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Tackling Health Inequalities

Date: 12th November 2024

Report of: Head of Democratic Services

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

- Health inequalities are systematic, unfair, and avoidable differences in health outcomes across the population and between different groups in society. They are connected to the conditions in which we are born, grow, live and work (the social determinants of health), our access and experience of healthcare (which can either amplify or mitigate against existing inequalities) and by commercial determinants. They are also related to individual factors – such as being from an inclusion health or protected characteristic group.
- Due to the wide range of factors that influence people's health, partners in Leeds, in particular the Local Authority, education, NHS services and the Third Sector all have a different but important role to play in tackling health inequalities.
- The Adults, Health and Active Lifestyles Scrutiny Board therefore agreed to utilise its November 2024 meeting to have a themed focus on how partners are working collaboratively towards tackling health inequalities in Leeds.
- Relevant information has therefore been provided to the Scrutiny Board by Public Health and the broader Leeds Health and Care Partnership, which is appended to this report.

Recommendations

Members are requested to consider and provide any comment on the information appended to this report as well as determining what, if any, further scrutiny work it may wish to undertake on this matter.

What is this report about?

1 The Adults, Health and Active Lifestyles Scrutiny Board agreed to utilise its November 2024 meeting to have a themed focus on tackling health inequalities.

2 To aid the Scrutiny Board's discussions, the following information has been provided:

- A report from Public Health (set out in Appendix 1) describing how the city council and specifically Public Health are working with partners to reduce health inequalities and provides an overview of the role and contribution of Leeds Public Health function.

- A report from the Leeds Health and Care Partnership (set out in Appendix 2) describing how partners providing health and care services are working to address health inequalities, including an update on the Healthy Leeds Plan and how partners are working to minimise the health inequality impact of cost improvement measures.

What impact will this proposal have?

3 Tackling health inequalities is everyone's business and while each individual organisation in the Leeds Health and Care Partnership has its own health inequality responsibilities, the Scrutiny Board is keen to explore how partners are working collaboratively towards tackling health inequalities in Leeds.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☒ Inclusive Growth ☒ Zero Carbon

4 The Best City Ambition states that by 2030, Leeds "will be a healthy and caring city for everyone: where those who are most likely to experience poverty improve their mental and physical health the fastest, people are living healthy lives for longer, and are supported to thrive from early years to later life". The contribution of the Leeds Health and Care Partnership to the health and wellbeing strategy is delivered through the Healthy Leeds plan. This also places inequalities centrally within its plans; its vision is for a "healthy and caring City for all ages where people who are the poorest improve their health the fastest".

What consultation and engagement has taken place?

Wards affected:		
Have ward members been consulted?	☐ Yes	☐ No

5 Representatives from Public Health and the Leeds Health and Care Partnership will be attending the Scrutiny Board's meeting to present the appended information and contribute to the Board's discussion.

What are the resource implications?

6 Details of any related resource implications will be captured within the appended information.

What are the key risks and how are they being managed?

7 Details of any related risk management implications will be captured within the appended information.

What are the legal implications?

8 This report has no specific legal implications.

Appendices

- Appendix 1 – A report from Public Health describing how the city council and specifically Public Health are working with partners to reduce health inequalities and provides an overview of the role and contribution of Leeds Public Health function.

- Appendix 2 - A report from the Leeds Health and Care Partnership describing how partners providing health and care services are working to address health inequalities, including an update on the Healthy Leeds Plan and how partners are working to minimise the health inequality impact of cost improvement measures.

Background papers

- None.

Reviewing progress in addressing health inequalities: Public Health (including Marmot City).

1 Purpose of report.

1.1 In Leeds, despite significant attention and effective partnership working over many years, health inequalities remain persistent, and, in some cases, improvements in key indicators have stalled or have begun to worsen. COVID -19 and the recent economic context has had a negative impact on the health of the population, exacerbating existing inequalities. This is not unique to Leeds and reflects a UK wide picture.

1.2 Due to the wide range of factors that influence people's health [1], partners in Leeds, in particular the Local Authority, education, NHS services and the Third Sector all have a different but important role to play in tackling health inequalities.

1.3 **This report** describes how the city council and specifically Public Health are working with partners to reduce health inequalities and provides an overview of the role and contribution of Leeds Public Health function. This includes some areas of work relating to health service provision, such as vaccinations programmes.

1.4 The **following report** as part of this agenda item describes how partners providing health and care services are working to address health inequalities (including an update on the Healthy Leeds Plan, and how partners are working to minimise the health inequality impact of cost-improvement measures). This includes some areas of work to relating to the wider determinants of health, such as employment policies.

1.5 The role of Leeds City Council and Public Health, the Third Sector and wider partners is central to improving health and reducing health inequalities – evidence suggests at least 80% of health and health outcomes are related to 'the social determinants of health' – to factors such as housing, access to green spaces, employment and poverty, with only around 20% attributable to activity delivered by healthcare services.

1.6 There may be specific opportunities within the emerging national policy landscape to go further to 'improve the health of the poorest the fastest'. Leeds is well placed to take advantage of these opportunities, given the city's comprehensive and well-articulated approach to addressing health inequalities through the Leeds Health and Wellbeing Strategy, Team Leeds approach and Best City Ambition.

[1] Including housing, education, employment, the physical environment, transport and active travel, food, social and community networks, health and care services and personal behaviours.

2 Leeds Context

2.1 Leeds has a relatively young population and is one of the fastest-growing cities in England. However, not everyone benefits from the city's thriving economy in the same way. Economic and social inequalities are entrenched in some parts of Leeds and have been exacerbated by the pandemic and the cost-of-living pressures. One in four of all Leeds adults and more than one in three school children live in the most deprived 10% of neighbourhoods nationally. The most deprived neighbourhoods are home to the youngest and most ethnically diverse communities.

2.2 The differences in geography, economic and social conditions across the city lead to large inequalities in health and wellbeing. People living in the poorest wards in Leeds live more of their life in ill-health and die around 12 years earlier than people in the most affluent ward, whilst the gap is 9 years between the most deprived 10% of neighbourhoods (i.e. IMD1) and those living in the least deprived 10% of neighbourhoods (i.e. IMD10).

2.3 As a large, global city, Leeds is also home to significant numbers of people from communities with specific health needs, for example refugees and people seeking asylum, specific ethnic groups including Gypsy, Roma and Traveller communities, LGBT+ communities, people who are homeless and a large student body. This brings a range of assets and opportunities to the city; it also means that there are large numbers of people who benefit from tailored support on priority health issues.

3 Health Inequalities

3.1 Health inequalities are systematic, unfair, and avoidable differences in health outcomes across the population, and between different groups in society. They are connected to the conditions in which we are born, grow, live and work (the social determinants of health), our access and experience of healthcare (which can either amplify or mitigate against existing inequalities) and by commercial determinants. They are also related to individual factors – such as being from an inclusion health or protected characteristic group.

3.2 There are many inter-related 'causes' of health inequalities; these include (but are not restricted to) structural and interpersonal discrimination; access to good quality housing; early life experiences; education and employment and barriers to accessing healthcare services.

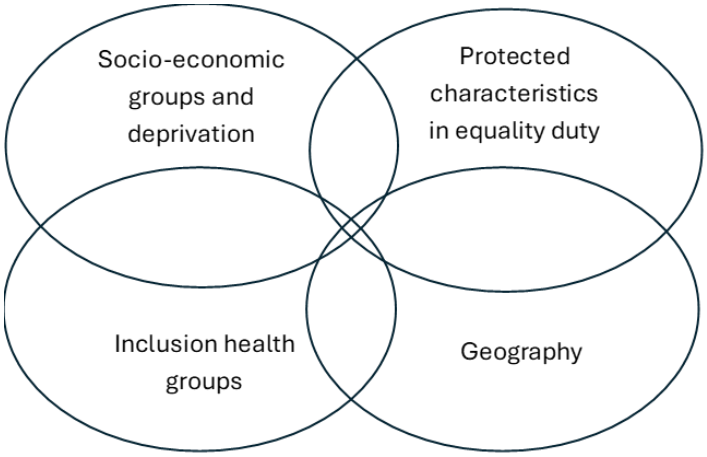

Figure 1: Intersections of different types of groups at high risk of experiencing health inequalities

3.3 Whilst individual behaviour is often cited as a key driver of poor health and health inequalities, there is significant evidence to suggest that broader socio-economic factors constitute around 80% of health status and that behaviours must be understood within their wider context. Furthermore, whilst healthcare plays an important role in protecting health and treating illness it is estimated to account for only up to 20% of health outcomes.

3.4 As the causes of health inequalities are complex, so action to address them must be whole system, at a sufficient intensity to meet need and involve many stakeholders.

4 The Leeds approach to reducing health inequalities.

4.1 Partners in Leeds (in particular, the Local Authority, education, NHS services and the Third Sector) work together to reduce health inequalities– with NHS services primarily focused on healthcare inequalities and the Local Authority responsible for improving the social determinants of health. The Third Sector plays a key role across all areas; increasingly, through the Leeds Anchor's programme, private businesses are also now contributing.

4.2 The Best City ambition clearly articulates the city's goal: 'for Leeds to be the Best City in the UK – where we work together in partnership to achieve our goals, proud of our strengths and track record of success, but focused fiercely on tackling poverty and reducing inequalities wherever we can'. Three strategies underpin the ambition – the Health and Wellbeing Strategy, the Inclusive Growth Strategy and Zero Carbon – with the health and care system contribution to the Health and Wellbeing Strategy detailed in the Healthy Leeds Plan.

4.3 The city's commitment to become a Marmot City supports the approaches and strategies described above. The Fairer, Healthier Leeds (Marmot City) programme sets out to maximise opportunities to address health inequalities by developing and building a 'Health Equity' system. This means enabling

all partners to place fairness and health at the centre of decision-making, service development and resource allocation.

5 Overview of progress in addressing health inequalities

5.1 Public Health monitors progress through analysis of a range of population health outcome and service level indicators. These are reported to Leeds Scrutiny Board every six months. The most recent report (January 2024) noted the following trends.

5.2 In line with the national picture, overall life expectancy in Leeds remained largely unchanged between 2011/13 and 2018/20. From this point onwards, life expectancy in the city has declined slightly. This downward trend started before the onset of Covid-19 so it cannot be wholly attributed to the impact of the pandemic. However, it is likely that deaths from Covid-19 are affecting the most recent figures.

5.3 There have been several recent improvements in key indicators. These include: The number of people taking up an offer of an NHS Health Check. This indicator continues to recover after Covid (increasing from 48% to 62% over the last quarter) and Leeds rates remain above the regional and England average. Emergency admissions to hospitals due to falls (in people over 65 years old) shows a decreasing overall trend alongside a steeper downward trend in the most deprived parts of the city. Smoking prevalence continues to decline in line with national and regional rates.

5.4 Rates of ‘all age’ deaths from circulatory disease have shown an increase in the latest period. This reflects the national picture and may be due to the impact of Covid on NHS and preventative services– including delayed diagnosis, testing and identification of cardiovascular disease along with the pausing of NHS health checks. Deaths from causes that are considered preventable in people aged under 75 years old has also decreased overall. However, the gap between ‘most deprived’ and ‘least deprived’ parts of the city remains significant.

5.5 Entrenched inequalities between the most deprived and least deprived communities can also be seen across a range of other indicators including those for alcohol, smoking status by occupation, excess weight and physical inactivity in adults. New HIV diagnosis rates and STI rates (excluding chlamydia under 25) have increased in this latest period. The increase is likely to be attributable to the provision of proactive and targeted testing alongside the demographic of the Leeds population.

5.6 National data is expected to become available during 2025 that measures the gap in Healthy Life Expectancy. This will be adopted locally as part of future reporting. Healthy Life Expectancy is a key indicator that details the age at which different communities or parts of the population start to develop chronic or life-limiting illnesses – as such, along with overall life expectancy it is an important measure of inequality.

5.7 Alongside the indicators reviewed as part of the Public Health Performance report the Fairer, Healthier Leeds – Marmot City programme has identified 15 indicators that align with Marmot principles and that can be disaggregated by either ward or Index of Multiple Deprivation decile. These are set out in the *Fairer, Healthier Leeds: Reducing Health Inequalities* report (See Appendix A). These measures are already reported in the system via the Health and Wellbeing Strategy, Social Progress Index and Public Health performance report.

5.8 The indicators have been adopted by the Best City Ambition scorecard. They enable a high-level view (across both the social determinants of health and healthcare inequalities) of progress the city is making in addressing health equity and reducing health inequalities.

6 Public Health and Health Inequalities

6.1 Public Health works to protect and improve the health and wellbeing of all communities in Leeds. Some responsibilities are legally mandated whilst others reflect identified local health needs and priorities. At the centre of all Public Health activity in Leeds is the aim of reducing health inequalities. It does this by:

- Partnership working and system leadership.
- Assessing the health of the population and evidence of what works to improve this.
- Commissioning, delivering, managing, and influencing a wide range of public health services, programmes and interventions to improve health and reduce health inequalities based on evidence of what works
- Measuring and evaluating performance and outcomes and share learning to inform future developments and decision making.

6.2 In some cases, Public Health has relatively high level of control in addressing health inequalities – for example in the way public health services are commissioned. In other areas e.g. population levels of healthy weight, Public Health must work with a range of stakeholders - across the many departments of the local authority, Third Sector and NHS to influence a diverse range of policy and resource decisions.

7 Fairer, Healthier Leeds - a Marmot City

7.1 The Fairer, Healthier Leeds programme is a citywide programme hosted and facilitated by Public Health. In April 2023 a formal partnership began with the Institute of Health Equity (IHE) – led by Professor Sir Michael Marmot. The aim of the Leeds programme in the first year has been to enable the city to better understand how to maximise opportunities to address health inequalities, particularly related to the social determinants of health.

7.2 The decision to become a Marmot City was made as the city emerged from the pandemic. Despite the well-established programmes described in this

paper, there was recognition that there was a need to go further and faster to mitigate against the impact of the pandemic on health.

7.3 In the first year, the work has been delivered under three key workstreams. The first of these 'whole system review' has assessed the Leeds approach to addressing health inequalities, and the connection between strategic commitments, programmes and services. It has also reviewed health outcomes across the city alongside inequalities in the social determinants of health.

7.4 As a result of this workstream the *Fairer, Healthier Leeds: Reducing Health Inequalities* report and suite of accompanying documents was published in October 2024. This report contains 15 high level recommendations which challenge Leeds to go further to become a 'health equity system'.

7.5 Fairer, Healthier Leeds aims to shift culture and practices in Leeds so that fairness and health are at the centre of every decision. The Marmot Strategic Delivery Partnership is constituted of a range of stakeholders who are currently co-ordinating the system response to the recommendations.

7.6 Similar analysis, report production and recommendations have followed under the second workstream 'collective action'. This has focused on two identified priorities: Housing and on children aged 0-5s and their carers. Both sets of recommendations are being considered at relevant partnership groups and action plans will be developed during October – December.

7.7 The three Fairer, Healthier Leeds reports and associated recommendations provide Leeds with a clear framework for going even further and faster to address health equity and reduce health inequality in the coming years.

7.8 The programme has also added value over the last 12 – 18 months by delivering bespoke pieces of work and/or acting as a catalyst for new developments across the city.

7.9 These include:

- The development and roll out of a social determinants template in Primary Care. This means that GPs and other staff can more easily refer people to local support in a range of areas including benefits advice and housing.

- Adoption of the Fairer, Healthier Leeds indicators as part of Best City Ambition scorecard. This enables a regular high-level analysis of the progress the city is making in addressing health equity.

- Proposed additions to the University of Leeds medical curriculum to improve a focus on health equity.

- An evaluation of the existing Selective Licensing scheme in Harehills and Beeston. The evaluation has informed and supported a business case for extending the scheme.

- Delivery of joint training between housing and health staff to improve the advice and support offered to people living in Leeds. Establishment of an operational 'private rented sector and housing group' to co-ordinate closer working between LCC housing and Local Care Partnerships.

- Agreement to bring together a strategic and operational focus on health inequalities for children 0-2s and children aged 3-5 years – maximising opportunities to improve the health of families and address health inequalities.

- Bringing together housing data on fuel poverty and energy performance certificates with local health data to better inform prioritisation of funding.

7.10 The third workstream is 'cross-cutting priorities', in the first-year closer working has been established between public health and inclusive growth, mapping of community insight – linked to the Marmot principles has informed the work and there has been a particular focus on ensuring that ethnicity is considered all the work to ensure that inequalities related to diverse communities are clearly identified. In the second year, work will be delivered linked to Marmot Principle 7 'Addressing racism and discrimination and their outcomes'.

7.11 Finally, engagement packs and communications resources have been produced which will enable different teams and services across the city to practically embed health equity at strategic and operational levels.

7.12 Leeds is part of a national network of Marmot places committed to 'health equity'. Health equity can be defined as having a relentless focus on putting fairness and health at the centre of every decision - across a range of stakeholders and organisations. Many Marmot places are now working towards developing a 'health equity system'; this combines bold leadership and accountability with practical tools and approaches that enable more equitable decisions about services and resource allocation.

Summary of contribution of Public Health programmes of work in addressing health inequalities:

8 Improving the health and wellbeing of children and young people

8.1 The aims of this public health programme are to improve the health of the poorest fastest and ensure all children experience the best start in life. The Marmot principles of proportionate universalism are systematically and culturally adopted across commissioned services and work areas.

8.2 The 0 – 19 Public Health Integrated Nursing Service delivers the Healthy Child Programme with the aim of improving health and reducing health inequality. The service is commissioned to deliver five mandated child

health and development reviews with families where children are aged under 5. The antenatal review is not currently being delivered to the whole population due to service capacity but families in greatest need are prioritised. During these mandated contacts family's needs are assessed and families are provided with universal, targeted or specialist levels of support informed by defined pathways which provide structure for addressing needs and delivering early interventions.

8.3 The service delivers a range of pathways including economic wellbeing, drug and alcohol use, parental mental health and in development, housing. Antenatal Education is also provided by the 0-19 service. In addition, there are targeted programmes for communities with complex needs e.g. Preparation for Birth and Beyond for refugee and asylum seeker families and Babysteps targeted at parents with additional needs.

8.4 The Economic Wellbeing pathway describes how Early Start practitioners in Children Centres support families to achieve economic wellbeing as part of their universal service offer. This approach ensures families are aware of the vast range of support that is available to reduce widening financial inequality. This includes child place and benefit entitlement, including access to dental care and prescriptions during pregnancy and support through food banks, Healthy Holiday clubs alongside the provision of ASDA vouchers for those in immediate need.

8.5 The Healthy Child Programme also contributes to reducing inequalities through supporting breastfeeding. Increasing breastfeeding rates is a priority for Leeds as there is strong evidence that it promotes health, prevents disease and helps contribute to reducing health inequalities, both in the short and long term.

8.6 Breastfeeding rates in Leeds for initiation and 6-8 weeks have steadily improved with the most notable rise in 6-8 weeks rates from around 30% to 47.3% since the UNICEF Breastfeeding Friendly Initiative and Breastfeeding Partnership Plan was introduced in 2006. Notably the current overall breastfeeding initiation rate in Leeds is 75.8% and above the England average of 71.7%. However, sociodemographic inequalities persist, with more affluent areas like Guiseley & Rawdon reaching initiation rates of 88.5% compared to 54% % in the more deprived areas of Killingbeck & Seacroft.

8.7 The programme also commissions a wide range of services across the age range – including (infant mental health, breast feeding peer support, oral health, healthy schools, a school-based resilience service to support good mental health and physical activity projects e.g. skateboarding and dancing. All services are required to target areas of higher deprivation and higher public health need and consider how children and young people and families can influence service delivery.

8.8 The programme contributes significant funding to children's centres which are based in communities living in the highest areas of deprivation and also fund work with the Roma community who experience health inequality.

8.9 The work to become a Marmot city has included a focus on children aged 0 – 5 and their families. The recommendations are imminently being taken to a joint Health and Wellbeing Board and Children and Young People's Partnership session to request endorsement. The recommendations suggest refreshing the Best Start strategy which focuses on 0 – 2 year olds to one focusing on 0 – 5 year olds.

9 Ageing Well

9.1 Leeds has a longstanding commitment to being Age Friendly. Addressing inequalities in later life is a key driver of the Age Friendly Leeds Strategy and Action Plan. The plan sets out key domains, objectives and actions and identifies a number of cross cutting themes. The plan will contribute to improving Healthy Life Expectancy through addressing factors that are evidenced to contribute to increasing the number of years spent in good health.

9.2 Inequalities are addressed through recognising the barriers faced by older people who are, or are at risk of, being vulnerable or disadvantaged, and putting interventions in place to remove or reduce these barriers. This includes protected characteristics and the intersection with age e.g. age, gender, ethnically diverse communities. Progress is reported to the Age Friendly Leeds Board quarterly.

9.3 Commissioned services/support to enable people to age well, include: Home Plus; Falls Strength and Balance; Lunch Clubs and 'Stay Well this Winter' Grants. These all have a primary focus of targeting and focussing resources to areas in the city and groups of people in later life who experience poorer outcome, with the aim of increasing the number of years that people in these groups and areas spend in good health.

9.4 For example, lunch clubs receive weighted funding based on location (IMD 1 and 2 areas). Strength & Balance classes are focussed in areas of the city with the highest levels of emergency admissions for falls and IMD1 and 2 areas.

9.5 The Ageing Well programme also led the underpinning work towards the recent 2023 Director of Public Health Report 'Ageing Well: Our Lives in Leeds' which highlighted the inequalities facing older people in the city and made recommendations to address them.

9.6 Emergency admissions to hospitals due to falls (in people over 65 years old) shows a decreasing overall trend alongside a steeper downward trend in the most deprived parts of the city.

10 Tobacco and Nicotine

10.1 The tobacco and nicotine control programme works with partners across the city to reduce access to and uptake of tobacco and nicotine products, increase the numbers of smoke free areas and offer support to people who wish to stop smoking.

10.2 Although all interventions are available across the city, the smoking cessation offer prioritises those groups and communities where smoking rates are higher e.g. most deprived communities, people with a mental health illness, those in routine and manual employment and the unemployed.

10.3 Over the years, the approach has resulted in a reduction in the gap between smoking rates in the most affluent areas and those in the most deprived areas as a result of both rates reducing, but most steeply in the most deprived areas.

11 Physical Activity

11.1 The city's vision for physical activity 'Leeds is a place where everyone moves more every day' contributes to achieving the Best City Ambition as well as the Leeds Marmot City Commitment to create a fairer, healthier city for everyone. The Leeds Physical Activity Ambition focuses on the persistent inequalities around how active people are, with disabled people, people living with long-term health conditions, and people residing in areas of socio-economic deprivation being particularly affected. There are 3 key priorities; ensuring the environments people live in support people to move more every day, creating a social norm where it is an easy choice to be active, working in partnership to create a healthier place, greener city and stronger local economy.

12 Healthy Weight (Adults)

12.1 The Healthy Weight work programme focuses on delivering whole population approaches that have the greatest impact on the people living in the most deprived neighbourhoods. This work is primarily delivered through the development of the Leeds Food Strategy and Healthy Weight Plan and includes actions to increase accessibility, affordability and availability of healthy foods, and reduce promotions of ultra-processed foods high in fat, sugar and salt.

12.2 In Leeds levels of adult obesity are fairly static and align with the national average, but the inequalities remain due to the cost-of-living crisis and wider determinants that influence a healthy weight.

13 Healthy Places

13.1 The environments in which we live are inextricably linked to our health throughout our lives, impacting on mental and physical health and wellbeing outcomes. Working closely with colleagues in Planning Services, we use health data and evidence to influence local planning policies and planning decisions for new developments, ensuring health is a key consideration in decision making, with a focus on the developments that are likely to impact our most deprived areas.

14 Public Mental Health

14.1 Public mental health refers to the strategies and actions aimed at promoting mental well-being, preventing mental illness, and addressing poor mental health at a population level. In Leeds, the programme aims to strengthen factors that support good mental health while reducing the impact of risks that contribute to poor mental health. Working with communities that live in the most deprived areas of Leeds and inclusion health groups, the programme focuses on reducing stigma and discrimination. The local authority plays a key role in coordinating suicide prevention efforts and minimising harm in communities.

14.2 Locally, Public Mental Health achieve this by:

- Commissioning a range of interventions including Being You Leeds, Unfolding and Mindful Employer. These programmes, in turn, work with communities most at risk by promoting protective factors, support volunteers to support others and bring local employers together to champion positive mental health at work.

- Advocating for and commissioning training to other organisations around self-harm, suicide prevention and mental health

- Supporting multiagency partnership work to reduce stigma associated with mental health.

- Co-leading work to address ethnic inequalities in mental health, which includes providing grants to community-based organisations.

- Leading the Leeds Suicide Prevention Action Plan, providing grants to organisations to prevent suicide and commissioning the Leeds Suicide Bereavement Service.

14.3 Improvements in well-being, measured using the Warwick and Edinburgh Wellbeing Scale, have been reported across public mental health interventions delivered in the most deprived 10% of communities in Leeds. Challenges persist in understanding the prevalence and impact of common and serious mental health conditions across communities in Leeds, primarily due to underreporting driven by stigma and barriers to accessing support.

15 Communities and Primary Care

15.1 This workstream takes an asset-based, community-focused approach to tackling health inequalities. The team has close working relationships with local partners and are specialists in locality public health, implementation, primary care and inclusion health.

15.2 Specific work to address health inequalities includes:

- Intelligence, advice and support to improve health and reduce health inequalities in priority wards, including Health Needs Assessments,

advice and support on community centred approaches, leading public health input to inner city Local Care Partnerships, working with councillors.
- Specific projects in communities to reduce inequalities, e.g. Heating on Prescription
- Commissioned services/funded projects – Better Together community health development; supporting health and wellbeing for Gypsy and Traveller communities; Roma grants; Women's health matters work with refugees and asylum seekers; Community Champions
- Strategic public health leadership for migrant health through the Migrant Health Board
- Work to champion the needs of inclusion groups, including Healthy Communities Together work with sex workers, asylum seekers, Trans+ people and Gypsy and Traveller communities.
- Supporting primary care to understand and reduce health inequalities in their area through supporting PCNs to develop priorities for their local population and connect to wider determinants, and specific projects and tools for primary care (e.g. health inequality infographics, health inequalities toolkit)

16 Drugs and Alcohol

16.1 The vision is for Leeds to be a compassionate city that works with individuals, families, and communities to address the harms caused by drug and alcohol use. Drug and alcohol use leads to significant health inequalities for individuals and communities and is often related to wider health issues or challenges with an impact on health, e.g. housing, mental health, trauma. Inequalities related to drug and alcohol are addressed through:

- Work to reduce the number people using drugs and alcohol and harm, e.g. through action on licensing and addressing negative visible drug use in communities
- Identifying people with substance use early, ensuring that they have access to high quality treatment and harm reduction to reduce health harms through the commissioned service Forward Leeds
- Supporting visible recovery in the city to address stigma
- Specific programmes of work for people from inclusion health groups or experiencing complex disadvantage, e.g. tailored support for people from Gypsy and Traveller communities, work with rough sleeping populations and sex workers.

17 Long term conditions and cancer

17.1 To address health inequalities, work is targeted in areas of highest deprivation and in specific groups where long term conditions (LTC) and cancer prevalence (including risk factors) is greatest and outcomes are poorer.

17.2 The commissioning of NHS Health Checks ensures a focus on 'most likely to benefit groups', which includes those living in most deprived neighbourhoods, culturally diverse communities, smokers, and those who are obese (BMI>30In addition, community-based approaches to delivering NHS Health Checks specifically targeting Health Inclusion Groups are currently being designed and tested. Recent reporting shows that just over half of NHS Health Checks delivered for 23/24 were from one or more of these groups.

17.3 The Leeds Health Awareness Service is commissioned to deliver targeted community awareness raising of risk factors, knowledge of signs and symptoms of both LTCs (including cardiovascular disease; diabetes, respiratory disease, and priority cancers) and promoting NHS Cancer screening uptake. The contract has a remit to reduce inequality and as such focuses activity on the most deprived areas of Leeds and targeting the following priority groups: Adults with learning disability; Adults with severe mental illness; Ethnically diverse communities; Men; Communities with known higher prevalence of risk factors.

17.4 In addition, this programme works with a range of partners on projects and activity to support reducing inequalities in LTCs and cancer including community-based projects to support early identification; influencing service and system design, and improving clinical pathways to enable more equitable access and outcomes for priority groups.

18 Health Protection

18.1 The Leeds Health Protection function deliver a range of proactive programmes to minimise health risks and protect communities from infectious diseases, environmental hazards, and other public health threats. These include improving Tuberculosis (TB) screening and vaccination uptake across the life course, focussed work to address Antimicrobial Resistance and supporting those facing a disproportionate burden of health outcomes due to extreme weather events. Strong system wide processes are also in place to respond to outbreaks of infectious diseases across the city, the health protection team work to mitigate inequalities during outbreaks.

Examples of activity to address inequalities include:

- Health equity and inequalities are considered as part of the risk assessment and selection of control measures as part of Outbreak management responses. While outbreaks of infectious diseases can happen across Leeds, there is an increased risk for those living in deprived areas and amongst communities experiencing the highest levels of inequalities.
- The Community Infection Prevention and Control Co-operation Agreement aims to mitigate the spread of infection through reducing inequalities in Health Care Associated Infections, improving outcomes for high-risk settings, providing support in

responding to communicable disease outbreaks and delivering training and capacity building for wider health care workers.

- The Leeds Community TB service (in collaboration between LTHT and LCH, working with Bevan Health Care and UKHSA) provides advice, support, and specialist care for both active and latent Tuberculosis (TB) in adults and children. The service provides, latent TB screening and treatment for new entrants to the UK from countries with a high incidence of TB and those with no fixed abode. The service also works closely with a community outreach worker, promoting TB detection and prevention messages amongst at risk communities.
- Addressing low vaccination uptake across the life course – working closely with NHS partners to influence programme delivery and utilise data to identify and develop interventions to address inequalities in uptake. For example, this includes working with third sector partners to improve awareness of the importance of vaccinations, with primary care providers to improve accessibility to vaccinations.
- Anti-Microbial Resistance (AMR) – An AMR community engagement group has been established to support addressing the disparities between both in the inappropriate use of antimicrobials and the proportion of resistant infections between communities. Collaborative work in schools, community outreach and engagement has been delivered for communities where prescribing rates are highest.
- Adverse weather programmes focus on providing additional support to those facing a disproportionate burden of health outcomes due to extreme weather events.

19 Sexual health

19.1 The aim of this programme of work is to ensure all people in Leeds experience good sexual and reproductive health and wellbeing and are supported to develop safe, healthy, enjoyable, and consensual sexual relationships. However, sexual ill health is not equally distributed: deprivation, social and cultural norms, education and health literacy, sex, gender identity and sexual orientation, and behaviours all impact on outcomes. Activity, therefore takes a proportional universalism approach. Health promotion and prevention activity, alongside testing and treatment services, are available for all. However, increased effort, resource and innovative approaches are deployed to meet the needs of most at-risk and vulnerable groups and those seldom seen in universal, clinical services.

19.2 This approach has contributed to high levels of chlamydia screening in young people, declining under 18 conception rates, a slow decline in late HIV diagnoses and increased PrEP (pre-exposure, HIV prophylaxis) use in those with PrEP need.

19.3 Key activity includes:

- Commissioning and contract managing the city's open access sexual health service. Clinics are geographically located where need is

greatest, whilst the responsive outreach team provide testing and treatment at community venues, alongside trusted community partners.

- Commissioning and contract managing the sexual health improvement service, delivering holistic, culturally appropriate prevention, testing, outreach and support to people most at risk of HIV and sexual ill health.
- The Well Wave service offers community-based sexual health information and support, including free condoms and STI testing kits, to young people across Leeds. The offer is universal; however, work is ongoing to ensure most at risk and seldom seen young people are targeted through promotion and visibility in spaces they use.
- Collaborative working with wider sexual and reproductive health commissioners to develop solutions to mitigate inequalities in service access arising from fragmented commissioning arrangements.

Appendices:

- Appendix A - *Fairer, Healthier Leeds: Reducing Health Inequalities* report. October 2024.

Appendix A

INSTITUTE of HEALTH EQUITY

FAIRER, HEALTHIER LEEDS: REDUCING HEALTH INEQUALITIES

INTRODUCTION

A growing number of people are living in poverty and with worse health in Leeds, West Yorkshire. This is the result of continuing impacts of reduced funding for local authorities in England, pressures related to the increasing cost of living, and the lingering effects of the COVID-19 pandemic. Meanwhile, the demographic characteristics of Leeds are changing, affecting how the city must plan its future services: the city's population is growing in every age band and becoming more ethnically diverse, particularly in areas of high deprivation.

To better tackle health inequalities in the city and enable Leeds to maximise its opportunities, the *Fairer, Healthier Leeds* programme[1] was launched in June 2023. This report draws on learning from the programme's first year and provides a short analysis of health inequalities in Leeds, recommends action to reduce them and ways to improve the social determinants, or building blocks of health.

Since the programme's inception, the Institute of Health Equity has identified several excellent approaches and examples of good partnership working in Leeds, and this is to be built upon. However, Leeds can go further. A whole-system 'Marmot Leeds' approach that develops and delivers interventions and policies to improve health equity based on the Marmot principles requires:

- **A** — **Strengthening and further developing the current system to one in which all partners work collaboratively to improve the building blocks of health and tackle health inequalities.**
- **B** — **System leadership for health inequalities within and across system partners with clear lines of accountability, along with strengthened workforce capacity.**
- **C** — **Strengthening partnerships to have an ambitious, collegial and trusting approach to improving the building blocks of health and to be bold in adopting a proportionate universalist approach to the design and delivery of actions and in their resourcing.**
- **D** — **Shifting funding to longer-term and primary prevention approaches, in line with a health equity in all policies approach.**
- **E** — **Ensuring those acting to reduce inequalities work with communities to identify how best to improve the lives and health of those living in the most deprived neighbourhoods in Leeds.**

By placing an even stronger strategic focus on health inequalities and inequality more broadly, Leeds will be better positioned to tackle these problems and reverse the impacts of COVID-19, inflation and the rising cost of living. This requires that all partners work collaboratively, prioritising health equity and strengthening the whole 'health equity system'. Without steadfast commitment to action, Leeds like many other locations in the UK, may witness inequalities worsening faster and further.

[1]The Fairer, Healthier Leeds programme is led by the Public Health team, with political support from the executive member for equality, health and wellbeing and the executive member for adult social care, active lifestyles and culture.

THE IHE METHOD

The building blocks or the social determinants of health, describe the social and environmental conditions in which people are born, grow, live, work and age, which shape and drive health outcomes (1) (2). There are eight Marmot principles to reduce health inequalities based on shaping these determinants:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention
7. Tackle racism, discrimination and their outcomes
8. Pursue environmental sustainability and health equity together.

A **Marmot approach** develops and delivers interventions and policies to improve health equity based on these eight principles; it embeds health equity approaches in local systems and takes a long-term, whole-system approach to improving health equity. A Marmot approach is **proportionate universalist** – that is, it applies policies to all but with services and support increasing at a scale and intensity proportionate to the degree of need. The aim is to raise overall levels of health at the same time as flattening the gradient in health. (2) ***Only focusing on one group of individuals or a few geographical areas will not deliver change.***

In our first year in Leeds, to help deliver this whole-system approach, IHE, in partnership with the city's public health team and other stakeholders:

- Analysed health outcomes and data related to the building blocks or social determinants of health (e.g. housing, education).
- Reviewed existing city approaches to tackling health inequalities by making a 'health equity' assessment of its strategies, policies and programmes.
- Mapped community insights aligned to the eight Marmot principles.
- Focused on two key priorities: Best Start (for children aged 0–5 years) and housing, meeting key stakeholders delivering these services and holding two workshops.
- Developed health equity indicators to measure progress.
- Created **Fairer, Healthier Leeds Marmot recommendations** to challenge Leeds to focus on the system changes needed to comprehensively address health equity and embed health equity and fairness in decision-making. The recommendations focus on actions across organisations: Leeds City Council, businesses, public services, communities and community organisations and health and social care.

This report addresses three key areas in turn: leadership and accountability, partnerships and research/data. Evidence of inequalities in Leeds is provided in data packs on the IHE website, alongside the Fairer, Healthier Leeds Marmot recommendations, full indicator set and other related publications. (3)

Leeds is now part of the **Marmot places network**. (4) Marmot places commit to making a more concerted and focused effort to address health inequalities. This involves identifying leaders to improve understanding of health inequalities across stakeholders and committing to consistently hold the city system accountable for tackling inequalities.

THE LEEDS CONTEXT

Leeds is a city of over 820,000 residents. Its population is growing and is poorer than the England average: 24% of its population live in the most deprived decile, IMD 1,[2] compared to 10% of England's population living in this decile.

Leeds targets many of its services and approaches to reduce inequalities based on deprivation deciles, frequently concentrating its action on those living in IMD 1 neighbourhoods. The numbers living in high deprivation in Leeds are increasing: the Office for National Statistics estimates 24% of Leeds' population live in IMD 1 neighbourhoods, increasing from 179,000 in 2013 to 200,000 in 2022. (5) In 2024 37% of children in Reception were living in the most deprived neighbourhoods in Leeds, compared with 34% in 2021. (6)

Life expectancy for all populations in Leeds was stagnating before COVID for both men and women but the most recent figures show that while life expectancy has increased slightly after the worst of the pandemic, wide inequalities remain within the city. Women living in Leeds's most deprived neighbourhoods live, on average, nine years less than women living in the least deprived neighbourhoods; for men, the difference is 10 years (see Table 1). This difference in life expectancy is even greater for certain groups. For example, Gypsy and Traveller communities in Leeds have an average life expectancy close to 50 years, compared with the city average of 78 years.

Table 1. Estimated female and male life expectancy at birth, averages for most deprived (IMD 1) and least deprived (IMD 10) neighbourhoods in Leeds, 2019–21 and 2020–22

Source: Office for National Statistics (7)

	2019-21	2020-22
Female IMD1 (most deprived)	77.4 years	77.6 years
Female IMD 10 (least deprived)	87.2 years	86.9 years
Male IMD 1 (most)	72.9 years	73 years
Male IMD 10 (least)	82.9 years	83 years

Figure 1 shows these inequalities in life expectancy clearly: as levels of deprivation increase in Leeds's wards, life expectancy decreases. It can be seen that Harewood is among the least deprived neighbourhoods and has high average life expectancy, and Hunslet and Riverside, the fourth most deprived ward in Leeds, has the lowest life expectancy.

Figure 1. Estimated female and male life expectancy at birth and deprivation (IMD 2019), Leeds wards, 2016–2020

Source: Office for National Statistics (8)

[2]IMD is the Index of Multiple Deprivation (IMD), the most common measure of the socioeconomic circumstances in which people live. The IMD summarises how 'deprived' an area is. Neighbourhoods are ranked from 'most deprived' to 'least deprived'. IMD 1 is the most deprived 10%, IMD 2 is the second most deprived decile and IMD 10 the least deprived.

The Leeds Joint Strategic Assessment and Leeds Observatory provide an extensive analysis of health inequalities in Leeds. (9) (10) These reports outline the significant and persistent inequalities in Leeds across a range of outcomes. Inequalities are evident in health outcomes such as life expectancy and the incidence of low birthweight babies, and in the building blocks/social determinants of health such as earning a 'living wage' and good educational attainment. Leeds compares unfavourably across several measures with other core cities in England. A detailed analysis of health outcomes and data covering the building blocks of health are included in the IHE slide set that accompanies this report.[3]

Leeds has an ethnically diverse population; in particular, the Black/Black British and African ethnic minority population is slightly larger proportion-wise than the England average. (11) The population living in the most deprived neighbourhoods is more ethnically diverse than the rest of Leeds: 63% of the city's Black/Black British ethnic group, 40% of its mixed ethnic group and 36% of its Asian ethnic group live in the most deprived neighbourhoods (in IMD 1). (12)

AUSTERITY PRESSURES

> "These aren't choices Leeds City Council would want to have made."
>
> (Leeds City Council)[4]

> "Systems are under unbelievable pressure."
>
> (Leeds City Council)

The cuts to local government budgets in the last 14 years have hit Leeds City Council hard, and in the last year budget cuts and increasing pressures on the NHS in Leeds have led to shortfalls being forecast for at least the next three years. (13) These cuts, in addition to persistent short-term central government funding settlements (of six months or a year), prevent places from implementing longer-term, preventive approaches that would better enable them to address issues such as health inequalities and increasing poverty.

The **cuts to local authority budgets in England have severely impacted services that are supportive of many of the building blocks or determinants of health** and have been linked to decreases in life expectancy. Between 2013 and 2017, it is estimated that each £100 reduction in annual central funding to local government (per person) was associated with an average decrease in life expectancy of 1.3 months for men and 1.2 months for women. (14) This is worsened by the fact that cuts to local government spending have been regressive: areas of highest deprivation have seen the deepest cuts. Between 2009/10 and 2019/20 the most deprived tenth of councils saw their fiscal revenue per person decline by just under 30%, or £453 per person. In comparison, the least deprived tenth of councils saw their fiscal revenue decline by 16%, £166 per person. (15) In the region **where Leeds is located, Yorkshire and the Humber, spending per person fell by 23%,** significantly greater than the cuts of 15% in the South West. (15) The Institute for Fiscal Studies estimates that councils in England will receive 4% less in real terms in 2024/25 than they might have expected a year ago. (16)

[3]See: https://www.instituteofhealthequity.org/resources-reports/new-marmot-places-work-announced-in-leeds

[4]All quotes are taken from interviews carried out during the first year of IHE's work in Leeds.

SYSTEMS CHANGE TO IMPROVE HEALTH EQUITY

A. LEADERSHIP AND ACCOUNTABILITY FOR HEALTH EQUITY

Strong, accountable and identifiable leadership on health equity within organisations is needed to lead action. Leadership involves giving workforces in different organisations greater capacity to act on the building blocks of health and putting in place measures to hold people accountable for this action. The challenge is to take existing bold statements, strategies and policies and implement the further action necessary, focus staff and approaches to improve healthy life expectancy, and – in Leeds's own words – improve the health of 'the poorest the fastest'. Where bold strategies do not exist, the challenge is to create new ones, in partnership. The Fairer, Healthier Leeds Marmot recommendations we present in this report challenge Leeds to be more specific in setting aspirations to tackle health inequalities and to have clear accountability measures across the city's systems to support delivery of the recommendations.

LEEDS CITY COUNCIL FOR HEALTH EQUITY

> "How do we do health inequalities as a system? We need senior leadership for the city – leaders talking to each other – to create joint accountability, joint budgets, joint posts. When money gets difficult, people retreat."
>
> (Leeds City Council)

Effective leadership for health equity focuses on addressing health equity across organisations and working in partnership. Bringing together housing, economic development, environment, transport, education and culture challenges departments and people to shift their current ways of working. Across Leeds City Council there has been ambitious leadership action to reduce health inequalities.

Scaling up good practice

- Leeds City Council has made a clear commitment to create and sustain healthy and thriving places. Its **Best City Ambition** states that by 2030, Leeds "will be a healthy and caring city for everyone: *where those who are most likely to experience poverty improve their mental and physical health the fastest*, people are living healthy lives for longer, and are supported to thrive from early years to later life". (17) The contribution of the Leeds Health and Care Partnership (HCP) to the health and wellbeing strategy is delivered through the **Healthy Leeds plan**. This also places inequalities centrally within its plans; its vision is for a "healthy and caring City for all ages where people who are the *poorest improve their health the fastest*". (18)
- In April 2023 Leeds City Council **increased its minimum pay rate to the UK Real Living wage** of £12.00/hour, above the central government-set UK living wage. The City Council also committed to pay the national minimum rate of pay for apprentices, above the national recommended rate. (19)
- Leeds is one of about 20% of council areas in England to have a **Selective Licensing (SL) scheme**, which aims to improve the management and condition of properties in the private rented sector. SL requires all private landlords in a selected area to obtain a licence for each property they rent out. The licence has conditions by which a landlord has to abide during the period of the scheme, which can be up to five years. The Scheme also requires that an applicant for a licence has to be considered a "fit and proper person" to hold a licence.
  - > Parts of Beeston and Harehills, densely populated areas of Leeds, are covered by the SL scheme. Landlords pay £825 per licence. Homes are inspected and up-to-date gas safety certificates are required, along with electrical appliances and furniture. The scheme also includes a discussion with tenants where information about health and the building blocks of health are collected.
  - > The current SL scheme in Leeds is due to finish in 2025. In 2023 Leeds's Public Health team offered to work in partnership with Leeds City Council Housing team to support an evaluation of the current scheme to understand its impact on health and inequalities. The evaluation provided evidence of the impacts of SL processes on health and inequalities. A 2023 evaluation of SL in London found improvements in area-based mental health outcomes and reductions in antisocial behaviour. (20) In March 2024 the Council's Executive Board approved the consideration of further SL schemes in Leeds. Any further SL schemes, if approved, will build on the lessons learned and involve better partnership working with health as well as evaluation built-in from conception.

- Leeds's local approach to **temporary accommodation** has meant it has kept these numbers low compared with other areas, improving the support it offers and saving the council money. Across the UK, the lack of private rented sector housing is increasing pressure on temporary accommodation. Leeds's approach involves speaking to people who need temporary accommodation at the earliest opportunity: ***"We're proactive to opening cases at the earliest time to help to prevent homelessness. When there are a few cracks, that's when we want to talk to people."*** To keep temporary accommodation lists small, they fund specialist advice to people in need, provide funding for bonds in the private rented sector and a rent guarantee scheme for landlords where they guarantee tenants for 12 months. A fundamental difference to other cities is that Leeds gives customers who are rehoused in the private sector the option to remain on the Leeds Housing Register.

  > The rate of people living in temporary accommodation has increased in Leeds in the last two years although the numbers remain far below England averages. In 2022 there were only eight families in temporary accommodation; in June 2023 there were 66 families, with some in B&B accommodation. Recent data shows the highest number of households in temporary accommodation on record. (21)

Unified leadership across Leeds can go further to identify goals for the short and long term, and identify when, for example, 'task and finish' groups are needed (such as existing Breakthrough groups – see below) or when longer-term partnerships are better.

- The **Health and Housing Breakthrough Group** is made up of Leeds City Council, NHS and Third Sector partners. This group was initially established as a short-term task and finish group. However, due to its successes, it has now become a formally established strategic partnership. In its first few months the group mainly discussed actions related to housing and respiratory conditions in children. Despite the positive aspects, interviewees also spoke of the desire for this group to be ***"more strategic"*** and to identify ***"longer-term goals"*** and opportunities for ***"joint commissioning, or combined commissioning and joint budgets"***.

HEALTHCARE SYSTEMS FOR HEALTH EQUITY

Recent policy changes, such as the requirement for Integrated Care Boards (ICBs) to address health inequalities, has led to health equity and the building blocks of health being of central concern for the NHS. Leeds NHS Boards can strengthen and focus their strategies on the building blocks, working in partnership to extend activity beyond usual anchor approaches. In addition, primary care in Leeds can better support action to reduce inequalities by working to improve local living and working conditions, being a strong advocate and working with individual patients to improve the building blocks of health.

Scaling up good practice

Several groups and strategies in the NHS in Leeds are addressing inequalities. There is value in consolidating this work and clarifying the role of each.

- The **Leeds Health and Social Care Hub**, a new partnership between national and local government, seeks to address and improve action on health inequalities and improve health and life outcomes for Leeds's residents.
- The **Tackling Health Inequalities Group** was set up in June 2020. The group provides expert advice on health inequalities related to healthcare services and recommends how NHS funding on inequalities should be spent and challenges where health inequalities funding goes.
- The **Communities of Interest Network** highlights the needs and challenges faced by groups and communities that experience the greatest inequalities.
- The **Leeds Out of Hospital (OOH) project** was awarded recurrent funding in 2023/24 and offers short-term intensive support to rehabilitate people who are homeless with a long-term health need/reablement need, through nine beds in temporary housing units. It is managed by a multi-disciplinary team (a clinical lead – nurse, GP, housing worker, dedicated social work time, and wellbeing workers). The project supports people to move to permanent accommodation. It has reduced A&E attendance for those who have completed their journey and been discharged from the temporary housing units, and has reduced unplanned admissions. Between April 2022 and April 2023 all patients who were homeless were discharged into either local authority tenancies, private rentals or to a nursing home.

The NHS in Leeds can go further to address health inequalities. Across England, NHS organisations are looking at what they can do within their own buildings and among their staff, using NHS data to look at how they can reduce inequalities. For example, this can involve looking at 'did not attend' rates for services according to level of deprivation (as measured by the IMD) and ethnicity, and taking small, clear actions, such as redesigning letters to improve clarity, and shifting times of clinics. This involves leaders and senior managers listening and considering the urgency of change, and including people from the places and communities suffering from avoidable ill health to allow them to "influence how services are organised…for radical change, not small tweaks or business as usual". (22)

Primary prevention delivered in partnership with the NHS and partners outside of health is needed to reduce inequalities. As part of its action to reduce inequalities, the Leeds Health and Care Partnership has concentrated on reducing the number of Emergency Department attendances and inpatient stays among children with asthma. This is a welcome city-wide partnership approach to addressing health inequalities; however, its action still focuses on secondary prevention of health problems after they have occurred. A primary prevention approach in Leeds would focus more on working across the city's IMD 1 neighbourhoods, bringing together key partners to reduce the likelihood of health problems starting. With regard to children and asthma, a primary prevention approach would involve working with partners such as housing providers, communities, schools, nurseries and the Third Sector to better support the families of children likely to develop this condition. **Addressing the causes of the causes, improving these building blocks of health – the social determinants – is needed to reduce inequalities at scale**.

Better focusing on primary prevention to reduce health inequalities involves **adopting a proportionate universalist approach**. Long-term funding should be allocated to organisations that are working in Leeds's most deprived neighbourhoods to achieve improved and more equitable outcomes in the building blocks of health, including investments for communities and the Third Sector and shifting to recurrent, dependable funding.

Primary care in Leeds can go further by working better with the NHS and other partners to take more action on the building blocks of health. Primary Care Networks (PCNs), with their budgets and workforce capacity (especially link workers), have the potential to better tackle health inequalities. Leeds PCNs commission Linking Leeds to provide social prescribing in the city. Social prescribing can tackle health inequalities but it needs to be targeted at areas of higher deprivation and be given time to work with clients and do more than refer. Interviewees stated that **social prescribing has further potential to address health inequalities** but requires more innovative commissioning and service redesign. In addition, the primary care system should monitor and reduce the risk of inequalities widening in **Leeds's inner-city areas of high deprivation due to the difficulties of recruiting staff in these areas**.

BUSINESSES FOR HEALTH EQUITY

The IHE report *The Business of Health Equity: The Marmot Review for Industry* examined the ways in which businesses shape the conditions in which people live and work and, through these, their health. (23) Businesses affect the health of their employees and suppliers through the pay and benefits they offer – hours worked, job security and conditions of work. They affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held. Three-quarters of the estimated 413,000 people who work in Leeds work in the private sector.

Businesses can also affect the health of individuals in the communities in which they operate and in wider society, through local partnerships, procurement and supply networks, and in the way they use their influence through advocacy and lobbying. Reducing the harmful impact of business and enhancing their positive contribution is vital for health and wellbeing and reducing inequalities.

Scaling up good practice

- **The Leeds Health and Care Talent Hub** works to get people living in areas of high deprivation or who have been out of work for a long time back into work in health and care organisations in the city. This work is based on **Connecting Communities with Health and Care Careers (CCHCC)**, a city-wide partnership that aimed to reduce health inequalities. CCHCC targeted specific communities to work within the health and care system. This collaboration between Leeds City Council and Leeds Teaching Hospital Trust (LTHT) and local charity *Learning Partnerships* initially supported residents in Lincoln Green through a recruitment and employment programme to improve IT skills, build confidence and support with job application and interview skills. (24) (25) The Talent Hub has transformed into a wider partnership between universities, the Third Sector, City Council and NHS in Leeds. It has developed pre-employment programmes to meet Leeds's health and care workforce needs, providing a pool of potential employees. In 2023/24 it supported more than 1,600 candidates living in Leeds's most deprived neighbourhoods. The largest proportion came from Black, African, Black British and Caribbean ethnic groups and were aged between 18 and 35 years. The vast majority were unemployed and female.

Three Leeds anchor networks and an inclusive growth strategy are examples of how the system in Leeds is seeking to improve equality.

- The **Leeds Business Anchors Network** encourages businesses to work together, alongside other partners in the city such as the City Council, to maximise their contribution to benefit the people of Leeds. This Network also encourages businesses to adhere to the city's Inclusive Growth Strategy.

- The **Leeds Inclusive Anchors Network** is a group of 13 of the city's largest, mainly public sector employers. They focus on areas where they can make a difference for people as an employer, through procurement, service delivery or as a civic partner. As part of this network, the NHS has assessed its role as an anchor institution and committed to leveraging its position as employers, purchasers of goods and services, owners of local buildings, land and other assets and leaders in the community to effect change.

- The **Leeds Community Anchor Network** is a movement of independent local organisations promoting citizen-led activity and partnerships. In addition to their own activities, Community Anchors help and support other groups and communities, and act as advocates at a city level.

Leeds City Council has taken a number of steps to understand how to improve equity in the city. **The Leeds Inclusive Growth Strategy** signals that the city wants a different style of growth, one that focuses on good health and opportunities for its employees on lower incomes as much as on all other employees. (26) It is a signal that businesses can work better with local communities, taking more than a corporate social role to truly work in partnership and be key players in improving the building blocks of health.

The **Leeds Social Value Guidelines and Charter** guide organisations to make changes in the way they work to make Leeds a fairer, more equal place. Leeds commissioned the Centre for Local Economic Strategies (CLES) to drive their inclusive strategy to better reduce gender inequalities. CLES recommends working with women in the city to place **gender equality** at the core of Leeds's economic approach and to create a baseline to measure the impact of interventions. Our Fairer, Healthier Leeds Marmot recommendations for the inclusive growth plan are similar in that we recommend making reducing inequities central to the inclusive growth strategy.

Leeds can take the Inclusive Anchors Network further by encouraging its members to agree to place skills development and local recruitment at the top of their agenda and focusing in the coming year on increasing the opportunities for young people living in IMD 1 and 2 neighbourhoods. This could be achieved by committing to new approaches and partnerships with education, primary and secondary schools, further education, the Third Sector and Leeds Learning Alliance. Improving employment opportunities is key to increasing social mobility, giving local opportunities to local young people. This also necessitates better training, mentoring and interning opportunities and working with employers to provide careers advice relevant to the Leeds job market.

THIRD SECTOR AND COMMUNITIES FOR HEALTH EQUITY

Leeds has an active and respected Third Sector, which is included in many of the city's and NHS's strategies. Building relationships and coalitions with the Third Sector, and with local residents and communities, is key to the success of interventions and policies to reduce health inequalities and improve the building blocks of health. Encouragingly, the majority of the registered charities and Third Sector organisations already have aims to improve the building blocks of health.

Scaling up good practice

Voluntary Action Leeds, the voluntary sector infrastructure organisation, is actively engaged with reducing health inequalities and improving the social determinants of health. In Leeds an additional organisation, **Forum Central**, provides key organisational functions for Third Sector organisations working in health and social care and acts as the collective voice for the sector delivering these services in Leeds. Forum Central is jointly funded by Leeds City Council and the NHS.

- Many Third Sector organisations are working with their local communities to improve aspirations. For example, **CATCH Leeds** is helping young people "reach their full potential". It believes its work is effective because of the collaborative approach it takes with the public sector, Third Sector organisations and the private sector. It states it is able to "join up capacity, resources and service provision around relevant groups that others cannot engage well with, and focus on the needs of those groups". CATCH's funders see their role in the building blocks of health but are often reluctant to fund action because, according to CATCH, "they all see their part of the picture, but not the whole picture and their part in it". CATCH, like many other Third Sector groups, has multiple partners and sources of funding, including: police, fire and ambulance services; schools, colleges, universities and local Cluster teams [see below]; the youth justice service; early intervention practitioners; the armed forces; local authority departments, including Communities, Safer Leeds, Public Health, Parks & Countryside; charities (local and national) and informal community groups and businesses (national and local). (27)

While the **Third Sector** offers a wide range of services in Leeds, there are **further opportunities to provide its organisations with strategic power to tackle health inequalities**. This requires understanding the entirety of the services they offer across the city and communicating the impacts of their work on health inequalities. In 2024 the Third Sector called for Leeds's city leaders to ***"remove process obstacles that hamper operational cross working"*** and asked that:

- resources into areas or communities be pooled to better address health inequalities
- more focus for the city's budgets be placed on areas of higher need
- bureaucracy be reduced in reporting how Third Sector organisations spend their money
- budgets be spent on public sector and Third Sector staff together, carrying out more collaborative working, and delivering "what works".

Leeds can make efforts to work more in partnership with the Third Sector to improve action on health inequalities. In interviews, people gave numerous examples of the Third Sector and communities working together. Many interviewees remembered the trusting relationship that existed between statutory services and the Third Sector during the pandemic and lamented the missed opportunities to build on the cohesive service delivery that happened during that time. In particular, they referred to the list of 'vulnerable residents' created during the COVID-19 pandemic, where many people were identified who were not previously known to any service providers. They suggested this powerful tool and approach to creating the list be resurrected to better coordinate services for this group.

Third Sector organisations are dealing with budget cuts from key funders such as the NHS and Leeds City Council, increasing energy and staff costs, and a drop in charitable donations and volunteers. Across Marmot places, a recurrent theme is the challenge of short-term funding streams; successful services have to close down or spend months dedicating staff time to finding funding instead of delivering services. A smaller Third Sector would have a negative impact on all partners working to reduce health inequalities in Leeds, and increase pressures on the statutory sector. The Third Sector in Leeds acknowledges central government's funding is pushing local Leeds commissioners to think in the short term but it has argued that: "Short-term funding results in a focus on outputs rather than outcomes, encourages people to engage with Third Sector organisations in a less meaningful way, and creates fluctuations in staffing and workflows. Although there is an understanding that central government funding is devolved to our public sector partners with a specific time-frame to spend it, we should continue to work together to explore ways to flex funding streams, so that they are sustained and responsive to local need." (28)

HEALTH EQUITY IN ALL POLICIES

Another way for Leeds to improve its success in addressing health inequalities is by adopting a 'health equity in all policies' (HEIP) approach. Far from being a tick-box exercise, an HEIP approach relies on effective, consistent and committed leadership. It places equity at the beginning of planning processes in services delivered by the council, NHS and key partners. The approach is not a panacea but it is a tool to ensure every policy, strategy and intervention is considered for its equity impact on residents, from where cycle lanes are situated to where trees are planted and take-away planning applications are accepted or rejected, from where nurseries are closed down to where family hubs are created – these are decisions that cumulatively contribute to health inequalities.

For Leeds to take this approach requires additional focused commitment from public health so that the wider Leeds system and its leaders (i.e. Boards and Councillors) are provided with knowledge and inspiration to improve the building blocks of health to help the city's system create, deliver and sustain programmes to support greater equity.

LEADERSHIP AND ACCOUNTABILITY RECOMMENDATIONS

AIM: Increase accountability, ensure action takes place and measure impact

1. Identify named senior leaders who are accountable for health equity in Leeds.
2. Commit to closing the gap in health outcomes as measured by the Fairer, Healthier Leeds Marmot indicators over a five to ten-year period and set out implementation plans to do this.
3. Leaders, organisations and partnerships to adopt a health equity in all policies approach to identify, test and embed processes that deliver health equity across the system.
4. Continue to allocate senior capacity and resource in public health to lead the Leeds health equity approach and maximise the expertise of the wider public health team in planning and delivery.
5. Continue to deliver the inclusive growth agenda with a focus on IMD 1 and 2 neighbourhoods. Leeds City Council to convene partners and anchor organisations to maximise the impact of their work in these areas. Scale up employment and skills training that meets the needs of communities and residents in IMD 1 and 2 neighbourhoods.
6. Leeds health and care partnership to continue to build on Core 20PLUS5 to reduce inequalities in health ensuring action is scaled up to meet the needs of communities in IMD 1 and 2 neighbourhoods.
7. Continue to enable the Third Sector to play a lead strategic role in addressing heath equity and, through fairer funding agreements, to deliver sustainable action on the social determinants of health.
8. Ensure the needs of ethnic minority populations in Leeds are addressed in all citywide strategies to reduce inequalities.

B. EFFECTIVE PARTNERSHIPS FOR HEALTH EQUITY

> "We need ourselves and partners to work in a different way."
>
> (Leeds City Council)

Stakeholders we interviewed in Leeds stated that current partnerships often involve the same people asking similar questions. People from across the system spoke of ***"duplication"*** and the need to ***"have less meetings and more outcomes"***; others spoke of working in ***"silos"*** or ***"little bubbles"*** despite these partnerships. Many spoke of depending on personal relationships rather than a trusting partnership approach that values helping colleagues within their own organisation and beyond.

Lack of governance structures can inhibit partnerships between, for example, the NHS and local authorities and this seems to be relevant in Leeds. One interviewee observed: ***"We have groups of partners coming together and running programmes of work but no link to a formal governance structure. We don't have a clear way to make decisions across the city."*** Partnerships in themselves do not guarantee change: they require clear governance and goals focused on reducing health inequalities.

Scaling up good practice

Leeds is on its way to working better across organisations and services. Partnerships are at the centre of its Best City Ambition and the Health and Housing Breakthrough Group are a blueprint for a more joined-up and strategic approach to tackling inequalities. The Health and Housing Breakthrough Group is a city-wide strategic partnership that focuses on improving housing, one of the key building blocks of health. Based on the achievements of this group, future new partnerships and existing partnerships tackling health inequalities in Leeds should identify specific short- and long-term goals, actively hold partners to account and include a wide membership (e.g. other public services, including schools, transport, housing and regeneration).

Schools and partnerships

- There are **22 'Clusters'** in Leeds providing place-based partnerships to support families, children and young people most in need of help, and all are based in IMD 1 and IMD 2 neighbourhoods. (29) The Clusters include staff from schools, health services, Area Inclusion Partnerships, Early Start teams in children's centres, police, social work, the Third Sector, and other relevant services such as housing. The role of health and public health in the Clusters varies and **no formal evaluation of the work of Clusters has been done**, including if any of them are improving educational attainment or reducing health inequalities.
- The **Leeds Learning Alliance** (LLA) is a network that provides a space for schools to share experiences, support each other and improve outcomes for pupils in the city. Members include many of the same partners present in the Clusters: the police, primary to university education institutions, the private sector, Leeds City Council and the Third Sector. LLA focuses on inclusion and inclusive leadership.
- A whole-school partnership approach, can address health inequalities. Such as approach involves the senior leaders listed above, along with teachers, parents, mental health specialists, inclusion workers and the wider community working together to develop children's essential emotional and social skills. (30) In addition, a whole-school approach can better link Leeds's education strategy with its inclusive growth strategy to help improve social mobility.

Improving partnerships for children aged 0–5

Attendees at our 0–5s workshop in January 2024 stated that the needs of parents and families of children in this age group should be the starting point and that services need to break out of their silo mentalities and work better together. A key theme was the need to better connect services. Many attendees stated it was difficult to find the 'right' people to work with – in education and schools, health, the council and the Third Sector. Many said they did not know exactly what services were offered to 0–5s and that parents also struggled. They called for leadership to facilitate better sharing of information between partners and consequently between families and key stakeholders.

Communities and partnerships

- Leeds has a number of neighbourhood and community approaches. A review in 2021 recommended Leeds adopt a "more holistic, less siloed approach to early intervention and prevention and ways of working to tackle poverty and address inequality especially in the least advantaged 1–10% areas... **Services [need to be] more accountable to and co-produced with communities.**" (31) Interviewees reiterated this point, and also spoke of the need to reduce duplication and better coordinate community approaches, making them ***"more citizen led"*** and to ***"create a clearer narrative for communities"*** with the comment ***"there's lots going on but how does it connect?"***
- **Current approaches**, such as the Leeds Locality Working approach and prioritising certain wards, **lack evaluations specifically analysing their impact on reducing health** inequalities. Interviewees wanted help to create measures ***"to ensure they are on the right trajectory"***. There is an **opportunity here for universities to help Leeds better evaluate** existing and future interventions, including working with the Third Sector in IMD 1 and 2 neighbourhoods to better develop future approaches and understand the impact of these 'bottom-up' approaches.
- Some partnership approaches will require more fundamental reconsiderations because of the duplication in areas and lack of connectivity in others. As one Leeds City Council interviewee stated: ***"We operate on different footprints – ward boundaries, community committee boundaries, local care partnerships, school clusters – all services working to funding footprints. It's not impossible but we haven't cracked how to focus on the person and not the service footprint. We need a person-centred solution."***

EFFECTIVE PARTNERSHIPS RECOMMEDATIONS

AIM: Existing and future partnerships prioritise greater health equity in Leeds

9. Adopt more ambitious health equity goals in existing strategic partnerships.

10. For each Marmot principle, ensure that membership of relevant networks and/or partnerships is broad enough to facilitate actions on the social determinants of health.

11. Working with the Third Sector, involve communities in identifying drivers of poor health and in the design, implementation and evaluation of actions to reduce them.

12. Clarify community approaches to addressing the social determinants of health in IMD 1 and 2 neighbourhoods, including joining up programmes, reducing duplication and scaling up what works.

C. RESEARCH AND MONITORING FOR HEALTH EQUITY

> "We need a stronger research basis with universities – more important[ly] than ever. [Otherwise] how do we genuinely influence what is going on on the ground?"
>
> (Leeds City Council)

> "We don't stop and understand, we don't know what is working and if Leeds are doing it."
>
> (Leeds City Council)

Building the evidence base of what works in Leeds and utilising the range of academic expertise in the city and region are ways for Leeds to improve its approach to reducing health inequalities in the short and long term. **Two existing partnerships have the capacity to accelerate evidence-based action** in the city to improve the building blocks of health:

- The **Leeds Academic Health Partnership** (LAHP) brings together the NHS, Leeds City Council, Leeds Beckett University, University of Leeds and Leeds Trinity University with the aim of reducing health inequalities in the city.
- The **Leeds Inclusive Anchors Network** brings together Leeds's largest public sector employers and the three universities also participate in this network.

It is essential for **both these partnerships to align their broad research agendas** and to provide the capacity for individual researchers and research centres to **study the causes and consequences of health inequalities and approaches to improving the building blocks of health in Leeds**.

Developing research and monitoring for health equity in Leeds and focusing on what works to reduce inequalities involves **collaborating with the individuals and communities** affected by health inequalities in the design and implementation of research. In addition, the Third Sector is a key partner and the LAHP should work more actively with its organisations to explore their role in research to reduce health inequalities and to understand the Third Sector's role in creating an inclusive economy. (32)

The LAHP can help Leeds to better integrate evaluation into interventions and help identify the effective actions that should be scaled-up and those that should not. These efforts should also include data intelligence, to communicate findings to commissioners, boards and residents who want to understand what stakeholders are doing.

Robust, timely, reliable and appropriately disaggregated data covering the Marmot 8 principles and related health outcomes is essential to help evaluate and track the impact of policies and interventions, to identify new and emerging issues and ensure there is accountability for health inequalities.

The **Fairer, Healthier Leeds Marmot indicators** were created in partnership with Leeds. The indicator set is the best available data to assess and monitor action on improving and reducing inequalities in the building blocks of health, factors that affect the early years, children and young people in school, and factors related to work and housing. The indicators are inspired by Marmot indicator sets in other Marmot places: Cheshire and Merseyside, Gwent and Coventry. (33) (34) The Fairer, Healthier Leeds Marmot indicators align with the Social Progress Index (SPI), which aims to understand the impact of the Best City Ambition and inclusive growth strategy.

Health equity in research: rapid mapping of inequalities through resident engagement in Leeds

The public health team mapped recent consultations and engagement work to understand residents' views in relation to the Marmot 8 principles. The aim was to identify gaps in understanding and good practice in hearing community voices to improve the building blocks of health.

The mapping exercise found primary and secondary pupils were frequently engaged by researchers for their views but also identified gaps, which included the views of families with children aged 0–5. Leeds City Council had researched the impact of the cost-of-living crisis and living in poverty but there was less analysis of the impact of housing on health – although the Centre for Ageing Better has reported on the impacts of housing on elderly residents in Leeds.

This quick mapping exercise showed how Leeds City Council can improve its approaches in engaging with communities to better understand the impact of and ways to address health inequalities.

RESEARCH AND MONITORING RECOMMENDATIONS

AIM: Drive more effective interventions and evaluations and collect data on the Fairer, Healthier Leeds Marmot indicators

13. Leeds Academic Health Partnership to continue to have 'reducing health inequalities' as its central focus and to increase activities to facilitate closer working and better understanding of the social determinants of health within the Leeds academic community.

14. Develop the Fairer, Healthier Leeds Marmot indicators and collect data and communicate progress against them.

15. Ensure that the Fairer, Healthier Leeds Marmot indicators findings influence strategic approaches (e.g. Joint Strategic Assessment and Best City Ambition) and delivery of programmes (e.g. Early Years, planning).

The second year of IHE's work in Leeds will focus on supporting the city's response to the recommendations and how it further develops its ambitions to tackle health inequalities and improve the social determinants of health.

FAIRER, HEALTHIER LEEDS (MARMOT CITY) INDICATOR SET

	Leeds Marmot Indicator	Disaggregation	Source
1	Life expectancy at birth in years	Ward MSOA IMD Decile Sex	NHS Digital and ONS
2	Babies with low birth weight, rate per 1,000 live births	Ward MSOA IMD Decile Sex	NHS Digital
3	Percent of children with a healthy weight at reception age (4-5 years olds)	Ward MSOA IMD Decile Sex Ethnicity FSM status	NHS Digital
4	Percent of pupils achieving a good level of development at end of reception	Ward MSOA IMD Decile Sex Ethnicity FSM status	National Consortium of Education Results
5	Percent of pupils meeting expected standards in reading, writing and maths (combined) end of Key Stage 2	Ward MSOA IMD Decile Sex Ethnicity FSM status	Local
6	Average Attainment 8 score	Ward MSOA IMD Decile Ethnicity FSM status	Local
7	Percent of school children who reported feeling happy every or most days	tbc	Leeds My Health My School survey
8	Percent of 16-17 year-olds not in employment, education, or training	Ward MSOA IMD Decile Sex Ethnicity	Local with DfE definitions
9	Prevalence of common mental health issues, recorded by GPs, all ages, directly age standardised rate per 100,000 people	Ward MSOA IMD Decile Sex Ethnicity Age	Local
10	Prevalence of severe mental illness, recorded by GPs, all ages, directly age standardised rates per 100,000 people	Ward MSOA IMD Decile Sex Ethnicity Age	Local
11	Percent of people earning less than UK Real Living wage	Ward MSOA IMD Decile Sex Ethnicity Age	Local
12	Number of households in temporary accommodation	LA	ONS, ASHE Survey
13	Percent of physical inactivity, recorded by GPs, adults 50+ years	IMD decile / MSOA Ethnicity	Local
14	*Households in fuel poverty - annual*	*In development**	*In development*
15	*Workforce by ethnicity (TBC)*	*In development***	*In development*

* Developmental indicator - as a place holder pending the development of WYCA fuel poverty measure.

** Developmental indicator - support the development of this aspirational indicator by reporting current information made available at city level.

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Leeds Health & Care Partnership

Proud to be part of West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Reviewing progress linked to relevant workstreams within the Healthy Leeds Plan and exploring any accumulative consequential impacts of existing cost improvement measures across health and social care.

1. What is this report about?

1.1. In Leeds, despite significant attention and effective partnership working over many years, health inequalities remain persistent, and, in some cases, improvements in key indicators have stalled or have begun to worsen. COVID -19 and the recent economic context has had a negative impact on the health of the population, exacerbating existing inequalities. This is not unique to Leeds and reflects a UK wide picture.

1.2. Due to the wide range of factors that influence people's health[1], partners in Leeds, in particular the Local Authority, education, NHS services and the Third Sector all have a different but important role to play in tackling health inequalities.

1.3. **The previous report** as part of this agenda item describes how the city council and specifically Public Health are working with partners to reduce health inequalities and provides an overview of the role and contribution of Leeds Public Health function. This includes some areas of work relating to health service provision, such as vaccinations programmes.

1.4. **This report** describes how partners providing health and care services are working to address health inequalities (including an update on the Healthy Leeds Plan, and how partners are working to minimise the health inequality impact of cost-improvement measures). This includes some areas of work to relating to the wider determinants of health, such as employment policies.

1.5. The role of Leeds City Council and Public Health, the Third Sector and wider partners is central to improving health and reducing health inequalities – evidence suggests at least 80% of health and health outcomes are related to 'the social determinants of health' – to factors such as housing, access to green spaces, employment and poverty, with only around 20% attributable to activity delivered by healthcare services.

1.6. There may be specific opportunities within the emerging national policy landscape to go further to 'improve the health of the poorest the fastest'. Leeds is well placed to take advantage of these opportunities, given the city's comprehensive and well-articulated approach to addressing health inequalities through the Leeds Health and Wellbeing Strategy, Team Leeds approach and Best City Ambition.

[1] Including housing, education, employment, the physical environment, transport and active travel, food, social and community networks, health and care services and personal behaviours.

2. What do we mean by health inequalities?

2.1. Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society.

2.2. The factors that influence our health are mostly outside of the influence of health and care services ("health inequalities result from social inequalities" - Marmot Review, 2010), however - health and care partners still play a critical role in addressing inequalities associated with outcomes, experience and access to services.

3. The Healthy Leeds Plan and progress against the relevant workstreams

3.1. The Leeds Health and Care Partnership (LHCP) is made up of organisations that provide, commission, assure or support the delivery of health and care services to the people of Leeds. It includes NHS partners, the city council and third sector organisations[2]. The partnership is committed to sharing resources, ideas and best practice to improve health outcomes and reduce health inequalities across the city.

3.2. Tackling health inequalities is everyone's business and each individual organisation in the LHCP has its own health inequality responsibilities. These vary from statutory duties across the whole Population (e.g. LCC and the ICB), to contractual and legal obligations specific to care provision (e.g. health and care providers), or to the founding articles of incorporation (e.g. Healthwatch).

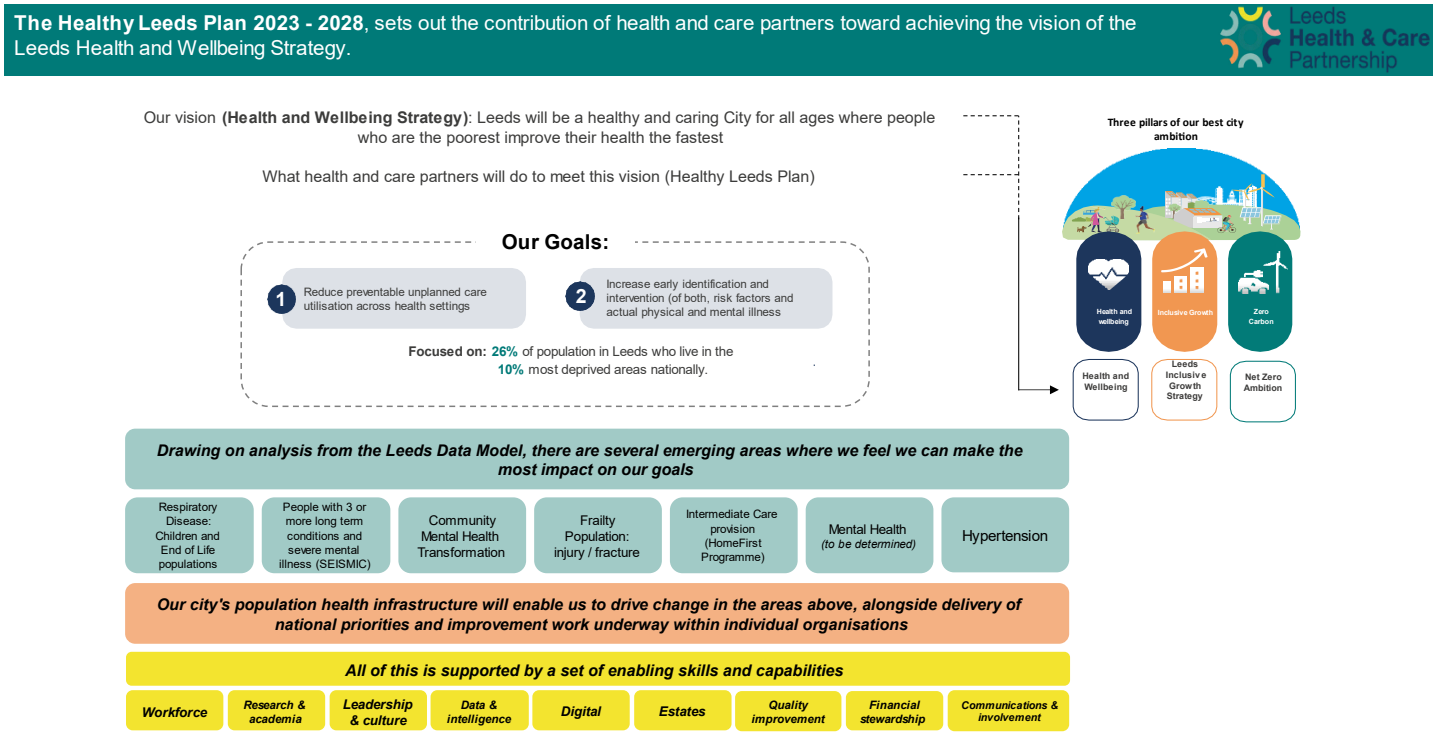
3.3. On top of their individual requirements, partners of the LHCP have agreed a set of shared priority areas. These shared priorities - the key health risks the partnership wishes to tackle together - are set out within The Healthy Leeds Plan and are focussed on the health inequalities associated with deprivation (whilst there are many different lenses for health inequalities, deprivation captures much of the intersectionality associated with a wide range of health inequality characteristics).

3.4. The Healthy Leeds Plan priorities are grouped under two themes. The first set relate to the health risks currently visible within the population today, grouped under Goal 1 (reducing preventable unplanned care utilisation). The second set relate to the health risks that may affect the population in the future, grouped under Goal 2 (increasing early identification and intervention). The two goals are intended to be complimentary – those in our most deprived communities use unplanned care more than those in the least deprived communities, and in part, that is because health and care needs are often identified *later* in the course of disease for those communities.

[2] Leeds City Council, Forum Central, Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, Leeds and York Foundation Trust, Leeds GP Confed, Healthwatch, Leeds Office of the West Yorkshire ICB

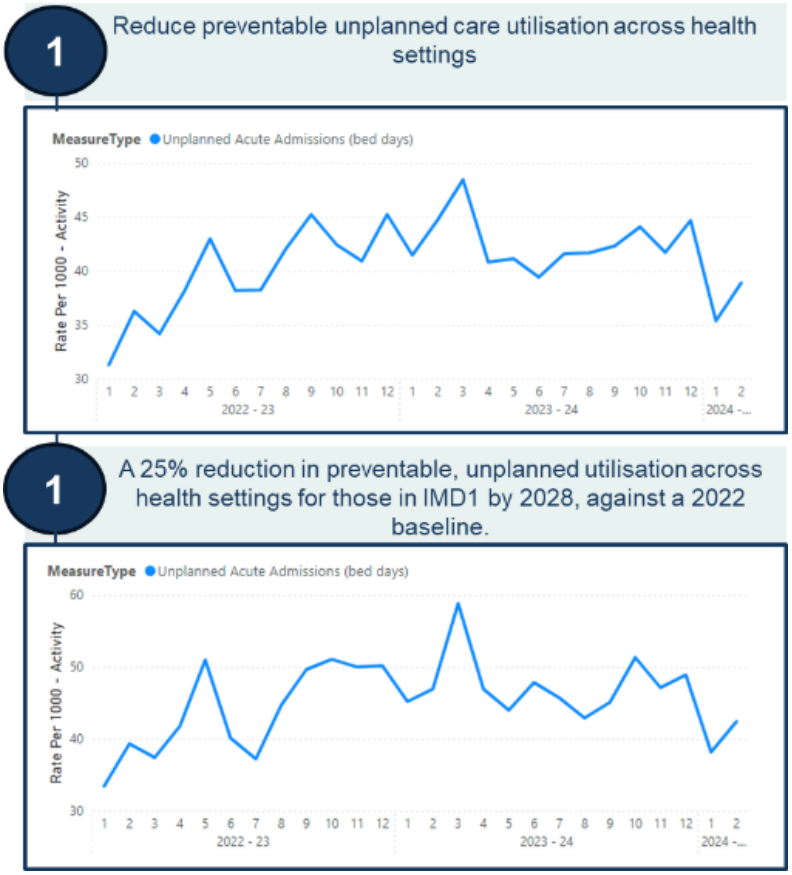
3.5. Priority areas under Goal 1 were identified by analysing the most common reasons people in our most deprived populations present in crisis to health and care services (specifically those in IMD1 – the 10% most deprived nationally, but representing 28% of the Leeds population). Priority areas under Goal 2 were identified by analysing where the largest differences are in early diagnosis (relative to life expectancy) between our most and least deprived populations – they represent the areas of greatest inequity between IMD1 and IMD10. An overview of all the priorities is included in Table 1.

3.6. Goal 2 priority areas were only agreed by health and care partners in September 2024. As such, the mechanism for measuring and tracking their combined impact has not been confirmed. For Goal 1 however, the ambition is that the collective impact of these priority areas would directly enable our ambition to see a 25% decrease in unplanned care utilisation across the partnership, and in IMD1 specifically, from 2023 to 2028.



3.7. Currently, unplanned utilisation across health settings is comparable but slightly lower this year relative to the same period last year (shown right – Q1 last year vs. Q1 this year). This is despite a growing population and importantly, is true for IMD1 as well as the wider population.

3.8. However, given the marginal decrease, and that many of the priority programmes (apart from HomeFirst and Community Mental Health Transformation) are in their early phases of development and delivery, it is unlikely that these small decreases can be directly attributed to the partnership work on the shared priority areas.



Programme Name	Description of project & intended outcomes	Current stage and description	Geographic area(s) of focus and people involved	Recent highlights
SEISMIC	Collaboration with Leeds University to develop an application for Leeds to become a centre of excellence in long term conditions research. Aligned with a local case for change for multi-morbidity interventions in the Leeds Health and Care Partnership.	Data analysis and engagement to inform the submission by 30th Jan 2025	Leeds wide. Focussed on people with 3 or more long term conditions and mental health condition in IMD 1	£200,000 Seed funding secured through NIHR (National Institute of Health Research) to progress the work to submission stage in January 2025. System hackathon held on the 3rd October.
End of Life – Respiratory Disease	Aims to reduce unplanned admissions and episodes of crisis care for people at the End of Life / Severe Frailty living in IMD1 areas by supporting individuals closer to home.	Diagnostic completed with multiagency and service user engagement. Interventions to be trialled over winter 2024/25	Focused on people with severe frailty or at end of life with respiratory needs living in Seacroft, Middleton and Hunslet and Cross Gates	Interventions aiming to reduce unplanned utilisation by 20% (equal to over 700 days spent in the hospital)
People living with frailty – injuries / fractures	Aims to aims to identify a way to reduce preventable unplanned admissions for people living with frailty for injuries / fractures for people living in IMD1	Diagnostic work underway and due for completion at the end of Nov	Initially focused on BHR, York Road and Armley PCNs	Diagnostic work, combined with service user and staff feedback, is highlighting a small number of Leeds tower-blocks and care homes with concentrated needs.
Children and Young People (CYP) – Respiratory Disease	Respiratory disease is the main reason for admission amongst CYP in Leeds, particularly 0-4s. This project will consider how this could be reduced.	Diagnostic work underway and due for completion at the end of Nov.	Initial focus in BHR, York Road, and Seacroft	Involvement of the acute trust in the design group and links with Public Health being further explored.
Intermediate Care Provision (Home First)	Aims to review and redesign Leeds' intermediate care offer to take us towards our shared vision for: a sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence.	Nearing completion of the programme.	Cross Leeds approach for people needing intermediate care	October 2024 data shows an annual impact of 1204 fewer adults admitted to hospital, 626 more people benefiting from reablement and 410 more people going directly home after a hospital stay.
Community Mental Health Transformation	Create a radical new model of joined-up primary and community mental health that responds to local populations' needs and will remove barriers to access, so that people can:	Early implementation sites currently being evaluated, programme is testing stakeholder & service users hypotheses and undertaking workshops to identify gaps and resources required.	Cross Leeds approach focusing on adults and older people with ongoing and complex mental health needs (severe mental illness/'SMI'). Est'd 8,000 people on SMI register in Leeds (higher need in reality)	Mobilisation of the new model, including expanded community support with the VCSE, new peer support worker roles, involvement workers and community wellbeing connectors
Goal 2 focus - Hypertension	Currently being scoped to understand areas of focus. Across West Yorkshire est. 600,000 people have high blood pressure but only half know they have it. People are twice as likely to die from heart disease under 75 if you live in the most deprived areas			
Goal 2 focus - Mental Health (including SMI)	Currently being scoped to understand areas of focus. There is increasing excess mortality for those with serious mental illnesses has been increasing since 2015-16, this links to and builds on the Community Mental Health Transformation work.			

4. Wider partnership work to tackle health inequalities

4.1. The Healthy Leeds Plan describes our shared priorities to tackle health risks within our population, focussing on the most deprived areas of Leeds – it is not however, the sum of our partnership work. There are multiple additional partnership-projects underway – some seek to tackle health inequalities by addressing the wider determinants of health, for example, the **Marmot City** work – which health and care partners support, others operate across a wider geography, for example inequality programmes delivered across **West Yorkshire**.

4.2. In addition, individual organisations across the Health and Care System in Leeds are seeking to maximise their contribution to tackling health inequalities. In particular, a huge amount of work in this area is driven by our **Third Sector Partners**, represented and supported by **Forum Central**. The voluntary, community and social enterprise (VCSE) sector in Leeds is a vital source of knowledge and expertise for our health and care system. Organisations within the sector have unique relationships with and understanding of our diverse communities and innovative approaches to the delivery of care. Leeds has strong examples of where statutory partners have worked well with the sector and developed new ways of working. The third sector is a core member of the Partnership Leadership Team (directing the Healthy Leeds Plan priority projects), the Population Boards representing partnership transformation decisions linked to different populations, and is embedded within delivery of many of our collective priority areas. The breadth and diversity of the sector – as well as the number of organisations within it – mean that the following sections focus more on the overall approach of the City Council and NHS, but with the recognition that the Third Sector supports, enables, and jointly delivers much of this alongside statutory partners.

4.3. Over the past few years that has been a significant shift in strategic direction and a prioritisation of tackling health inequalities within provider organisations. For example, Leeds Community Healthcare Trust (LCH), established its health inequalities strategy in 2021 and in 2024 further demonstrated its commitment to equity by including it as one of the organisations five strategic goals. This increased strategic focus, and strong leadership on inequalities across the NHS Trusts is supporting a cultural shift towards making tackling inequalities everyone's business.

4.4. Health and Care organisations have focussed on **building the foundations** to rid systematic inequalities from access and experience of care. A select number of examples of this include:

- **Strengthening use of equalities data:** LCH, LTHT and LYPFT have all developed or are developing health inequalities dashboards. This data can then be used by services to identify inequalities issues and inform service improvement. NHS trusts and the ICB

in Leeds are moving towards making inequalities reporting a standard part of performance and assurance reports. The NHS England **Core20Plus5** framework sets out the five clinical areas for adults and children where evidence suggests the NHS can have a significant impact on health inequalities[3]. The Leeds Core20Plus5 working group is supporting the development of a single dashboard to track impact across these areas, which in turn can be embedded into wider reporting processes.

- **Embedding equity within business processes:** Equality and health inequalities impact assessments are vital for embedding equity at the heart of service change. LCH are systematic in undertaking impact assessments for all relevant service changes and have embedded this process within their financial efficiencies programme. Leeds City Council has also broadened the equality domains it considers within its business processes – it recently agreed to adopt care-experience as a protected characteristic alongside the others set out within the Equalities Act.

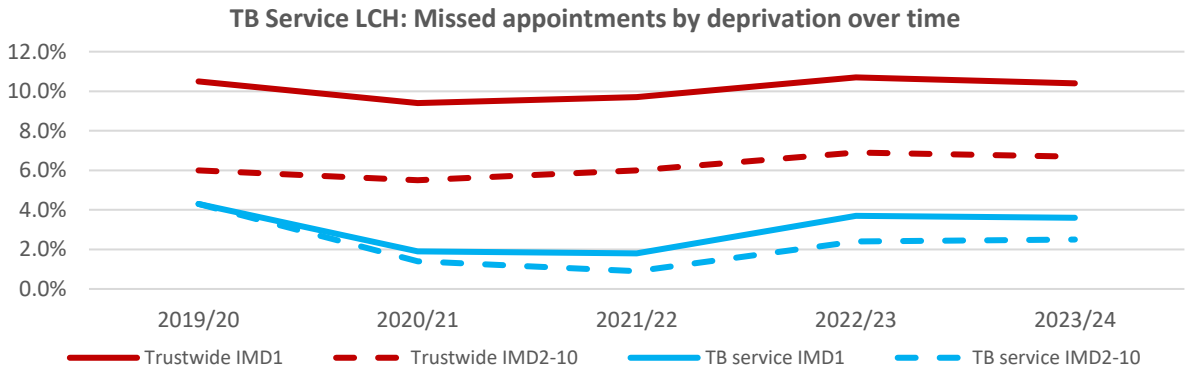
- **Workforce development:** A wide range of activity is taking place to build the skills, motivation and capacity of the workforce to tackle inequality such as cultural competency training being delivered to staff across LYPFT. Similarly, the West Yorkshire Health Inequalities Academy and Health Equity Fellowship seeks to develop system-expertise in health inequalities and public health. At a broader scale, a whole health and care system approach to workforce development on health inequalities is currently being established through the Leeds One Workforce Strategy.

- **Community Engagement and Insights:** Forum Central and Healthwatch have developed a community insights resource which is embedded within the Leeds Health and Care Tackling Health Inequalities Toolkit. The Healthwatch 'How does it feel for me' programme, capturing patients experiences of care, is a valuable resource for all organisations. Alongside publishing key decisions well in advance, and ensuring decisions-making meetings are held in public, Leeds City Council also directly supports and engages with local communities or groups on a much more local scale, such as through neighbourhood networks (described below), to ensure that local voices fundamentally guide service-decisions. A number of these have been established to ensure that Leeds is also meeting the needs of its ethnically diverse communities – for example the Forum for Race Equality, the Al Khidmat Centre, or the Hamwattan Centre.

[3] For adults: Maternity; Severe mental illness (SMI); Chronic respiratory disease; Hypertension; Cancer. For Children: Asthma; Diabetes; Epilepsy; Oral health; and Mental health.

4.5. Health and Care organisations across Leeds are starting to make strides in their **delivery of equitable clinical services and preventative programmes.** Some examples are provided below:

- Despite a large proportion of patients within the service experiencing multiple layers of deprivation, Leeds Community Healthcare LCH Tuberculosis service have managed to keep missed appointment rates low for those in IMD1 through a person-centred approach. Similarly, to support children from high deprivation areas to access their outpatient appointments, LTHT has begun scheduling appointments for the few days after benefits are received to ensure families have the finances to travel to their appointments – and have seen a significant reduction in the rates of children missing appointments.



- Preventative programmes are also clearly a significant part of what health and care can do to reduce inequalities. Smoking accounts half the difference in life expectancy between the richest and poorest in society[4]. Over the last 2 years LTHT have initiated and expanded the delivery of Stop Smoking Services for its inpatient and maternity services, seeing over 962 quits achieved at 28 days, reducing readmissions and saving lives. Leeds City Council also has a long-standing history of investing in preventative services largely delivered across the diverse third sector that the city boasts – for example Neighbourhood Networks, a nationally-recognised preventative offer for older people in terms of reducing social isolation, improving health and wellbeing and maximising people's independence through a range of community-based interventions.

[4] Action on Smoking and Health

- Partners also help deliver initiatives that fundamentally enable access to health and care services for people in Leeds who might otherwise struggle. The Street Support team supported by Leeds City Council is a good example. The service focuses on those at the highest risk of sustained homelessness and the associated risks that this places people at - including risk of early death, alcohol and substance misuse, being a victim of crime, harassment and exclusion and inability to access services. This includes a Resource Centre, assertive street outreach and a range of supported accommodation and visiting support. Leeds has utilised Government grant to extend this offer to include women only accommodation, modular units and Housing First.

- A range of innovation around reducing health inequalities is also visible in GP practices and across Primary Care in Leeds. The Leeds GP Confederation worked with Burmantofts, Harehills & Richmond Hill PCN to improve uptake of cervical screening by working with female medical students with language skills in Urdu, Punjabi & Bengali to reduce the language and cultural barriers preventing these communities accessing services. Yeadon PCN has been working with the Roma Community to explore access issues linked to appointment times and language, and has worked with Leeds Playhouse to encourage attendance at children's immunisation clinics.

4.6. Whilst this gives an *indication* of the breadth of work underway across partners, it is impossible to capture here all activities occurring across health and care organisations. There has been dramatic transformation over the past few years, recognising tackling inequalities as central to providing quality health services. This is increasingly visible in national policy direction, but systematic inequality will take time to undo. Examples of good practise need to be scaled, and equity needs to be meticulously embedded across all business processes, systems and resource allocation decisions.

5. Minimising the health inequality impact of cost improvement measures

5.1. Alongside statutory duties associated with continually improving patient outcomes and experience, and reducing health inequalities, the ICB also has a statutory duty to ensure its "resource use does not exceed the limit specified in a direction by NHS England" (Health and Care Act, 2022). The recent Darzi report noted the impact of changes to remit and challenges to NHS funding in its recovery from the pandemic. Similarly, the recent CQC State of Care report emphasised the persistent challenges associated with continued reductions in funding for adult social care. In line with the national picture, LHCP members in Leeds have this year managed huge budgetary pressures across health and social care, around £36m n Adult Social Care and Childrens Social Care and

£187m in the NHS, on top of funding changes to third sector partners.

5.2. Organisations across Leeds have worked collaboratively to ensure the brunt of these changes has been managed internally. The System Finance Executive Group for example, brings together NHS executives to share visibility of their collective financial plans, and has developed a decision-making framework that helps minimise the risks of changes in one organisation impacting another and having an adverse effect on our population's health or health equity. Similarly, Leeds City Council annually sets out where changes to services may be planned for scrutiny by councillors and the public, allowing for careful assessment of the potential impact and efforts to mitigate the consequences of change where possible

5.3. In line with their statutory requirements, all public sector organisations routinely undertake quality and equality impact assessments to understand the risks posed to different populations, and identify opportunities for mitigation. A potential area for future development as a health and care partnership would be to consider how these align across organisations, to ensure consistency in methodology and approach – although this would also need to ensure organisations are able to follow existing governance requirements.

5.4. Whilst funding for health and care has been constrained overall in Leeds, there have also been deliberate and targeted increases or protection of funding in some areas – typically for populations that face the greatest health risks or greatest inequalities. From an NHS perspective this includes

a) ***Mental Health – increase in spend of £7.1m*** in 2024/25 to support some of the rising pressures and in line with the Mental Health Investment Standard.

b) ***Community Mental Health Transformation*****.** The NHS in Leeds had already invested recurrently £4.8m in this area in 2023-2024 and has protected its plans in 2024-2025 with an additional £0.5m. Over 33% of this has been delivered through the 3rd sector.

c) ***Weight Management:*** Weight management services have been a challenge for Leeds, and specialist NHS services have recently closed to new referrals. An additional £500k has been invested to provide Wegovy to those most in need on waiting lists. Whilst not at an ideal scale, this should enable the list to re-open in due course and support the most deprived populations.

d) **Core20PLUS5:** The NHS is meeting this investment standard in 2024-25, and has adjusted the support provided to GP schemes to give a much stronger focus on Core20PLUS5

e) **Children and Young People:** The increase in the needs and numbers of Children and Young people, especially the most vulnerable and Looked After Children continues to present a challenge. NHS partners in Leeds have committed to an increase in this area of c£3m.

5.5. There are likely to be wider impacts from protecting these areas. One such area is on the Third Sector, and the NHS application of an c3% reduction in Third Sector contracts and grants will have had an impact, as well not continuing non-recurrent funding of certain schemes, although not all these contracts are entirely related to addressing health inequality.

6. Towards next year – continuing a focus on health inequalities

6.1. Some of the financial challenges highlighted above are linked to a reduction in the provision that was rapidly implemented during the COVID-19 pandemic. As such it is unlikely that the scale of changes this year will be repeated. Whilst implementing these has been incredibly difficult, it has stressed, tested and improved areas of joint working between health and care partners in Leeds.

6.2. The LHCP continues to improve its governance and ways of working through a **Partnership Development Programme** that was put in place at the start of the year. A key area within the first phase of this programme has been on prioritisation and focus – with a rationale that with less resource, it is critical to co-ordinate and prioritise effectively toward the most important areas of work we need to do together. There are seven criteria that will inform LHCP decisions on future priorities. Three of these relate to inequalities (Strategic fit with the Healthy Leeds Plan goals, improving outcomes, risk). In addition, the next phase of the partnership development work includes a review of our health inequality governance structures across health and care partners (e.g. the Tackling Health Inequalities Group) – which has clear links to the Marmot City work described in the preceding paper.

6.3. Beyond this, work will continue on the delivery of the Healthy Leeds Plan priority areas, as well as those areas of focus outlined within the Core20PLUS5 programme.