Public Health Annual Report 2018

The best start in life
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Child poverty as an issue is growing and there are no signs to suggest that the risk of poverty will improve in the short term and the potential for poor outcomes and widening inequalities is great. The focus of this report is the impact of poverty on children’s health from pregnancy through to the end of primary school.

We have chosen to focus on this age range because this is where evidence shows that offering support to parents, families and children can be most effective in reducing the impacts of poverty and deprivation on children’s health. We do however recognise that there is a large body of work happening to support children right through to adulthood and as they become parents themselves. Although, we are primarily looking at impacts on younger children, we will include some data on the health and wellbeing of older children.

We will look at a range of health and wellbeing indicator areas where poverty is known to have an impact on children’s development, and where inequalities in outcomes exist. We have also included some information on adverse childhood experiences.

We have also included a view on health in cold homes as a result of fuel poverty.

In addition, we provide a brief update on progress with the recommendations from last year’s Public Health Annual Report, “Health starts where we live”, as well as some useful population level statistics.

I should like to thank Samuel Heyward and the Public Health Cornwall team for preparing this Annual Report and I hope that you enjoy reading it and helping to ensure that its nine recommendations are delivered.
Yma boghosogneth flogh owth ynkressya ha herwydh an sinyow ny vydh gwellheans berrdermyn y’n peryl a voghosogneth hag yma chons bras a sewyansow drog ha dibarderyow gwettha. Fog an derivas ma yw an effeyth a voghosogneth war yeghes flogh a veghyegeth bys dhe dhiwedh skol gynsa.

Re ervirsyn fogella war an aray a osow ma awos bos omma dustuni a dhiskwa bos profya skoodhyans dhe gerens, teyluyow ha fleghes fordh an moyha effeythus dhe lehe effeythyow a voghosogneth ha divotter war yeghes fleghes. Yth aswonyn, byttegyns, bos meur a ober ow hwarvos rag skoodhya fleghes war an fordh hir dhe dhos ha bos tevesigyion ha kerens aga honan. Kyn hwithryn yn kynsa le fatel yw effeythys fleghes yowynka, y synsyn ynno ynweth manlyon ow tochya yeghes ha sewena fleghes kottha.

Y hwithryn aray a arwodhuyow ow tochya yeghes ha sewena leow may ma kevren aswonyss ynter boghosogneth ha displayyeans fleghes, ha may ma dibarderyow yn sewyansow. Re ynworsyn ynweth kedhlow ow tochya prevyansow negedhek flogholeth.

Re ynworsyn keffrys breus ow tochya yeghes yn anedhow yeyn drefen difyk keunys.

Dres hemma, ni a brovi nowodhow kott a’n avonsyans wosa an gussel y’n Derivas Bledhynnyek Yeghes Poblek, “Y talleth yeghes le may trigyn”, keffrys ha nebes statystygyon dhe les a’n nivel poblans.

Y fynnsen ri gras dhe Samuel Heyward ha’n para Yeghes Poblek Kernow a bareusi an Derivas Bledhynnyek ha govenek a’m beus hwi dhe omlowenhorth y redya ha ri gweres dhe surhe bos delivrys y 9 komendyans.
Child Poverty

Executive Summary

“Fewer children living in poverty” is one of the strategic priorities for Cornwall Council.

In Cornwall and the Isles of Scilly (2015) 16% of children under 16 were living in poverty (14,310 children). This is higher than for the South West (13.7%) and slightly below the England average (16.8%). While we are below the national average overall, child poverty in some neighbourhoods is more than double the national average.

Although only a small proportion of children on the Isles of Scilly are affected by poverty, living on the islands exacerbates the impact of poverty. Addressing poverty requires multi-agency, cross directorate working across Cornwall and the Isles of Scilly and is closely aligned to the principles of inclusive growth and reducing inequalities.

The disadvantage associated with child poverty continues into adulthood. The Marmot Review (2010) suggested that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty will improve health outcomes and increase healthy life expectancy, and break the intergenerational cycle of poverty.

The Child Poverty Act 2010 set a target of eradicating child poverty by 2020. The Child Poverty Commission, later changed to the Social Mobility Commission, has concluded that the 2020 child poverty target is likely to be missed by a considerable margin. There is no current national strategy to tackle child poverty in England.

The Child Poverty Act required local authorities to have a strategy for the local area that mitigates the effects of child poverty through local partnership and co-operative arrangements.

In Cornwall the Children’s Trust’s Children, Young People and Child Poverty Plan 2015 – 2020 has five key drivers;

- Tackling worklessness
- Tackling debt
- Strengthening families
- Tackling educational failure
- Tackling poor health

More recently the One Vision Partnership Plan has been developed. The priorities within this address many of those adverse outcomes associated with child poverty and therefore implementing the plan could mitigate the effects of child poverty. Priority Outcome 5: ‘Making a positive contribution to the community’ includes a priority of parental employment, particularly for parents with mental health or substance misuse problems and a priority for adult education. These two priorities could contribute to reducing the number of families in poverty.

The One Vison success measures related to these two priorities are:

- Parents/carers of supported families are more likely to gain sustainable employment.
- Parents/carers of supported families are more likely to join in education and training.

“Fewer children living in poverty” is one of the strategic priorities for Cornwall Council.
What is covered in the rest of this report?

The focus of this report is the impact of poverty on children’s health from pregnancy through to the end of primary school. We have chosen to focus on this age range because this is where evidence shows that offering support to parents, families and children can be most effective in reducing the impacts of poverty and deprivation on children’s health. We do however recognise that there is a large body of work happening to support children right through to adulthood and as they become parents themselves. Although we are primarily looking at impacts on younger children, we will include some data on the health and wellbeing of older children. We will look at a range of health and wellbeing indicator areas where poverty is known to have an impact on children’s development, and where inequalities in outcomes exist. We have also included some information on adverse childhood experiences. In addition we provide a brief update on progress with the recommendations from last year’s Public Health Annual Report, “Health Starts Where We Live”, as well as some useful population level statistics. A glossary of terminology and abbreviations used can be found at the end of the report.

“ Inequalities We will look at a range of health and wellbeing indicator areas where poverty is known to have an impact on children’s development, and where inequalities in outcomes exist.”
Recommendations

1. The One Vision Partnership should continue to influence all plans and strategies that impact on children and young people developing a clear focus on tackling inequalities and mitigating for the effects of child poverty including an assessment and refresh of the Child Poverty Plan.

2. To improve levels of healthy eating including reduced sugar intake resulting in better oral health, especially in socio-economically-deprived communities.

3. Work together across disciplines to improve the prevalence of healthy weight in children, through a life course approach delivering the ambitions of the Healthy Weight Strategy 2017-22.

4. Ensure that the design and delivery of integrated place based services at a locality level incorporates a universal and targeted programme of prevention and early help for children and families (engaging with fathers) across the life course.

5. Develop and provide training opportunities for the children services workforce to ensure that they are aware of risks of incidents to infants and children and support an anticipatory guidance approach with families.

6. Ensure that the prevention of adverse childhood experiences and trauma awareness are prioritised into organisational strategies.

7. Give priority to and refresh the approach to motivate parents and carers to take advantage of the free early years child care offer.

8. Reduce the gap in attainment at EYFS across the social gradient.

9. Utilise the Cold Homes tool kit for children living in poverty and incorporate into the assessment of need.
A young person’s view

Through the work of HeadStart Kernow a group of young people were asked what is was like growing up and making healthy choices.

What do you think about growing up in Cornwall and the Isles of Scilly?

“"As you get older you can make some choices on your own
It’s hard to get to places and to do things
You wait too long to get help
You hear a lot of different stuff about being healthy – in school, online, from friends… it can be confusing
Adults don’t tell us things we want to know
Hard to ask for help (e.g. parents / teachers etc.), its often embarrassing
Bullying makes it harder to grow up ""
What are the good bits?

“The beaches • Special places • Space • Places to go”

Are there any bad bits?

“Nothing exciting happens • No buses • It’s lonely • Too much traffic in summer • I can’t see my friends out of school • Too expensive • I can’t get to town to do anything • Nothing to do where I live • It rains too much • Seagulls • Rubbish (e.g. on beaches etc.) • Not enough jobs”

How do you get help and advice for your physical health, wellbeing and mental health?

“Parents and family • Go to the doctor • HeadStart • Food banks • Clubs and sports • Health lessons / PSHE in school • PE to get fit • Friends • Support staff in school”

5 ways to wellbeing are a good idea

Find out more at www.mindyourway.co.uk
Poverty and its impact on children’s health and wellbeing
How does living in poverty impact on children’s health and wellbeing?

Child poverty is directly linked to worse health outcomes for children and impacts upon social, emotional, cognitive and physical development. Child poverty acts across a social gradient, with the most disadvantaged children suffering from the worst health outcomes.

Sir Michael Marmot recommended in Fair Society, Healthy Lives, that breaking the link between child poverty and poor health outcomes was central to reducing health inequality across the life course;

"Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken... For this reason, giving every child the best start in life is our highest priority recommendation.

Fair Society, Healthy Lives (2010)

Poverty can give rise to poorer outcomes across the following areas:

Physical health
- Higher rates of infant deaths
- Lower birth weights
- Worse oral health
- Higher numbers of accidents and injuries
- Asthma

Mental health and wellbeing
- Brain development in the first 2 years
- Maternal and paternal depression
- Poorer memory
- Depression, stress and anxiety
- Antisocial behaviour

Lifestyle factors
- Lower rates of breastfeeding
- Poorer diet
- Obesity
- Lower levels of physical activity
- Higher rates of Smoking
- Poorer sexual health
- Higher rates of teenage pregnancy

Environment
- Lower educational attainment
- Living in lower quality housing

Experiencing poverty during childhood has long lasting impacts on health and wellbeing as adults with an increased risk of developing:

- Coronary heart disease
- Stomach cancer
- Lung cancer
- Stroke
- Respiratory disease
- Accidents
- Alcohol-related deaths

**Who is at risk of being affected by child poverty?**

Despite significant regeneration and economic growth throughout Cornwall over the past decade, Cornwall has one of the highest rates of child poverty in England. To successfully reduce child poverty in Cornwall, we need to understand what the drivers of child poverty are, the impact they are having and the characteristics of the families and children that are affected by poverty. Certain lifestyle and situational factors can increase the risk that a child will live in poverty; vulnerable groups include:

- Lone parents
- Large families
- Children with disabilities
- Children with disabled parents
- Looked after children and children leaving care
- Children of teenage parents
- Low income families
- Children from diverse ethnic backgrounds
- Asylum seekers
- Gypsy and traveller families
- Children affected by homelessness or unstable housing tenure
- Children with parents in prison
- Children with parents with lower educational attainment

**How is child poverty measured?**

Poverty may be defined as when a person or family’s resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities.

There are a number of poverty measures; these include relative poverty and absolute poverty, which are both based on disposable household income. Deprivation is another measure of poverty and is often used when analysing health data, the Index of Multiple Deprivation (IMD) which uses deprivation measures is described on the following pages. Another measure is free school meals status, which is also described later. Trends and patterns of distribution can appear quite differently depending on which measure of poverty is used.

The Child Poverty Act (2010) defines an individual to be in relative poverty if “household equivalised income” (see glossary) is below 60% of the median in that year. The Act defines a household in absolute poverty as a household in which equivalised income is below 60% of the 2010-11 median income, adjusted for inflation.

Most UK statistics related to poverty are based on relative poverty. Relative poverty is defined as income below 60% of the median income in the UK. Being in relative poverty means a family can’t afford an ordinary living pattern and they’re...
excluded from the activities and opportunities that the average family enjoy 4,5.

Often, income is measured before and after housing costs are deducted because poorer households tend to spend a higher proportion of their income on housing and this needs to be taken into account.

**Child poverty in the UK**

In the UK four million children were living in poverty in 2015/16 which represents 30% of all children and means that, on average, 9 children in every school class of 30 is living in poverty 6.

The number of children affected by child poverty has been increasing nationally 7. In 2015/16, before housing costs were taken into account 2.7 million children were in relative low income, 100,000 more than the previous year. This represents 20% of all children being in relative low income households before housing costs.

After housing costs are taken into account, this increases to four million children being affected by relatively low incomes. Again, this is 100,000 more than the previous year, or 30% of all children. Similar increases have been seen in Cornwall and the Isles of Scilly.

**Child poverty and deprivation in Cornwall**

As described nationally, housing costs need to be taken into account when looking at child poverty. After housing costs are taken into account, a higher proportion of children in Cornwall and the Isles of Scilly are living in poverty.

When looking at child poverty before and after housing costs are taken into account the distribution of child poverty changes across the county. Camelford, Newlyn and Mousehole, and Falmouth Penwerris wards have the highest proportion of households in poverty before and after housing costs are taken into account.

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18,900 children live in poverty across Cornwall and the Isles of Scilly (before housing costs) rising to 29,599 after housing costs; and since 2013, the number of children in poverty has risen across Cornwall. Whilst, nearly a third of Wards (36 out of 123) in Cornwall and the Isles of Scilly have in excess 25% of children living in poverty (before housing costs). The figures after housing costs show 84% of all wards in Cornwall and the Isles of Scilly (103 of 123) have in excess 25% of children living in poverty, and figures for 10 of these wards show 2 in every 5 children live in poverty. The latest data shows fewer Wards with less than 20% of children living in poverty and conversely a rise in those with in excess of 20% of children living in poverty.

**Figure 2** Percentage of children in poverty after housing costs
Source: Cornwall Council 2018

**Figure 3** Percentage of children in poverty by ward before housing costs
Source: GIS map
Homelessness

A report from 2014\(^8\) indicated that over half (55\%) of people accepted as homeless and in priority need for housing have dependent children, with a number of pregnant women affected by homelessness. Nationally published statistics for 2017, show that in December 2017\(^9\), one family in Cornwall and the Isles of Scilly had been in Bed and Breakfast accommodation for more than 6 weeks. Data from the Ministry of Housing, Communities and Local Government for October to December 2017 shows that 16 couples with dependent children were eligible for assistance with housing, as well as 23 single parents.

Measures of deprivation

The Index of Multiple Deprivation (IMD) 2015\(^{10}\) is the official measure of relative deprivation for small areas (or neighbourhoods) in England. It ranks every neighbourhood in England from 1 (most deprived area) to 32,844 (least deprived area). It is common to describe how relatively deprived an area is by saying whether it falls among the most deprived 10\% or 20\% of areas in England. 17 Cornish neighbourhoods are in the 10\% most deprived in England, with 44 neighbourhoods in the 20\% most deprived in England, an increase from 33. Cornwall ranks 143 out of 326 local authorities in England, with 1 being the most deprived.

Treneere in Penzance has been identified as the most deprived neighbourhood in Cornwall and ranks 414 in England. Previously Pengegon in Camborne was the most deprived (now fourth). Bodmin Town Centre, Berryfields and Newquay Narrowcliff have all been identified as being in the most deprived 10\% nationally.

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Figure 4 Percentage of children in poverty after housing costs
Source: GIS map
Camborne and Redruth community network area has the highest number of neighbourhoods in the most deprived 20% in England with five in the 10% most deprived. Over a quarter of neighbourhoods are in the most deprived 20% in China Clay, Camborne and Redruth, West Penwith, and Bodmin community network areas.

**How many children are affected by child poverty in Cornwall and the Isles of Scilly?**

In England, a Free School Meal (FSM) is a statutory benefit available to school aged children for families who receive qualifying benefits and have been registered with the scheme.\(^ {11}\)

The use of FSM status as an approximate measure of child poverty has been questioned by academics.\(^ {12}\) However, for the purposes of this report, children's FSM status provides an approximate picture of the number of children affected by child poverty in Cornwall and the Isles of Scilly and has therefore been used for some of the statistics reproduced within this report.

Data for 2017 from the Department of Education\(^ {13}\) shows that 4,810 nursery and primary age children in Cornwall were eligible and claiming for a Free School Meal, and that 3,101 secondary age children were eligible and claiming. This means that at least 7,900 children live in households where low income affects day to day living.

It should be noted that other statistics related to child poverty are available, such as the child poverty basket of local indicators\(^ {14}\). This information has not been reproduced within this report as it was last updated in 2014.

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Child poverty a priority for Cornwall and the Isles of Scilly

Fewer children living in poverty is one of the identified priorities for Cornwall Council and is set out in our Business Plan for 2018-22\(^\text{15}\). Reducing child poverty is closely aligned to the principles of inclusive growth and reducing inequalities in Cornwall and the Isles of Scilly. Reducing inequality will require working across the directorates and teams of the Council, as well as working in partnership with a range of organisations and service providers.

The Isles of Scilly Children and Young People Plan (2015-17)\(^\text{16}\) recognises that although only a small proportion of children living on the Islands are affected by poverty, their difficulties can be complicated by localised issues associated with living on the islands, such as lower earnings, higher housing costs and higher food and fuel costs. The plan prioritises action to mitigate against these additional factors.

Cornwall’s Child Poverty Plan 2015-2020

The current Child Poverty Plan for Cornwall\(^\text{17}\) sets out five priorities for partners involved in providing care and support for children and families affected by poverty. The priorities are as follows;

1. To provide good quality, consistent and multi-disciplinary practice in the help and protection we provide to children and young people.

2. To develop and deliver family-centred and outcome-focused early help services that are responsive to need and achieve value for money through effective partnership working.

3. To ensure healthy pregnancy from conception to birth, preventing unintentional injuries, improving emotional wellbeing and mental health and improving access and quality of services to children, young people and their families.

4. To enable children and young people to fulfil their academic potential and make informed choices about their futures by raising aspiration and enabling pathways into high quality opportunities in education, training and employment.

5. To drive systems change and integrated approaches to working through key strategic programmes and investment to improve the quality of services to children, young people and their families.

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One Vision

Since the Child Poverty Plan was developed in 2015, the “One Vision” Partnership Plan has been created; this sets the foundation for the future integration of education, health and social care services for children, young people and their families in Cornwall and the Isles of Scilly. It is an ambitious plan produced jointly by Cornwall Council, the Council of the Isles of Scilly and NHS Kernow, in partnership with Cornwall Partnership NHS Foundation Trust (CPFT) and the Royal Cornwall Hospitals NHS Trust (RCHT). It adds a wider context to the previously developed priorities for mitigating against the impacts of poverty on children.

The Plan has been based on consultation with children and young people, parents and carers, along with the participation of practitioners and clinicians from a wide range of services. There are five priority outcomes partner organisations are working towards to improve the lives of the most vulnerable children and young people in Cornwall and the Isles of Scilly. These are:

1. **Strengthening families and communities** by providing high quality preventative services for all and targeted early support for those who are vulnerable.

2. **Promoting and protecting children’s physical, emotional and mental health** by developing improved early years services, promoting healthy lifestyles and emotional resilience and providing support to help children and young people recover from adverse childhood experiences like neglect and abuse.

3. **Helping and protecting children from the risk of harm** by providing services to support children at risk of neglect and abuse arising from parental problems like mental health problems, alcohol and/or substance misuse and domestic abuse.

4. **Raising the aspiration and achievement of children and young people towards economic wellbeing**, focusing on providing support in early years to improve school readiness, raise progress and achievement at all stages above the national average, and improve outcomes for children with special educational needs and disabilities, children in care and care leavers.

5. **Making a positive contribution to the community** by supporting parents / carers to find employment through coaching, education and training opportunities. Working with partners to reduce anti-social behaviour, homelessness, and drug and alcohol problems. Providing guidance and support to young people at risk of not being in education, employment and training and providing educational, housing and employment support for care leavers.
Support services

Support for children and families experiencing poverty may come from a variety of services delivered through the Cornwall Partnership. The support offered will depend upon the needs of families themselves. Throughout pregnancy, the early years, primary years and secondary years a range of services are available to support families with their health and wellbeing needs, including, but not limited to:

- Midwifery services
- Health Visiting services
- Real Baby Milk
- The Healthy Pregnancy Service
- Healthy Cornwall
- Schools
- School Nurses
- HeadStart
- Child and Adolescent Mental Health Services
- Voluntary organisations
- Cornwall and Isles of Scilly Drug and Alcohol Action Team

Representatives from various services have helped us to compile this report, and have provided statistics and information related to their work supporting families from more deprived areas. Unfortunately, we haven’t been able to speak to everyone for this report, but hopefully the information contained within will spark valuable discussions about this very important issue for the children of Cornwall and the Isles of Scilly.
Health inequalities during and after pregnancy
There are approximately 5,500 births each year in Cornwall and the Isles of Scilly.

Around 80% of babies are born in the managed area of the RCHT at Treliske. Local data and population predictions indicate that the birth rate will rise over the next 10 years. What can also be seen is a rise in the complexity of pregnancy with maternal obesity, maternal age and mental health needs increasing.

Pregnancy and the first years of life are one of the most important stages in the life cycle\(^\text{18}\). This is when the foundations of future health and wellbeing are laid down, and is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life.

Deprivation impacts upon health outcomes from before conception through to adulthood. Pregnant women from areas of socioeconomic deprivation are at higher risk from a range of poor health outcomes and associated risk factors. Pregnancies in areas of highest social deprivation are 50% more likely to end in stillbirth or neonatal death\(^\text{19}\). Deprivation is associated with perinatal mental health problems and postnatal depression and there is a strong link between deprivation and teenage conceptions. Pregnant women from deprived areas are more likely to be affected by the following risk factors;

- Smoking before, during and after pregnancy
- Poor maternal nutrition and higher rates of obesity
- Alcohol misuse during pregnancy
- Substance use during pregnancy

Men from areas of high deprivation are the most likely to engage in health-impacting behaviours and have poor health outcomes, with some of the lowest life expectancy. Fathers who actively engage with the home environment and with their children develop less negative health behaviours and have lower associated risks of death and ill health\(^\text{20}\). Fathers from more deprived areas are less likely to engage in parenting support available from services and may be less likely to gain the health benefits expected.

The Cornwall and Isles of Scilly Maternity Transformation Plan states that there is a social gradient that impacts on maternity outcomes. In areas of higher deprivation we see a slightly increased fertility rate, a slightly lower likelihood of multiple births, a greater risk of low birth weight and a greater chance of the pregnancy ending in stillbirth or early infant death. Women in areas of deprivation are less likely to breastfeed, more likely to use recreational drugs and more likely to smoke through pregnancy.

Furthermore, although teen conception rates in Cornwall and Isles of Scilly are below national levels we would still be more likely to see higher conception rates in areas of deprivation for women under the age of 18. These conceptions are less likely to end in termination of the pregnancy compared to other areas\(^\text{21}\).

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Health inequalities due to deprivation can be avoided by services responding to these public health challenges by:

- Improving preconception health
- Improving perinatal mental health
- Increasing the number of Smokefree pregnancies and reducing the number of parents who smoke
- Improving breastfeeding rates
- Engaging with and supporting fathers’ health and wellbeing

In this section we will have a look at the risk factors outlined, find out what services are doing to support pregnant women and their partners, and also about what is being done to mitigate against the impacts of poverty.

Inequalities which begin before birth can adversely impact health throughout adult life, and can persist across generations. Inequalities can impact on pregnancy, including maternal and perinatal death.

Centre for Maternal and Child Enquiries (2011)

Case Study

Gemma was referred to the Healthy Pregnancy Team for additional healthy eating and activity support. She was concerned about excess weight gain as she experienced this in her two previous pregnancies. The team supported her during her pregnancy to set small realistic goals to make healthier food choices and increase her activity, resulting in her only gaining 3lb throughout her pregnancy. Gemma loved the interactive resources and learning about the other health topics discussed such as Healthy Start and immunisation. She thanked the team for their support and has since lost 2 stone and is really looking forward to attending our Ready Steady Eat session in the New Year with her little one!
Mental wellbeing during and after pregnancy
(Perinatal mental health)

One of the best predictors of child wellbeing in the early years is the mental health and wellbeing of their parents. Perinatal mental health disorders are those that complicate pregnancy and the postpartum year. Around one in five women experience a mental health problem during pregnancy or within a year of giving birth. New fathers can also be affected by mental illness. Perinatal mental health conditions may develop throughout the perinatal period or may redevelop from relapse of pre-existing conditions. A higher proportion of those experiencing poor mental health during this time will come from deprived areas.

Perinatal mental illness can affect the development of early attachment between mother and baby and can lead to long term impacts on health outcomes and mental health. There is a substantial body of evidence to indicate a clear association between parenting and child emotional and behavioural problems. Children of mothers experiencing perinatal mental illness are at increased risk of:

- Prematurity
- Low birth weight
- Irritability
- Sleep problems in infancy
- Behavioural problems
- Emotional problems
- Conduct disorders
- Delayed language development
- School readiness

Mental illness can have a serious impact on a parent’s ability to cope with day-to-day life, including parenting their infant and other children. In extreme cases perinatal mental illness can increase the risk of a child being abused or neglected (Public Health England, 2017).

Women who experience perinatal mental illness are at risk from self-harm and suicide with 12-15% of maternal deaths in pregnancy and six months postpartum associated with psychiatric disorder.

The mental health of young children is a strong predictor of their mental health in adulthood. An infant’s progression from absolute dependence to relative independence is dependent on the quality of the care received from parents.

Fathers can also develop or be affected by relapse of mental illness when they become a parent, with illness exacerbated by the financial pressures that come with parenthood. Additional financial pressures will have a greater impact on families already struggling to make ends meet.

Mental illness is closely associated with smoking, alcohol and substances abuse. More information on each of these issues and how they impact on children from deprived backgrounds can be found later within this report.

For support and information please visit:

www.cornwallft.nhs.uk and search perinatal mental health team

www.cornwallft.nhs.uk

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Support and prevention

In order to mitigate against the impacts of deprivation on mental health, services should aim to support positive mental health in pregnant women and fathers to be through a focus on:

- Promoting healthy pregnancies
- Promoting healthy lifestyles
- Primary and secondary prevention
- Early identification
- Timely provision of quality specialist care

Evidence shows that the treatment of serious mental illness in pregnancy and following childbirth by Specialised Perinatal Mental Health Services (In-Patient Mother and Baby Units and/ or Perinatal Community Psychiatric Teams) results in improved mental health outcomes for women, their children and wider family, compared to standard psychiatric care.

How many people are affected by perinatal mental illness?

- 20% of women experience a mental health problem during pregnancy or within a year of giving birth
- 10-15% suffer from mild to moderate postnatal depression
- Around one in five men experience depression after becoming fathers
- Two in every 1,000 women who give birth will suffer from a postpartum psychosis and are admitted to a Psychiatric Unit
- A further two in every 1,000 women who give birth will be admitted suffering from other serious/complex mental health disorders
- Approximately four in 1,000 pregnant women are at high risk of recurrence of relapse in pregnancy and after delivery

How are parents supported locally?

NHS Kernow commissions a Specialist Perinatal Mental Health Service that is delivered by Cornwall Partnership Foundation Trust (CPFT). This service provides pre conception support, support to pregnant women and support to parents with babies up to the age of one.

Pre conception service

This service is for women who have an existing or past history of mental illness who are considering having a baby. Patients are offered a face to face appointment with the service Consultant who will look at the patients previous record. They will consider any risk factors and discuss potential treatment options, and what their potential care pathway would look like. Support also includes crisis and contingency planning.

“
I had help from the perinatal mental health team when I was pregnant. It was invaluable. I can confidently say that my daughter and I are healthier and happier, as a result. I didn’t have depression - I have OCD and they really helped with that! It’s had such a big impact on my family life and career.

"  A patient

For women who are pregnant and women who have had babies (up to 12 months old)

This service offers women skilled and specialist perinatal staff to ensure access to assessment, information, and guidance at all stages in the care pathway, including pre-conception advice. The service offers targeted support for vulnerable women and their children and a shared approach to care planning and health promotion. The service offers early intervention, including access to psychological therapies for mild to moderate mental health problems and access to high quality specialist psychiatric assessment, treatment and care where needed. This includes comprehensive, multidisciplinary support for women, infants and families at home and in the community, and access to high quality specialist inpatient care where required.

Wider support

Each of the Community Mental Health teams has a perinatal champion; with perinatal training being delivered within key Mental Health Trust services such as the Home Treatment Team and Early Intervention Service.

Areas for service development

There are still areas for development for the service, currently around 20% of deliveries take place across the border in Devon and Plymouth. Services in the East of the County could be enhanced, with increased coverage in the area and improved links to the hospitals in Devon (who do not commission the same service). NHS Kernow and Cornwall Partnership NHS Foundation Trust have recently applied for transformation funding to enhance the service further.

The DadPad

The DadPad is designed to help health professionals engage with new dads during the perinatal period, and give new dads the information they need to confidently care for their new baby and support themselves and their partner. The DadPad is a guide which includes information on mental health, relationships, communication and attachment as well as practical information on caring for a new born baby such as:

- Supporting your baby’s mum
- Feeling sad, worried or depressed is common

The DadPad app is now being launched alongside the physical DadPad. The app allows dads to access the content and links to local support for fathers and new families. Dads who are struggling with their mental health will now be able to find the service they need at a touch of a button through the app and write down thoughts and questions they have, helping them self-monitor their emotions during the pregnancy and beyond.
Smoking during and after pregnancy

Cigarette smoking is the single greatest cause of preventable death in the UK, with one in two long term smokers dying because of smoking. Smoking causes 79,000 deaths annually in England and 1,000 annually in Cornwall and the Isles of Scilly.

Smoking is the main modifiable risk factor during pregnancy and is linked to a range of complications during and after labour. It increases the risk of miscarriage and stillbirth, premature birth, low birth-weight and sudden unexpected death in infancy (Public Health England, 2017). In the UK each year smoking causes up to:

- 5,000 miscarriages
- 2,200 premature births
- 300 perinatal deaths

There is a stark social gradient to smoking with the highest number of smokers living in the most deprived areas. Smoking is an addictive habit that is intergenerational, heavily based upon, and intertwined with, cultural, psychological and socio-economic factors.

Smoking is particularly harmful for both the pregnant woman and the unborn baby.

Case Study

Dani was identified as a smoker at her midwife booking appointment. However she declined to be referred for help to quit. At her 12 week scan Dani was seen by the resident Healthy Pregnancy Advisor who was able to discuss with Dani the importance of smoking cessation in pregnancy, including the risks to her unborn baby and the effective and safe help available. The motivation of seeing her baby at scanning coupled with face to face support and guidance led to Dani eventually quitting! Dani’s partner also engaged with smoking cessation which resulted in a smoke free home for their new baby.
Smoking increases the risk of:
- low lying placenta
- bleeding during pregnancy
- ectopic pregnancy
- miscarriage
- birth defects such as cleft palate

Babies and children exposed to tobacco smoke are at higher risk of:
- cot death
- asthma
- glue ear
- gastroenteritis
- behavioural problems, including attention and hyperactivity difficulties
- respiratory conditions
- learning difficulties
- problems of the ear, nose and throat

The links between child poverty and smoking in Cornwall and the Isles of Scilly

Estimates from the Ash Poverty Reckoner (2016) approximated that there are 52,948 households in Cornwall and the Isles of Scilly with at least one smoker. If net income and smoking expenditure is taken into account, 12,700 or 24% of households with a smoker fall below the poverty line. If these smokers were to quit, 2,974 households, and 2,582 dependent children would be elevated out of poverty.

Data from the Public Health Outcomes Framework (PHOF) show that in 2016/17 13.2% of women were smokers at the time of delivery. Trend data shows that these rates have been staying relatively static, whereas in the rest of the country rates have been decreasing. A greater proportion of these smokers will be from more deprived areas, with a disproportionate number of children who grow up in poverty affected by smoking.

Data from the Health Visiting service Early Help Assessment 30 shows this inequality between the most deprived areas of Cornwall and the Cornwall average; with almost twice as many children aged under 5 who live in a deprived households having a parent who smokes compared to the Cornwall average.

Almost 40% of children in the most deprived 10% of households has a parent who smokes compared with an average of 21.5% of all of Cornwall.

What we are doing to support parents to quit smoking

Healthy Cornwall’s dedicated Healthy Pregnancy advisers work closely with midwives to support pregnant women, their partners and other family members to quit smoking. Advisers provide advice around vaping and e-cigarettes and actively promote the importance of smoke-free environments during pregnancy and following birth. The advisers cover each locality in the county and offer support at a range of locations, including; community venues, family hubs, GP practices and at RCHT sites. A Healthy Pregnancy adviser is now available to all women and their partners attending their 12 week scan at RCHT.

Advisers work with a range of health professionals, including midwives, to promote and reinforce the importance of smoking cessation. As part of their mandatory training midwives across the county are trained in stop smoking brief intervention, and all have carbon monoxide monitors to reliably confirm a women’s smoking status and in turn make a referral to Healthy Cornwall.

“Giving up is hard as I have tried before but this help definitely makes it easier...what you say about the risks makes me want to do it...thank you”

A patient

Next steps for the Healthy Pregnancy service

The Healthy Pregnancy service is developing the support they offer to pregnant women, partners and families from vulnerable groups, whose children will be at risk of the effects of poverty. The service are currently developing tailored support for teenagers, gypsy and traveller communities, individuals with learning difficulties and those who do not have English as a first language. These groups may not be accessing the universal service as it may not meet their needs. This development includes reviewing resources and intervention delivery as well as active consultation with service users and stakeholders.

Building on the success of the partnership with the midwifery service, the Healthy Pregnancy service is developing their work with health visitors. They want to offer support to new parents to continue smoking cessation and ensure the importance of smoke-free environments is actively promoted and encouraged throughout the early years.

Further, the service is seeking to widen their new 12-week scan support to those attending pregnancy appointments outside of Cornwall.

For support to quit smoking contact Healthy Cornwall on:

01209 615 600 or visit www.healthycornwall.org.uk
Case Study - Jo (22) from Camborne

Jo was referred by her midwife when pregnant with her third child. She had previously declined the support. Both Jo and her partner smoked at least 20 cigarettes a day and while now concerned about their unborn baby; they were not fully aware of the dangers of second hand smoke to their other two children. Both Jo and her partner engaged with the Healthy Pregnancy advisor assigned to their locality. Jo wasn’t sure she could quit as she liked smoking and saw it as her “treat”. However, after discussing the various types of nicotine replacement therapy (NRT) and being assured that it was safe to use them in pregnancy she decided to use patches and an inhalator. Jo’s partner also actively engaged with the advisor. Both Jo and her partner successfully quit smoking commenting that they wished they had done it sooner and did not realise how easy it was with NRT and tailored support.

Healthy weight and nutrition during pregnancy

Poor nutrition during and after pregnancy can impact on mother and babies health and can lead to a range of health conditions for mother and baby, including low birth weight, maternal obesity and birth defects. Good nutrition ensures healthy tissue growth and strong bone development in the unborn child. Women in low income groups are the most likely to be affected by poor nutrition and unhealthy weight before, during and after pregnancy. Maternal obesity is defined as a having a Body Mass Index (BMI) of 30kg/m2 or more at the first antenatal consultation. Women who are obese when they become pregnant face an increased risk of complications during pregnancy, childbirth and postnatally. Maternal obesity is associated with increased risk of the following adverse health outcomes;

- Impaired glucose tolerance
- Gestational diabetes
- Miscarriage
- Pre-eclampsia (high blood pressure related to being pregnant)

I would have liked more support to know about portion sizes and how my body would change throughout my pregnancy. I have had an eating disorder in the past and it was really difficult watching the scales rise and my body develop more curves. More promotion & support for postnatal health would be really good

A patient

More information highlighting the link between poverty and childhood obesity can be found later within this report.

National data from Public Health England (2015)\textsuperscript{35} shows that a higher proportion of low birth weight babies are born to mothers from deprived areas. Low birth weight is also associated with other health impacting behaviours such as alcohol and substance use during pregnancy. Similar patterns can be expected in Cornwall and the Isles of Scilly.

In order to reduce health inequalities due to poor nutrition and excess weight, services should focus on supporting parents from more deprived areas to enjoy a well-balanced diet, access vitamin supplements and to participate in appropriate levels of physical activity. Those pregnant women with more complex issues, such as substance use will need appropriate levels of support from specialist services.

For information and support please visit: www.healthycornwall.org.uk/

\begin{itemize}
  \item Thromboembolism (blood clots)
  \item Severe illness
  \item Spontaneous first trimester miscarriage and recurrent miscarriage
  \item Heart disease
  \item Post-caesarean wound infection
  \item Infection from other causes
  \item Postpartum haemorrhage
  \item Hypertension (raised blood pressure)
  \item Depression
  \item Maternal death
\end{itemize}

Risks for the unborn child of maternal obesity include;

\begin{itemize}
  \item macrosomia (large babies)
  \item congenital anomalies (cleft palate)
  \item stillbirth
\end{itemize}

Maternal obesity also contributes to the health risks of offspring and can increase health inequalities across generations. As well as poor outcomes during pregnancy it is associated with low breastfeeding rates, cardiovascular and respiratory problems in children, and childhood obesity\textsuperscript{33}.

Approximately half of all women of childbearing age in England are either overweight or obese. There is strong evidence that maternal obesity is related to socioeconomic deprivation, with risk increasing with greater levels of deprivation. A higher proportion of pregnant women with severe obesity (BMI >50kg/m\textsuperscript{2}) come from areas with the greatest levels of deprivation (Public Health England, 2015).

Although we don’t have local data that links maternal obesity and deprivation, data from the South West Clinical Network Maternity Dashboard\textsuperscript{34} for 2017 indicate that almost one in five mothers (18.8\%) are obese at the time of booking their pregnancy. It is likely that the greatest proportion of these women will be from deprived areas.

Healthy Start is a UK government scheme that aims to improve the health of low-income pregnant women and families on benefits and tax credits by providing vouchers for milk, fruit, vegetables and vitamins. The scheme has been shown to increase fruit and vegetable intake in populations who are at risk of nutritional deficiencies\(^\text{36}\).

The scheme is available to women who are at least 10 weeks pregnant and to families with children under four years old. To qualify for Healthy Start a family needs to be receiving:

- Income Support,
- Income-based Jobseeker’s Allowance,
- Income-related Employment and Support Allowance,
- Child Tax Credit (with a family income of £16,190 or less per year)
- Universal Credit (with a family take home pay of £408 or less per month)

Women under 18 qualify for the entirety of their pregnancy, even if they are not in receipt of any benefits. Once they have had their child they must meet the same qualifying criteria as the other Healthy Start families to continue receiving support from the scheme.

Eligible women receive vitamin coupons which they can swap for Healthy Start vitamins and vouchers worth £3.10p a week. Currently Healthy Start voucher uptake in Cornwall (67.4%) is higher than the national average (66.5%)37. Only limited data is available on the uptake of vitamins, with data indicating that uptake is very low amongst eligible families.

**Healthy weight in pregnancy**

Cornwall Healthy Weight 38 offers a support programme for pregnant women. The service offer one to one, individual support to pregnant women who are above a healthy weight, by offering support and education around healthy eating, physical activity and weight management. Support covers:

- The importance of healthy eating during pregnancy
- Eating well on a budget and healthy eating tips for families
- The importance of being active during pregnancy
- Weight management during pregnancy
- Promotion of Healthy Start Scheme and breastfeeding support services
- Discussion of local support, community groups and classes
- Access to useful resources, tools and personal action-plans

Referrals can be made from midwifery services and are ideally made at booking appointments (first contact with the maternity service).

**Next steps for healthy weight and nutrition during pregnancy**

Local service planners for the Healthy Start scheme have suggested a range of actions that can be taken to increase the uptake of Healthy Start vitamins, including; universal provision, working with Children’s Centres and improving staff training and awareness for the scheme.

Maternity services would like to work with Healthy Cornwall to review the healthy weight support available to pregnant women. They would like to take the learning from the Healthy Pregnancy service and look at offering healthy weight support within Midwifery Units.

**Under-18s conception and teenage pregnancy**

Teenage pregnancy is both a cause and consequence of health inequality, with poor outcomes for young parents and their children contributing to inter-generational inequalities (Public Health England, 2018).

Public Health England (2018) describes the following risk factors as being associated with young women experiencing pregnancy before the age of 18.

- Child poverty
- Persistent school absence
- Slower than expected academic progress
- First instance of sexual intercourse before 16
- Looked after children and care leavers
- Experience of sexual abuse and exploitation
- Young lesbian or bisexual women
- Alcohol use
- Experience of a previous pregnancy

Nationally, one in 12 young women aged under 20 accessing drug and alcohol services are either pregnant or a teenage mother. Young people who have experienced a number of Adverse Childhood Experiences will be at significantly greater risk of teenage pregnancy39, more detail on these risk factors can be found within Section 5 of this report.

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Young parenthood is associated with;

- Poverty
- Increased rates of stillbirth and infant mortality
- Low birth weight of full term babies
- Not breastfeeding
- Poor emotional wellbeing and maternal mental health difficulties
- Poor child development
- Not finishing education and adolescents not in education, employment or training (NEET)

Over the last 18 years, national under-18 conception rates have fallen by over 60%. As well as this fall in rates inequalities have also been reduced, with the biggest declines in areas with the highest levels of deprivation. However, nationally, rates of conception in under-18s are still higher in deprived areas (Public Health England, 2018).

In Cornwall and the Isles of Scilly the same patterns are seen, with rates of teenage pregnancy higher in areas of deprivation. Further, because of Cornwall’s rurality, people living on low incomes can face real difficulty in accessing services.

Data from the Health Visitors’ Early Help Assessment shows that 1.35% of children aged under five living in deprived areas have a parent aged under 18. This is over three times the average for Cornwall and the Isles of Scilly at 0.4%. Local and national data focusses on conception rates and pregnancies in girls under the age of 18. Limited data are available on the number boys aged under 18 involved in these conceptions, or the number of young fathers in Cornwall and the Isles of Scilly.

More data related to under-18s conceptions can be found in Section 8 of this report.

What can be done to further reduce the number of under 18 conceptions in Cornwall and the Isles of Scilly?

The Cornwall and Isles of Scilly Sexual Health Strategy prioritises reducing the number of unwanted pregnancies and reducing the number of under-16 and under-18 conceptions. Further, the strategy seeks to build knowledge and resilience among children and young people, with a focus on improving their sexual health outcomes. Research evidence highlights two key factors that support a sustained reduction in teenage conception rates; these are:

- Comprehensive relationship and sexual health education (RSE), advice information and guidance
- Improving young people’s access to effective contraception

Young people living in deprived areas need access to services and support that enable them to develop and enjoy healthy sexual activity and make positive reproductive choices whilst avoiding unwanted pregnancy. Work delivered in partnership in Cornwall and the Isles of Scilly focuses on:

- Ensuring access to robust RSE for young people
- Ensuring the workforce have the right knowledge and confidence to engage and talk to young people about sex and relationships
- Identifying and supporting at-risk young people
- Ensuring young people have access to contraceptive services

41. Cornwall Council (2017) Online: www.cornwall.gov.uk
Further support is offered to young parents, and focuses on providing services according to their individual family needs and supporting the health and wellbeing of young mums, dads and their children.

Engagement with young people at a recent event looking at services in Cornwall and the Isles of Scilly identified a range of viewpoints.

The most common barrier preventing people from using sexual health services was if they were ‘hard to get to’. Other common perceived barriers reported were ‘fears of seeing someone you know’, ‘unfriendly staff’ and ‘embarrassment’.

The majority of respondents wanted sexual health information and guidance to be online.

**Sexual health services and support for young people in Cornwall and the Isles of Scilly**

**Brook**

Brook offer a range of sexual health services at locations across Cornwall; services available include:

- Contraception and emergency contraception
- Pregnancy testing
- Screening for infections
- Referrals for termination of pregnancy
- Relationships and Sex Education (RSE) to secondary schools

For more information and to find your closest Brook clinic, please visit: www.brook.org.uk

**Royal Cornwall Hospitals NHS Trust Sexual Health Service**

RCHT Sexual health service provides confidential advice, support or treatment for anything to do with sexual health, including contraception and pregnancy. Services are free, confidential and available to anyone, regardless of age, gender or sexual orientation.

To book an appointment or for more information, please call: 01872 255 044 or visit: www.royalcornwall.nhs.uk

**WILD Young Parents Project**

WILD is a specialist service for young parents aged under 23 years and their children. It is a learning and development charity that has been running groups across Cornwall since 1992. WILD works with parents or parents to be, who are often marginalised from training and employment opportunities, and experience the wider effects of social exclusion. The charity aims to provide young mothers and their children with opportunities to develop their skills, improve self-esteem, make positive and healthy choices, protect themselves, participate as equal members of their communities and achieve their potential. WILD acts as advocates for young women to do their best for themselves and their families.

WILD works in the poorest communities in Cornwall, right across the county from Launceston to Penzance.

For more information please visit: www.wildproject.org.uk
Case Study - WILD Young Parents

Healthy eating needs space, equipment, money and know-how. Our supermarket partnership provides supplies which we use to cook and share healthy food. Our families learn to grow and prepare food, budget and plan. We provide resources for cooking in crisis situations, work closely with Foodbanks, and run projects with local chefs.

Only 35% of WILD families were registered with a dentist. We approached public health, established a multi-agency task group, and ran a programme of dental nurse visits, interactive education, registration support and free resources. The number of families registered doubled.

We support our links to perinatal mental health services with an arts programme that helps young mums explore childhood issues, develop confidence and self-identity, and raise aspirations. This includes a WILD choir, sculpture, printmaking, creative writing and music. 95% of participants showed improvements after taking part.

Healthy Cornwall

Healthy Cornwall delivers a range of programmes to support young people’s sexual health, including:

- **Relationships and Sex Education (RSE)**
  Young people who have a broad programme of RSE that starts early in schooling are more likely to delay having sex until they are older, use contraception, and have fewer sexual partners. Healthy Cornwall help schools to explore and improve RSE, through professional development and training, curriculum and policy development and ongoing support. Brook run a programme of RSE in most of our secondary schools whilst Barnardos/Firstlight run a healthy relationships programme.

- **C-Card Scheme**
  The C-Card Scheme is a free condom distribution service for young people aged 13-24 living in Cornwall and Isles of Scilly. The scheme is delivered through a range of Young People friendly services, and includes targeted promotion events.
What next for sexual health services in Cornwall and the Isles of Scilly?

Young people increasingly access sexual health information, support and testing online. Service planners in Cornwall and the Isles of Scilly are seeking to deliver a stronger digital sexual health service that includes the offer of online testing.

In order to ensure young people can access sexual health services across the area and when and where they need them, service commissioners are working to ensure better access and opening times for outreach services.

Speakeasy Cornwall

Speakeasy Cornwall offers a range of training opportunities for parents, carers and professionals. Speakeasy Cornwall aims to get parents and carers together to talk about the best ways to chat with their children, whatever their age, about growing up, body changes, sex and relationships.

For more information about SRE support, the C-Card Scheme and training please call: 01209 615 600 or visit: www.healthycornwall.org.uk
Health inequalities in infancy and the early years
Providing support to children and their parents during the early years will have long lasting positive impacts on their health and wellbeing throughout their life course\(^ {42}\). From conception to age two children’s brains and neurological pathways are rapidly developing, setting the foundations for health and wellbeing, learning, social interactions and behaviour, throughout the rest of their life\(^ {43}\).

Giving children the best start in life is central to reducing health inequalities. Nationally, children growing up in the most deprived households are the most likely to develop heart disease, stroke, cancer, respiratory disease, and mental health issues in adulthood. They are also more likely to smoke, drink alcohol at unsafe levels, be physically inactive and be overweight in adulthood\(^ {44}\).

Parents will have the biggest influence on their child’s health, wellbeing and learning. Parental influences are underpinned by a range of other factors. Public Health England describes a number of influences that are key to positive early development, including:

- Socio-economic status
- Sensitive attuned parenting
- High quality early education
- High quality health care

Supporting families in the early years can improve babies' and children's health outcomes, and will impact upon:

- Early cognitive and non-cognitive development
- Social development
- Children’s readiness for school
- Later educational outcomes

Public Health England suggests a number of key factors impact on the health and wellbeing of children, including:

- Socio-economic status
- Maternal and paternal health and wellbeing
- Maternal smoking
- Maternal nutrition
- Breastfeeding
- Parenting skills (type of parenting)
- Weaning and early years nutrition
- Physical activity

To further mitigate against the effects of poverty and deprivation, the following areas need to be prioritised for targeted support for families living in areas of deprivation:

- Education
- Emotional and social support for families
- Preventing childhood abuse
- Vaccination programmes
- Injury prevention

In this section of the report we will have a look at the following indicator areas:

- Infant mortality
- Breastfeeding
- Vaccinations
- Screening
- Early childhood injuries

And data from Health Visiting Services:

- Early help assessment
- Ages and stages questionnaire

\(^{43}\) 1001 Critical days (2016) The 1001 Critical Days, The Importance of the Conception to Age Two Period. Online: www.1001criticaldays.co.uk
**Infant mortality**

The death of children, particularly those under the age of one, is extremely difficult for parents, staff and wider society. No matter what the cause the death of a baby is a particularly difficult type of grief for parents.

Infant death can be caused by a wide range of economic, social, environmental and individual factors. It can have long lasting impacts on families and can act as a compounding factor for other indicator areas described in this report, including; perinatal mental health issues, substance and alcohol use, risk taking behaviours and even smoking.

Although, all services want to stop infant deaths from happening, when it does happen infant mortality data can be used to provide a picture of general health of the population and give insights into the wider determinants of health. This information can be used by service planners to prevent infant deaths in the future. Stillborn rates and early infant death rates are a particular reflection of mother and newborn health. National data from Public Health England shows us that a greater number of families from deprived areas are affected by these issues.45

Data from the Health Visiting Service’s Early Help Assessment, shows us that 0.87% of families in Cornwall and the Isles of Scilly has been affected by previous sudden infant death; this compares to 1.43% of families living in the most deprived areas. The same data set also shows us that 3.09% of families in Cornwall and the Isles of Scilly, and 4.96% in the most deprived areas, have been affected by a significant bereavement; this may include some infant deaths.

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Online: www.fingertips.phe.org.uk
What can services do to prevent infant deaths?

Stillbirth and infant death can be a result of a range of factors. Midwifery services conduct risk assessments throughout pregnancy and provide support and care accordingly. Postnatally, health visitors will provide support and information to parents about reducing the risk of infant death. Health visitors may provide information on safe sleeping practices, home safety, and parent’s health and wellbeing, as well as a range of other related information.

Public Health England has created evidence based guidance on reducing rates of infant mortality within the London boroughs; the same principles apply for the population of Cornwall. The guidance suggests the following priorities to reduce infant mortality;

- Reducing child poverty and mitigating against its impacts
- Providing antenatal support and education to at risk groups
- Supporting teenage parents
- Reducing maternal smoking rates
- Increasing breastfeeding rates
- Improving vaccination uptake

We have already described what is being done locally to reduce the number of parents who smoke and provided an overview of teenage pregnancies.

Over the following pages we will have a look at the information we have for Cornwall and the Isles of Scilly that is related to breastfeeding and vaccination as well as childhood injuries.

If you have been affected by the death of a baby and would like information or support please visit: www.sands.org.uk

For all parents, an infant feeding guide is provided when booking in to the maternity services. Within the guide are also a range of materials covering common risks and advice for sleep safety including position and sharing of beds or sofa sleeping.

Childhood injuries and emergency hospital admissions

Children from deprived areas and disadvantaged backgrounds are more likely to be affected by unintentional injuries and be admitted to hospital as an emergency than children from less deprived backgrounds. The Faculty of Public Health states that the higher rates of accident and injury affecting children from deprived backgrounds is due to greater exposure to hazards as opposed to risk taking behaviour. The Faculty suggests that children living in poverty are more likely to;

- Live in poorly maintained and unsafe accommodation
- Have fewer safe places to play outside
- Live in houses that open out on to the street
- Have parents who cannot afford high quality safety equipment (Car seats, Safety catches etc.)
- More likely to travel on foot (older children are also more likely to travel unaccompanied)

Nationally, accident and injury is one of the main causes of premature death and illness for children (Public Health England, 2017). Again, there is a strong link between child injuries and social deprivation, with children from the most disadvantaged families far more likely to be killed or seriously injured due to accidents. Every year in England;

- 60 children under the age of five die from injuries that happen in and around the home
- There are 450,000 visits to Emergency Departments and 40,000 emergency hospital admissions each year because of accidents at home among under-fives

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Paediatric emergency department attendances and diagnosis

The following charts are reproduced from the 2016 review of Emergency Departments Attendances in Cornwall\(^\text{49}\). The diagnoses are coded at the time of Emergency Department consultation, some patients would be admitted and have a separate diagnosis recorded at discharge from hospital. The data used to produce the following charts covers the period, 2012-15. The charts provide a breakdown of the diagnosis of children aged under 1 and children aged 1-4 years.

**Figure 10 Under ones emergency department attendances, Cornwall Public Health, Paediatric ED attendance**
Source: Hospital Episode Statistics 2015

**Figure 11 Emergency department attendances, Cornwall Public Health, Paediatric ED attendance write up**
Source: Hospital Episode Statistics 2015

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The following map shows the crude estimates for emergency hospital admissions for children aged under 5 in Cornwall. Higher rates of emergency admissions are seen within the Camborne, Ladock, St Clement and St Erme, and Newlyn and Goonhavern wards.

Figure 12 Crude rate of under fives emergency admissions, Public Health England, local health map
Source: Hospital Episode Statistics

What can we do to reduce the number of children affected by unintentional injury in Cornwall and the Isles of Scilly?

The Royal College of Paediatrics and Child Health suggests that local authorities have a responsibility to provide strategic leadership for preventing childhood injury. Local authorities have the opportunity to bring together the work of a wide range of services from across sectors including health, social care, education and housing. Relevant training on injury prevention should be offered to all professionals that come into contact with families. They will then be equipped to support parents on injury prevention and home safety advice. Public Health England has produced national guidance on injury prevention for people working with under fives.

As we can see from the data a proportion of children are admitted to hospital due to gastrointestinal illness, upper and lower respiratory tract infections, and bronchiolitis. One way to reduce the number of hospital admissions due to these illnesses is through increasing rates of breastfeeding.

The Child Accident Prevention Trust can offer information and support.
Please visit: www.capt.org.uk

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Breastfeeding

Breastfeeding reduces the risk of numerous childhood illnesses such as ear, respiratory and gastrointestinal infections, asthma, obesity, type 2 diabetes, leukaemia and even Sudden Infant Death Syndrome (Chung et al, 2007). Breastfed children show increased early development of white matter in the brain. Breastfeeding is linked with higher performance on intelligence tests54 which has long term implications on attainment at school and employment. UNICEF and World Health Organisation recommend children should be exclusively breastfed up to six months55.

Breastfeeding also has positive effects for the mother such as reduction in the risk of breast and ovarian cancer and post-partum depression (Chung et al, 2007). These illnesses increase hospital admissions and lead to less healthy adults and result in a greater cost burden for the NHS, local authorities and communities.

Children in more deprived areas are less likely to be breastfed. Data for England from 2016/17 showed that in the most deprived 10% of areas 68.8% of parents initiated breastfeeding; this is in comparison to the least deprived areas where 81.2% did56. The cost of formula feeds is £30-60 per week which may impact on parents on low incomes, while breastfeeding is free57. It is also likely that parents who don’t breastfeed will have to take more time off from work due to their children being ill, further impacting on household incomes.

Breastfeeding rates in Cornwall and the Isles of Scilly

Data for 2016/17 from the Public Health Outcomes Framework (PHOF) shows that 79.1% of mothers in Cornwall and the Isles of Scilly initiated breastfeeding. The trend has been fairly static over the past 5 years. PHOF data for 2016/17 also show that only 49.1% of women are breastfeeding at 6-8 weeks after birth. This is above the national average of 44%.The same data set show us that those living in the most deprived areas of Cornwall are the least likely to initiate and to continue to breastfeed.

Breastfeeding support in Cornwall and the Isles of Scilly

Breastfeeding support is offered to families in Cornwall and the Isles of Scilly through a broad programme, including;

- The Real Baby Milk organisation, website and peer support groups:58 www.realbabymilk.org
- Information about breastfeeding on Start4Life:59 www.nhs.uk
- Access to the National Breastfeeding Helpline: 0300 100 0212 (9.30am to 9.30pm, daily)
- The UNICEF Baby Friendly Initiative:60 www.unicef.org.uk

![Figure 13 Breastfeeding initiation by deprivation decile](source: PHE Fingertips - Pregnancy and birth profile, 2015)

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**Areas for service development**

The development of Family Hub provision may affect a family’s access to antenatal education classes and breastfeeding support groups. As the number of people attending support groups due to reduced accessibility decreases, the retention of Breastfeeding Peer Support groups becomes a challenge. This may impact on rates of Breastfeeding across Cornwall, but particularly...
in more deprived areas. Service planners need to ensure that all families are given the opportunity to access the universal services of antenatal education and Breastfeeding Peer Support. Further support offered should focus on improving the maintenance phase of breastfeeding (with nearly 80% of mothers in Cornwall and the Isles of Scilly initiating breastfeeding but just above 40% still exclusively breastfeeding at 6-8 weeks).

**Introduction of solids**

Healthy Cornwall offers a number of sessions across the Cornwall and the Isles of Scilly through a programme called Ready Steady Eat. It engages with parents considering the introduction of solid food at the recommended age of six months and can be booked through Healthy Cornwall. The sessions have been found to be interactive and useful to families, starting where families are with their food journey and introducing skills, knowledge, recipe ideas and budgeting.

My husband and I attended a Ready Steady Eat session in Penzance in October. It was an invaluable experience as, despite already having 2 older children, the information provided there both reinforced what we already knew and educated us on things we didn’t know. One thing we both took away from the session was the amount of sugar hidden in food. We have adjusted our shopping habits for our family and shall continue to do this. It was also great to meet with other new parents!

**And on the Isles of Scilly**

There is a regular session run at the Isles of Scilly Children’s Centre to promote healthy eating in the under-fives and encourage parents to cook their own food from scratch and bulk-freeze rather than opt for the convenient alternative.

**Vaccinations**

One thing that can help protect all children from ill health is ensuring that they are vaccinated against infectious diseases. Vaccines work by making our bodies produce antibodies that fight diseases; they do this without infection. When a child who has been vaccinated comes in contact with a disease their body will already be able to fight off an infection as they will be able to quickly produce antibodies. Babies are born with some passive immunity to certain diseases, because antibodies have been passed from their mothers via the placenta. Breastfeeding can also boost passive immunity. However, it may only last for a few weeks. It is important to ensure that as many children as possible are vaccinated in order to prevent illness in children who cannot be vaccinated; this is called “herd immunity.” Usually 95% of the child population need to be vaccinated to protect against disease in the wider population.

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### Vaccination planner

#### 8 weeks

**1st: diphtheria, tetanus, pertussis, polio, Hib, hepatitis B**
The 6-in-1 vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type B (Hib) and hepatitis B.

**1st: pneumococcal infection**
The PCV vaccine protects against pneumococcal infection, which can cause pneumonia, septicaemia and meningitis.

**1st: rotavirus**
This oral vaccine protects against rotavirus, a common and highly contagious stomach bug.

**1st: Men B**
This protects against infection from meningococcal (Men) group B bacteria.

#### 12 weeks

**2nd: diphtheria, tetanus, pertussis, polio, Hib, hepatitis B**
The 6-in-1 vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type B (Hib) and hepatitis B.

**2nd: rotavirus**
This oral vaccine protects against rotavirus, a common and highly contagious stomach bug.

#### 16 weeks

**3rd: diphtheria, tetanus, pertussis, polio, Hib, hepatitis B**
The 6-in-1 vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type B (Hib) and hepatitis B.

**2nd: pneumococcal infection**
The PCV vaccine protects against pneumococcal infection, which can cause pneumonia, septicaemia and meningitis.

**2nd: Men B**
This protects against infection from meningococcal (Men) group B bacteria.

#### 12-13 months

**Hib, meningitis C**
The Hib/MenC vaccine protects against Haemophilus influenzae type b (Hib) and Meningitis C.

**1st: measles, mumps, rubella**
The MMR vaccine protects against measles, mumps and rubella.

**Booster: pneumococcal infection**
The PCV vaccine protects against pneumococcal infection, which can cause pneumonia, septicaemia and meningitis.

**Booster: Men B**
This protects against infection from meningococcal (Men) group B bacteria.

#### 2 & 3 years

**Annual: children’s flu vaccine**
This is an annual nasal spray vaccine for two-, three- and four-year-olds, plus children in school years 1 to 4.

#### 3 years 4 months

**Booster: diphtheria, tetanus, pertussis, polio**
The 4-in-1 booster vaccine protects against diphtheria, tetanus, pertussis (whooping cough) and polio

**2nd: measles, mumps, rubella**
The MMR vaccine protects against measles, mumps and rubella.

#### 4-8 years

**Annual: children’s flu vaccine**
This is an annual nasal spray vaccine for two-, three- and four-year-olds, plus children in school years 1 to 4.

#### 13-18 years

**Booster: diphtheria, tetanus, polio**
The 5-in-1 booster vaccine protects against diphtheria and polio.

**Men ACWY**
The Men ACWY vaccine protects against septicaemia and meningococcal (Men) A, C, W and Y diseases.

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**Figure 14 Vaccination planner**
Source: NHS Digital
A vaccination programme that protects children against 13 diseases is offered during childhood. Some vaccinations require multiple doses to be effective against specific diseases.

Evidence summarised by NICE (2016)\textsuperscript{63,64,65,66} shows that children and young people with risk factors associated with child poverty may also be at risk of not being fully immunised, these children include:

- Looked after children
- Children with physical or learning disabilities
- Children of teenage or lone parents
- Younger children from large families
- Vulnerable children, such as those whose families are travellers, asylum seekers or are homeless
- Those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- Those not registered with a GP
- Children who are hospitalised or have a chronic illness
- Those from some minority ethnic groups
- Those from non-English speaking families

Unfortunately, we do not have data that tell us about which groups are missing out on vaccinations in Cornwall and the Isles of Scilly. However, we do have data that tell us about overall vaccination coverage locally.

Generally across Cornwall we see high rates of completion of vaccination programmes with excellent achievement on the Isles of Scilly.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
Cohort & Indicator & Standard & Geography \ 2015/16 \\
\hline
\textit{12} months & Population vaccination coverage - Dtap / P / Hib (1 year old) & 95 & Cornwall \ England \ 94.5 \\
\hline
& Population vaccination coverage - MenC & 95 & Cornwall \ England \ 96.3 \\
\hline
& Population vaccination coverage - PCV & 95 & Cornwall \ England \ 94.7 \\
\hline
\textit{24} months & Population vaccination coverage - Dtap / P / Hib (2 years old) & 95 & Cornwall \ England \ 95.8 \\
\hline
& Population vaccination coverage - Hib / MenC booster (2 years old) & 95 & Cornwall \ England \ 92.6 \\
\hline
& Population vaccination coverage - PCV booster & 95 & Cornwall \ England \ 93.2 \\
\hline
& Population vaccination coverage - MMR for one dose (2 years old) & 95 & Cornwall \ England \ 92.5 \\
\hline
\textit{5 years} & Population vaccination coverage - MMR for one dose (5 years old) & 95 & Cornwall \ England \ 96.2 \\
\hline
& Population vaccination coverage - Hib / Men C booster (5 years old) & 95 & Cornwall \ England \ 95.1 \\
\hline
& Population vaccination coverage - MMR for two doses (5 years old) & 95 & Cornwall \ England \ 91.6 \\
\hline
\end{tabular}
\caption{Immunisation uptake for Cornwall and the Isles of Scilly 2015/16}
\end{table}

\textit{Source: PHOF, PHE}

How can we increase the number of children from at risk groups who are vaccinated?

A range of services that offer support to parents in the early years have a role to play in increasing vaccination coverage. NICE (2016) suggest the following for increasing the uptake of vaccinations in vulnerable groups:

- Checking that parents are vaccinated
- Improving access to immunisations
- Ensuring parents have been given relevant and appropriate Vaccine information
- Improving Health care providers have robust information systems
- Working with schools and early years settings to check if children have been vaccinated
- Targeting vaccinations to at risk groups who might not regularly access services

Screening

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to pregnant women and their children.

The following screening programmes are offered during pregnancy and infancy:

- NHS fetal anomaly screening programme
- NHS infectious disease in pregnancy screening programme
- NHS newborn and infant physical examination screening programme
- NHS newborn blood spot screening programme
- NHS newborn hearing screening programme

Although there is limited national evidence available linking low uptake of antenatal and newborn screening and deprivation, it is known that adults from deprived areas are less likely to engage with screening activity.

Unfortunately, national and local data related to the uptake of antenatal and newborn screening programmes by deprivation are not currently available. However, data for 2017/18 from Public Health England\(^68\) show that population coverage of the programmes in Cornwall and the Isles of Scilly is good, with all but one programme meeting acceptable levels of coverage. The only one where coverage was not as expected is for the newborn physical examination (90.8% target 95%).

**Screening vision and hearing at school entry**

Currently, all children in schools in Cornwall and Isles of Scilly are offered both vision and hearing screening at school entry.

**Vision screening**

In 2016 there were 6,051 children screened (100%) with 5,029 (83%) pass, 5% were already receiving treatment and 6% were referred for treatment. The referral rate for the last six years has consistently been between 5% and 7%. Of those referred, 49% received glasses, 6% an orthoptist review, 19% were referred to Plymouth and 2% referred to Barnstaple.

**Hearing screening**

In 2015/16, 5,797 children were invited for screening with 10 declining. 5,491 (95%) passed the screening test. Of those requiring follow up 15% were already known to audiology and 249 (81%) of the remaining referred for treatment.

Unfortunately, no data are available linking child poverty and referrals for vision and hearing treatment.

**Data from Health Visiting Services in Cornwall and the Isles of Scilly**

Cornwall Partnership NHS Foundation Trust currently leads the delivery of the local Healthy Child Programme (0-19) for every child born or living in Cornwall and the Isles of Scilly. The service has a central role in improving the health outcomes of populations, reducing inequalities, protecting children from harm and identifying additional needs at the earliest opportunity.

The 0-5 Healthy Child Programme is primarily delivered by health visitors. Health visitors are qualified nurses with additional training in family and community health. They work in community based teams and with a range of services across Cornwall and the Isles of Scilly\(^69\).

Health visitors search for health needs and provide information, advice, guidance and interventions to help parents. They offer support for families with children up to the age of five, offering a universal service to families, with more targeted and tailored support for those who need it. The aim is to support parents to give their children the best start in life.

Four levels of support are offered to families through the Health Visiting Service;

- Community (your neighbourhood)
- Universal Services (offered to every family)
- Universal Plus (further support for families)
- Universal Partnership Plus (for families who need additional support)

The Health visitor teams are organised into six localities across Cornwall and the Isles of Scilly that closely align with Cornwall Council’s children’s teams. The Isles of Scilly are included in Locality 1 for service planning purposes.

Two primary assessment tools that are used by the Health Visiting Service are the Early Help Assessment and the Ages and Stages Questionnaire. These two assessment tools are used to support families with targeted support and interventions. The data collected can also provide a snapshot of families’ needs across Cornwall and the Isles of Scilly. Some of the data from these two assessments has been included in this report\(^70\).

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\(^69\). Cornwall Partnership NHS Foundation Trust (2017) Health Visitors Cornwall. Online: www.cornwallft.nhs.uk

Early Help Assessment and deprivation

The Early Help Assessment (EHA) is an evidenced based assessment tool that encompasses child development, parenting capacity and environmental factors. The assessment tool aims to:

- Give children and young people a more authentic voice in the key decisions that affect their lives
- Empower parents and carers to take ownership of concerns about the welfare of their children. This is based on an understanding of their strengths and the resources they bring to turning things around and improving their child’s life
- Enable practitioners to respond purposefully and effectively to the complex situations and dilemmas families face

When health visitors work with families to assess their health needs they ask them a range of questions relating to their health, wellbeing and circumstances. An analysis of the data collected showed that children growing up in poverty and areas of deprivation are more likely to be affected by almost all issues covered by the assessment. However, in comparison to the Cornwall and Isles of Scilly average there is a stark difference in the number of families in deprived households affected by the following issues:

<table>
<thead>
<tr>
<th></th>
<th>Living in poverty and/or areas of deprivation</th>
<th>Average value for Cornwall and the Isles of Scilly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental smoking</td>
<td>40%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Problems with literacy</td>
<td>26.8%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Living in temporary accommodation</td>
<td>13.2%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Parents who are depressed/suffer a mental illness</td>
<td>24.3%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Low income, dependent on benefits</td>
<td>29.3%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Violence within the family</td>
<td>21.5%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

Figure 16 Poverty and need
Source: CPFT 2017

Additional indicators affecting over 10% of families in the most deprived households, include:

- Major wage earner unemployed (17.96%)
- Frequent accident and injuries (13.81%)
- Parenting problems (12.92%)
- Parent(s) ‘in care’/abused as child (11.24%)

The above indicators are areas that need to be prioritised for action for families living in the most deprived households in Cornwall and the Isles of Scilly. The chart overleaf shows the percentage of children living in the most deprived areas of Cornwall affected by each of the issues covered by the EHA.
Ages and stages questionnaire and deprivation

The Ages and Stages Questionnaire (ASQ) is a screening tool used for assessing the development of children in the early years. The tool is designed to detect any developmental delays early and can be used to improve child outcomes. The tool is designed to be “Strengths based” and should make it easy for professionals to share results and talk about a child’s development with parents. The tool also encourages parent involvement and can be used to educate families on their children’s needs.

Health visitors assess children using the ASQ at their two year review. The tool covers five developmental areas, including:

- Communication
- Gross motor skills
- Fine motor skills
- Problem solving
- Personal-social skills

There are six questions in each area. The questionnaires are scored by a health visitor with the scores entered into a scoring grid; this then tells us if a child is developing typically, or if a family needs additional support. The results of the questionnaire are then analysed to inform service delivery.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cutoff</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

Figure 17 Percentage of children in the most deprived LSOA’s affected by issue Source: CPFT 2017

Figure 18 Ages and stages assessment table Source: Ages and Stages

Cornwall level data

The following ASQ data covers the period 2014-17. It shows us the percentage of children in Cornwall and the Isles of Scilly who were assessed as being below where they are expected to be at age two (below cut off).

<table>
<thead>
<tr>
<th>Number of children with a Communication score</th>
<th>Number of children below Communication cut off</th>
<th>Percentage of children below cut off</th>
</tr>
</thead>
<tbody>
<tr>
<td>11944</td>
<td>873</td>
<td>7.31%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children with a Gross Motor score</th>
<th>Number of children below Gross Motor cut off</th>
<th>Percentage of children below cut off</th>
</tr>
</thead>
<tbody>
<tr>
<td>11944</td>
<td>251</td>
<td>2.10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children with a Fine Motor score</th>
<th>Number of children below Communication cut off</th>
<th>Percentage of children below cut off</th>
</tr>
</thead>
<tbody>
<tr>
<td>11941</td>
<td>365</td>
<td>3.06%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children with a Problem Solving score</th>
<th>Number of children below Problem Solving cut off</th>
<th>Percentage of children below cut off</th>
</tr>
</thead>
<tbody>
<tr>
<td>11940</td>
<td>394</td>
<td>3.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children with a Personal - Social score</th>
<th>Number of children below Personal - Social cut off</th>
<th>Percentage of children below cut off</th>
</tr>
</thead>
<tbody>
<tr>
<td>11933</td>
<td>331</td>
<td>2.77%</td>
</tr>
</tbody>
</table>

The Ages and Stages questionnaire and deprivation

The ages and stages questionnaire data have also been analysed using deprivation scores which focuses on those children with below cut off scores for the five developmental areas and their relative deprivation scores using home postcode. It should be considered that the number of children who live in LSOAs within each IMD decile varies, so small numbers do impact on average percentages. These small numbers explain the high percentage of children affected by communication difficulties who live in Cornwall and the Isles of Scilly least deprived areas.

The chart shows us that a higher proportion of children living within the three most deprived deciles have scores below ASQ cut-off. The analysis highlights that supporting communication development is a priority area for action for the whole of Cornwall and the Isles of Scilly but is especially important for families living in the most deprived households.
In order to know where communication difficulties are an issue, the ages and stages questionnaire data has been used to produce the following map. The Health Visiting locality areas are defined by the bold black border lines. Where small numbers do not allow for mapping, MSOAs have been left blank.

Figure 20 Percentage of children with ASQ scores below cut off
Source: CPFT 2016-18

Figure 21 MSOA map showing proportion of children below ASQ cut-off for communication at 24 month review
Source: CPFT 2016-18
Health inequalities in primary school years
Parents continue to play an active role in their Children’s health and wellbeing during their primary school years, but this is a key life stage where children start to develop their own lifestyles behaviours, including a healthy or unhealthy diet, participation in physical activity and oral hygiene. Children will also be affected by new friendships, learning and becoming more independent. Each of these things will impact on children’s physical health and emotional wellbeing.

A range of services offer support to families during this time, but schools and teachers play probably the most active support role for families. As well as teaching and assessing the abilities of children, schools play an active role in children’s physical, social and emotional development.

The School Nursing Service offers health based support to primary age children (and their parents) and conduct a number of initiatives to improve the health and wellbeing of children. During primary school children participate in the National Child Measurement Programme, have their hearing and vision screened and receive a few more vaccinations (most notably the flu immunisation given by a nasal spray). Within the programme available there is an offer of a health assessment by a school nurse when a child moves up to Reception class. Current data suggest that this offer is not well taken up and requires a different approach to engaging with parents such as using an integrated approach with the admissions process.

Data from the Schools Health Education Unit (SHEU) Health Related Behaviour Survey (2017)72 highlights that there may be a number of inequalities experienced by children aged 7-11 living in Cornwall and the Isles of Scilly when compared to a wider national sample. The survey shows;

- 31% of Year 6 pupils said that they would like to lose weight.
- 33% of Year 6 pupils in Cornwall recorded levels of high self-esteem.
- 42% of Year 6 pupils in Cornwall said that they were afraid of going to school at least sometimes because of bullying.
- 29% of pupils in Cornwall said they had been bullied in the last 12 months.
- 59% of Year 6 pupils travelled to school by car.

Identified throughout this report, children affected by poverty are more likely to have poorer health outcomes than those children from more affluent families. Data for 2017 from the Department of Education show that 4,810 nursery and primary age children in Cornwall were eligible

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for a FSM (not including Reception to year two FSM). Of those key stage 2 pupils receiving Free School Meals, 39% are not reaching the expected standards in reading, writing, and maths. Across primary and secondary schools, 61% of children with permanent exclusions, and 56% of children with one fixed-term exclusion are eligible for free school meals.

In this section, we will have a look at three areas related to children’s health and wellbeing where poverty and deprivation are known to have a negative impact:

- Healthy weight (National Child Measurement Programme)
- Oral health
- School readiness (Early Years Foundation Stage)
- Health inequalities in primary school summary and recommendations

**Healthy weight (National Child Measurement Programme)**

Obesity is a risk factor for a number of diseases such as diabetes, cancer, heart disease, mental health problems, and many more. It can reduce a person’s life expectancy by an average of nine years. Overweight children grow up to become overweight adults. Obesity rates are at an all-time high in the UK and are continuing to rise with Cornwall as no exception to the county’s obesity problem.

Nationally, an estimated 30,000 deaths occur in the UK every year as a result of obesity. The cost burden to the NHS of obesity is significant; between 2014 and 2015 the NHS spent £6.1 billion on overweight and obesity-related ill-health.

In Cornwall and the Isles of Scilly, 68.4% of adults and 26.8% of children aged 4/5 years were either overweight or obese in Cornwall and the Isles of Scilly in 2015/16. This is a significantly higher rate than England as a whole, and there is no evidence of a reversal in this trend.

The Marmot review (2010) identified income, social deprivation and ethnicity as having an important impact on the likelihood of becoming obese.

Food poverty is the inability of individuals and households to secure an adequate and nutritious diet. It can affect those living on low incomes, with limited access to transport and poor cooking skills.

The National Child Measurement Programme (NCMP) is a nationally mandated public health programme and is a key element of Cornwall’s approach to tackling childhood obesity. Over ten thousand children’s height and weight are measured annually across Cornwall and the Isles of Scilly. This provides reliable data on rates of childhood weight across the area.

During delivery of the programme, the height and weight of each child in Reception class (aged 4 to 5 years) and in year 6 (aged 10 to 11 years) are measured. The measurements are used to assess the rates of underweight, healthy weight, overweight, and obesity in children within primary schools. These data are used to inform the delivery of local public health programmes and services.

Data from the 2016/17 NCMP Annual report indicate that over a quarter of children in Reception year were overweight including obese when measured. The prevalence of overweight in reception has remained the same since 2015/16 but is significantly higher than the national average. The prevalence of obesity was higher for boys than girls, with obesity prevalence higher for children who live in areas of higher deprivation. 0.1% of boys and 0.2% of girls are underweight.

The following charts show these differences.

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75. ONS (2017) Statistics on Obesity, Physical Activity and Diet.
Figure 22 Prevalence of underweight, overweight and obese children in Reception year and Year 6, 5 years combined data
Source: PHE Fingertips 2017

Figure 23 Trends in weight status for Reception year
Source: PHE Fingertips 2017
Children who grow up in poverty are more likely to be overweight than those who do not. National data show us this relationship between child poverty and higher rates of childhood obesity. The following chart shows the percentage of reception year children in IMD 1+2 (most deprived) and 8+9 (least deprived) whose BMI centile is greater than the 95th percentile. This is based on IMD 2015 by child postcode. These data show us that rates of obesity are much higher in more deprived areas than less deprived ones.

What is happening in Cornwall and the Isles of Scilly to mitigate the effect of child poverty on rates of childhood obesity?

Children’s diets are mainly determined by their parents/guardians and schools, so work needs to focus on improving parents diet and the food available within and around schools. This is as well as increasing the amount of physical activity families participate in. As well as the NCMP a range of work is happening locally to improve diets and increase participation in physical activity; this includes the Sugar Smart campaign detailed under oral health.

The new Healthy Weight Strategy 2018-2022 sets out partnership priorities and approaches to promoting a healthy weight and tackling obesity in Cornwall and the Isles of Scilly. It uses three core themes to drive work forward, including action across the healthy weight environment, supporting people to achieve and maintain a healthy weight, and working with professionals and partners to promote healthy weight.

Under the strategy several important work streams will impact on childhood obesity, including the delivery of the following;

**Healthy schools awards**

- Cornwall Healthy Schools are part of the Healthy Cornwall Service and the Public Health Team.
- Cornwall Healthy Schools offer targeted support to schools throughout Cornwall and the Isles of Scilly and aim to raise attainment and achievement by improving health and wellbeing for pupils, staff, parents and carers in the wider school community. There is an additional focus on schools with high percentage of children living in poverty.
- The team offers a range of support, training and information that includes advice on healthy diet, low sugar snacks and good oral health.

For more information please visit: www.cornwallhealthyschools.org

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Cornwall Healthy Weight

As part of the Cornwall Healthy Weight programme there are a range of healthy weight support services available for parents and children of all ages. Weight management support is primarily delivered by Healthy Cornwall and the LEAF programme. For more information please visit www.cornwallhealthyweight.org.uk

There is a range of other work to reduce childhood obesity rates locally, this includes:

- **Making Every Contact Count (MECC)** – A programme to encourage professionals to promote healthy lifestyles
- **Daily Mile** – Encouraging schools and workplaces to take part in walking/running a mile each day
- **Ready Steady Eat** - A programme by Healthy Cornwall for introducing solids to infants and feeding toddlers

For more information please visit: www.cornwallhealthyweight.org.uk

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Next steps for Cornwall and the Isles of Scilly

To reduce rates of childhood obesity, partners in Cornwall and the Isles of Scilly will need to ensure that the action points within the Healthy Weight Strategy are being supported and delivered. Services will need to further encourage schools with intakes from deprived areas and parents on low incomes to promote children partaking in the NCMP, and to promote the Healthy schools award with them. Healthy Cornwall has now developed a Healthy Years award for early years settings which launched to all settings in October and has 70 settings already registering interest. The public health team developed and are evaluating a new summer hunger programme that supported families affected by poverty with the cost of healthy food during the school holidays.

**Oral health**

There is a very strong relationship between dental decay and social deprivation. Generally children from poorer families will suffer higher rates of dental decay than their ‘better off’ counterparts. It is therefore reasonable to assume that these children will need greater support in maintaining good oral health.

Through reducing sugar consumption, regular brushing with fluoride toothpaste and routine dental visits 90% of tooth decay is preventable. Children’s baby/milk teeth are more susceptible to decay than their adult teeth. Milk teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria. Infant’s and toddler’s teeth can also be affected by an aggressive form of decay called ‘early childhood caries’. The disease is linked with the frequent consumption of sugary drinks in baby bottles or sipping cups. The decay tends to occur in the upper front teeth and spreads rapidly to others.

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82. Faculty of Dental Surgery (2017) Shocking 24% increase in tooth extractions performed on children aged 0-4 in last decade. Online: www.rcseng.ac.uk
Poor dental health as a child increases risk of poor adult dental health. It also causes pain resulting in missed school and parents missing work. It can affect children’s confidence, emotional well-being and general health which again can lead to poorer academic and social achievements and impact on future employment.

Nationally, one in four of England’s five year olds have tooth decay. This leads to over 26,000 hospital admissions each year and means that tooth decay is the most common cause of hospital admissions for children aged 5 – 9 yrs. Tooth extractions often require general anaesthetics which are both costly and come with health risks for children. Nationally, the annual cost to the NHS for tooth extractions in the under 18s is £35 million.

Poor oral health and tooth decay can be more detrimental for children who grow up in poverty with higher rates in areas of deprivation. 2015/16 data for England from the Dental Public Health Epidemiology Programme revealed that children in the second most deprived decile had 71% of five year olds free from decay in comparison to the least deprived decile which had 80%.

In Cornwall in 2015/16, 78.3% of 5 year olds were free from dental decay. This was above the national average of 75.2%. Each year approximately 950 children in Cornwall are referred for dental extractions.

What’s happening in Cornwall and the Isles of Scilly to support families in deprived areas with oral health?

Nationally the new Sugar Drinks Industry Levy will help to reduce the amount of sugary drinks families are consuming, which will help to impact on rates of tooth decay (as well as excess weight).

There are a range of programmes happening in Cornwall and the Isles of Scilly to support families to improve oral health and prevent children from developing dental carries; this includes the healthy school awards covered earlier.

Smile Together “Brighter Smiles” Programme
Cornwall Council commissions an evidence-based Oral Health Improvement Programme (OHIP) for young children, which contributes towards meeting its public health responsibilities and follows guidance from the National Institute for Health and Care Excellence. The OHIP aims to prevent dental decay in young children whose risk of poor oral health is relatively high, thus reducing oral health inequalities. The OHIP is currently provided in selected early years' settings by “Brighter Smiles”, part of the Smile Together Community Interest Company; it consists of:

- Home education and tooth brushing packs for children at all participating sites
- Oral health education for children, parents and staff in participating sites
- Supervised tooth brushing clubs at selected nurseries
- Fluoride varnish applications at selected schools for children in reception classes.

Brighter Smiles are currently targeting over 30 schools in areas where we see the worst of oral health outcomes in children and are delivering oral health education and support. The programme has been running for 3 ½ years. During the first 2 years over 650 children participated in brushing clubs and 825 children have participated in the fluoride varnishing programme.

For more information please visit:
www.smiletogether.co.uk
Sugar Smart Cornwall

The Cornwall Sugar Smart campaign launched in February 2018; the aim of the campaign is to reduce people’s sugar intake. The campaign team want to make it easier to choose healthy food options when families are out and about. The team are working with different settings across the county to make sure that healthier, low sugar options are available and desirable.

An approach to Sugar Smart is seen as an important element in achieving the Healthy School Award.

For more information please visit:
www.cornwall.gov.uk

Next steps for improving oral health in the most deprived areas

As well as delivering campaigns and support to schools we will need to ensure that families from deprived areas are engaged in the support available to them. We want to make sure that our Smile Together “Brighter Smiles” campaign is effective. It makes sense that bringing schools and dentists together will help bring an end to one of the biggest causes of hospital admissions for children. However we will need to conduct an evaluation of the service to ensure the programme is supporting the highest risk families living in the most deprived areas of Cornwall and the Isles of Scilly.

School readiness

The Early Years Foundation Stage (EYFS) is a statutory framework that sets the standards for learning, development and welfare for children from birth to the 31st August following their fifth birthday. All schools and Ofsted-registered early year’s providers follow the EYFS. This includes childminders, preschools, nurseries and school reception classes. The EYFS covers learning, development and care of children from birth to age five. The EYFS covers the following areas of learning 84:

- Communication and language
- Physical development
- Personal, social and emotional development
- Literacy
- Mathematics
- Understanding the world
- Expressive arts and design

In Cornwall and the Isles of Scilly, children are assessed throughout their Reception year in school. End of year data is collected across 17 areas of learning and this information is moderated and compared to national data returns through an assessment known as the Early Years Foundation Stage Profile 85.

The key measure for children being ready for school and for the transition to Key Stage 1 is that they have a “Good Level of Development” (GLD) by the end of the reception year. Data for Cornwall shows that 68.9% of children assessed were reaching GLD, this compares to 70.5% for England. Whilst this is not quite in line with national rates this does represent better progress than in England. Outcomes have increased by 19.5% in Cornwall from 2013 compared to 19% over the same period in England.

In the prime areas of learning within the EYFS a focus on supporting children’s communication skills is beginning to have an impact with 83% of children at expected levels in Cornwall compared to 82.10% in England. There is a slight variation in physical development at expected levels in Cornwall at 87.3% compared to 87.5% for England. Areas that remain a focus for improvement include personal social and emotional development (Cornwall 84.2%, England 85.2%).

Analysis from the EYFS 2017 profile shows the Localities with the lowest proportion of children reaching a good level of development by age 5 are Locality 1 (64%) and Locality 2 (65%). A lower proportion of boys (61.2%) than girls (76.9%) are reaching a good level of development at the end of their reception year.

of their Reception year. Boy’s development in Reception year is lower than girls across all of the indicators in EYFS. However, reading (Cornwall, 71.0% National, 77%) writing (Cornwall, 63.7% National, 73%) and numbers (Cornwall, 74.3% National, 79%) are all areas where boys aged under 5 are further underperforming.

National studies continue to show that a number of income-related inequalities persist:

- Low-income children often have language skills that are below the age-related expectations at the time they enter reception – putting them at an educational disadvantage from the start.
- Enriching home learning activities are consistently associated with family income and parental education. In particular, middle and upper-income children are more likely to be read to and go on educational outings in comparison with their low-income peers.
- Middle and upper-income children are also more likely to experience ‘language rich’ home learning environments involving frequent caregiver-child conversations that reflect the child’s personal interests.

Outcomes for children from lower income families (based on Free School Meal eligibility) were lower than the Cornwall average (68.9%) and were worse when compared to the same group nationally. Only 51% of children with Free School Meal eligibility achieved expected levels of development; this compares to 56% for children with FSM eligibility in England and 68.9% for Cornwall.

A good quality home learning environment can:

- Moderate the effect of disadvantage and offers partial protection against the effects of disadvantage, even into the teenage years.
- Moderate the impact of socioeconomic background on cognitive skills and socio-emotional difficulties.

### Early Year’s education

All three and four year olds are entitled to free part time education from the term following their third birthday. This is up to 15 hours a week for 38 weeks of the year. These places are only available in settings that are registered with Children, Schools and Families. Settings that are listed through the Family Information Service have been Ofsted inspected and meet the standards required to deliver a good quality of education that will enable children to meet their Early Learning Goals for Foundation stage.

The Early Years Inclusion team can support families of children with additional needs to access appropriate educational provision. They can be contacted on: 01872 266 360.

### Family Hubs

Family Hubs are designed for children and their families to receive high quality integrated services and information within their communities. Family Hubs are a great place for families with children aged under five to go and take part in activities, health services, training opportunities and to seek support with many aspects of family life. Many of the activities and sessions are free and all centres offer a friendly and informal atmosphere. Services available at Family Hubs can offer support with:

- Relationship and parenting support
- Child and family health
- Supporting families with complex needs
- Supporting vulnerable children through high quality education
- Employment and training support

A number of engagement events for One Vision took place in 2018. A flavour of what young people said is outlined below:

### How would you want to get help when you need it?

Young people would like professional advice from trained staff. A number expressed self-help through online resources.

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What is important about the help offer?

be there, be present, help, help more when struggling not in 6 weeks’ time

Parents would be more likely to want to access advice at the hub in the evening

Over 50% of young people want to receive service face to face but their parents want to know about the services by email

What next for Early Year’s settings?

From April 2019 Health Visiting Services will be delivered by Cornwall Council across Cornwall and the Isles of Scilly. This will present some unique opportunities for integrated working between Health Visitors and School Nurses, Early Years staff and social care teams using Family Hubs along with maternity services as a focus. A collaborative integrated model of working is already in place on the Islands. Being part of the same organisation should provide an opportunity for smarter ways of working, with important information flowing more easily between professionals offering seamless support to families. This will allow for more tailored and targeted support to be offered to children and parents affected by poverty.
Adverse Childhood Experiences (ACEs)
Experiences during childhood have a long-lasting impact on a child’s physical and mental health and wellbeing. It is known that sensitive and responsive care from parents, primary care-givers, and other family members, helps to shape positive brain development and secure attachment in children. ACEs impact directly on children’s developing brains through exposure to ongoing ‘toxic stress’ and have a strong influence on children developing health impacting behaviours and mental health problems later in life.

Children affected by poverty and growing up in deprived areas are more likely to be affected by a range issues than children from more affluent areas. Children who are impacted by the following adverse childhood experiences are more likely to suffer from poor health and wellbeing later in life:

- Verbal abuse
- Physical abuse
- Sexual abuse
- Parental separation
- Domestic Violence
- Incarceration
- Mental illness
- Alcohol abuse
- Drug use

Children who are impacted by four or more of these events during childhood are the most likely to experience mental health related issues later in life and are more likely to engage in health impacting behaviours (Public Health England, 2017). Compared to those adults experiencing no childhood ACEs, an adult who experiences four or more during childhood is:

- Four times more likely to be a high risk drinker
- Six times more likely to be a current smoker
- Six times more likely to have had sex under 16 years of age
- 11 times more likely to have smoked cannabis
- 16 times more likely to have used heroin or crack cocaine

Data from the Health Visiting Early Help Assessment show us that around 4.3% of children aged under five in Cornwall and the Isles of Scilly have been affected by four or more ACEs. When we look at this data across the area the highest proportion of children affected by 4 or more ACEs is in Locality 1. These children will be the most likely to suffer poor health in adulthood.

87 NICE (2016) Early years: promoting health and wellbeing in under 5s. Online: www.nice.org.uk
There is currently no national guidance on tackling ACEs. However, a number of approaches have been applied in other areas of the Country, and Public Health Wales has developed approaches to this area of work. There is also a programme of work developing locally that aims to tackle the problem of ACEs. Current approaches applied to mitigating against the negative effects of ACEs include:

- Identification of children affected by ACEs and intervening
- Supporting parents and care givers to avoid ACEs
- Developing children’s resilience
- Minimising the effect on children of indirect harm
- Focussing support and intervention in the early year’s
- Focussing support for individual issues

In this section we will have a look at data related to each of the Adverse Childhood Experiences. At the end of this section an approach designed by the Wave Trust has been used to describe how this area of work could be taken forward locally and we will also describe a number of services that provide support to children and parents affected by ACEs.

### Parent’s mental health

Earlier in this report we looked at mental illness affecting parents during the perinatal period. Data from the Early Help Assessment indicates that 15.6% of children aged under 5 in Cornwall and the Isles of Scilly have a parent affected by mental illness or depression. This compares to 24.3% of children living in a deprived area who have a parent with mental illness.

These data indicate that there has been an increase in the number of parents self-reporting mental illness or depression. This may reflect wider societal changes in talking about mental illness, with more people willing and able to talk about their mental health. This trend also suggests that health visitors are more equipped to prompt parents about experiences of mental illness.

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In 2004 it was found that one in 10 children aged 5-16 had a mental health condition. We now know that in the intervening years this has increased.

Data from the Headstart project’s Wellbeing Measurement Framework conducted with children and young people in year 7 and year 9 shows that children who are eligible for free school meals have poorer overall mental health and wellbeing when compared to their peers who are not eligible for free school meals. Children eligible for free school meals also score poorly when assessed for emotional strengths and skills, and when their support networks are assessed. This indicates that by the time children from more deprived families reach year 7 their mental health and wellbeing has already been impacted by experiences in early childhood.

This is backed up by the recent 2017 survey on mental health in children. One in eight 5-19 year olds has a mental health disorder. For the 5-15 age group this has risen from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017. When including the 5-19 age group the prevalence is 12.8% but this cannot be compared to earlier years. Mental health disorders are grouped into four broad categories, emotional, behavioural, hyperactivity and other less common disorders.

Children and young people living in households with the lowest levels of equivalised household income were about twice as likely as those living in the highest income quintile to have a disorder. This pattern was evident in both boys and girls.

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Abuse

Abuse can take many forms and includes verbal, physical and sexual abuse. Child abuse and neglect can seriously affect a child’s health and wellbeing. The effects on Children who experience abuse include; but are not limited too;

- Problems with growth and physical development
- Impaired language development
- Behavioural difficulties
- Impaired ability to socialise, play and learn
- Increased likelihood of being involved in antisocial behaviour
- Increased likelihood of suicidal thoughts and attempts during adolescence

As with other adverse childhood experiences the effects of abuse in childhood can go on into adulthood and can mean poor outcomes across the life course.

Data from May 2018 for Cornwall and the Isles of Scilly showed that 382 children were subject to a Child Protection Plan. Of those children, 149 were being affected by at least one form of abuse and 233 by neglect.

<table>
<thead>
<tr>
<th>Reason for safeguarding plan</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>233</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>82</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>57</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>10</td>
</tr>
<tr>
<td>Total number of children</td>
<td>382</td>
</tr>
</tbody>
</table>

Data from the Early Help Assessment show in the last 3 years 2.79% of children assessed by health visitors in Cornwall and the Isles of Scilly were at serious risk of harm, or were already on the child protection register, this compares to 5.66% of children living in the most deprived areas.

Further data from the Early Help Assessment shows that 4.69% of parents of under fives in Cornwall and the Isles of Scilly reported being abused as a child; this compares to 11.66% of parents from the most deprived areas.

Other risk factors and poor outcomes are associated with child abuse. Alcohol plays a part in 25% to 33% of known cases of child abuse (Public Health England, 2016). Sexual violence, particularly during childhood, can lead to increased smoking, drug and alcohol misuse, and risky sexual behaviours in later life. It is also associated with perpetration of violence (for males) and being a victim of violence (for females), (Safer Cornwall, 2015). Further information on these factors is detailed in this section.

![Figure 30 Children on a safeguarding plan](source: CPFT)

![Figure 31 Children at risk of significant harm including those on the child protection register](source: CPFT)

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Parental separation

The mental health and wellbeing of children whose parents separate may be impacted by feelings of loss, fear, anger, worry and guilt. Parental separation can increase financial strain, result in issues with housing and mean that children have to move school, potentially further exacerbating poor wellbeing. Disruption at home can also impact on children’s participation and learning at school.

Data from the Early Help Assessment show that 3.98% of children aged under five in Cornwall and the Isles of Scilly were affected by divorce or parental separation within the last year. This compares to 8.17% of children from the most deprived areas of Cornwall and the Isles of Scilly. Further data from the Early Help Assessment show us that 8.21% of families with children aged under five in Cornwall and the Isles of Scilly are one parent families. This compares to 16.2% of children from the most deprived areas of Cornwall.

Figure 33 Children experiencing separation and divorce by locality
Source: CPFT

Figure 34 Percentage of one parent families
Source: CPFT

96. Royal college of psychiatrists (2018) Divorce or separation of parents - the impact on children and adolescents: information for parents, carers and anyone who works with young people. Online: www.rcpsych.ac.uk
Domestic violence

The World Health Organisation (WHO) describes intimate partner and sexual violence as one of the greatest health inequalities for women and girls97. WHO recognises domestic abuse and sexual violence to have serious short- and long-term physical, mental, sexual and reproductive health problems for survivors and for their children, listing impacts such as;

- Homicide or suicide
- Injuries
- Unintended pregnancies, induced abortions, gynaecological problems, and sexually transmitted infections
- Increased likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies, and higher rates of infant and child mortality and morbidity
- Depression, post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress, depression, problem drinking and suicide attempts.

Health effects can also include headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health.

Children who grow up in families where there is violence may suffer a range of behavioural and emotional disturbances. These can also be associated with perpetrating or experiencing violence later in life.

The Safer Cornwall Strategic Assessment 2015/1698 identified that domestic abuse and sexual violence continues to present one of the highest overall risks to communities in Cornwall. Data from the Safer Cornwall Domestic Abuse and Sexual Violence Needs Assessment 2015/16 indicate that in the UK, an estimated 8.5% of women and 4.5% of men experienced domestic abuse in the last 12 months. This is equivalent to 18,800 victims in Cornwall and the Isles of Scilly.

Data from the Early Help Assessment show us that 10.94% of children aged under five in Cornwall and the Isles of Scilly are affected by violence within the family. This compares to 21.46% of children within the most deprived areas being affected by the same issue.

**Figure 35 Violence within the family**
Source: CPFT

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**Incarceration**

There are no official figures available on the number of children nationally, who have one parent or both parents in prison. However, Barnardo’s estimate that up to 200,000 children across England and Wales are affected by parental imprisonment 99.

Safer Cornwall states that 34% of male offenders and 43% of female offenders have parental responsibility 100.

Parents who have difficulties with alcohol and substance use, have mental health issues or are victims or perpetrators of domestic violence, may be at higher risk of offending, and being imprisoned.

Children with parents in prison are at higher risk from safeguarding issues and are more at risk of being affected by:

- Stress
- Anxiety
- Depression
- Behaviour and conduct disorders
- Underperformance at school
- School exclusion
- Offending
- Arrest or imprisonment

Children affected by this issue who are effectively supported will be at reduced risk of youth offending. The rate of first-time entrants into the justice system in Cornwall and the Isles of Scilly is 321/100,000. This represents approximately 150 young people per year101.

People in prison who maintain contact with their families are less likely to reoffend. Parents who do offend require support with parenting skills and breaking intergenerational patterns of offending.

**Parental substance misuse**

Alcohol and substance misuse impact not just on the person misusing substances but also on family members around them. If a parent or caregiver misuses alcohol or drugs, there can be an impact on a baby, toddler or child’s development. Children affected by parental alcohol or substance misuse are more likely to have physical, psychological and behavioural problems102.

**Alcohol**

Parental alcohol misuse is strongly correlated with family conflict and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences.

There are 700 people in drug and alcohol treatment in Cornwall and the Isles of Scilly who are living with children (27% of the treatment population total), which is in line with the national average. These households are recorded as having a total of 1,300 children103. Areas in Cornwall and the Isles of Scilly with the highest risk for alcohol and drug misuse are detailed under drug use.

Drinking in pregnancy can lead to long-term harm to the baby; the more a pregnant woman drinks the greater the risk104. Data from the Cornwall and Isles of Scilly Alcohol needs assessment 2014/15105 shows that around 2% of people accessing treatment are pregnant.

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In a study of young offending cases where the young person was also misusing alcohol, 78% had a history of parental alcohol abuse or domestic abuse within the family\textsuperscript{106}.

Data from the Early Help Assessment show us that 2.87% of children aged under five in Cornwall and the Isles of Scilly are affected by at least one parent who abuses alcohol. This compares to 6.31% of children within the most deprived areas being affected by the same issue.

Drugs

Children are especially affected by a parent’s substance misuse problem as their parents’ ability to protect and care for their children, attend to their health, feed them and financially support them may be greatly diminished by drug use\textsuperscript{107}.

Parents who have drug use issues who live with children may see a positive impact on their own treatment outcomes. However, the level of successful completions amongst drug users (opiates and non-opiates) living with children has been in decline.

As previously stated there are approximately 1,300 children living in households with a drug or alcohol user (Safer Cornwall, 2017).

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
\textbf{Drug group} & \textbf{Number of people} & \textbf{% in treatment} & \textbf{National % in treatment} \\
\hline
Opiate & 369 & 29% & 28% \\
Non-opiate & 45 & 29% & 24% \\
Non-opiate and alcohol & 90 & 26% & 22% \\
Alcohol & 193 & 25% & 24% \\
Total & 697 & 27% & - \\
\hline
\end{tabular}
\caption{Drug and alcohol use in families and young children}
\end{table}

Although reasons for people being affected by drug addiction are complex, drug misuse is more prevalent in socially deprived areas\textsuperscript{108}, with poverty, deprivation and inequality all strongly associated with problematic drug use. The most deprived members of our population are at the highest risk, including homeless people and those in care.

The Complex Families Index indicates that families living in areas categorised as deprived, are most likely to present with complex multiple needs, with those families living in the most deprived areas of Penwith and Restormel, Bodmin, Penzance, Marazion and St Just (West Penwith),

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figures/proportion_of_children_living_with_parents_who_drink_high_levels_of_alcohol_by_locality.png}
\caption{Proportion of children living with parents who drink high levels of alcohol by locality}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figures/drug_and_alcohol_use_in_families_and_young_children.png}
\caption{Drug and alcohol use in families and young children}
\end{figure}

\begin{itemize}
\item 107. Safer Cornwall Partnership (2017) Cornwall and Isles of Scilly Drugs needs assessment 2016/17. Online: www.safercornwall.co.uk
\end{itemize}
St Austell and Mevagissey, St. Blazey, Fowey and Lostwithiel, Camborne and Redruth at the highest risk of drug misuse (Safer Cornwall, 2017).

Data from the Early Help Assessment show us that 2.95% of children aged under five in Cornwall and the Isles of Scilly are affected by at least one parent who abuses drugs. This compares to 6.96% of children within the most deprived areas being affected by the same issue.

Tackling Adverse Childhood Experiences

The Wave Trust has outlined an approach to preventing Adverse Childhood Experiences and their effects\(^ {109}\). This approach has been developed through evidence based approaches delivered in Ireland, Wales and Scotland.

The approach includes a focus on the first 1001 days of a child’s life, from conception to age two. Pregnancy and the early years is when the foundations are laid for children’s health and wellbeing experienced throughout the rest of their life.

Their approach outlines a how programmed support should be given to parents to prevent ACE’s happening and should aim to:

- Prevent and tackle parental substance use
- Support victims of domestic violence and prevent perpetration
- Support parents with mental health issues

Their three-level approach to ACE’s includes:

- Conducting ongoing risk assessment
- Offering additional support where needed with a focus on parent-child attachment
- Using asset based community development and trauma informed communities to increase community engagement with these issues

Through the One Vision Partnership plan, health, education and social services are working together to prevent children being affected by ACE’s and are supporting those that have already been impacted by them. A range of other services are working to tackle ACE’s, including:

**HeadStart**

HeadStart Kernow is a partnership programme to develop resilience and mental wellbeing in young people. It is Cornwall Council-led and Big Lottery-funded. The local programme focuses support to young people aged 10 – 16. The programme has been co-produced with young people and including universal prevention with targeted support.

The HeadStart team offer a range of training and resources for staff working with young people. This includes training for senior leads on trauma informed schools.

**For more information about HeadStart Kernow please contact the team via email:**
HeadStartKernow@cornwall.gov.uk

Over the course of a year we are training up teams of young people to plan, produce and film a series of short films. The aim is to focus on what life is like for 10 – 16 year olds in Cornwall in 2018, and the videos can be about anything young people want to talk about.

Young people have created the project from scratch – naming it, creating the logo and shaping the way we work.

Some comments from young people taking part:

“The best payment is being allowed to be a part of all this” (young person in response to a suggestion we ‘pay’ for his artwork / design skills as he had approached the tasks so professionally)

I think YOUth in Mind is a great idea because it for young people, by young people and it is great they can watch it in a video form and we can make it fun and engaging. The best part about YOUth in Mind is that we are understanding, not ranting at young people. The best thing about Headstart, I think, is how understanding and how much say young people get. Everything is made fun and engaging and not just helping young person with mental health and wellbeing but also raising awareness in a very fun way. (E, Y9)

The best thing about HeadStart Kernow is you get to do things to help your mental health

**For more information or to get involved visit:**
www.youthinmind.piratefmedutrain.co.uk/
Safer Cornwall

Safer Cornwall is a partnership of organisations working together to improve community safety across Cornwall. A number of projects delivered through the partnership take ACEs and their impacts into account. Training programmes are delivered through Safer Cornwall to community safety staff that is related to ACEs and they are currently developing Routine Inquiry into Adverse Childhood Experiences (ACEs) training.

Together for Families Programme

The Together for Families programme has been working to better capture the impacts of ACEs on the families they are supporting. ACEs form part of the assessment for individuals, with information used to check what support has been received or is needed.

Next steps

Although services are delivering targeted projects and programmes that consider ACEs in their delivery, there is no current universal programme that brings all of these work streams together.

Under the One Vision partnership, develop an ACEs support pathway that includes the three levels described by the Wave Trust, with ongoing assessments, targeted support and a universal community engagement programme.

This support pathway may include

- Delivery of ACEs training to multidisciplinary teams
- Identifying at risk children, and children already affected by ACEs and sharing information between services
- Developing and delivering appropriate offers of support to those children and families identified

Support for ACEs

A range of support is available to children and families affected by ACEs, please contact the following organisations for support or information.

Early Help Hub

The Early Help Hub is a single point of access for Council and CPFT Early Help services for children and families. The Early Help Hub consists of a team of professionals who will direct referrals to the most appropriate service, the Early Help Hub can be contacted on: 01872 322 277

Child abuse
Multi Agency Referral Unit (MARU) on : 0300 123 1116

Domestic Violence
Twelves Company on: 0300 777 4777

Children affected by parental imprisonment
Dreadnought on: 01209 218764

Substance use
Addaction on: 0333 2000 325
The health of older children
Poverty is directly linked to poorer health and wellbeing in adulthood. Often, health-impacting behaviours and poor health begin to manifest when children become teenagers, with poor outcomes exacerbated by Adverse Childhood Experiences. National data from the PHOF highlights that teenagers from deprived backgrounds are the most likely to have poor health, engage in risk taking behaviour or not engage with support services. The following data highlight health and wellbeing indicators for adolescents in Cornwall and the Isles of Scilly where outcomes are worse than expected.

### Sexual health
- Chlamydia detection rate/100,000 aged 15-24: Cornwall and IoS: 1801/100,000 England: 1882/100,000
- Annual HPV vaccine uptake – Year 8 girls + Coverage at 12-13 years: Cornwall and IoS: 78.6%, England: 87.2%

### Risk taking behaviour and emergency admissions
- ED Attendances (15-17 years): Cornwall and IoS: 392.7/1000, England: 341/1000
- A&E attendances (15-19 years): Cornwall and IoS: 418.2/1000, England: 381.3/1000
- Emergency admissions under 18 years: Cornwall and IoS: 76.5/1000, England: 73.5/1000
- Emergency admissions under 0-19 years: Cornwall and IoS: 80.1/1000, England: 73.8/1000
- Percentage with 3 or more risky behaviours: Cornwall and IoS: 19.8%, England: 15.9%
- Emergency admissions for car occupants (0-24): Cornwall and IoS: 23.4/100,000, England: 16.5/100,000
- Emergency admissions for motorcyclists (aged 0-24): Cornwall and IoS: 18.8/100,000, England: 16.5/100,000
- Slight casualties from road traffic accidents (aged 0-24): Cornwall and IoS: 337/100,000, England: 276/100,000
- Car occupants killed or seriously injured in road traffic accidents (aged 15-24): Cornwall and IoS: 50.5/100,000, England: 27.8/100,000

### Substance use
- Admission episode for alcohol-specific conditions – Under 18s: Cornwall and IoS: 40.3/100,000, England: 34.2/100,000
- Smoking prevalence at age 15 – current smokers (WAY survey): Cornwall and IoS: 11.7%, England: 8.2%
- Smoking prevalence at age 15 – occasional smokers (WAY survey): Cornwall and IoS: 4.8%, England: 2.7%
- Percentage of 15 year olds who have ever had an alcoholic drink: Cornwall and IoS: 76.6%, England: 62.4%
- Percentage of 15 year olds who are regular drinkers: Cornwall and IoS: 9.3%, England: 6.2%
- Percentage who have been drunk in the last 4 weeks: Cornwall and IoS: 22.1%, England: 14.6%
- Percentage who have tried cannabis: Cornwall and IoS: 15.5%, England: 10.7%
- Percentage who have taken cannabis in last month: Cornwall and IoS: 7.5%, England: 4.6%

### Socioemotional health, mental health and wellbeing
- Persistent absentees – Secondary school: Cornwall and IoS: 14.3%, England: 13.1%
- Hospital admissions as a result of self-harm (10-14 years): Cornwall and IoS: 270.2/100,000 England: 211.6/100,000
- Hospital admissions as a result of self-harm (20-24 years): Cornwall and IoS: 514.3/100,000, England: 393.2/100,000
Living in a cold home
Living in a cold damp home can harm the health and wellbeing of those living there as well as wasting expensive energy. Improving the energy efficiency of homes can improve “affordable warmth” and result in multiple health gains. It leads to improved home finances, reduces the cause of avoidable, unjust health inequality and supports long term environmental gains. The lower your income the more likely you are to be at risk of fuel poverty.

There is a strong relationship between cold temperatures, cardiovascular and respiratory diseases, which has been associated with fuel poverty and cold housing.

For more information please visit:
Cornwall Council/Citizens Advice Cold Homes Toolkits : https://www.citizensadvice.org.uk

Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems as children living in warm homes.

Mental health is negatively affected by fuel poverty and cold housing for any age group. More that 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems.

Other indirect effects include a risk of carbon monoxide poisoning and a wider effect on wellbeing and life opportunities.

Local Authorities have a statutory duty to review and remove Category 1 hazards (hazards that pose a serious threat to the health or safety of people living in or visiting your home). Nationally over the last 10 years the proportion of households in the Private Rented Sector (PRS) with dependent children increased from 30% in 2004/5 to 37% in 2014/15. Therefore, given our known understanding of the quality of the stock, many more children are being exposed to hazardous property conditions

Cold homes and their health costs

- £1.4bn (first year treatment costs only)
- Impact on 3.6m children, 9.2m working age adults and 2m pensioners
- Mental health – poor housing affects 19% of households.

Housing impacts on health

When a house is damp as well as cold, mould is likely to occur. This increases the risk of respiratory illness, particularly asthma. Home energy efficiency measures have been shown to significantly reduce absence from school in children due to asthma, and recurrent respiratory infections.

110. Cornwall Council Private Rented Housing Strategy, 2018
111. ADASS Social Services and BRE
Low weight gain in infants: studies demonstrate that there is a relationship between living in cold homes and poor infant weight gain, attributed to the fact that children living in colder homes need greater calorific intake to fulfil growth potential.

**Mental and social health and wellbeing**

Damp, cold housing is associated with an increase in mental health problems, such as depression and anxiety. Living in these homes can affect people’s ability to go about their daily lives. Cold housing can also negatively affect children’s emotional wellbeing and resilience. It can be difficult for children to study or do homework in a cold house, which affects educational and long-term health and work opportunities.

Studies have suggested that more than one in four adolescents living in cold housing are at risk of developing mental health problems, compared with one in 20 living in a warm home.

Risk - children under the age of five are vulnerable to the cold due to immature thermoregulation and a high dependency level. Studies show that those most likely to be at risk of ill health from living in fuel poverty include children, people over 60 and on low income, and long-term sick and disabled people.

**Children in poverty:** The Marmot Review indicates that children living in poverty are at higher risk of premature mortality and poor health outcomes in adulthood compared to those who do not live in poverty.112

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112. PHE Making the Case: Why Long Term Strategic Planning for Cold Weather is essential for Health and Wellbeing
Vital statistics for Cornwall and the Isles of Scilly
## Mid-2016 Population Estimates
(Revised March 2018)

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

<table>
<thead>
<tr>
<th>All Persons</th>
<th>Population (000s)</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>28896</td>
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<td>5.1%</td>
</tr>
<tr>
<td>5 – 9</td>
<td>31204</td>
<td>5.5%</td>
<td>10.7%</td>
</tr>
<tr>
<td>10 – 14</td>
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<td>5.2%</td>
<td>15.9%</td>
</tr>
<tr>
<td>15 – 19</td>
<td>30700</td>
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<td>21.4%</td>
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<tr>
<td>20 – 24</td>
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<td>5.4%</td>
<td>26.7%</td>
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<tr>
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<td>31.7%</td>
</tr>
<tr>
<td>30 – 34</td>
<td>27785</td>
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<td>36.7%</td>
</tr>
<tr>
<td>35 – 39</td>
<td>29509</td>
<td>5.2%</td>
<td>41.9%</td>
</tr>
<tr>
<td>40 – 44</td>
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</tr>
<tr>
<td>45 – 49</td>
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<tr>
<td>50 – 54</td>
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</tr>
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<td>60 – 64</td>
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<td>65 – 69</td>
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<td>70 – 74</td>
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<td>89.5%</td>
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<tr>
<td>75 – 79</td>
<td>24029</td>
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<td>93.7%</td>
</tr>
<tr>
<td>80 – 84</td>
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<td>96.9%</td>
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<td>85 – 89</td>
<td>11102</td>
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</tr>
<tr>
<td>90 and over</td>
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<td>100.0%</td>
</tr>
</tbody>
</table>

**Source:** Office for National Statistics

### England Total Resident population by five year age bands

<table>
<thead>
<tr>
<th>All Persons</th>
<th>Population (000s)</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
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<td>6.1%</td>
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<td>30.0%</td>
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<td>1813420</td>
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<td>95.1%</td>
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<td>1369854</td>
<td>2.5%</td>
<td>97.6%</td>
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<td>85 – 89</td>
<td>856812</td>
<td>1.5%</td>
<td>99.1%</td>
</tr>
<tr>
<td>90 and over</td>
<td>495244</td>
<td>0.9%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Source:** Office for National Statistics
### Cornwall & Isles of Scilly
#### Male Resident population by five year age bands

<table>
<thead>
<tr>
<th>Age group</th>
<th>Population (000s)</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>14819</td>
<td>5.4%</td>
<td>5.4%</td>
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<td>5 – 9</td>
<td>16057</td>
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<td>11.3%</td>
</tr>
<tr>
<td>10 – 14</td>
<td>15144</td>
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<td>16.8%</td>
</tr>
<tr>
<td>15 – 19</td>
<td>15759</td>
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<td>22.6%</td>
</tr>
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<td>20 – 24</td>
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<td>28.2%</td>
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<td>25 – 29</td>
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<td>38.4%</td>
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<td>14250</td>
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<td>43.5%</td>
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<td>18197</td>
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<td>55.6%</td>
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<td>70.1%</td>
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<td>18319</td>
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<td>76.8%</td>
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<td>90.6%</td>
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<td>75 – 79</td>
<td>11402</td>
<td>4.2%</td>
<td>94.8%</td>
</tr>
<tr>
<td>80 – 84</td>
<td>7944</td>
<td>2.9%</td>
<td>97.7%</td>
</tr>
<tr>
<td>85 – 89</td>
<td>4395</td>
<td>1.6%</td>
<td>99.3%</td>
</tr>
<tr>
<td>90 and over</td>
<td>1953</td>
<td>0.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>All ages</td>
<td>273,781</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

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

<table>
<thead>
<tr>
<th>Age group</th>
<th>Population (000s)</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>14077</td>
<td>4.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td>5 – 9</td>
<td>15147</td>
<td>5.2%</td>
<td>10.1%</td>
</tr>
<tr>
<td>10 – 14</td>
<td>15147</td>
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<td>15.1%</td>
</tr>
<tr>
<td>15 – 19</td>
<td>14941</td>
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<td>20.5%</td>
</tr>
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</tr>
<tr>
<td>25 – 29</td>
<td>13843</td>
<td>4.8%</td>
<td>30.4%</td>
</tr>
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<td>30 – 34</td>
<td>14382</td>
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<td>35 – 39</td>
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<td>40.6%</td>
</tr>
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<td>16297</td>
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<td>46.2%</td>
</tr>
<tr>
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<td>20209</td>
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<td>53.2%</td>
</tr>
<tr>
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<td>21658</td>
<td>7.5%</td>
<td>60.7%</td>
</tr>
<tr>
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<td>20707</td>
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<td>67.8%</td>
</tr>
<tr>
<td>60 – 64</td>
<td>19718</td>
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<td>74.6%</td>
</tr>
<tr>
<td>65 – 69</td>
<td>21009</td>
<td>7.2%</td>
<td>81.9%</td>
</tr>
<tr>
<td>70 – 74</td>
<td>19611</td>
<td>6.8%</td>
<td>88.6%</td>
</tr>
<tr>
<td>75 – 79</td>
<td>12627</td>
<td>4.4%</td>
<td>93.0%</td>
</tr>
<tr>
<td>80 – 84</td>
<td>9904</td>
<td>3.4%</td>
<td>96.4%</td>
</tr>
<tr>
<td>85 – 89</td>
<td>6707</td>
<td>2.3%</td>
<td>98.7%</td>
</tr>
<tr>
<td>90 and over</td>
<td>4462</td>
<td>1.5%</td>
<td>100.3%</td>
</tr>
<tr>
<td>All ages</td>
<td>289,827</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Office for National Statistics
Under 18 conceptions

Under 18 conceptions (number and rates)\(^1\) 2000 - 2016\(^2\)

<table>
<thead>
<tr>
<th>Area of usual residence (^3)</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>142</td>
<td>161</td>
<td>175</td>
<td>199</td>
</tr>
<tr>
<td>England</td>
<td>17,014</td>
<td>19,080</td>
<td>21,282</td>
<td>22,830</td>
</tr>
<tr>
<td>South West</td>
<td>1,396</td>
<td>1,518</td>
<td>1,721</td>
<td>1,948</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

Notes:

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
<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>242</td>
<td>26.1</td>
</tr>
<tr>
<td>2011</td>
<td>279</td>
<td>30.3</td>
</tr>
<tr>
<td>2010</td>
<td>309</td>
<td>32.9</td>
</tr>
<tr>
<td>2009</td>
<td>292</td>
<td>30.5</td>
</tr>
<tr>
<td>2008</td>
<td>346</td>
<td>35.9</td>
</tr>
<tr>
<td>2007</td>
<td>322</td>
<td>33.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>26,157</td>
<td>27.7</td>
</tr>
<tr>
<td>2011</td>
<td>29,166</td>
<td>30.7</td>
</tr>
<tr>
<td>2010</td>
<td>32,552</td>
<td>34.2</td>
</tr>
<tr>
<td>2009</td>
<td>35,966</td>
<td>37.1</td>
</tr>
<tr>
<td>2008</td>
<td>38,783</td>
<td>39.7</td>
</tr>
<tr>
<td>2007</td>
<td>40,366</td>
<td>41.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Conceptions</th>
<th>Conception rate per 1,000 women in age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2,292</td>
<td>24.8</td>
</tr>
<tr>
<td>2011</td>
<td>2,552</td>
<td>27.3</td>
</tr>
<tr>
<td>2010</td>
<td>2,813</td>
<td>29.9</td>
</tr>
<tr>
<td>2009</td>
<td>3,077</td>
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</tr>
<tr>
<td>2008</td>
<td>3,347</td>
<td>34.9</td>
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<tr>
<td>2007</td>
<td>3,500</td>
<td>36.2</td>
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Trend in under 18 conceptions (number and rates) 1998 - 2016

Source: Office for National Statistics
Under 18 conceptions (number and rates)\(^1\) 2007 - 2016\(^2\)

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of usual residence (^3)</td>
<td>Maternity rate per 1,000 women in age group</td>
<td>Abortion rate per 1,000 women in age group</td>
<td>Maternity rate per 1,000 women in age group</td>
<td>Abortion rate per 1,000 women in age group</td>
</tr>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>6.2</td>
<td>9.8</td>
<td>8.9</td>
<td>8.8</td>
</tr>
<tr>
<td>England</td>
<td>9.1</td>
<td>9.8</td>
<td>10.1</td>
<td>10.6</td>
</tr>
<tr>
<td>South West</td>
<td>7.2</td>
<td>8.6</td>
<td>7.7</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

Mortality statistics

Mortality statistics - underlying cause, sex and age, 2016 (A00-R99,U00-Y89 All causes, all ages)

<table>
<thead>
<tr>
<th>Cornwall and the Isles of Scilly</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>All Ages</td>
<td>3,066</td>
<td>3,240</td>
</tr>
<tr>
<td>Under 1</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>1-4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5-14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>36</td>
<td>14</td>
</tr>
<tr>
<td>35-44</td>
<td>44</td>
<td>24</td>
</tr>
<tr>
<td>45-54</td>
<td>105</td>
<td>86</td>
</tr>
<tr>
<td>55-64</td>
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<td>184</td>
</tr>
<tr>
<td>65-74</td>
<td>633</td>
<td>428</td>
</tr>
<tr>
<td>75-84</td>
<td>936</td>
<td>783</td>
</tr>
<tr>
<td>85+</td>
<td>1,018</td>
<td>1,704</td>
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Source: Office for National Statistics
### Year 2016-2012

<table>
<thead>
<tr>
<th>Area of usual residence</th>
<th>Maternity rate per 1,000 women in age group</th>
<th>Abortion rate per 1,000 women in age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall UA and Isles of Scilly UA</td>
<td>6.2</td>
<td>9.8</td>
</tr>
<tr>
<td>England</td>
<td>9.1</td>
<td>9.8</td>
</tr>
<tr>
<td>South West</td>
<td>7.2</td>
<td>8.6</td>
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Source: Office for National Statistics
Update on the Director of Public Health
Annual Report 2017

“Health starts where we live”
Recommendations from 2017

The 2017 Public Health Annual Report presented the evidence linking health and wellbeing with the home, and set out 12 recommendations to strengthen the relationship between housing and health in Cornwall:

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 wellbeing, 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.
Update on progress

The report demonstrated that the home environment is more than the physical condition of the housing stock that we live in, and also includes the supply, affordability and the wider built and natural environment. The home environment influences almost every aspect of our lives, including how well we sleep, how often we see our friends and how safe and secure we feel, and is therefore essential to our health and wellbeing.

While much of the work linking health and the home is routinely addressed by other departments within the Council or partner agencies through our statutory duties, the 12 recommendations looked to strengthen the communication and engagement between built environment and health professionals to support the health and wellbeing of residents.

Following the launch of the 2017 Public Health Annual Report, we held a Health and Housing Roundtable event with stakeholders from across Cornwall Council, NHS Kernow, Devon and Cornwall Police, Cornwall Home Solutions, the University of Exeter, affordable housing and private landlord representatives, and the voluntary sector to further develop these recommendations.

We have developed a Health and Housing Memorandum of Understanding (MOU) to establish a shared commitment to joint action across the Council, health, and housing sectors in Cornwall. The MOU sets out our shared objectives, including the 12 recommendations of the Annual Report and the further recommendations made by participants of the Health and Housing Roundtable, detail how we plan to work together, and enable an integrated approach to delivering health through the home for the benefit of all residents. This was approved by the Health and Wellbeing Board (Sept 18) and launched/signed at the Housing and Construction Conference (September 2018).

Around 350 homes have had first time central heating fitted with more to follow through £8m Warm and Well Cornwall Public Health led programme to retrofit and upgrade heating in homes, annual Winter Wellbeing Programme (assist circa 1,500 households a year, and Concession Agreement with SSE (run from 2017-2021) to support energy efficiency improvements. Improved joint working with Private Sector Housing to upgrade private rented housing using new powers under MEES (Minimum Energy Efficiency Standards) and Housing Health Safety Rating System (HHSRS). Development of evidence studies to inform current practice and lessons for future, through Smartline programme (Coastline/European Social Fund).

Public Health (Cornwall Council) has produced Cold Homes Toolkits for national use in health sector and local authorities, in partnership with Citizens Advice and on behalf of Government (Department of Business Energy and Industrial Strategy (BEIS)). Information sharing is part of the Toolkits.
Glossary and abbreviations

**Affluent**
The Index of Multiple Deprivation is designed to identify aspects of deprivation, not affluence. For example, the measure of income deprivation is concerned with people on low incomes who are in receipt of benefits and tax credits. An area with a relatively small proportion of people on low incomes may also have relatively few or no people on high incomes. Such an area may be ranked among the least deprived in the country, but it is not necessarily among the most affluent.

**Attachment**
Attachment theory states that a strong emotional and physical attachment to at least one primary caregiver is critical to personal development.

**Bronchiolitis**
Bronchiolitis is caused by a virus known as the respiratory syncytial virus (RSV), which is spread through tiny droplets of liquid from the coughs or sneezes of someone who’s infected. The infection causes the smallest airways in the lungs (the bronchioles) to become infected and inflamed.

**Congenital**
a disease or physical abnormality present from birth.

**(Mental health) crisis**
Everybody will have a different experience of a mental health crisis or emergency, but in general, this happens when a person cannot cope or be in control of their behaviour.

**Decile**
Ten equal groups into which a population can be split.

**Deprivation**
The Index of Multiple Deprivation measures relative deprivation in an area and is suitable for use where deprivation is concentrated in small areas. Within every area there will be individuals who are deprived and individuals who are not. The Index is not a suitable tool for targeting individuals.

**Equivalisation**
Equivalisation adjusts incomes for household size and composition, taking an adult couple with no children as the reference point. For example, the process of equivalisation would adjust the income of a single person upwards, so their income can be compared directly to the standard of living for a couple.

**Fibromyalgia**
Fibromyalgia, also called fibromyalgia syndrome (FMS), is a long-term condition that causes pain all over the body. As well as widespread pain, people with fibromyalgia may also have: increased sensitivity to pain, fatigue (extreme tiredness) muscle stiffness.

**Gastrointestinal**
Relating to the stomach and the intestines.

**Herd immunity**
The resistance to the spread of a contagious disease within a population that results if a sufficiently high proportion of individuals are immune to the disease, especially through vaccination.

**Indicator**
A thing that indicates the state or level of something.

**Median**
Median household income divides the population, when ranked by equivalised household income, into two equal-sized groups. Contemporary median income refers to the median income in the survey year being considered.

**Paediatric**
Relating to the branch of medicine dealing with children and their diseases

**Perinatal**
occuring during or pertaining to the phase surrounding the time of birth, usually from the twentieth week of gestation to the twenty-eighth day of newborn life. In this report Perinatal refers to any time during pregnancy and the first year of an infants life.
Postpartum
Following childbirth.

Prematurity
The birth of a baby at fewer than 37 weeks gestational age.

Psychiatric
Relating to mental illness or treatment.

Respiratory
Relating to or affecting respiration, breathing, or the organs of respiration, the lungs.

Toxic stress
Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity, such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship, without adequate adult support.

Trimester
A period of three months, especially as a division of the duration of pregnancy.

Macrosomia
The term “fetal macrosomia” is used to describe a newborn who's significantly larger than average.

Multidisciplinary
Combining or involving several academic disciplines or professional specialisations in an approach to a topic or problem.

Resilience
The capacity to recover quickly from difficulties

ACE’s (Adverse Childhood Experiences)
ASQ (Ages and Stages Questionnaire)
BMI (Body Mass Index)
CPFT (Cornwall Partnership NHS Foundation trust)
LSOA (Lower Supper Output Area)
MSOA (Middle Supper Output Areas)
NCMP (National Child Measurement Programme)
PHOF (Public Health Outcomes Framework)
RCHT (Royal Cornwall Hospitals Trust)
UNICEF (United Nations International Children’s Emergency Fund)
WHO (World Health Organisation)
Contact us

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