At other times, leave all the doors to different rooms open to allow the air to circulate.

To avoid condensation in bedrooms, open the windows for 15 minutes each morning. Human breathing puts considerable moisture into the indoor air.

Move items of furniture away from the wall slightly so that air can pass behind them. Leave the doors of cupboards open from time to time to air them.

When away from home, the temperature in the rooms should not drop under 15 degrees Celsius to avoid condensation and increased humidity levels.

Do not heat up cold bedrooms in the evening by opening the door to heated rooms. The warm and humid air will condensate on the cold walls of the bedroom.

Good insulation of the building helps preventing mould growth due to higher temperature of the walls. Again: note that tight windows and buildings require more active ventilation.

Don’t smoke indoors - The best way to maintain a smoke-free house is to refrain from smoking or vaping. In addition, adopting smoke-free rules inside the home reduces involuntary exposure to secondhand smoke and improves health. A leading cause of residential fire deaths is smoking.

Clean/ Dust - Allergen levels can be controlled by vacuuming and cleaning hard surfaces. In addition, frequent washing of plush toys and bedding, using mattress and pillow covers. If you have pets, regularly wash pet bedding and vacuum areas in which they rest to help reduce dander, and keeping pets out of bedrooms has been demonstrated to reduce exposure to allergens162.
Keep Dry

- **Maintain** - It is fundamental to the preservation of all buildings that defects or damage are remedied or treated as soon as possible. Routine maintenance and repair help prevent rising damp, water ingress and resulting damp and the proliferation of house dust mites and moulds, as well as entry of pests such as rodents and cockroaches etc. Areas to check routinely include:
  - Blocked gutters, especially in the hidden valleys of the roof or defective rainwater goods.
  - Defective surfacing to valley gutters and flat roofs.
  - Missing, broken, displaced or loose tiles or slates.
  - Faulty flashing around chimneys.
  - Deterioration of mortar in brickwork joints.
  - Blocked air-bricks.
  - Cracked or broken pipes, both water-pipes and waste pipes.
  - Overflow from cisterns or water tanks.
  - Climbing plants which may hide many of the above faults and plants and trees in close proximity to exterior walls where roots may undermine foundations causing breaks in damp courses.

Reduce Risks

- **Household Chemicals and Medicines** - Store household chemicals and medicines with in locked cabinets. Lock outbuildings that store chemicals such as automotive supplies, paints and garden pesticides or fertilisers. Wherever possible, limit use. Increase ventilation or isolate affected rooms if using household chemicals (e.g. bleach through to paints) inside the home.

- **Prevent Falls** - installing grab bars in bathtubs and showers and adding handrails and good lighting in stairwells, can help protect older or frail occupants from fall-related injuries. Childhood fall injuries can be prevented through the instillation of stair gates and window locks or guards for windows above ground level. It is also advisable to keep floors free of anything that may cause tripping.

- **Take Measure to Prevent Drowning, Choking, Suffocation, and Strangulation in Children** - Never leave children alone near water and use child-proof fencing around ponds, pools etc. Avoid window blinds with looped cords, which may cause strangulation if not stored out of children’s reach. Keep plastic bags and drawstring cords away from children.
**Install smoke and carbon monoxide detectors** - installing and maintaining smoke and carbon monoxide detectors can prevent death and injury from fire, smoke and carbon monoxide exposure. Test detectors every month and change their batteries every year, as well as check whether furnishings etc. are fire resistant.

**Radon test** – Cornwall has areas where radon levels are naturally high. If your house is in a radon affected area Public Health England recommends undertaking a Radon Test to ensure homes are under the recommended levels set by the Government. Further information on testing and ways to reduce radon are available at http://www.ukradon.org

**Summary Infographics 2017**

Whilst this report focuses on health and housing, as a Public Health Team the work continues on our core responsibilities. The following section provides summary infographics on the current position across Cornwall and the Isles of Scilly in regards to our population health:

**5 Lifestyle Behaviours**
- Reducing harm from tobacco
- Being more active
- Healthy eating
- Taking responsibility for alcohol
- Connecting with others

**Other Priority Areas**
- Healthy Children
- Looking after sexual health
- Public mental health
- Drugs – reducing harm and promoting recovery
- Reducing Fuel Poverty and improving winter warmth

**Health Profiles**
To support our understanding of the health needs of our local areas we published health profiles for each of our 19 Community Network Areas across Cornwall.

Reducing harm from tobacco (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community
In Cornwall and the Isles of Scilly there are...
- 983 deaths per year
- £142.5 million annual cost to local society
- £13.8 million annual social care costs
- £24.9 million annual NHS costs
- 57 tonnes of waste annually
- 13 tonnes of cigarette waste discarded as street litter

Tony’s story
I had a stroke at 63. I was told I had to give up all my favourite things – smoking and booze. I wasn’t very happy, but they were nice to me. We talked, a lot, about how I was feeling and how I could cope with wanting a cigarette. The next week I went back, and was proud to say I hadn’t smoked. I saw them once a week for four months. It has been a year now since my stroke and I haven’t had a cigarette, although I still dream of them sometimes. I feel better – my speech and walking which were bad after my stroke have improved, and the speech therapist has said that stopping smoking has helped. They stuck with me.

Personal costs
- over 80% start smoking before the age of 20
- 50% of smokers will die prematurely
- 15X more likely to die from lung cancer
- £24.9 million annual NHS costs
- £13.8 million annual social care costs
- £11 million annual tobacco costs

What are the local outcomes?

Adult smoking rates
- 2015: 16.9% England, 18.2% Cornwall

Smoking in pregnancy rates
- 2015/16: 10.6% England, 13.3% Cornwall

Smoking rates in routine and manual workers
- 2015: 26.5% England, 32.2% Cornwall

Notes:
1. PHE, 2016 Cornwall Health Profile
2. Ash, 2016 The Local cost of Tobacco
3. Ash, 2015 Young People & Smoking fact sheet
4. Ash, 2016 Smoking & Disease fact sheet
5. BMJ, 2004 Doll R et al. Mortality from cancer in relation to smoking: 50 years observations on British doctors
6. PHE, 2015 Local Tobacco Control Profiles
7. ONS Family spending in the UK survey 2014 Table A6 Detailed Household Expenditure by gross decile income group, UK, 2014
8. ONS, 2016 Adult Smoking Habits in GB, 2014
Evidence
A wide range of NICE guidance is used including evidence on effective stop smoking services, smoking prevention in schools, stop smoking in workplaces, Health Checks and reducing smoking rates in pregnancy.

Partnerships
Tobacco Control Alliance
including Stop Smoking Service, Fire & Rescue Service, Trading Standards, Public Health, Children’s Services and Environmental Health

Why invest?
£16 for every £1 invested in smoking cessation in Cornwall and the Isles of Scilly

Local advice and support
For free, friendly support to stop smoking please call 01209 615600 or email smokefree@nhs.net
Local Authority Tobacco Profile (range of indicators) www.tobaccoprofiles.info
ASH – the case for local action on tobacco www.ash.org.uk/localtoolkit


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Being more active (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community
Physical inactivity contributes to 1 in 6 deaths in UK\textsuperscript{1}, representing 800 deaths a year locally

Local annual cost\textsuperscript{2} £19m

Personal costs
Inactivity\textsuperscript{1} increases risk of developing high blood pressure, heart disease and osteoporosis\textsuperscript{3}
Being inactive can lead to being overweight, which can lead to pre-diabetes and type 2 diabetes

Inactive people have x3 the rate of moderate to severe depression as active people\textsuperscript{5}

What are the local outcomes?
Recommended daily physical activity for children\textsuperscript{8} at least one hour of moderately physical activity per day

21% achieved
17% achieved

Notes:
6. HSCIC, 2013 Health Survey for England 2012
7. PHE, 2016 Health matters: getting every adult active every day https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day
8. DOH, 2011 Start Active, Stay Active: A report on physical activity for health from the four home countries’ Chief Medical Officers
9. PHOF, 2016 Physical Activity

Rebecca’s story
I first heard about Cornwall Healthy Weight when I went for an asthma check-up and was told that “added weight” can make asthma worse and I should try to lose some. Over the 12 week programme I became more knowledgeable, educated and healthier and now here I am healthier and happier and no longer have asthma.
I have gone from no exercise to now seeing my personal trainer every week (who is fab); swimming, and have now started attending a local gym.
I could not have achieved any of this without doing the healthy weight adult programme. They are an amazing, inspiring bunch of people and I can’t thank them enough. I consider them all now very good friends.

Inequalities
People in the most deprived areas are 2x as likely to be physically inactive as those in the least\textsuperscript{4}

Not active enough for good health

1 in 5 men
1 in 4 women

Disabled people are half as likely to be active compared to non-disabled people\textsuperscript{7}

58%

Adults who did at least 150 minutes of physical activity a week in 2014\textsuperscript{9}
57% National Average in 2015

"
What is being done locally to address this issue?

The promotion of physical activity is central to the work of Cornwall Healthy Weight through a range of innovative activity programmes. Individuals of all ages and abilities are given the opportunity to be active in a safe and supportive environment and with specialist guidance and expertise encouraged to explore the valuable health benefits of physical activity.

Get Active Cornwall

Get Active Cornwall has over 1,123 Cornish providers.

Get Active 2015 Workplace Challenge had 285 teams with 186,460 miles recorded.

200 businesses have signed up to Cornwall’s Workplace Health programme, with 40,000 employees benefiting.

Cornwall’s Open Space strategy in 16 large towns ensuring open green spaces, walk paths, allotments and play areas.

Cornwall Sports Partnership

3,930 children from 124 schools participated in the 2015 School Games.

Over 200 adults and 14 different organisations participated in the 2015 Beach Games.

Health Checks - Potentially 272 people could increase their physical activity following a Health Check.

Partnerships

Local partners in a variety of organisations and agencies work to encourage communities and individuals of all ages in Cornwall to be more active.

Key drivers include Cornwall Healthy Weight, Cornwall Sports Partnership and Get Active Cornwall, Time 2 Move – Cornwall’s PE and School Sport framework, Hearty Lives Project and Cornwall Healthy Schools Plus Programme.

Why invest?

£16 returned over two years for every £1 invested in the Healthy Weight Programme.

Notes

10. Data supplied by Get Active Cornwall http://www.getactivecornwall.co.uk/ 09/01/17
11. PHE NHS Health Check Ready Reckoner Version 9.28/05/2014 (assuming 20% of the eligible cohort is offered a Health Check and 50% receive one) http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/making_the_case/
12. NICE Guidance https://www.nice.org.uk/
13. Analysis is based on the NICE Return on Investment Tool for Physical Activity, version 1.05 http://www.nice.org.uk/
Healthy eating (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community

**£60m**

Local annual cost of diet-related ill health

Severely obese adults are three times more likely to need social care

50%

Poor diet contributes to nearly 1/2 of coronary heart disease

33%

Poor diet contributes to 1/3 of all cancer deaths

Healthy Weight 7-13 years programme

My two children and myself have just completed the programme. We found the course very rewarding, knowledgeable and fun. We all adapted to it reasonably easily and looked forward to the new challenges every week. At the end of the course we found the results were fantastic and we were all very pleased that the children lost weight, and grew at the same time. The course leaders were very friendly, approachable and knowledgeable also giving lots of encouragement to both the children and the adults. I would like to thank you for accepting us to take part in the programme and your support throughout.

Personal costs

**Poor diet contributes to**

Low birth weight

More tooth decay in children

Risk of falls and fractures in older people

Being overweight increases risk of high blood pressure, high cholesterol and pre-diabetes

Severe obesity reduces life expectancy by 8-10 years

What are the local outcomes?

Reception children who are obese or overweight

69.9% adults were obese or overweight in 2014 (64.6% national average)

66%

National Average

22.5%

Inequalities

Percentage of budget spent on all food

People in more disadvantaged communities eat less fruit and veg

Lowest income

Highest income

Childhood obesity is 2x more likely in our most deprived communities compared to the least deprived

Notes


Personal costs

**Poor diet contributes to**

Lowest income

Highest income

Severe obesity reduces life expectancy by 8-10 years

Notes


Notes

What is being done locally to address this issue?

The National Child Measurement Programme (NCMP) 2014 -15
233 out of 237 schools are in the programme

Cornwall was awarded **£100,000** from the British Heart Foundation to help local schools, children and families achieve healthier lifestyles

**Cornwall Healthy Weight 2014-15**
1, 259\(^2\) adults participated in a Healthy Weight programme, with an additional 114 families and teenagers\(^3\) completing weight management programmes
Potentially 1,000 people could complete a weight loss programme following a Health Check\(^4\)

**Early Years interventions 2014-15**

70% of the 85 early years settings engaged with Nippers Nutrition Programme achieved the two highest levels of accreditation\(^5\)

179 pregnant women received one to one advice\(^6\)

Evidence
Recommendations based on NICE Guidance\(^7\) including:
Having a balanced diet; reducing salt, sugar and saturated fat intake, and eating 5 pieces of fruit and vegetables a day

**Local advice and support**

Cornwall Healthy Weight
[https://www.cornwallhealthyweight.org.uk](https://www.cornwallhealthyweight.org.uk)

Food & Cornwall:
[https://www.foodandcornwall.org.uk](https://www.foodandcornwall.org.uk)

Food in Schools:
[https://www.supportincornwall.org.uk/kb5/cornwall/directory/service.page?id=gNRbwv8AUnI](https://www.supportincornwall.org.uk/kb5/cornwall/directory/service.page?id=gNRbwv8AUnI)

Cornwall Healthy Schools
[http://www.cornwallhealthyschools.org](http://www.cornwallhealthyschools.org)

**Notes**
12. Data from Cornwall Healthy Weight (2015) including: 528 completing Healthy Weight 18+; 285 receiving a 1:1 Physical Activity Review, and 446 taking part in Physical Activity Interventions (Swimming, Walking, Cycling)
13. Including the following programmes: LEAF 0-6, Healthy Weight 7-13, Healthy Weight 13-17 14. Based upon PHE’s NHS Health Check Ready Reckoner (Version 9 28/05/2014) and assuming 20% of the eligible cohort is offered a Health Check and 50% receive one 15. Data from Cornwall Healthy Weight Programme, 2015 16. Programme open to women with a BMI >= 30, offering guidance about healthy eating, physical activity and weight management in pregnancy 17. NICE Guidance PH11, PH27, PH38, PH47 and CG43

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**Partnerships**
Local organisations and agencies support strategy to encourage healthy eating and improve diet in the Cornwall population

In the Food and Cornwall Programme, partners include; community chefs, school catering services, food foundations, NHS dietetic, primary and community services, charity and faith groups and Cornwall Council who coordinate the Programme

Healthy Schools- Eating Well
Food in Schools Training and Support; FIS awards; Healthier lunchboxes; Working with Jamie’s Kitchen; Garden Project; Breakfast clubs

Food and Cornwall: Creating Food Wealth so that no one in Cornwall is hungry. A whole systems approach working with economic, environmental, community and political systems to improve access to good food for people of all ages in local communities

70% of the 85 early years settings engaged with Nippers Nutrition Programme achieved the two highest levels of accreditation

179 pregnant women received one to one advice
Taking responsibility for alcohol (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community

Recent regional research suggests that 1 in 3 adults in the South West drink above the recommended level.

The national estimate suggests that in Cornwall 25% of adults drink above the recommended level which includes:

- 84,000 binge drinkers
- 4,900 dependent drinkers

Alcohol costs the NHS £3.5 billion nationally.

Every 5,000 patients screened in primary care may prevent 67 A&E visits and 61 hospital admissions

Costs £25,000 Saves £90,000

One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions

Costs £60,000 Saves £90,000

Every 100 alcohol-dependent people treated can prevent 18 A&E visits and 22 hospital admissions

Costs £40,000 Saves £60,000

Rehab case study

I was in Boswyns for 6 weeks. I came off the alcohol, then came off the anxiety medication. For the first time in 10 years, my body was free of substances, and it was absolutely terrifying. I was then resident at Bosence Farm for 8 months. I was given time, and an overwhelming amount of love, support and understanding; which allowed me to start to learn how to interact with people and live life. A miracle was worked there. I am approaching 2 years sobriety and have been blessed with a love of life. I’m making positive contributions to my local community. My personal relations with family and friends have been restored. I have a self-confidence and self-assurance of which I could only have dreamed.

Notes

2. Public Health Action, 2015 Alcohol Insight Study South West
4. PHE, 2014 PH ProfIles Local Outcomes
What is being done locally to address this issue?  

**Identification and brief advice**  
2,000 staff trained in under 3 years  
Delivered in a wide range of medical, criminal justice and non-medical community settings  

**Health interventions**  
Alcohol Care Team at Treliske Hospital, to identify cases earlier. Alcohol detox can be delivered at home by GPs, in 4 community hospitals, or in residential units  

**Families**  
Family Interventions offers a range of services supporting families affected by alcohol misuse  

**Specialist treatment**  
In 2014 1,835 people accessed specialist treatment for alcohol misuse. 32 young people in treatment where alcohol was an issue  

**Alcohol Awareness Retail**  
Training delivered to 461 staff in 119 licensed premises. In the last 3 years, over 25 premises in Cornwall have passed the Best Bar None accreditation standards  

**Prevention**  
Safer Cornwall’s ‘What Will Your Drink Cost?’ campaign, in key locations addressing alcohol related issues, such as road safety, domestic abuse, violence and health. 2 School worker’s who deliver a ‘stepped menu’ of interventions for Years 7 to 11  

**What are the local outcomes?**  

<table>
<thead>
<tr>
<th></th>
<th>Cornwall</th>
<th>South West</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol specific mortality per 100,000 population</td>
<td>9.5</td>
<td>10.6</td>
<td>11.6</td>
</tr>
<tr>
<td>Alcohol related mortality per 100,000 population</td>
<td>47.5</td>
<td>42.6</td>
<td>45.5</td>
</tr>
</tbody>
</table>

**For every eight at-risk drinkers who receive advice, one will reduce their drinking to within low-risk levels**  

**Evidence**  
Cornwall and Isles of Scilly have an annual Alcohol Needs Assessment to inform the Alcohol Strategy and Commissioning priorities. NICE guidance provides evidence on effective alcohol interventions  

**Notes**  
7. NICE Guidance  

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Local advice and support  
Anyone in Cornwall or the Isles of Scilly concerned about their own alcohol use (or someone else’s) can contact Addaction Cornwall for advice or support: 0333 2000 325
Why is this issue important for Cornwall and the Isles of Scilly?

Freddie (name changed) was referred to us. Ex heroin addict, dyslexic, poor mobility due to back problems, depression, frustrated with life, overweight, and unemployed.

There were lots of discussions about behaviour change, info on healthier eating & exercise, goal setting, overcoming barriers. He joined the swimming on referral scheme, and towards the end of our time together he was ready to start the Healthy Weight course. He is now losing weight and eating a much better diet; being more aware of what he is eating, and able to read food labels.

He is socialising more; has come on the walking group, played golf, swum and ridden a bike - all since we started meeting. He has also started a part time job and is hoping to apply for more hours.

Whole community
Isolated geography, dispersed population with poor transport links

70% of bus users generally travel by bus because they have no alternative

Earnings are 13% below Great Britain average (median) yet average house prices 9x annual income

In 2014 the local total economic output per capita was 75% of the EU average

Personal costs

42% Pupils 6-8 years said they sometimes feel scared to go to school because of other children

Loneliness can increase the risk of high blood pressure and depression

Loneliness can be as damaging as smoking and alcohol consumption

Notes:
What is being done locally to address this issue?

### Building resilience
Cornwall has been awarded £8.9m from the Big Lottery Fund’s HeadStart programme to continue its work in supporting the emotional wellbeing and mental health of children and young people over the next five years (2016-2021).

### Helping with employment
Since 2007 Inclusion Cornwall (Cornwall Works) has helped 13,000 people on long-term health related benefits to move back into work.

### Helping with homelessness
Since the start of the Cornwall Patient Hospital Discharge Service in January 2014 almost 450 patients have been discharged with a support plan in place, with a third of all patients discharged into accommodation. Since October 2015 over 170 patients were discharged with a support plan and over 75 into secure and suitable accommodation. Between 2014 to 2015 the service has made a cost saving of £280,500 across the Royal Cornwall Hospitals NHS Trusts (RCHT).

### Why invest?
Social interventions have been shown to give an SROI of £5.96 for every £1 invested.

### Partnerships
Partnership work between the NHS, Age UK, Health and Wellbeing Board, Local Nature Partnership, the Local Enterprise Partnership and VSF Cornwall.

### Helping lonely and isolated people
Active Plus utilises skills and experience of injured veterans, and has courses based on group work, making friends, building confidence and communication skills.

Age UK Cornwall & The Isles of Scilly befriending service aims to rebuild a person’s confidence and to help them re-connect to their community. Between 2013-14, 168 volunteers gave 2,536 hours of friendship to 161 people.

### Living Well’s person-centred ethos delivers care more efficiently, reduces loneliness and improves people’s health and wellbeing
People who took part last year said Mental wellbeing (happiness) improved nearly 20%.

Volunteer Cornwall’s Welcome Home scheme has supported over 517 people recently discharged from hospital, helping them get back home and settled as well as looking at social networks around them-friends, family, neighbours, volunteers or paid services. The scheme also raises awareness of community-based resources such as Memory Cafes, Coffee Mornings and Arts & Crafts groups.

### What are the reported local outcomes?

- Adult social care users who have as much social contact as they would like
  - 2014/15: 29.5%
  - Above 45.4% national average (2015/16)

- Adult carers who have as much social contact as they would like
  - 2014/15: 38.5% national average

### Local advice and support
Public Health 01872 327977
Inclusion Cornwall 01872 355015
Age UK Cornwall & The Isles of Scilly 01872 266 388
Shelter-Cornwall 07969 801807
For volunteering opportunities contact Voluntary Sector Forum (VSF) on 01872 241584

### Evidence
Key documents include:
- The Marmot Review Fair Society, Healthy Lives (2010);
- Public Health England’s Local action on health inequalities Reducing social isolation across the lifecourse (2015);

### Notes
6. Hawkley et al (2010), Loneliness Predicts Increased Blood Pressure: Five-Year Cross-Lagged Analyses in Middle-Aged and Older Adults  
7. Cacioppo et al (2006), Loneliness within a nomological net: An evolutionary perspective  
10. The Prince’s Trust. The Prince’s Trust MacQuire: Youth Index 2015  
11. ONS, 2011 Census  
13. Cornwall Council and Council of the Isles of Scilly
Healthy children (0-19) (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community

24.1% of 5 year olds are overweight or obese, compared to the national average of 21.9% ¹

31.8% of 11 year olds are overweight or obese compared to the national average of 33.2% ²

986 hospital admissions occurred as a result of injuries in children aged 0-14 years ⁴

22% of children aged 5 have one or more decayed, missing or filled teeth ³

Personal costs

In 2013-15

72 children died under the age of 1 year ²

5% of both boys and girls aged 13 to 15 reported drinking alcohol in the last seven days ⁶

40% of secondary pupils are ‘fairly sure’ or ‘certain’ that they know someone who takes drugs. 10% of pupils said that they have taken drugs ⁷

18% of 15 year olds have ever smoked ⁸

At any one time we will have approximately 4,400 children aged 5 to 17 years with a conduct disorder and 2,900 with an emotional disorder ⁹

Inequalities

21% of all 16-18 year old females who are not in education, training or employment are pregnant or mums ¹⁰

46% of year 8 girls and 54% of year 10 girls would like to lose weight ⁷

16.5% of children under 16 years old live in poverty ¹¹

Children living in poverty are susceptible to poor mental health outcomes ¹²

Notes


Breast feeding peer support

A peer supporter spent 5 hours on the post-natal ward at RCHT to support 5 mums. Midwives reported that the peer supporter was sensitive, patient and caring, just what this tired and tearful mum needed, and they enabled her with a practical plan which she and baby J were happy to follow overnight.

The ReSET programme (a case study for HS Plus in a small primary school)

Following a Resilience and Self Esteem Toolkit workshop we identified a need for some work on improving self-esteem and confidence with a group of children. In the repeat assessment following the programme all of the answers were more positive. One child performed in front of the class the other day which previously they have refused to do and when sent on an errand they had a go whereas a few weeks ago this child would have cried and refused. Overall, I believe that I have helped these children to begin a journey of believing in themselves and feeling more able to work independently and solve problems and also contribute more fully within a group situation.

Edited extract from full detailed case study.
What is being done locally to address this issue?

**Mental health and emotional wellbeing**

- Perinatal mental health pathway available for pregnant women
- 0-19 Healthy Child Programme allowing early intervention and prevention
- Parenting support offered by Health Visitors

**Partnerships**

- Children and Young People’s Mental Health and Emotional Wellbeing improved through a partnership plan
- Strong emphasis on supporting vulnerable children and young people through ‘Together for Families’ and Young Carers
- Head Start Kernow extended to improve resilience and mental health in 10 to 16 year olds
- Training the wider workforce for child development and mental health
- Whole school approach to mental health
- Reduction of self-harm through guidance and training

**What are the local outcomes?**

- **13.3%** of babies are exposed to the products from smoking cigarettes before they are born
- **79.3%** of babies start their life being breast fed
- **81%** of pupils have been to the dentist in the past 6 months
  - This is lower than the 90% of pupils saying this in SHEU 2014 reference sample
- **70%** Pupils 12-15 years report never being afraid of bullying
  - This is lower than the 79% of pupils saying this in SHEU 2014 reference sample

**Local advice and support**

- Kernow Savvy [https://www.savvykernow.org.uk/](https://www.savvykernow.org.uk/)
- Cornwall Healthy Schools [http://www.cornwallhealthyschools.org/](http://www.cornwallhealthyschools.org/)
- Youth Kernow [http://www.supportincornwall.org.uk/](http://www.supportincornwall.org.uk/)
- The Health Promotion Service [https://www.healthpromcornwall.org/](https://www.healthpromcornwall.org/)
- Promoting Health Information Line (PHIL) 01209 313419

**Starting Well**

- **Maternity**
  - The number of Peer Supporters who are actively volunteering is in Cornwall **148**
- **0-4 years**
  - Health Visiting and Family Nurse Partnership- improving outcomes for children
  - Oral health improvement programme for 3-5 year olds in areas where outcomes are poor
  - Improved access to Early Years education
  - Combined 2 year review
- **5-19 years**
  - School nursing- improving access to public health and early intervention including helping to reduce obesity, smoking, alcohol and drug misuse in school aged children
  - Peer mentoring and Youth Health Champions
  - Healthy Schools - supporting schools to develop a whole school approach to wellbeing to help equip children with the skills and strengths they need to embrace the challenges and opportunities of life

**Why invest?**

- A study in the USA has shown that every $1 spent on quality care and education saves taxpayers $13 in future costs

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**Notes**

Looking after Sexual Health (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Teenage conceptions result in a termination

The infant mortality rate is 44% higher for babies born to teenage mothers

There is also a strong association between deprivation and teenage conception rates across England with rates highest in the most deprived areas

£8M local annual health cost of unintended Pregnancy

Approx 3,000 new STI diagnoses locally each year

Young people and men who have sex with men are the groups most affected by STIs, but STIs can affect everyone

Whole community

46.3%

44%

Personal costs

Undiagnosed Chlamydia can cause long term problems including infertility

People who are diagnosed with HIV late face a ten times higher mortality risk in the year following diagnosis

Inequalities

Two thirds of chlamydia diagnoses in 2015 were amongst young people aged 15-24

Notes:
1. ONS, 2014 Conceptions to Women aged 18 & under by Local Authority
3. ONS, 2012 Mortality rate Infant mortality rate: Childhood, Infant and Perinatal Mortality in England and Wales
4. PHE, 2015 Sexual and Reproductive Health Profiles, New STI diagnosis rate/100,000 for Cornwall
5. PHE, 2014 HIV in the United Kingdom Report
6. PHE, 2015 Infection report - Sexual Transmitted infections and Chlamydia Screening in England
7. Brook www.brook.org.uk
What is being done locally to promote good Sexual Health?

Education
In 2014/15 Brook carried out 13,711 contacts with young people.
In 2014/15 Speakeasy became mandatory training for local authority foster carers.
Healthy Schools provide training and resources to help staff deliver effective, age-appropriate relationships and sex education.
Talk RSH multiagency training programme supports the children’s workforce to be positive sources of information and support for young people.

Changing culture
Talk RSH encourages people of all ages to talk about relationships and sexual health.
55 Brook Sexual Behaviours Traffic Light Tool training sessions have been delivered to professionals in Cornwall since its launch in 2014.
Savvy Kernow accredits young people-friendly sexual health services.

Why invest?
The Kings Fund estimates that every £1 spent in preventing teenage pregnancy saves £11 in health care costs alone.

Partnerships
Cornwall’s Sexual Health Partnership Group includes Public Health, Children’s Services, Royal Cornwall Hospital Trust, Brook, The Health Promotion Service and KCCG.

What are the local outcomes?

1998 39.8 females per 1,000

4 in every 100 females

2014 19.1 females per 1,000

2 in every 100 females

Cornwall & the Isles of Scilly aim to increase its detection of chlamydia from 1,844 per 100,000 (2014) to 2,300 per 100,000 in order to meet infection control targets.

Teenage conceptions
per 1000 females under 18
21.2 per 1,000 (national average) in 2015

Accessible Contraceptive and Sexual Health Services

23% of 15-24s had a Chlamydia screen in 2015.

91% GP practices provide Long Acting Reversible Contraception.

Local advice and support
To find out about sexual health services in your area please visit www.cornwallshac.org.uk
Further advice, information and guidance is available for young people at http://www.savvykernow.org.uk/
For more information about Cornwall’s approach to teenage pregnancy and meeting young people’s sexual health needs please visit www.cornwall.gov.uk/teenagepregnancy

Notes:
10. PHOF, Chlamydia detection rate indicator 3.02.
Public mental health (2017)
Why is this issue important for Cornwall and the Isles of Scilly?

Whole community
1 in 4 people in the UK has experienced a mental health problem each year\(^1\)

\[\text{= Approximately 140,000 people in Cornwall & Isles of Scilly}\]

5% of the population have a severe mental illness

yet they account for 18% of total annual deaths in the population\(^2\)

Costs are high
The economic cost of mental illness in Cornwall & Isles of Scilly (extrapolated from England data)\(^3\)

- 51% human cost
- 20% health & social
- 29% output losses

\[\£1\text{bn}\]

Inequalities
People with mental health problems are 3 times more likely to be in debt than the general population\(^4\)

People from the lowest income households are more likely to have a common mental health problem\(^5\)

Males are 3x more likely to die by suicide\(^6\)

For which groups is this particularly important?

Nationally, one in ten children aged 5-16 have a mental health disorder\(^7\)

Lesbian, gay and bisexual people are more likely to suffer from mental health problems and suicidal thoughts\(^8\)

Up to 40% of people diagnosed with a mental health condition also misuse substances\(^9\)

Men are less likely to acknowledge mental health problems and seek help\(^6\)

...though anyone can be affected at any time

Notes:
People with severe mental health problems are...

- more likely to suffer from coronary heart disease (3x)
- more likely to suffer from lung disease (10x)
- more likely to suffer from gastrointestinal disease (4x)

...and yet, people experiencing a mental health crisis often don’t receive timely and appropriate support from health services. People with severe mental illness die on average 15-20 years earlier.

What is being done locally to promote mental health and prevent mental illness?

In the last year:

- **Self-Harm Strategy** for Cornwall & the Isles Scilly developed
- Radio Cornwall celebrated its **50th** monthly mental health phone-in programme
- **89%** New mums offered maternal mood assessment
- **332** people trained in Applied Suicide Intervention Skills Training (1528 since 2010)
- **50%** of secondary schools using Award winning STOP Stigma resource
- Schools in two localities piloting the Headstart Kernow programme to build emotional resilience. Self-harm policy guidance available to all schools
- Cornwall’s Workplace Health Programme addresses mental ill-health and stress reduction
- In the last year, **189** people completed the Mental Health Awareness & Understanding training and **212** participated in the Stress in the Workplace training

Local advice and support

If you are concerned about your mental health: visit your GP, who will assess your needs and offer talking therapies, medication or referral if appropriate. Online information about mental health problems, service directory and self-help guidance is available at: [http://www.outlooksw.co.uk/](http://www.outlooksw.co.uk/)

Drugs - reducing harm and promoting recovery (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community

There are an estimated 2,382 problematic opiate and/or crack users (OCUs) in Cornwall.

Last year amongst 16-59 year olds

8.8% (1 in 11)
used illicit drugs =
24,700 people in Cornwall

3.1% used class A Drugs

2.3% used Cocaine

Costs

Estimated cost of crime per opiate/crack user not in treatment

£26k

Potential annual cost to local society

£106m

Personal costs

Deaths

16 drug related deaths annually

Deaths among heroin users are 10 times the death rate in the general population

10X

Hidden harms to children and families

Parent drug use is a risk factor in 29% of all children’s serious care reviews

Rehab case study

Before I came to Bosence Farm my life was upside down and any skills I had with regards to living had turned in on me and my fellow man. The drugs had taken over my life and my addiction was making all of the choices just so I could get more what I needed (drugs) to live, so I would not have to look at myself or my past. I hated who I was, what I had become. I could not see a way out.

I spent some time at the Farm looking at how my addiction had manifested and how it was affecting me. With the help of staff and my peers I was able to learn how to let go of old useless behaviours and put into practice new positive attitudes.

I learned to ask for help and was given hope and encouragement when all I felt was despair. The Farm showed me that the good person I was still in there.

I learned to look after myself and treat myself with respect; to treat others with respect and to take responsibility for my recovery; to face my fears and take my life back.

During my time at Bosence I not only had time to look at my life and where it was going but to turn it all around. I had the time to build up a support network to continue to help me after leaving Bosence.

Inequalities

14% - Over 6,700 people with a mental health condition in Cornwall and the Isles of Scilly are estimated to also have drug dependency.

Of drug treatment service users...

70% are on benefits

30% have a housing problem

Women make up 27% of adults in treatment and are more likely to be carers of children often experiencing poor mental health, domestic violence and abuse that may impact upon their recovery.

Evidence

Cornwall and Isles of Scilly have an annual Drug Needs Assessment to inform the Drug treatment Strategy and Commissioning priorities.

NICE guidance provides evidence on effective drug interventions.

Notes:
1. PHE (2014) Drug prevention, treatment and recovery for adults: JSNA support pack
3. PHE (2015) Alcohol and drugs prevention, treatment and recovery: why invest
What are the local outcomes?
Proportion in effective treatment

- **Opiate**
  - Cornwall: 98%
  - National: 95%

- **Non-opiate**
  - Cornwall: 92%
  - National: 86%

- **Non-opiate and alcohol**
  - Cornwall: 93%
  - National: 88%

Preventing blood-borne viruses

- **Accepted Hep B Vac**
  - Cornwall: 98%
  - National: 90%

- **Hep C Test Received**
  - Cornwall: 60%
  - National: 44%

Specialist treatment
1,139 opiate users and 543 non-opiate users engaged in specialist treatment in 2014/15

Young people
96 young people required specialist drug and alcohol treatment
Services were developed for those experiencing problems related to new psychoactive substances and prescription-only medication

Primary care
70% of drug treatment can be delivered by GPs, with 22 practices providing specialist drug treatment in the community

Families
Families can access help together, especially where more than one member requires assistance

Drug prevention can help young people get into education, employment and training

Local advice and support
Services are free and confidential
Anyone in Cornwall/Isles of Scilly concerned about their own use (or someone else’s) can contact Addaction Cornwall for advice or support: 0333 2000 325

Notes:
6. PHE (2015) Alcohol and drugs prevention, treatment and recovery: why invest?

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What is being done locally to address this issue?

Why invest?
Every £1 spent on drug treatment saves £2.50 in costs to society in Cornwall
Prevention of drug-related crime and increase in health and wellbeing in Cornwall: estimated £6m saved annually
Reducing fuel poverty and improving winter warmth (2017)

Why is this issue important for Cornwall and the Isles of Scilly?

Whole community
Cornwall and the Isles of Scilly are in top 3 local government areas for homes without central heating

11.0%
14.2%
19.4%

Households affected by fuel poverty in Cornwall and in Isles of Scilly

34,176 households
81,338* people experience poor health due to a lack of warmth

*Based on 2.38 people per household

Inequalities
The poorest and those who have existing health problems particularly affected

15% more people died in the winter months compared with the non-winter months

Each winter death is preceded by an average of eight emergency admissions, 30 social care and secondary care visits and GP appointments

Personal costs

Around 750 more people die each winter compared to the summer months

£13m
Annual local NHS costs
Cost to England is £1.3bn

Notes
1. ONS, 2011 Census: KS403EW Rooms, bedrooms and central heating, local authorities in England and Wales
2. DECC, 2015 sub-regional fuel poverty data
3. ONS, 2015/16 Excess Winter Mortality
4. DH, 2009 South East Regional Public Health Group Fact Sheet, HEALTH AND WINTER WARMTH, Reducing Health Inequalities
5. The Marmot Review Team, 2011 The Health Impacts of Cold Homes and Fuel Poverty
6. PHE, 2016 Cornwall Health Profile
7. Energy Bill Revolution website, 2015 Health
8. PHOF, Fuel Poverty indicator 1.17 and Excess Winter Deaths indicators 4.15

Fuel poverty is avoidable and it contributes to social and health inequalities

Marmot Review

Our aim

To reduce Excess Winter Deaths by one third by 2020, to below 200 a year

Winter Wellness 2014/15- Over 30 partners worked together to deliver common outcomes of reducing fuel poverty, improving health and progress to work
What is being done locally to address this issue?

What people have said…

A huge difference mentally and physically, I am able to function and keep my independence and continue giving back to the community with my volunteer services.

We have a problem with damp in the property and being so cold had made it worse and aggravated my daughter’s asthma.

My wife is paraplegic and it was very difficult with no hot water or heating. After help we were very grateful as my wife bathes every day as I do.

I can now think, because you freed up my money as it was all going on coal. I have completed my CV and am going to apply for jobs. I couldn’t face this when I was so cold. I lived in my fleece and pyjamas.

A study showed that energy efficiency interventions in lower income communities reduced:

- GP visits by 27%
- Days off work by 38%
- Days off school by 50%

Since 2011 Winter Wellness multi agency partnership achievements:

- 7,400 households helped (16,000 people)
- 818 hospital admissions prevented
- 1,450 households helped through Winter Wellness Emergency Fund
- 348 households remain in work and progress towards work

Why invest?

Social Return on Investment saves £3.39 for every £1 invested

Return on Investment saves NHS £2.09 for every £1 invested

Estimated 80 hospital admissions avoided last winter, saving NHS £71,000

Partnerships

Winter Wellness Partnership includes Cornwall Council, VCS, housing associations, Cornwall Community Foundation, Inclusion Cornwall, Council of the Isles of Scilly and the NHS

Local advice and support

Community Energy Plus Freephone advice line 0800 954 1956
Winter Wellbeing Helpline 0800 954 1956 and www.cornwall.gov.uk/winterwellbeing
Public Health 01872 327977

Notes

10. The Marmot Review Team, 2011 The Health Impacts of Cold Homes and Fuel Poverty
11. PHE, 2015 The Cold Weather Plan for England Protecting health and reducing harm from cold weather
12. BRE, 2015 Housing Health Cost Calculator
13. Social value UK www.socialvalueuk.org

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# Vital statistics

## Table 1: Cornwall & Isles of Scilly Total Resident population by five year age bands

Mid 2016 Population Estimates

<table>
<thead>
<tr>
<th>All persons</th>
<th>Population (000s)</th>
<th>%</th>
<th>Cumulative %</th>
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<td>90 and over</td>
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<tr>
<td>All ages</td>
<td>549,737</td>
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## Table 2: England Total Resident population by five year age bands

Mid 2016 Population Estimates

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<th>All persons</th>
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### Table 3: Cornwall & Isles of Scilly Male Resident population by five year age bands

Mid 2016 Population Estimates

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<tr>
<td>55 - 59</td>
<td>18,830</td>
<td>7.0%</td>
<td>70.3%</td>
</tr>
<tr>
<td>60 - 64</td>
<td>17,858</td>
<td>6.6%</td>
<td>76.9%</td>
</tr>
<tr>
<td>65 - 69</td>
<td>20,670</td>
<td>7.7%</td>
<td>84.6%</td>
</tr>
<tr>
<td>70 - 74</td>
<td>16,561</td>
<td>6.1%</td>
<td>90.7%</td>
</tr>
<tr>
<td>75 - 79</td>
<td>11,093</td>
<td>4.1%</td>
<td>94.9%</td>
</tr>
<tr>
<td>80 - 84</td>
<td>7,692</td>
<td>2.9%</td>
<td>97.7%</td>
</tr>
<tr>
<td>85 - 89</td>
<td>4,334</td>
<td>1.6%</td>
<td>99.3%</td>
</tr>
<tr>
<td>90 and over</td>
<td>1,864</td>
<td>0.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>All ages</td>
<td>269,848</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

### Table 4: Cornwall & Isles of Scilly Female Resident population by five year age bands

Mid 2016 Population Estimates

<table>
<thead>
<tr>
<th>Age group</th>
<th>Population (000's)</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>14,422</td>
<td>5.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>5 - 9</td>
<td>14,682</td>
<td>5.1%</td>
<td>10.0%</td>
</tr>
<tr>
<td>10 - 14</td>
<td>13,969</td>
<td>4.9%</td>
<td>14.9%</td>
</tr>
<tr>
<td>15 - 19</td>
<td>15,206</td>
<td>5.3%</td>
<td>20.4%</td>
</tr>
<tr>
<td>20 - 24</td>
<td>14,670</td>
<td>5.1%</td>
<td>25.6%</td>
</tr>
<tr>
<td>25 - 29</td>
<td>13,310</td>
<td>4.7%</td>
<td>30.3%</td>
</tr>
<tr>
<td>30 - 34</td>
<td>14,137</td>
<td>4.9%</td>
<td>35.3%</td>
</tr>
<tr>
<td>35 - 39</td>
<td>14,794</td>
<td>5.2%</td>
<td>40.4%</td>
</tr>
<tr>
<td>40 - 44</td>
<td>16,846</td>
<td>5.9%</td>
<td>46.9%</td>
</tr>
<tr>
<td>45 - 49</td>
<td>20,461</td>
<td>7.2%</td>
<td>54.1%</td>
</tr>
<tr>
<td>50 - 54</td>
<td>21,226</td>
<td>7.4%</td>
<td>61.2%</td>
</tr>
<tr>
<td>55 - 59</td>
<td>20,126</td>
<td>7.0%</td>
<td>68.1%</td>
</tr>
<tr>
<td>60 - 64</td>
<td>19,297</td>
<td>6.7%</td>
<td>75.1%</td>
</tr>
<tr>
<td>65 - 69</td>
<td>22,143</td>
<td>7.7%</td>
<td>82.8%</td>
</tr>
<tr>
<td>70 - 74</td>
<td>17,746</td>
<td>6.2%</td>
<td>88.4%</td>
</tr>
<tr>
<td>75 - 79</td>
<td>12,407</td>
<td>4.3%</td>
<td>92.7%</td>
</tr>
<tr>
<td>80 - 84</td>
<td>9,672</td>
<td>3.4%</td>
<td>96.1%</td>
</tr>
<tr>
<td>85 - 89</td>
<td>6,605</td>
<td>2.3%</td>
<td>98.4%</td>
</tr>
<tr>
<td>90 and over</td>
<td>4,428</td>
<td>1.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>All ages</td>
<td>286,147</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Table 5: Under 18 conceptions (numbers and rates)\(^1\) \(2009-2015\)^2

<table>
<thead>
<tr>
<th>Area of usual residence(^3)</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
<th>Number of conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>161</td>
<td>17.6</td>
<td>175</td>
<td>18.9</td>
<td>199</td>
<td>21.3</td>
<td>242</td>
<td>26.1</td>
<td>279</td>
<td>30.3</td>
<td>309</td>
<td>32.9</td>
<td>292</td>
<td>30.5</td>
</tr>
<tr>
<td>England</td>
<td>19,080</td>
<td>20.8</td>
<td>21,282</td>
<td>22.8</td>
<td>22,830</td>
<td>24.3</td>
<td>26,157</td>
<td>27.7</td>
<td>29,166</td>
<td>30.7</td>
<td>32,552</td>
<td>34.2</td>
<td>35,966</td>
<td>37.1</td>
</tr>
<tr>
<td>South West</td>
<td>1,518</td>
<td>16.8</td>
<td>1,721</td>
<td>18.8</td>
<td>1,948</td>
<td>21.2</td>
<td>2,292</td>
<td>24.8</td>
<td>2,552</td>
<td>27.3</td>
<td>2,813</td>
<td>29.9</td>
<td>3,077</td>
<td>32.4</td>
</tr>
</tbody>
</table>

Notes:
To preserve confidentiality, counts for Isles of Scilly UA have been combined with those for Cornwall UA respectively.

1 Rates are per 1000 female population aged 15–17.
2 Numbers and rates of conceptions are given by mother’s usual area of residence based on boundaries in place during the data year. The postcode of the woman’s address at the time of the maternity or abortion was used to determine the health authority she was living in at the time of the conception. Direct comparisons with conceptions data by area published in previous years are not always possible because of boundary changes. Conception rates for 2002 to 2010 at national level have been recalculated using mid-year population estimates based on the 2011 Census and therefore may differ from previously published figures.

3 Following the publication of 2011 Census figures, local authority conception statistics for 2011 are now only available on the current local authority boundaries (those in force from 1 April 2009 when new Unitary Authorities were formed). These 2011 statistics are no longer available for the former local authority districts abolished in 2009.
Mid-year population estimates (MYEs) for 2011 are also not available for the former local authority districts abolished in 2009.
The publication of 2011 conception statistics and MYEs for current local authorities only is consistent with the way in which 2011 Census statistics for local authorities are being published. Source: Office for National Statistics Cornwall UA and Isles of Scilly UA England South West.
Table 6: Trend in under 18 conceptions (numbers and rates) 1998-2015

![Chart showing trend in under 18 conceptions 1998-2015]

Key
- Cornwall UA and Isles of Scilly UA
- England
- South West

Table 7: Under 18 conception outcome, 2009-2015

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of usual residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>8.9</td>
<td>8.8</td>
<td>10.1</td>
<td>11.0</td>
<td>10.3</td>
<td>14.4</td>
<td>16.7</td>
</tr>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>11.0</td>
<td>10.3</td>
<td>14.4</td>
<td>16.7</td>
<td>13.6</td>
<td>18.4</td>
<td>17.7</td>
</tr>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>12.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>10.1</td>
<td>10.6</td>
<td>11.1</td>
<td>11.7</td>
<td>12.4</td>
<td>14.1</td>
<td>15.6</td>
</tr>
<tr>
<td>England</td>
<td>11.9</td>
<td>12.4</td>
<td>14.1</td>
<td>15.6</td>
<td>15.1</td>
<td>17.0</td>
<td>18.9</td>
</tr>
<tr>
<td>South West</td>
<td>7.7</td>
<td>9.1</td>
<td>9.2</td>
<td>9.6</td>
<td>10.5</td>
<td>12.7</td>
<td>14.2</td>
</tr>
<tr>
<td>South West</td>
<td>10.7</td>
<td>12.7</td>
<td>14.2</td>
<td>15.0</td>
<td>14.9</td>
<td>16.6</td>
<td>15.8</td>
</tr>
</tbody>
</table>
Table 8: Deaths (numbers): area of usual residence, by age and sex, 2015 registrations, England and Wales
England and Wales, England, regions, unitary authorities/counties/districts

<table>
<thead>
<tr>
<th>Age</th>
<th>Cornwall and the Isles of Scilly</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>All Ages</td>
<td>3,027</td>
<td>3,183</td>
<td>27,188</td>
</tr>
<tr>
<td>Under 1</td>
<td>11</td>
<td>14</td>
<td>124</td>
</tr>
<tr>
<td>1-4</td>
<td>0</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>5-14</td>
<td>0</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>15-24</td>
<td>15</td>
<td>7</td>
<td>128</td>
</tr>
<tr>
<td>25-34</td>
<td>24</td>
<td>10</td>
<td>225</td>
</tr>
<tr>
<td>35-44</td>
<td>42</td>
<td>31</td>
<td>464</td>
</tr>
<tr>
<td>45-54</td>
<td>117</td>
<td>81</td>
<td>1,077</td>
</tr>
<tr>
<td>55-64</td>
<td>248</td>
<td>171</td>
<td>2,289</td>
</tr>
<tr>
<td>65-74</td>
<td>591</td>
<td>402</td>
<td>4,931</td>
</tr>
<tr>
<td>75-84</td>
<td>962</td>
<td>765</td>
<td>8,238</td>
</tr>
<tr>
<td>85+</td>
<td>1,012</td>
<td>1,692</td>
<td>9,660</td>
</tr>
</tbody>
</table>

Table 9: Deaths (numbers and rates) by area of usual residence (administrative areas), 2015 registrations, United Kingdom and constituent countries
England and Wales: regions, unitary authorities/counties/districts
Scotland: council areas, Northern Ireland: local government districts

<table>
<thead>
<tr>
<th>Area of usual residence</th>
<th>Age standardised mortality rate</th>
<th>Infant mortality rate (per 1,000 live births)</th>
<th>Neonatal mortality rate (per 1,000 live births)</th>
<th>Perinatal mortality rate (stillbirths and deaths under 1 week)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>England</td>
<td>986.6</td>
<td>1,148.8</td>
<td>858.0</td>
<td>3.9</td>
</tr>
<tr>
<td>South West</td>
<td>932.1</td>
<td>1,090.2</td>
<td>807.2</td>
<td>3.7</td>
</tr>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>960.9</td>
<td>1,130.8</td>
<td>826.5</td>
<td>4.6</td>
</tr>
</tbody>
</table>

1 Age-standardised mortality rates are standardised to the 1976 European Standard Population, expressed per 100,000 population, they allow comparisons between populations with different age structures, including between males and females and over time. Age-standardised mortality rates (ASMRs) for Scotland and Northern Ireland will differ from those published by National Records of Scotland and Northern Ireland Statistics and Research Agency as their published ASMRs are based on only population data. ASMRs published here use live births instead of the population age under 1.
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51. DECC, 2015, Sub-regional fuel poverty data.


Glossary

The following section lists terms and acronyms used within this report.

ASIST
Applied Suicide Intervention Skills Training

BMI
Body Mass Index is a measure of body fat based on height and weight

BMJ
The British Medical Journal

CAMHS
Child and Adolescent Mental Health Service

CMO
Chief Medical Officer

DAAT
Drug and Alcohol Action Team

DCLG
Department for Communities and Local Government

DECC
Department of Energy & Climate Change

DH
Department of Health

GP
General Practitioner

GU
Genitourinary Medicine

Health Checks
NHS Health Checks Programme offered to 40-74 year olds

HPV vaccine
Human papilloma virus vaccine

HSCIC
Health & Social Care Information Centre

KCCG
Kernow Clinical Commissioning Group

LGA
Local Government Association

NHS
National Health Service

NICE
The National Institute for Health and Care Excellence

NOMIS
Nomis is a service provided by the Office for National Statistics to give official labour market statistics

ONS
Office for National Statistics

PHE
Public Health England

PHIL
Promoting Health Information Line

PHOF
Public Health Outcome Framework

PPV
Pneumococcal polysaccharide vaccine

QR code
Quick Response code is a barcode that can be read using smartphones and dedicated QR reading devices that can link directly to websites

ROI
Return On Investment

SHEU
The Schools and Students Health Education Unit

SROI
Social Return On Investment

STIs
Sexually Transmitted Infections

STOPS
Smoking Training Of Peer Supporters

VSF Cornwall
Voluntary Sector Forum Cornwall

WHO
World Health Organisation
More information

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Telephone: 01872 323583
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www.cornwall.gov.uk

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