

# Director of Public Health Kirklees

## Annual Report 2020 - 21



# FOREWORD

The purpose of this report is to **explore the nature and scale of health inequalities experienced by our communities in Kirklees**, using a **life course approach** to explore health inequalities from birth to the end of life. When we talk about health inequalities, differences in life expectancy and healthy life expectancy between demographic groups are often discussed. These are, of course, important differences in outcomes which must be highlighted and addressed as a priority. However, if we wish to improve the inequalities in years lived, we must address the inequalities that are present in childhood and throughout adulthood.

This also means addressing the **wider determinants of health**; the social, economic and environmental factors which influence our behaviours and opportunities for health.



Large and enduring health inequalities have always been present across society, but the **impacts of the COVID-19 pandemic** over the past year have rightly brought these inequalities to the forefront of people's minds. The pandemic has exposed and exacerbated the unjust and systemic inequalities in health and its determinants faced by many groups. If action is not taken to address these inequalities, the health and socioeconomic impacts of the pandemic threaten to further widen health inequalities and make more people vulnerable to poor health. The report therefore also highlights some of the significant impacts of COVID on our communities and across the life course, indicating challenges that are both ongoing and may be faced in the future.

**Health inequalities, and the conditions which lead to them, are not inevitable.** They can be addressed and reduced, but doing so requires deliberate action. Addressing inequalities is a priority for Kirklees Council, and builds on our vision to work with people and partners, using a place-based approach to improve outcomes for our local population, particularly those who are currently most disadvantaged and at risk of poor health.

Such action requires implementation of the principles which are core to both public health and local government:

- Using intelligence and insight to understand our local populations and inform action
- Using evidence-informed approaches
- Considering equity in all decision-making
- Working with and empowering people and communities
- Working with partners across our local place to achieve impactful and sustainable change

Improving health inequalities is a challenge. But seeing the inspiring efforts of Council colleagues and Councillors, our partner organisations, our communities, and volunteers in responding to the challenges of COVID-19 shows the humbling desire to do good and protect each other that we have in Kirklees, even in the most difficult of circumstances. **I would like to thank every colleague, Councillor, volunteer, and resident for the part each of you have played in protecting our communities over the past year – as Director of Public Health, I have never been more proud at seeing our combined efforts to help each other, and particularly to protect our most vulnerable populations.**

  
**Rachel Spencer-Henshall,**  
Director of Public Health

## ACKNOWLEDGEMENTS

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Nia Community Collective (NCC)  
- Local Community Group

# AN INTRODUCTION TO HEALTH INEQUALITIES

## WHAT ARE HEALTH INEQUALITIES?

Health inequalities are *avoidable and unfair differences in health outcomes between different people or groups* (1)

These differences in health can include:

- health status, for example, **life expectancy**, **healthy life expectancy** and **prevalence of health conditions**
- **behaviours important to health** (e.g. smoking rates)
- **access to services** (e.g. availability of healthcare services and other important resources for health and wellbeing)
- **quality and experience of health services** (e.g. levels of patient satisfaction)

## WHO EXPERIENCES HEALTH INEQUALITIES?

Health inequalities are observed **across a range of dimensions** (1) and between many different groups. In England, health inequalities are often analysed and addressed across four factors:

- **socio-economic factors**
- **geography**, for example, region or whether urban or rural
- **specific characteristics** including those protected in law, such as **sex**, **ethnicity** or **disability**
- **socially excluded groups**, for example, people experiencing homelessness.

## WHY ARE HEALTH INEQUALITIES A PRIORITY?

### The moral case:

Addressing health inequalities is a matter of fairness and social justice. People living in the least deprived areas of the country live around 20 years longer in good health than people in the most deprived areas (2). Reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are.

### The economic case:

Action taken to reduce health inequalities will benefit society in many ways, including reducing the economic losses associated with illness and premature death and disability related to health inequalities (productivity losses, reduced tax revenue, higher welfare payment, increased demand on health and care services, increased treatment costs) – in 2010 the Institute for Health Equity estimated that these combined costs total around £57 billion or more per year in England (3) – this figure will now be higher.

### Improving society and outcomes for all:

Global evidence suggests that even those not disadvantaged by inequalities benefit from living in a more equal society: societies with greater equality experience better outcomes at all levels (4).

# HOW CAN WE MEASURE INEQUALITIES?

## THE INDEX OF MULTIPLE DEPRIVATION

The Index of Multiple Deprivation (IMD) is the tool used to measure the overall relative deprivation of areas. **People living in the most deprived areas consistently have worse health outcomes than those living in the least deprived areas.**

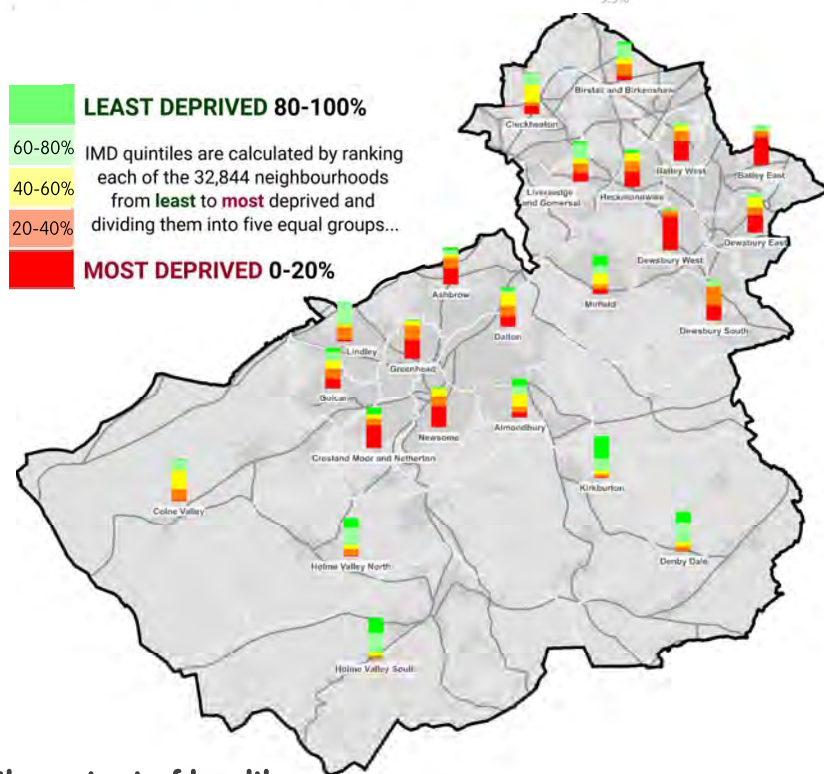
The IMD combines many indicators under 7 domains: income; employment; education; health; crime; barriers to housing and services; and living environment.

Based on these measures, the IMD 2019 (5) **rank Kirklees as 83 out of 317 local authorities in England** (where 317 is the least deprived, 1 the most deprived). For the income and employment domains, Kirklees is ranked as one of the most deprived local authorities in England (11 for income and 13 for employment).

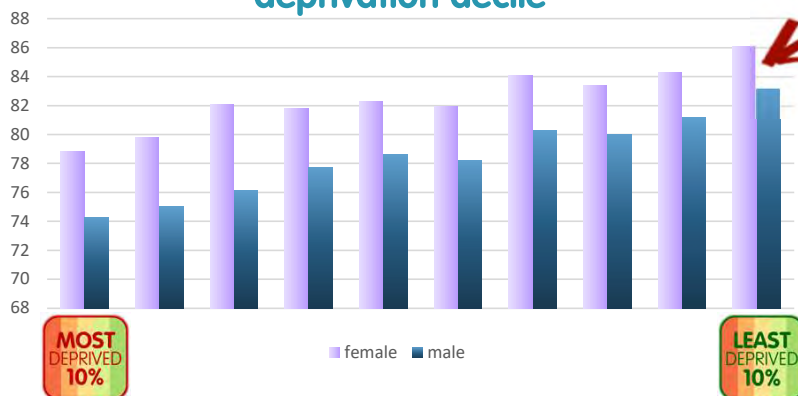
Within Kirklees, **the extent of relative deprivation varies greatly across the district**, with some wards having a high concentration of some of the most deprived areas in the countries, and others predominantly made up of some of the least deprived areas.

Using local IMD rankings, we can **measure the extent of health inequalities within our communities** by comparing health indicators, such as life expectancy between the most and least deprived – this demonstrates **the social gradient in health**.

### The seven domains of the IMD:



### Life expectancy at birth in Kirklees by deprivation decile



**8.9 year gap for men**  
**7.3 year gap for women**

In recent years, **the gap** has been **increasing** for **women**

& **life expectancy for women** in the **most deprived** areas has **decreased**



# HOW INEQUALITIES DATA IS PRESENTED IN THIS REPORT

## INEQUALITIES KEY

Throughout this report **inequalities in health and wider outcomes experienced by various different communities and demographic groups** will be highlighted. Communities frequently discussed and the icons used to signify facts or inequalities relating to them in this report are presented below. “Protected characteristics” refers to characteristics that are protected from discrimination by law (6).



**Deprivation deciles** show differences in outcomes between those living in the 10% most deprived areas and those in the 10% least deprived areas.



**Deprivation quintiles** show differences in outcomes between those living in the 20% most deprived areas and those in the 20% least deprived areas. Quintiles are sometimes used when numbers within deciles are small.



Inequalities can be compared between different **geographic areas**. In this report, we compare Kirklees figures to the **national figure**. Arrows show whether the Kirklees figure is higher or lower than England. Where applicable, green shows that Kirklees has better outcomes and red worse outcomes.



**Ethnicity** is a protected characteristic, and **people from black and minority ethnic communities** experience a range of health and wider inequalities.

Where ethnicity is recorded in data sources, any inequalities by ethnicity will be highlighted. It is worth noting that the recording of ethnicity can be inconsistent or sometimes not recorded at all – this is a **data development agenda** that should be addressed. Significant differences can exist between different ethnic minority groups; where appropriate and possible, a more nuanced ethnicity breakdown will be shown.



**Sexual orientation** is also a protected characteristic, and **lesbian, gay, bisexual (LGB)** and people with other non-heterosexual orientations can experience inequalities.

**Gender reassignment** is also a protected characteristics, but all **trans and non-binary** people may experience discrimination and inequalities.

Where LGBT+ data shows an inequality, this will be highlighted. Where possible, sexual orientation and trans data will be shown separately. However, **LGBT+ data is not always available**, meaning inequalities may go undocumented.



**Children living in poverty** experience many inequalities throughout childhood, including health inequalities.

One way we can measure these inequalities experienced by children living in poverty locally is by looking at the **outcomes for children receiving free school meals (FSM)**, and inequalities between FSM pupils and pupils not receiving FSM.



Both children and adults who have **English as an Additional Language (EAL)** can experience inequalities, sometimes due to issues with language accessibility and discrimination.

Annual school Census data allows us to look at children's outcomes and inequalities by EAL status. EAL data for adults is not always as readily available.



**Gender** is a protected characteristics, and we know there are gender inequalities in both health and the wider determinants of health.



**Disability** is a protected characteristics, and encompasses physical, mental, and learning disabilities. Evidence shows that people with disability experience significant health inequalities, as well as wider socioeconomic inequalities.

**Age** is a protected characteristics. Health outcomes vary significantly by age; this will be explored by looking at health and inequalities across the life course.

It is worth noting that there are other groups that we know from national evidence experience health inequalities or may be particularly vulnerable to poor health, including groups who have typically been excluded from services. These are sometimes known as **‘health inclusion groups’** and any action on health inequalities should consider these groups:

- **Migrants, refugees, and asylum seekers**
- **Gypsy and Traveller communities**
- Vulnerable **homeless** people and **rough sleepers**
- **Prisoners** and **offenders identified by the criminal justice system**
- **Sex workers**

# WHAT INFLUENCES HEALTH INEQUALITIES?

How well and how long people live is mainly linked to the **wider determinants of health**...

As little as **10%** of a population's **health and wellbeing** is linked to access to health care (7)

We need to look at the bigger picture...



Wider determinants are a diverse range of **social, economic and environmental factors** which impact on people's health.

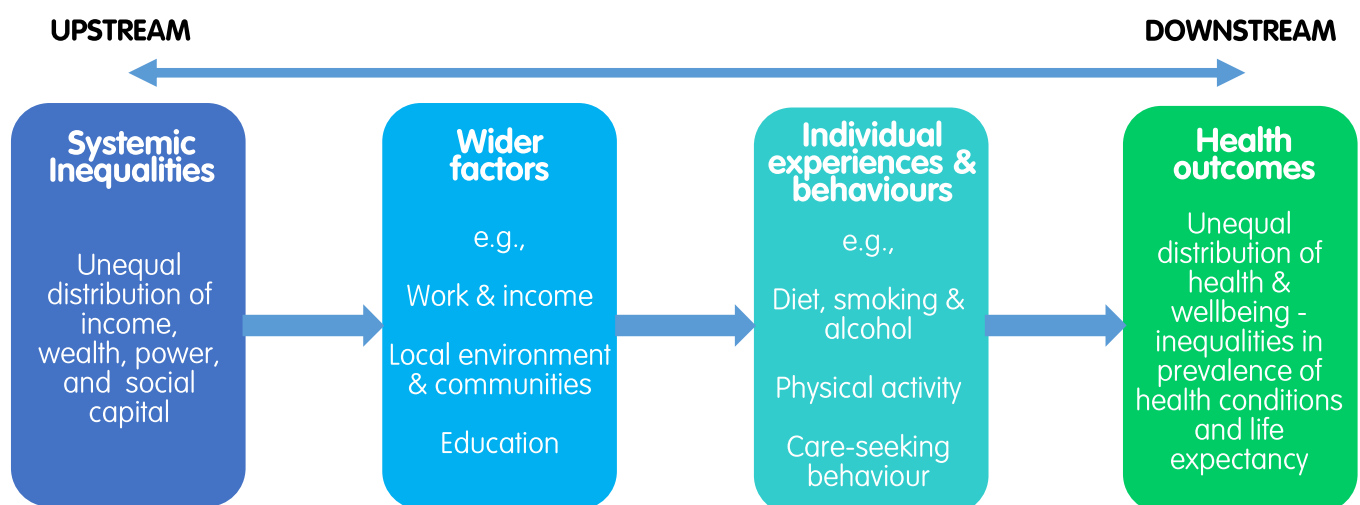
These are **the conditions in which people are born, grow, live, work and age**.

These circumstances are shaped by the **distribution of money, power and resources**.

These wider determinants **affect people in different ways**, according to factors like age, gender, ethnicity, sexuality and disability.

These '**causes of causes**' influence our **behaviours** – unhealthy behaviours are not usually the origin of poor health, but the end point of a long chain of causes and consequences in people's lives.

From wider inequalities to health inequalities: **systemic inequalities influence the wider determinants of health, which results in differential health outcomes**



# A LIFE COURSE APPROACH

The **wider determinants influence health and wellbeing outcomes and inequalities throughout life...**

## WHAT IS A LIFE COURSE APPROACH?

Whereas a disease-orientated approach focuses on a single conditions and interventions targeted at single conditions, a life course approach considers **the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.**

Life course epidemiology is the study of long-term biological, behavioural and social processes that link health in later life to physical or social exposures during gestation, childhood, adolescence, adult life or across generations. The life course approach to public health is based on evidence that experiences and exposures to hazards (physical and social) in early life stages affect health outcomes in later life stages (3).

### Example: Mental health

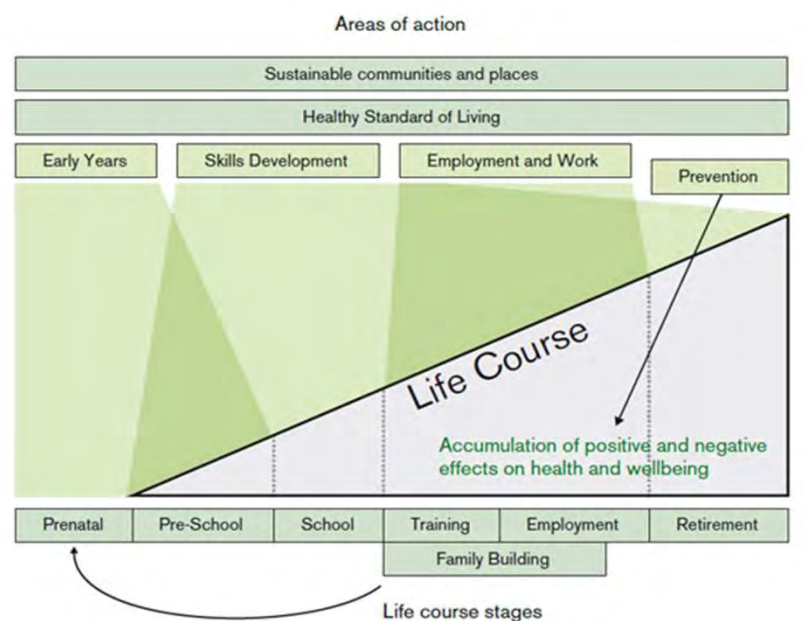
Evidence indicates that mental health problems are often established when people are young, with research showing that half of all lifetime cases of mental illness begin by age 14, and three quarters develop by the age of 24 (9). This highlights the importance of taking a life course approach to public health, and the need for preventative action in childhood if we are to reduce the prevalence of and inequalities in mental health problems at a population level.

## WHY TAKE A LIFE COURSE APPROACH?

One of the primary purposes of taking action across the life course is to **maximise the positive effects and minimise the negative effects of how the wider determinants of health influence people's outcomes across the life course.**

What a child experiences during the early years (starting in the womb), including their physical, social, and cognitive development, lays down a foundation for the whole of their life, strongly influences their school-readiness and educational attainment, which in turn influences their adult socioeconomic opportunities and long-term health. The influence of wider determinants, socioeconomic circumstances, experiences and behaviours throughout adulthood then further influence what our health and wellbeing, and ultimately our life expectancy, will be in later life.

**Different stages of the life course bring different potential risks to health, and therefore different opportunities to improve current and future health and to reduce health inequalities.**



Source: *Action across the life course, Marmot Review (2010)* (3)

## In this report, the life course is presented over 7 different stages:

**New beginnings (conception – age 2)**

**Early challenges (age 3 – 10)**

**Character development (age 11 – 17)**

**Seizing opportunities (age 18 – 34)**

**Settling down (age 35 – 59)**

**Changing pace (age 60 – 79)**

**Taking stock (age 80+)**

In reality, an individual's life trajectory will be constituted by clearly defined stages with precise age boundaries, but the stages used in this report are intended to approximately represent some of the main stages and transitions most people will experience from birth to end of life.



# APPROACHES TO HEALTH INEQUALITIES

The key principles for improving opportunities for health for everyone and tackling inequalities align with Our Council Plan approach of working with people and partners using a place-based approach

Kirklees 2030:

People — Partners — Place

We will work with people and partners using a place-based approach.

### Person-centred

Person-centred means *working with* people rather than *doing to*. Interventions at the individual level should be designed to meet that individuals particular needs, and take a holistic view of them as a person, rather than using a single-issue lens. Our **Wellness Service** is an example of this, working with people on a one-to-one basis to develop personally tailored health and wellbeing goals.

### Whole-system approaches

Whole-system approaches recognise that public health issues are complex, and influenced by a wide range of factors and partners outside the control of the health and care sector. **Health in All Policies** is a collaborative approach to embed health considerations across different service areas and sectors, acknowledging the whole-system influence on health outcomes.

### Localised approaches

Recognising that “one size doesn’t fit all”, and communities and local places are diverse, with different needs, and unique strengths and assets. We work in a place-based way to **understand community priorities** and the **best approach for each place**.

### Empowering communities

There is extensive evidence that connected and empowered communities are healthy communities. This means building **community resilience**, strengthening our communities to take action on the things that matter to them, and engaging with our communities as partners.

### Partnership working

Integral to whole-system approaches is partnership working: **identifying shared priorities** and **opportunities for collaboration**.

### Intelligence-driven

Decision-making on health inequalities should be **led by data and intelligence**, enabling the identification of at-risk populations and **areas where we could have the most impact** in improving outcomes.

An approach which can combine these elements is...

## POPULATION HEALTH MANAGEMENT

**Population Health** is an approach aimed at **improving the health of an entire population**.

It is about **improving the physical and mental health outcomes** and wellbeing of people, whilst **reducing health inequalities** within and across a defined population. It includes action to reduce the occurrence of ill-health, including **addressing wider determinants of health**, and requires **working with communities and partner agencies**.



**Population Health Management** improves population health by **data driven planning and delivery of proactive interventions to achieve maximum impact**.

Population data is analysed and modelled to identify local ‘at-risk’ cohorts, allowing interventions to more effectively prevent and manage ill health to be designed and targeted to meet local population needs. This can be at an individual, community, place or system level.



# THE IMPACT OF COVID-19

Over the last year, COVID-19 has **highlighted and exacerbated existing inequalities**; because of existing health and socioeconomic inequalities, **some groups are more at risk of both direct and indirect impacts of COVID**.

- Some groups have unequal direct exposure to the virus because of the influence of socioeconomic factors (e.g. working in frontline occupations or essential roles).
- Some people's situations may make it harder for them adhere to guidance, making them more likely to be exposed to the virus (e.g. those experiencing economic hardship, living in shared housing, or undertaking caring roles).
- Some groups are more likely to have poorer outcomes from COVID-19, such as older people, BAME communities, people with disabilities, and people with certain long-term health conditions
- Some people who already have health conditions or risk factors are further disadvantaged by COVID-19 restrictions (such as reduced access to treatment or support services).
- Some groups are more likely to be disproportionately affected by the indirect impacts of COVID-19, particularly the socioeconomic impacts of the pandemic and COVID regulations and guidance - many people have experienced job losses and reductions in their incomes.
- There are concerns that delays and pauses in screening and diagnostics and other preventative services will result in increasing inequalities if health and public health services are not reopened in an inclusive way which aims to prevent health inequalities from widening further.

## The same pandemic, unequal impacts: How people are experiencing the pandemic differently

It's been clear from the early stages of the COVID-19 pandemic that some groups are more affected than others.



**People living in the poorest areas are at higher risk from COVID-19**

People in the most affluent areas are **50% less likely** to die of COVID-19 than those in the poorest areas.



**Black and minority ethnic communities are more affected by COVID-19**

People of black ethnicity are **4 times as likely** to die from COVID-19 compared to people of white ethnicity.



**Disabled people have been hit particularly hard**

Disabled people have experienced death rates **2 to 3 times higher** than non-disabled people.



**Young people are most likely to lose employment**

One in three of 18–24-year-olds have been furloughed or lost their job – **twice the rate** of working-age adults.



**Health and social care workers have an increased risk of adverse mental health outcomes**

**4 in 5** social care workers in Scotland reported their work during COVID-19 negatively impacted their mental health.

# THE IMPACT OF COVID-19: community insight

## Vulnerable groups and poverty:

"Covid-19 has demonstrated the best of communities and of partnerships. This has been displayed in many ways, but perhaps none more so than in relationship with food – particularly enabling food access for vulnerable groups. Lockdown presented many challenges for vulnerable people – a dwindling food supply, challenges of affordability and many isolated people who had no one to support them to buy food. The local, place based response to enabling access to food has highlighted that despite the varied and complex challenges which the pandemic brought, communities across Kirklees were able to work together to meet local need. Within days of lockdown, local Councillors, community anchors, and Mutual Aid Groups were working together to deliver food to people who needed it most. This was in a variety of forms – hot food delivery, foodbanks, food distribution and food donations. There was an overwhelming response from communities across Kirklees which clearly showed the brilliance of partnerships and the depths of local compassion.

From a council perspective, we provided Public Health staff to work in the foodbanks, had Kirklees Neighbourhood Housing and local welfare staff and vans out delivering food and supported the foodbanks with maintaining their food supply. Local councillors also worked at local level to connect and support residents to food and other essential items. Public Health staff worked in the foodbanks for 2 months and KNH continue to deliver food to residents across Kirklees. Our local welfare provision continues to provide specialist support to many of our residents who find themselves in incredibly challenging circumstances."

- Lucy Wearmouth, Public Health Manager

## BAME communities:

We know from both national and local evidence that BAME communities face disproportionately higher risks from COVID-19, and have also in some cases experienced heightened stigma and negative attention due to this. This highlighted and exacerbated the systemic racism that many of our communities still face, but grassroots responses to the pandemic from within these communities has also shown the strength of their community assets and opportunities for the Council to support and work with these local community networks.

### Black African and Caribbean communities:

"Nia Community Collective (NCC) is a collation of grassroots-based community groups that was formed in the wake of the death to George Floyd, an event which put a microscope on systemic and institutional inequalities. NCC has set out to understand the issues of the Black Caribbean and African community in Kirklees by hosting consultation meetings and surveys to capture their lived experiences.

Our engagement has highlighted the impact of the pandemic in our community. Our community has experienced significant loss and faced challenges such as organising funerals and engaging in ancestral and cultural traditions such as Nine Nights. Members of our community work in jobs where they are unable to work from home e.g. hospitals, shops, factories, care homes, taxi drivers, transport, delivery couriers etc. This puts them at higher risk of contracting Covid-19 as statistics have shown.

*One survey respondent stated: 'I contracted COVID-19 so it has impacted on me directly.....because of all of the publicity I was very scared and thought I might die....I think it has affected my mental health and I think there has been too much scare-mongering in our community....like a death threat hanging over us.'*

There is a lack of trust in the government on a number of issues and distrust in the community around the Covid-19 vaccine. We are linking with Kirklees Council and the NHS as well as working with grassroots organisations to develop culturally competent interventions to address the issues faced by our community with particular focus on the impact of Covid-19, mental health as well as other health related issues."

- Nia Community Collective (NCC) leaders

### South Asian communities:

"Kirklees has had a sizeable South Asian population since the 1950s and supporting these and other communities has been a key responsibility in the pandemic response. Faith and community centres were established initially to provide very specific support before growing to meet wider community challenges. These were established and continue to run through volunteering. During the first COVID-19 lockdown this volunteering habit quickly established local groups relying on community kindness to provide support to people from all backgrounds.

However, the government's restriction of movement on the night of Eid led some in the Muslim community, who make up the majority of the South Asian community in Kirklees, to feel that they were being targeted. In addition, some narratives around the increased risk of COVID in South Asian communities have ignored the wider determinants that contribute to the disproportionate risk they face – such as being frontline workers, living in densely populated areas, and facing existing health inequalities – instead often appearing to blame the South Asian community for being at a higher risk of COVID.

It has been a challenging time with community norms, for example around funerals, being drastically changed. This has been hard for many to cope with.

In the post COVID-19 era addressing the inequalities, challenging perceptions and establishing trust will be key to working with the community and countering the impact of COVID-19."

- Cohesion Team, Kirklees Council

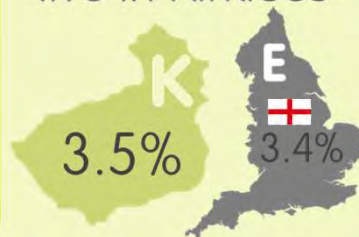


# NEW BEGINNINGS

Beginning at conception until a child's second birthday, the first 1000 days are a time of both enormous potential and vulnerability. Maternal health during pregnancy has a profound impact on her baby's ability to thrive. A child's early nutrition, environment and relationships are the foundation for their lifelong health. Positive early experiences have a huge effect on adaptability, resilience and achievement. Conversely, children are especially vulnerable to persistent negative influence during this period. Early support is considerably more effective in ensuring the best life chances than later interventions.

POPULATION

Around **15,500** 0-2 year olds live in Kirklees



The General Fertility Rate has fallen over the past 10 years  
68.8/1000 (2010) → 60.2/1000 (2019)

**At booking:**  
28% are obese (+22%)  
18% are smokers (+13%)

**At delivery:**  
73% initiate breastfeeding (+67%)  
12% are smokers (+10%)

8.8% ALL BABIES (+7.4%)  
3.4% TERM BABIES (+2.9%)  
44% breastfeeding at 6-8 weeks (+48%)

Life Expectancy at birth: 78.7 (2019) → 82.5 (2020)

Healthy Life Expectancy at birth: 60.5 (2019) → 63.4 (2020)

The Infant Mortality rate in Kirklees is increasing:  
2015-17: 4.9  
2016-18: 5.3  
2017-19: 6.2

The proportion of 0-2 year olds living in Relative Poverty is also rising:  
2016/17: 24.5%  
2017/18: 25.3%  
2018/19: 27.9%

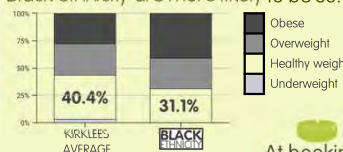


89% of children in Kirklees are at the expected level of development at age 2-2½ (+83%)

INEQUALITIES

## Health in pregnancy

In Kirklees, most pregnant women are above a healthy weight at the time of their booking appointment. Mothers of **Black ethnicity** are more likely to be so.



Smoking during pregnancy also disproportionately affects certain groups. At the time of booking, younger mothers, those of Mixed or White ethnicity and those living in the most deprived areas are more likely to smoke.

	At booking	At delivery
ASIAN ETHNICITY	4.0%	1.4%
BLACK ETHNICITY	5.7%	4.2%
Age 35-44	12.2%	8.5%
LEAST DEPRIVED 20%	14.2%	9.7%
KIRKLEES AVERAGE	17.8%	12.3%
MOST DEPRIVED 20%	19.4%	12.6%
WHITE ETHNICITY	22.2%	17.7%
MIXED ETHNICITY	26.4%	19.4%
Age 18-24	30.5%	21.7%

By 6 weeks, only **3 in 10** babies are exclusively breastfed & **over half of babies** don't receive any human milk.

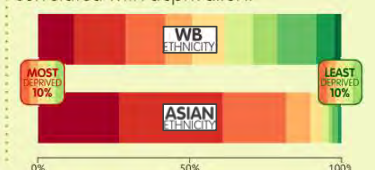
A proportion of pregnant women continue to smoke throughout pregnancy; there is a similar decline across all demographic groups.  
**1 in 8** babies born to mothers who smoke have low birth weight, compared with **1 in 20** who are born to non-smoking mothers.

## Health at birth

Most babies are breastfed when they are born, however certain groups are more likely than others to initiate breastfeeding. Culture, education, support, delivery type & self-efficacy can contribute to breastfeeding outcomes. Only **54.4%** of babies born to younger (18-24) White British mothers receive any breastmilk.

	Breastfeeding initiation
BLACK ETHNICITY	89.4%
Age 35-44	78.7%
LEAST DEPRIVED 20%	78.0%
KIRKLEES AVERAGE	72.6%
WHITE ETHNICITY	68.1%
Age 18-24	65.6%

More than half of Asian babies live in the most deprived IMD quintile. They are a third more likely than White British babies to be born with low birth weight, which is correlated with deprivation:

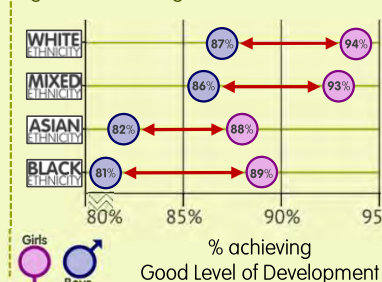


## Infant Mortality

The increase in Infant Mortality in Kirklees mirrors the rise in child poverty. Locally, **3 in 4** babies are born into households within the most deprived half of neighbourhoods:



National data shows that developmental inequalities are already emerging by age 2-2½ across genders and ethnicities:



COVID-19

COVID-19 changed the way health services are delivered, including some **maternity services**. We worked with maternity services and our local Maternity Voices Partnership to run a **survey for those who used local maternity services during the pandemic...**

Overall, experience of **face-to-face antenatal appointments, care during labour/birth, and support with infant feeding** was generally positive.  
For all of these services **over 84%** said their experience was **very good or good**

However, there were **inequalities** within this...  
**poor or very poor experience:**  
care during labour/birth: 8.2% (White) → 14.3% (BAME)  
infant feeding support: 5.2% (White) → 22.3% (BAME)  
BAME women **4X more likely** to report a poor experience

POPULATION HEALTH MANAGEMENT



Auntie Pam's is a support service for mums-to-be, and mums and their babies across Kirklees. Auntie Pam's was set up to provide a co-produced service to address a range of poor health outcomes and behaviours. The service is driven by **encouraging take-up by health-disadvantaged and marginalised women**, using **peer-support approaches** and being **led by service-user feedback**. With support from Auntie Pam's, women have been less likely to disengage from health and social care services, and have engaged more confidently in discussing and understanding the different aspects of their pregnancy, birth and parenthood.  
In 2020, Auntie Pam's started offering a **targeted smoking cessation offer aimed at reducing smoking in pregnancy by offering consistent and inclusive support**. Local maternity services directly refer women to the service for support, which is **predominantly provided by volunteers** who are Level 2 Smoking Cessation trained.

**General fertility rate:** Birth rate per 1,000 females aged 15 to 44 years  
**Infant Mortality:** Infant deaths under 1 year of age per 1000 live births  
**Relative poverty:** Living in a household with an income that is low relative to other households, as determined by whether the income is below 60 per cent of median income, before housing costs  
**Low birth weight:** All births (live and still births) with a recorded birth weight under 2500g

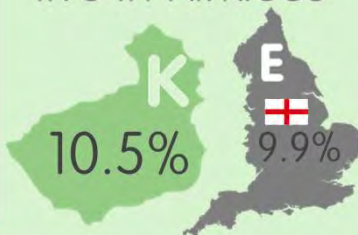
**Preterm birth:** A gestational age of less than 37 complete weeks  
**Good level of development at 2-2½:** Percentage of children who received a 2-2½ year review who were at or above the expected level in the in all five Ages and Stages Questionnaire-3 (ASQ-3) domains (Communication, Gross & Fine Motor Skills, Problem Solving, & Personal-Social)



# EARLY CHALLENGES

Following on from the first 1000 days, this stage of early childhood is the other significant period of the life course where benefits are reaped at later ages from ensuring that children get the best start in life. Schooling and educational attainment, along with building friendships, are a key part of this stage. Inequalities begin to emerge in both education attainment and healthy weight. Inequalities exist for children from the most deprived areas, those in receipt of Free School Meals, and some from ethnic minority groups, particularly Black children. It is also worrying that 1 in 4 young children in Kirklees are living in poverty.

Around **46,300**  
**3-10 year olds**  
live in Kirklees

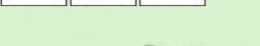


**70%** of children meet the expected standard of development by the end of their first year at Primary school

**23.0%** of children are above a healthy weight at the start of Primary school

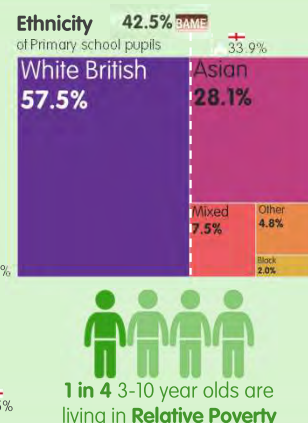
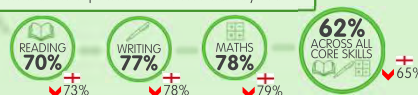
**62%** of children are at the expected standard in reading, writing & maths when they start Secondary school

The proportion of Primary school pupils eligible for **FSM** is increasing



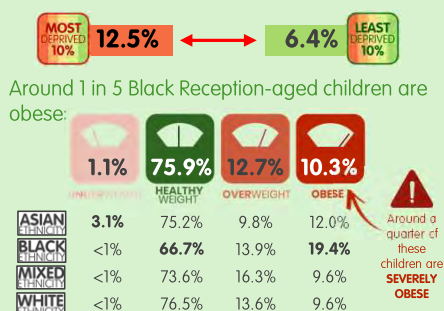
**79%** achieve at the expected level by Year 1

Achievement at the expected level in core skills by Year 6...



## Excess weight

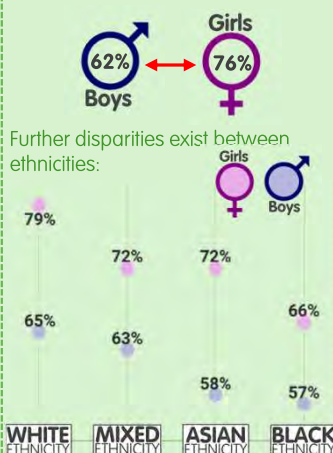
Levels of childhood obesity in Kirklees are rising in line with nationally. **Obesity** in children starting school is around **twice as prevalent** in those living in the most deprived areas compared to the least:



Only a small number of overweight and obese children return to a healthy weight in Year 6. However, **fewer children from Black and Asian groups, and those from more deprived areas** are returning to a healthy weight status.

## Attainment: beginning of Primary school

By age 4 to 5 years old, boys are less likely than girls to be at the expected standard of development:



Pupils eligible for free school meals are also less likely to be at the expected level by the **end of Reception**.

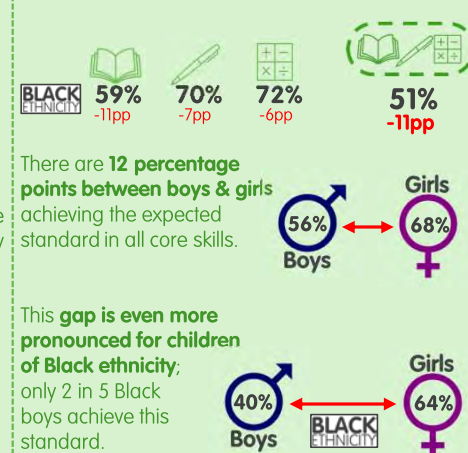


By the **end of Year one**, those eligible for FSM are still significantly less likely than their peers to be at the expected standard according to phonics screening.



## Attainment: end of Primary school

The ethnicity attainment gap continues throughout Primary school. By **Year 6**, children of Black ethnicity fall behind their peers in **all three core skills**:



There are **12 percentage points** between boys & girls achieving the expected standard in all core skills.

This **gap is even more pronounced for children of Black ethnicity**; only 2 in 5 Black boys achieve this standard.

The **wider impacts** of COVID-19 on **schooling** and **families** have raised a number of concerns about young children...

- The impact of **missed education on cognitive and social development** – **nearly half of all primary school children in Kirklees missed school due to COVID-19 between September-December 2020**
- Not all children have **access to technology for online learning**
- Increased risk of **experiencing adverse childhood experiences (ACEs)**, as there is evidence that domestic violence increased during lockdown
- The impact of increased family poverty, including **food insecurity**...

### Ensuring no child goes hungry

With rising unemployment, financial pressures, and foodbank referrals, there were national and local concerns about children going hungry during school holidays. When the government refused to fund free school meals during the October half-term, **the Council stepped in to provide free school meals** during the October and Christmas holidays – **ensuring more than 14,000 children in Kirklees would not have to go hungry**.

We take a **life course, whole-system** and **place-based** approach to **tackling obesity**, informed by **local intelligence**...

Ravensthorpe Junior School Head teacher contacted Kirklees Public Health at the end of 2016, concerned that **data** showed high levels of obesity within the school. A **working group with a range of partners** was established, with a **collaborative whole system/whole school approach** adopted. A **pupil/parent survey** was conducted to focus actions on areas of impact. Some of the **achievements to-date** include...

- Daily physical activity integrated into the school day**
- Healthy Ramadan activities and communications**
- Targeted health literacy workshops for both parents and pupils**
- Workshop for parents on healthy packed lunches**
- An increase in children taking part in and passing bikeability sessions**

**Excess weight:** Proportion of children classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference according to age and sex.

**Relative poverty:** Living in a household with an income that is low relative to other households, as determined by whether the income is below 60 per cent of median income, before housing costs.

**Expected level of development at 4-5:** Having reached at least the expected level in the early learning goals in the prime areas of learning- mathematics; literacy; personal, social and emotional development; physical development; communication and language.

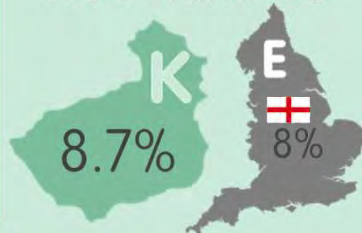
**Expected level of development at 10-11:** Having reached at least the expected level in reading, writing and mathematics.



# CHARACTER DEVELOPMENT

This is a stage of life which encapsulates much of adolescence; the gradual transition from childhood to adulthood, where young people are establishing their sense of identity, developing aspirations, and laying the groundwork for the future. It is a period which varies greatly across cultures and demographic groups, but one which features some universal similarities. It is a time to develop skills, knowledge and resilience, and acquire the independence which is an important part of adulthood. Health and attainment at this age is an important predictor of outcomes in adulthood, and it is therefore concerning that we see stark inequalities in both health and education outcomes at this stage.

Around **38,300**  
**11-17 year olds**  
live in Kirklees



36.3% of children are above a healthy weight when they start Secondary school  $\uparrow 35.2\%$



At age 15-16, the average Attainment 8 score is **45.4**  $\downarrow 46.9$

The rate of teen pregnancy has halved to **0.8%** over the last decade, in line with national trends  $\downarrow 0.7\%$

The proportion of Secondary school pupils eligible for **FSM** is increasing



The 2019 Young People's Survey revealed...

5% are smokers

72% feel in good health

3.1% of 16-17 year olds who are NEET is falling  $\downarrow 5.5\%$

EAL

21.3%  $\uparrow 17.1\%$

11.3% have a SEN  $\uparrow 12.9\%$

Ethnicity

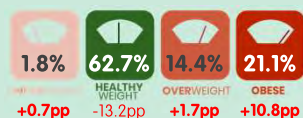
of Secondary school pupils



1 in 10 14-year-olds identify as being **LGBT+**

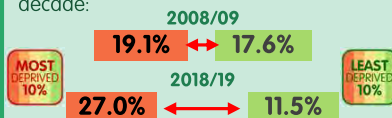
## Excess weight

A substantial number of children **move out of the healthy weight category** as they pass through Primary school:



Compared with Reception data:

The **Obesity gap at age 10 to 11**, between those living in the most and least deprived areas, has been widening over the last decade:



Black children continue to be disproportionately affected by obesity at age 10 to 11; **27.4%** of this group is obese.

## Physical & emotional health & wellbeing

The results of our annual Young People's Wellbeing Survey revealed some of the disparities between the general population & **LGBT+** young people at age 13 to 14.

1 in 5 compared to 1 in 10 **worry about being the victim of crime**

7 in 10 compared to 4 in 10 **worry about not fitting in**

1 in 3 compared to 1 in 5 **have been involved in "sexting"**

**LGBT+** young people are...

...more than 3x as likely to say their health is bad

...2x as likely to worry about bullying

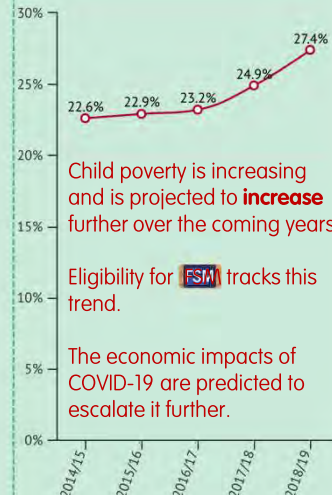
...almost 3x more likely to smoke

## Attainment 8

By the end of Key Stage 4, the average 'Attainment 8' score varies greatly amongst different groups.

ASIAN ETHNICITY	48.6
KIRKLEES AVERAGE	45.4
WHITE ETHNICITY	42.1
MIXED ETHNICITY	40.7
BLACK ETHNICITY	38.2
FSM	33.4
SEN (No statement)	28.1
Looked After Children	25.1
SEN (EHCP)	13.6

## Recent poverty trend



Child poverty is increasing and is projected to **increase further** over the coming years.

Eligibility for **FSM** tracks this trend.

The economic impacts of COVID-19 are predicted to escalate it further.

More than three-quarters of 11-17 year olds **living in relative poverty** are from **working families**

There have been **ongoing disruptions to education**, which **will potentially have long-lasting impacts**...

**More than half of secondary pupils in Kirklees missed some schooling between Sep-Dec 2020 due to COVID-19**

In summer 2020, we surveyed 11-16 year olds. When asked about returning to school...

- "What are you most worried about?"
1. Forgetting some of the things I'd learnt before
  2. Finding learning hard
  3. Not having time to get used to a new routine

Before 2020 A-level grading switched to teacher assessment, 40% of pupils had their grades downgraded – **those from the most disadvantaged areas were more likely to be downgraded (1)**. This resulted in some students losing university places before the switched to teacher-assessed grades.



There are **17 Community Hubs** across Kirklees, bringing together local networks of schools to work together with partners to deliver a range of services for children and families. The hubs enable **place-based working**, where schools, wider partners and families, supported by the Council can **identify local priorities for action** and **how best to implement actions** and **utilise community assets**.

The Young People's Survey is an **annual survey of all Year 9 pupils** in Kirklees, asking young people about their health, wellbeing, behaviours, and other topics such as social media. This is a key source of intelligence used to **inform public health actions**, **identify inequalities** or health needs amongst young people, and **give insight** to schools and community hubs.



**Good health:** Reporting their general health to be "good" or "very good".

**Excess weight:** Proportion of children aged 10-11 years classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference according to age and sex.

**NEET:** Not in education, employment or training.

**Child poverty:** children living in relative poverty, defined as living in a household with an income that is low relative to other households, as determined by whether the income is below 60 per cent of median income, before housing costs.

**Attainment 8:** Average score based on revised GCSE grading, from 9 (highest/best) to 1 (lowest/worst).



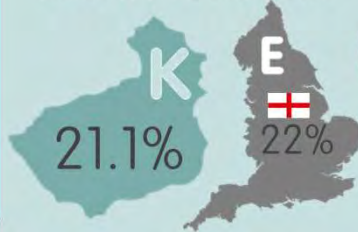
# SEIZING OPPORTUNITIES

Early adulthood is a significant transitional period, where young adults move into further education and employment. For many, this will mean living independently for the first time. This period brings opportunities: careers are started, social networks are grown, health behaviours and habits are formed, some may become parents, and important decisions which will influence the rest of the life course are made. However, this period can also be precarious and challenging, with some groups experiencing inequalities in education, employment, income and health, with mental health being of particular concern for this age group. Those who experienced inequalities in childhood are most likely to continue to experience inequalities into adulthood.

## POPULATION

Around **92,800**  
**18-34 year olds**

live in Kirklees



63% report having a LTC

41% are above a healthy weight

74% feel in good health

20% smoke

7% are living with a disability (20-34 only)

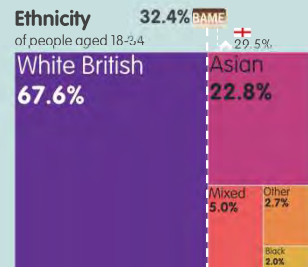
9 in 10 feel confident in managing their own health

7 in 10 have a high level of life satisfaction

1 in 10 consume above the recommended alcohol limit; lower than any other adult age group

3 in 10 worry about money most or all of the time; higher than any other adult age group

Fewer than half of 18-34 year olds own their own home

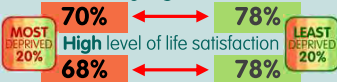


Age 16-24: 5.3% are LGB  
Age 25-34: 3.7% are LGB

## INEQUALITIES

### Health

Even in early adulthood, deprivation-based inequalities are evident:  
Feeling in **good health**



SWEMWBS mean wellbeing scores across IMD quintiles show the correlation between deprivation and wellbeing in those aged 18-34:

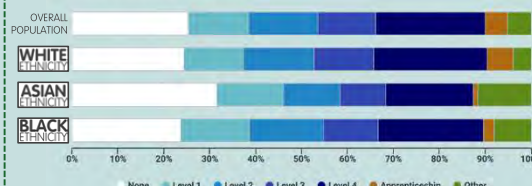


More than **1 in 3** 18-34 year olds have a mental health condition. Whilst the self-reported prevalence is higher in White British adults, a lower proportion of BAME adults with mental health conditions are accessing services:



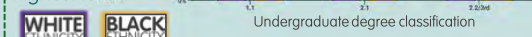
### Education

In Kirklees, adults of Asian ethnicity are more likely to be unqualified than other groups.



Locally, fewer than half of disabled adults are qualified to Level 2 or above (46% compared to 59% overall).

Nationally, there has been an increase in the proportion of Black adults gaining a place in higher education, however, they are less than half as likely as their White peers to achieve at the highest level.



### Economic

Nationally, the gender pay gap increases with age due to...

...increasing gender equality over time resulting in closer employment and pay equality for younger people

...the impact of having children on women's earning over their lives

The **median** gender pay gap in Kirklees is lower than nationally:



**BAME** people are underrepresented in both local government and NHS senior management and leadership positions.

The **mean** gender pay gap in Kirklees Council is almost three times higher than the local government average (5.0%):

**Kirklees Council = 14.2%**

Disabled adults are more likely than the Kirklees average to live in a lower income household (<£20k pa).

Post-graduation, **national average earnings across ethnicities differ considerably.**

	+1 year	+5 years	+10 years
All	£19,900	£26,000	£30,500
Indian	£21,900	£28,500	£33,100
Pakistani	£18,400	£22,400	£24,700
African	£19,500	£23,900	£28,700
Caribbean	£18,000	£23,300	£27,500
White	£20,000	£26,100	£30,700

## COVID-19

The proportion of **working-age people claiming unemployment benefits in Kirklees** has **more than doubled to 6.8%** (12-months to Oct-2020).

### National data shows... (1)

Young adults have been worst affected by unemployment and economic impacts

Unemployment rates are **highest** in those aged 18-24 and 25-49

People aged 16-25 were **more than 2x more likely** than older workers to have **lost their job**

**6 in 10** people aged 16-25 saw their **incomes fall**

Young adults are also **more likely** to have been affected by...

Increased prevalence of **mental health problems**

Missing rent or mortgage payments

Homes with **small living spaces** and **no garden access**

## POPULATION HEALTH MANAGEMENT

### Place Partnerships to support good mental health

The Council identified mental health as a priority, with £1m in funding allocated to **support good mental health in communities**. 7 'place partnerships', formed of neighbouring wards and led by a Councillor, were brought together to **identify place-based priorities** and allocate funding to **specific initiatives** to support these. **Intelligence packs**, with a range of mental health and wider indicators, were compiled for each place partnerships to **support place-based** and **intelligence-led decision making**.

**Funding has been committed for a number of local projects:**

**Mental Health Champions Training Programme and Support Network**

**Mental health first aid training**

**Improving access to green spaces**

**Promoting physical activity**

**A two-year pilot to better understand and raise awareness of menopause**



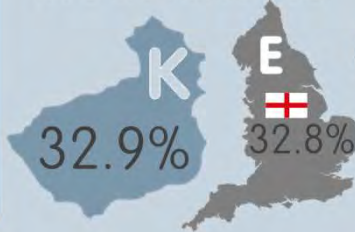
# SETTLING DOWN

This stage encompasses the largest part of someone's working life, but is also the stage where people are most likely to have caring responsibilities. Adults in this life stage are often working, caring for children, and may also be supporting elderly parents. These pressures and responsibilities may create barriers to healthy behaviours. For some, they may feel their health and wellbeing begin to decline and develop a long-term condition. Promoting resilience and confidence in managing health and wellbeing is important for this group, but there are large inequalities in people's subjective experience of their own health and their ability to manage it.

POPULATION

Around **144,600**  
**35-59 year olds**

live in Kirklees



73% report having a LTC

60% are above a healthy weight

63% feel in good health

17% smoke

16% are living with a disability

1 in 5 have caring responsibilities  
2 in 5 have children living at home  
4 in 5 are in employment  
1 in 20 have all three responsibilities

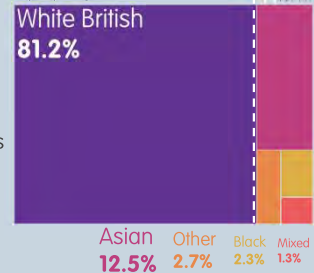
Significantly lower SWEMWBS score than other adult age groups

1 in 5 consume above the recommended alcohol limit

1 in 4 worry about money most or all of the time

7 in 10 35-59 year olds own their own home

Ethnicity of people aged 35-59

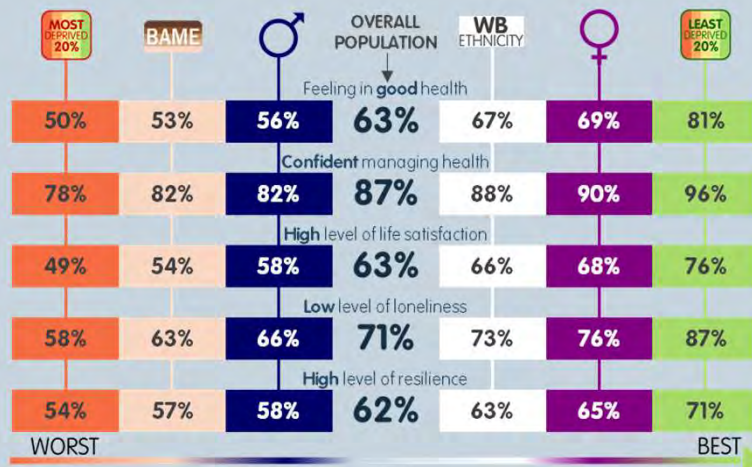


Age 35-49: 2.9% are LGB  
Age 50-64: 2.2% are LGB

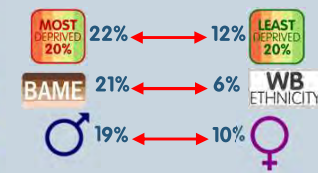
INEQUALITIES

## Subjective health & wellbeing

Five measures of subjective health & wellbeing demonstrate a pattern of significant inequality in Kirklees. Demographic groups, including those living in the most deprived quintile, males, and BAME adults consistently report lower average wellbeing and self-efficacy:



Of all the adult age groups, the 35-59 year olds are most likely to **lack important social connections (15%)**:

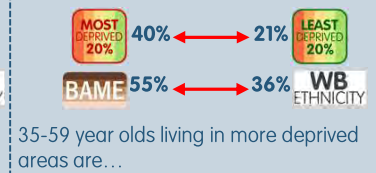


They are also the group most prone to experiencing **very frequent sleep problems (28%)**. There are significant differences between IMD quintiles:



## Employment

Employability, career mobility and therefore earning potential are often dependent on qualifications. **44% of this age group aren't qualified to Level 2**; there are inequalities relating to deprivation and ethnicity:



35-59 year olds living in more deprived areas are...

...more likely to have been prevented from working in the last 12 months by a physical or mental health condition:



...more likely to be on long-term sick leave/disabled:



COVID-19

The **older group of working-age adults** have been **significantly impacted by the economic consequences** of COVID-19, including **unemployment, furlough, and decreased income**.

The 35-59 age group has the largest number of **parents of school-age children**, therefore...

the **economic impacts** they face result in **rising child poverty**

**School closures and children self-isolating** means many parents have had to **homeschool**, sometimes **struggled for childcare**, had to take **time off work**, or **work from home with children**

National evidence shows some groups have been more impacted... (1)

A **third of working mothers lost work or hours** due to lack of childcare. This rose to **44% amongst BAME mothers**

The **gender gap** for time spent on **childcare** has grown (2)

POPULATION HEALTH MANAGEMENT

## Suicide Prevention

The **Kirklees Suicide Audit** told us that 119 people in Kirklees took their own life between 2016 and 2018.

The audit identified **important risk factors**: relationship breakdown; being single, divorced or separated; living alone; unemployment; debt; physical health problems; a mental health diagnosis

Data also shows that **men aged 46-55** are the group **most likely** to take their own life, and **three out of four suicides are men**

This intelligence informed...

The Kirklees suicide prevention action group took an **early intervention** and **prevention approach** to tackling suicide, setting up a **suicide prevention men's grant scheme**. Projects are **place-based** and **person-centred**, in areas of concern and fundamentally aim to reach disengaged men in activities that connect them and reduce isolation.



# CHANGING PACE

This is a stage of transition from working-age adulthood to older adulthood and retirement. People's health and quality of life can vary greatly during this period, in large part due to the influences of their experiences, environment and behaviours earlier in life. This is the most common stage of life for people's health to decline and them to acquire additional health needs; effective prevention and management of long-term conditions is therefore crucial. Getting prevention and early detection and management of disease right earlier in the life course can greatly improve outcomes in this stage. Inequalities in life expectancy are first seen during this stage, with premature mortality disproportionately affecting those living in the most deprived areas.

Around **82,000**  
**60-79 year olds**



86% report having a LTC

66% are above a healthy weight

55% feel in good health

11% smoke

40% are living with a disability

4 in 5 feel confident in managing their own health

1 in 3 feel resilient

1 in 5 consume above the recommended alcohol limit

1 in 10 people aged 60-79 need support to remain in their own home

1 in 3 live alone

1 in 5 experience frequent feelings of loneliness

Ethnicity of people aged 60-79

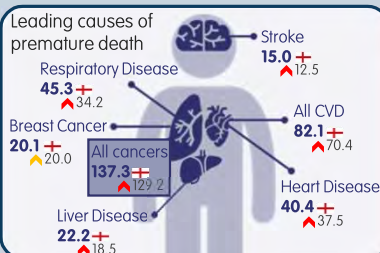
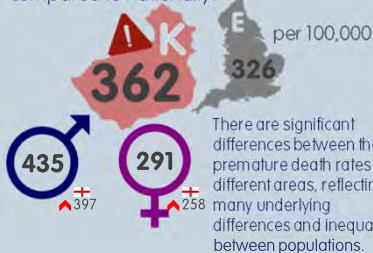
White British 90.5%

Asian 5.5%  
Other 2.4%  
Black 1.4%  
Mixed 0.3%

Healthy Life Expectancy at age 65  
73.2 (♂) 74.4 (♀)

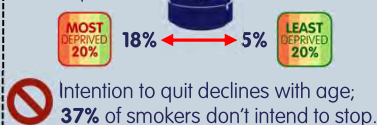
## Premature Mortality

The rate of premature mortality (under 75 years) is significantly higher in Kirklees compared to nationally:

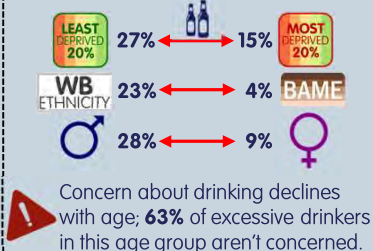


## Risk factors

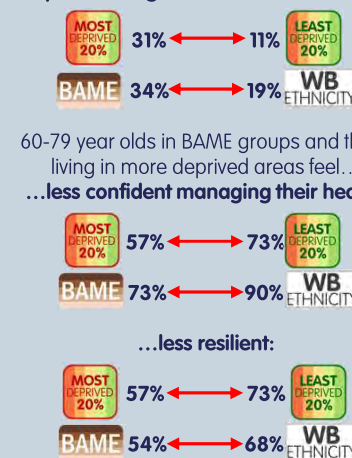
Those living in the **most deprived** neighbourhoods are more than 3 times as likely to **smoke** as those living in the least deprived:



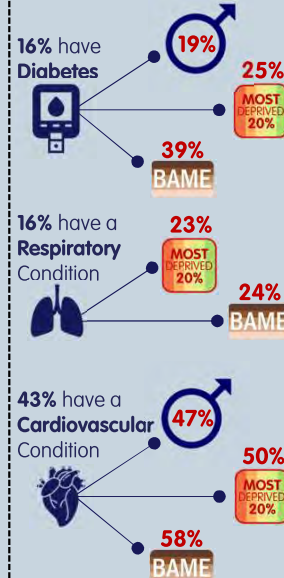
Conversely, those living in the **least deprived** areas are more likely to **drink** more than the recommended limit:



Social isolation and loneliness **significantly** increase risk for premature mortality. Those living in areas of high deprivation and BAME groups are at higher risk of experiencing frequent feelings of loneliness:



## Conditions



There are approximately **18,100 clinically extremely vulnerable people** in Kirklees, identified as being at **increased risk from COVID-19**, who were **asked to shield** themselves by staying at home and reducing contact with others for extended periods of time. This increased the risk of **social isolation**.

The **60-79 age group** has the **largest number of CEV people**. The age group represents 45% of the CEV list in Kirklees.



COVID-19 caused **delays and disruptions** to health services, including to **screening and diagnosis** services – such as **cancer screening** and diagnostics, and **health checks**.

There are concerns about what the **impact of these delays** will be on **health outcomes and inequalities** – there is therefore a **need to reopen services inclusively** and **target public health services**

## A place & person based approach to Health Checks

The NHS Health Check is a check-up for adults 40 to 74 every 5 years. The check is designed to spot early signs of cardiovascular (CVD) conditions, type 2 diabetes and dementia.

We are looking to **maximise the impact** of health checks, finding creative ways to **target and reach those most at risk of poor health** from CVD conditions, and to **provide person-centred support** to enable better outcomes for people. A pilot has been designed to **increase uptake** of Health Checks by groups disproportionately affected by CVD conditions, and support people to reduce their own risk and improve their wellbeing. The pilot will be delivered in a **Primary Care Network (PCN)**, allowing **local place insight** to be used to help **engage priority groups**. Data will be used to choose a PCN with a high-risk population and/or low health check take-up. The **Kirklees Wellness Service** will deliver the activity, complementing ongoing primary care activity.

### The Wellness Service

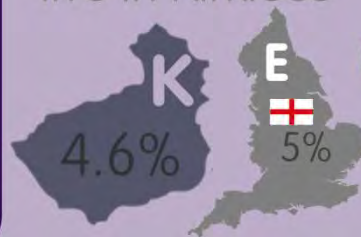
The Wellness Service is an integrated, holistic and wrap-around service, providing 1:1 support for adults to develop and achieve personally tailored health and wellbeing goals.



# TAKING STOCK

At this stage in life, the large majority of older adults are managing at least one long-term condition, and often more. Many will require ongoing health and social care, and effective community-based care is critical in promoting health for this age group. Both physical and cognitive impairments, including dementia, are common amongst this age group, and both of these can increase the risk of experiencing social isolation. Access to appropriate social care is crucial, but can be affected by affordability and availability. End of life care pathways and planning are important for ensuring people are comfortable and have their wishes respected as they reach the end of life.

Around **20,200** people aged 80+ live in Kirklees



89% report having a LTC

37% feel in good health

77% are living with a disability

44% need support with at least one daily care activity

55% live alone

1 in 4 have memory impairments

1 in 4 have visual impairments

1 in 2 have hearing impairments

1 in 4 people aged 80+ need support to remain in their own home

3 in 4 have mobility problems

1 in 3 has had a recent fall

3 in 10 experience frequent feelings of loneliness

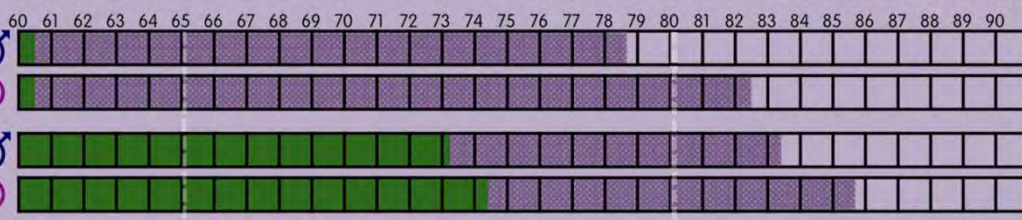
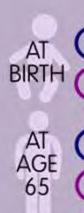
**Ethnicity** of people aged 80+  
White British 92.6%

Asian 3.3%  
Other 2.9%  
Black 1.0%  
Mixed 0.3%

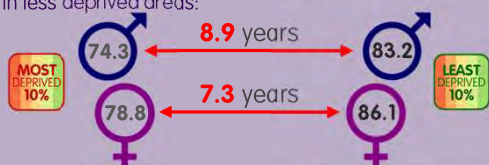
Life Expectancy at age 65  
Males 83.4  
Females 85.7

## Age-related inequalities

There are a number of ways in which older people can experience health inequalities. Disparities between life expectancy for males and females, a higher prevalence of sensory impairments, age-related mobility problems and availability of adequate support can all affect health status.



Children born into families living in the most deprived areas of Kirklees can expect to have a significantly shorter lifespan than those living in less deprived areas:



National data shows an even wider gap in healthy life expectancy. Compared with their counterparts living in the most deprived IMD decile, males living in the least deprived areas can expect to live 18.9 more years in good health and females, 19.4 years.

Of those age 65 to 79, 18% use a mobility aid..... This increases to 45% for those aged 80+

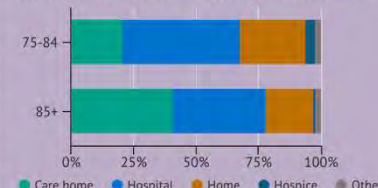
There are significant IMD inequalities in levels of dependency and in unmet need. Of those aged 65+, those living in the most deprived areas are more than twice as likely to require help with day-to-day living:

Most Deprived 20% | 47% | 21% | Least Deprived 20%

Furthermore, they are twice as likely to have an unmet support need:

Most Deprived 20% | 41% | 19% | Least Deprived 20%

Of those aged 75+, 1 in 10 live in a care home. The proportion of people dying in a care home increases with age, while deaths at home and in hospital decrease.



The 80+ age group is the most at-risk of hospitalisation and death from COVID-19

1 in 5 aged 80+ are CEV (clinically extremely vulnerable)

Among people with a positive test, those aged 80+ were 70x more likely to die (compared to those aged under 40)

Shielding and social restrictions have further increased social isolation and loneliness

Care homes have been significantly impacted by COVID-19

Up to the 20th Nov 2020, around 36% of COVID-related deaths were residents in care homes for older adults

Public Health England's review into disparities in risk and outcomes of COVID-19 found...

Most Deprived 20% had worse survival outcomes

BAME Black and Asian ethnic groups had the highest death rates

## Shared and integrated data to support shielding patients

At the start of the first wave of the COVID-19 pandemic, people identified as clinically extremely vulnerable were put onto a "Shielded Patients List" (SPL) asked to "shield", not leaving their homes at all. Kirklees Council, with partners, coordinated a local support offer. A call centre was set up to contact all local shielding patients to check what support they may need. The SPL was enhanced with data provided by healthcare partners and held on other council systems to ensure support was offered to the most vulnerable first

## Local partnerships and community assets



The Kirklees Dementia Hub is a partnership between Community Links and Age UK Calderdale & Kirklees and offers community activity, awareness raising and information and advice sessions for adults of any age a diagnosis of dementia.

The Kirklees Dementia Action Alliance (KDAA) has an aim to make Kirklees 'Dementia Friendly'. 'Dementia Friendly' training sessions can be provided by the alliance to businesses, schools and community groups.

DAA Kirklees Dementia Action Alliance

# SUMMARY

In Kirklees, **large and persistent inequalities in health and the wider determinants of health exist across the life course**. These inequalities affect many of our communities in Kirklees, and we see inequalities across a range of influences on health and between a range of demographics.

Viewing health outcomes and inequalities through a life course lens highlights the **different challenges and opportunities that each stage of the life course presents**, from the importance of early childhood experiences in influencing health and educational attainment, which in turn influences socioeconomic opportunities in early adulthood, which go on to have impacts on health outcomes throughout adulthood and ultimately life expectancy.

## KEY CHALLENGES AND OPPORTUNITIES FOR EACH LIFE STAGE

	CHALLENGES	OPPORTUNITIES
New beginnings: conception to 2	<ul style="list-style-type: none"> <li>The infant mortality rate in Kirklees has risen for the last 3 years, and is significantly higher than the national and regional rates</li> <li>Levels of smoking in pregnancy in Kirklees are significantly higher than the national average</li> <li>There are inequalities in breastfeeding initiation, and less than half of women are still breastfeeding at 6-8 weeks compared to nearly 3 in 4 at initiation</li> <li>Babies born to mothers of South Asian ethnicity are disproportionately more likely to have low birth weight</li> </ul>	<ul style="list-style-type: none"> <li>Focus on the first 1000 days, using our local assets (such as Auntie Pam's and the Nurturing Parents Programme), to target support with the aim of reducing inequalities</li> <li>Explore barriers and enablers for breastfeeding for new mums in our local communities</li> </ul>
Early challenges: Age 3 to 10	<ul style="list-style-type: none"> <li>Child poverty has been rising and is projected to rise further</li> <li>Nearly 1 in 4 children are above a healthy weight when they start school</li> <li>There is a significant educational attainment gap seen for pupils receiving Free School Meals</li> <li>There are attainment inequalities by ethnicity, particularly for Black pupils</li> </ul>	<ul style="list-style-type: none"> <li>Continue to work with and support our local foodbanks, while exploring opportunities to provide support for families living in financial precarity and prevent the need for foodbank use</li> <li>Review and consider expanding on the place-based healthy weight pilot in Ravensthorpe</li> <li>Continue building on the work of the Healthy Weight Declaration to make Kirklees a place that creates environments which support healthy weight, including for children</li> </ul>
Character development: Age 11 to 17	<ul style="list-style-type: none"> <li>Over a third of children are above a healthy weight when starting secondary school</li> <li>There are inequalities in excess weight – the gap between children in the most and least deprived areas has tripled since 2010</li> <li>Children of black ethnicity are disproportionately affected by excess weight</li> <li>Children identifying as LGBT+ are more likely to report poor wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>Continue to support the Community Hubs to identify local priorities for action, including for children and young people</li> <li>Explore opportunities to increase physical activity levels, healthy eating, and health literacy amongst children and young people</li> <li>Work with school wellbeing leads to understand mental health and wellbeing challenges young people face and how to address these</li> </ul>



## KEY CHALLENGES AND OPPORTUNITIES FOR EACH LIFE STAGE

	CHALLENGES	OPPORTUNITIES
<b>Seizing opportunities: Age 18 to 34</b>	<ul style="list-style-type: none"> <li>More than 1 in 3 18-34 year olds have a mental health condition and wellbeing scores for this age-group show a clear social gradient.</li> <li>A lower proportion of BAME adults with mental health conditions are accessing services compared to those of White British ethnicity.</li> <li>Locally, BAME adults are underrepresented in senior positions within the NHS and local government.</li> </ul>	<ul style="list-style-type: none"> <li>Continue to build on the work of mental health place partnerships, embedding action to support good mental health across our communities.</li> <li>Work with local partners to understand and address any barriers in accessing support for mental health.</li> <li>Continue to work on increasing inclusion and diversity and development opportunities within the Council, working with our employee networks.</li> </ul>
<b>Settling down: Age 35 to 59</b>	<ul style="list-style-type: none"> <li>Local intelligence shows that over half of 35-59 year olds are overweight or obese, and 17% are smokers.</li> <li>For self-reported measures of health, wellbeing, loneliness and resilience amongst adults in Kirklees, those living in the most deprived areas, men, and people of BAME ethnicity have outcomes significantly worse than the Kirklees average.</li> </ul>	<ul style="list-style-type: none"> <li>Use the opportunities provided by the Wellness Services to enable everyone to enjoy good health, wellbeing, and resilience.</li> <li>Explore more opportunities for the Wellness Service to undertake targeted work with priority groups, such as the Health Checks pilot.</li> </ul>
<b>Changing pace: Age 60 to 79</b>	<ul style="list-style-type: none"> <li>The rate of premature mortality (under 75 years) is significantly higher in Kirklees compared to England, and premature mortality has a clear social gradient.</li> <li>Nationally, there is a gap of over 20 years in Healthy Life Expectancy between those living in the most and least deprived areas. Locally, there is a 13 year gap between our wards with the highest and lowest HLE.</li> </ul>	<ul style="list-style-type: none"> <li>Continue to work with our Primary Care Networks and the CCGs to understand and address local health inequalities which contribute to lower Healthy Life Expectancy and premature mortality, including inequalities in cancer screening uptake.</li> </ul>
<b>Taking stock: Age 80 to end of life</b>	<ul style="list-style-type: none"> <li>45% of adults aged 80+ use a mobility aid, and sensory impairments are common.</li> <li>Over half of those aged 80+ live alone, and 3 in 10 report frequently feeling lonely</li> <li>There is a life expectancy gap of 8.9 years between men living in the most deprived areas and the least deprived areas of Kirklees, and a gap of 7.3 years for women.</li> </ul>	<ul style="list-style-type: none"> <li>Work with local assets, the VCSE sector, and PCNs to make Kirklees an age-friendly place where older people can maintain independence and health for as long as possible, as well as reducing social isolation amongst older people.</li> <li>Target preventative actions earlier in the life course as to reduce the inequalities in life expectancy seen in later life.</li> </ul>
<b>Across the life course</b>	<ul style="list-style-type: none"> <li>Those of BAME ethnicity and those living in the most deprived areas and/or from low income households consistently suffer health inequalities across each stage of the life course.</li> <li>These inequalities are seen in health behaviours, self-reported wellbeing, mental health, physical health conditions, the socioeconomic determinants of health, and, for those living in the most deprived areas, healthy life expectancy and life expectancy.</li> </ul>	<ul style="list-style-type: none"> <li>Embed action to enable good health across the Kirklees place and all council services using our Health in all Policies and partnership approaches.</li> <li>Review the health needs and opportunities for those groups most at risk of experiencing health and wider inequalities in Kirklees, including those living in poverty and BAME communities.</li> </ul>

# LOOKING FORWARDS...

## A COMMITMENT TO TACKLING INEQUALITIES: to reduce health inequalities and improve health and its determinants for all of our communities, deliberate action must be taken.

Such action must be both:

**Targeted and specific** – in order to address the most urgent inequalities experienced by particular groups.

**Embedded across everything we do** – to create health-enabling places and services which will improve outcomes for all, and particularly those experiencing the greatest disadvantage and health risks, in a sustainable way.

## RECOMMENDATIONS:

### People

1. Incorporate actions to address health inequalities and the wider determinants into the Wellness Service.
2. Undertake a Health Needs Assessment for children and adults living in poverty.
3. Engage the public and service users in any proposals to tackle inequalities.
4. Support increased health literacy and self-management of health and wellbeing.
5. Support and enable communities to continue building resilience and their capacity to act on their local priorities, building on the coproduction approaches which have been successful in the COVID-19 response.

### Partners

1. Fully engage partners across the Kirklees place in the commitment to tackle inequalities and the development of any proposals, including the health and social care system, other statutory services, and the voluntary, community, and social enterprise (VCSE) sector.
2. Work with local and regional networks to understand what actions may be taken at scale and share learning.
3. Establish shared priorities and actions on health inequalities with partners.
4. Use partnerships and commissioning to move towards equitable service provision, where services are delivered at a scale and intensity proportionate to the degree of need.

### Place

1. Continue to use and expand on our use of place-based approaches and partnerships, including building on the success of the place-based community engagement undertaken during the pandemic.
2. All decision-making should be led by a population health management approach, utilising local data and risk stratification. Also consider place and impactability (where and who to target to achieve the greatest impact).
3. Review any gaps in data and intelligence on inequalities and explore possibilities to address these, including population surveys and bespoke research.
4. Work with partners to create integrated datasets to support population health management and address data gaps.



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