HEALTH AND INEQUALITIES ACROSS THE LIFE COURSE

Director of Public Health Kirklees
Annual Report 2020 - 21
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

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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].
**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 ranks 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**.

![Life expectancy at birth in Kirklees by deprivation decile](image)

- **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 characteristic, 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 characteristic, and we know there are gender inequalities in both health and the wider determinants of health.

Disability is a protected characteristic, 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 characteristic. 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
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

UPSTREAM

Systemic Inequalities
Unequal distribution of income, wealth, power, and social capital

Wider factors
- e.g., Work & income
- Local environment & communities
- Education

Individual experiences & behaviours
- e.g., Diet, smoking & alcohol
- Physical activity
- Care-seeking behaviour

DOWNSTREAM

Health outcomes
- Unequal distribution of health & wellbeing - inequalities in prevalence of health conditions and life expectancy
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 condition 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.

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:

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.

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.

Partnership working

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

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 to 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.
- Black and minority ethnic communities are more affected by COVID-19.
- Disabled people have been hit particularly hard.
- Young people are most likely to lose employment.
- Health and social care workers have an increased risk of adverse mental health outcomes.

Source: The Same Pandemic, Unequal Impacts, The Health Foundation (2020)[9]
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 depth 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 scaremongering 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.

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

- 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.
  - 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 breast milk.
  - Smoking during pregnancy also disproportionally 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.

- Health at birth
  - 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.

- 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.

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% of White British women, 14.3% of BAME women
  - Infant feeding support: 5.2% of White British women, 22.3% of BAME women

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 differences and 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.

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

**Population**

**3-10 year olds**

Around 46,300 3-10 year olds live in Kirklees K 10.5%

**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:

- **Most deprived** 12.5%
- **Least deprived** 6.4%

Around 1 in 5 Black Reception-aged children are obese.

**Inequalities**

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.

**The wider impacts of COVID-19 on schooling and families**

- 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.

**COVID-19**

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.

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.

**Ethnicity**

- **White British** 57.5%
- **Asian** 28.1%
- **Other** 5.9%

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

- **62%** write or speak fluently in English
- **53%** achieve the expected level by Year 6
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.

At age 15-16, the average Attainment 8 score is 45.4.

The rate of teen pregnancy has halved to 0.8% over the last decade, in line with national trends.

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

72% feel good health.

The proportion of 16-17 year olds who are NEET is falling.

1 in 10 14-17 year olds identify as being gay.

Excess weight

A substantial number of children move out of the healthy weight category as they pass through primary school.

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.

Physical & emotional health & wellbeing

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

Attainment 8

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

Recent poverty trend

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

Ineligibility for FSM tracks this trend.

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

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

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.

COVID-19

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

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. This resulted in some students losing university places before the switched to teacher-assessed grades.

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.

SEN: 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 0 (lowest) to 1 (lowest).
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.

Aaround 92,800 18-34 year olds live in Kirklees 74% feel in good health 21.1% are living with a disability

POPULATION

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

Health

70% High level of life satisfaction

82% Least to Most

SWEMWBS mean wellbeing scores across 10 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.

INEQUALITIES

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

Education

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

The median gender pay gap in Kirklees is lower than nationally.

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

The proportion of working-age people claiming unemployment benefits in Kirklees has more than doubled to 6.8% (2019 to Oct-2020).

The Council identified mental health as a priority, with £1m in funding allocated to support good mental health in communities.

COVID-19

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

LTC, Long-Term Condition or Illness expected to last 12 months or more.

Exess weight Having a BMI of 25 or above.

SWEMWBS: The Short Warwick-Edinburgh Mental Wellbeing Scale is a validated measure of overall wellbeing using the mean metric score of responses to seven positively worded statements.
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.

Around 144,600 35-59 year olds live in Kirklees. 63% feel in good health, 17% smoke, and 6% are living with a disability. 73% report having a LTC. 60% are above a healthy weight. 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 of the time. 7 in 10 35-59 year olds own their own home.

**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.

<table>
<thead>
<tr>
<th>Overall Population</th>
<th>WB Ethnicity WB Ethnicity</th>
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<tbody>
<tr>
<td>Feeling in good health</td>
<td>63%</td>
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<tr>
<td>Confident managing health</td>
<td>82%</td>
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<tr>
<td>High level of life satisfaction</td>
<td>58%</td>
</tr>
<tr>
<td>Low level of loneliness</td>
<td>66%</td>
</tr>
<tr>
<td>High level of resilience</td>
<td>58%</td>
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</table>

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:

- Most to Least
  - WB Ethnicity: 25% to 6%
  - BAME: 21% to 6%
  - Not BAME: 55% to 36%

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.

**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.

**COVID-19**

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

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

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

The economic impacts they face result in rising child poverty.

National evidence shows some groups have been more impacted…

- 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.

**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, and 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.

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.
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.

82,000
60-79 year olds
live in Kirklees
55% feel in good health
11% smoke
40% are living with a disability
86% report having a LTC
66% are above a healthy weight
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

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

There are significant differences between the premature death rates in different areas, reflecting many underlying differences and inequalities between populations.

**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.
Intention to quit declines with age, 37% of smokers don’t intend to stop.

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

**Conditions**
16% have Diabetes
16% have a Respiratory Condition
43% have a Cardiovascular Condition

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 cardio-vascular (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

37% feel in good health

55% live alone

77% are living with a disability

44% need support with at least one daily care activity

1 in 4 have memory impairments

1 in 4 have visual impairments

1 in 2 have hearing impairments

1 in 2 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

White British 92.6%

Asian 3.3%

Other 3.1%

Mixedoker Other 1.0%

Life Expectancy at age 65

83.4

85.7

84.3

84.0

At birth

60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90

At age 65

74.3

83.2

78.8

86.3

8.9 years

7.3 years

6.0 years

5.4 years

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 are least

47%

21%

21%

41%

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

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:

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.

Share 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) to help "shield" them, i.e., 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.

COVID-19

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

Among people with a positive test, those aged 80+ were 70x more likely to die (compared to those aged under 65)

Care homes have been significantly impacted by COVID-19

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

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

Most had worse outcomes

BAME Black and Asian ethnic groups had the highest death rates

LTC: Long-Term Condition or illness expected to last 12 months or more.

Clinically extremely vulnerable (CEV). People who are defined as clinically extremely vulnerable are thought to be at very high risk of serious illness from coronavirus.

The Kirklees Dementia Hub

The Kirklees Dementia Action Alliance (KDAA)
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

<table>
<thead>
<tr>
<th>New beginnings: conception to 2</th>
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<tbody>
<tr>
<td>- The infant mortality rate in Kirklees has risen for the last 3 years, and is significantly higher than the national and regional rates</td>
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<tr>
<td>- Levels of smoking in pregnancy in Kirklees are significantly higher than the national average</td>
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<tr>
<td>- 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</td>
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<tr>
<td>- Babies born to mothers of South Asian ethnicity are disproportionately more likely to have low birth weight</td>
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<table>
<thead>
<tr>
<th>Early challenges: Age 3 to 10</th>
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<tbody>
<tr>
<td>- Child poverty has been rising and is projected to rise further</td>
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<tr>
<td>- Nearly 1 in 4 children are above a healthy weight when they start school</td>
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<tr>
<td>- There is a significant educational attainment gap seen for pupils receiving Free School Meals</td>
</tr>
<tr>
<td>- There are attainment inequalities by ethnicity, particularly for Black pupils</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Character development: Age 11 to 17</th>
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<tbody>
<tr>
<td>- Over a third of children are above a healthy weight when starting secondary school</td>
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<tr>
<td>- There are inequalities in excess weight – the gap between children in the most and least deprived areas has tripled since 2010</td>
</tr>
<tr>
<td>- Children of black ethnicity are disproportionately affected by excess weight</td>
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<tr>
<td>- Children identifying as LGBT+ are more likely to report poor wellbeing</td>
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#### Opportunities

<table>
<thead>
<tr>
<th>New beginnings: conception to 2</th>
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<tbody>
<tr>
<td>- 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</td>
</tr>
<tr>
<td>- Explore barriers and enablers for breastfeeding for new mums in our local communities</td>
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<table>
<thead>
<tr>
<th>Early challenges: Age 3 to 10</th>
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<tr>
<td>- 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</td>
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<tr>
<td>- Review and consider expanding on the place-based healthy weight pilot in Ravensthorpe</td>
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<tr>
<td>- 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</td>
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<thead>
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<th>Character development: Age 11 to 17</th>
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<tbody>
<tr>
<td>- Continue to support the Community Hubs to identify local priorities for action, including for children and young people</td>
</tr>
<tr>
<td>- Explore opportunities to increase physical activity levels, healthy eating, and health literacy amongst children and young people</td>
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<tr>
<td>- Work with school wellbeing leads to understand mental health and wellbeing challenges young people face and how to address these</td>
</tr>
<tr>
<td>Key Challenges and Opportunities for Each Life Stage</td>
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<tr>
<td>------------------------------------------------------</td>
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<tr>
<td><strong>Challenges</strong></td>
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<tr>
<td>• More than 1 in 3 18-34 year olds have a mental</td>
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<td>health condition and wellbeing scores for this</td>
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<td>age-group show a clear social gradient.</td>
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<td>• A lower proportion of BAME adults with mental</td>
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<td>health conditions are accessing services compared</td>
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<td>to those of White British ethnicity.</td>
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<td>• Locally, BAME adults are underrepresented in</td>
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<td>senior positions within the NHS and local</td>
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<td>government.</td>
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<td>• Local intelligence shows that over half of the</td>
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<td>35-59 year olds are overweight or obese, and 17%</td>
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<td>are smokers.</td>
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<td>• For self-reported measures of health, wellbeing,</td>
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<td>loneliness and resilience amongst adults in</td>
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<tr>
<td>Kirklees, those living in the most deprived</td>
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<tr>
<td>areas, men, and people of BAME ethnicity have</td>
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<td>outcomes significantly worse than the Kirklees</td>
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<td>average.</td>
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<tr>
<td>• The rate of premature mortality (under 75 years)</td>
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<td>is significantly higher in Kirklees compared to</td>
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<td>England, and premature mortality has a clear</td>
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<td>social gradient.</td>
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<td>• Nationally, there is a gap of over 20 years in</td>
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<td>Healthy Life Expectancy between those living in</td>
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<td>the most and least deprived areas. Locally, there</td>
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<td>is a 13 year gap between our wards with the</td>
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<td>highest and lowest HLE.</td>
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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.
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.
REFERENCES

Introduction pages:


Character development: Age 11 to 17


Seizing opportunities: Age 18 to 34


Settling down: Age 35 to 59


Taking stock: Age 80 to end of life
