Public Document Pack

HEALTH AND WELLBEING BOARD

Meeting to be held in the Council Chamber, Civic Hall, Leeds, on Thursday, 16th September, 2021 at 10.00 a.m.
(Pre-meeting for all Board members at 9.30 a.m.)

MEMBERSHIP

Councillors
S Arif S Golton N Harrington
A Smart
F Venner (Chair)

Representatives of Clinical Commissioning Group
Dr Jason Broch – Chair of NHS Leeds Clinical Commissioning Group
Tim Ryley – Chief Executive of NHS Leeds Clinical Commissioning Group
Dr Alistair Walling – Chief Clinical Information Officer of Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Victoria Eaton – Director of Public Health
Cath Roff – Director of Adults and Health
Sal Tariq – Director of Children and Families

Representative of NHS (England)
Anthony Kealy - NHS England

Third Sector Representative
Alison Lowe – Director, Touchstone

Representative of Local Health Watch Organisation
Dr John Beal - Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Joint Representative
Paul Money – Chief Officer, Safer Leeds
Supt. Richard Close – West Yorkshire Police

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

Agenda complied by: Harriet Speight
Governance Services 0113 37 89954

Note to observers of the meeting: To remotely observe this meeting, please click on the 'View the Meeting Recording' link which will feature on the meeting's webpage (linked below) ahead of the meeting. The webcast will become available at the commencement of the meeting.

https://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=965&MId=11450&Ver=4

Due to current restrictions arising from the pandemic, there will be limited capacity in the public gallery for observers of the meeting. If you would like to attend to observe in person, please email FacilitiesManagement@leeds.gov.uk to request a place, clearly stating the name, date and start time of the committee and include your full name and contact details, no later than 24 hours before the meeting begins. Please note that the pre-booked places will be allocated on a 'first come, first served' basis and once pre booked capacity has been reached there will be no further public admittance to the meeting. On receipt of your request, colleagues will provide a response to you. Please Note - Coronavirus is still circulating in Leeds. Therefore, even if you have had the vaccine, if you have Coronavirus symptoms: a high temperature; a new, continuous cough; or a loss or change to your sense of smell or taste, you should NOT attend the meeting and stay at home, and get a PCR test . For those who are attending the meeting, please bring a face covering, unless you are exempt

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			WELCOME AND INTRODUCTIONS	
2			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
3			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED** – That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

4			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
5			**DECLARATION OF INTERESTS** To disclose or draw attention to any interests in accordance with Leeds City Council's 'Councillor Code of Conduct'.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the previous Health and Wellbeing Board meeting held 29 April 2021 as a correct record.	9 - 16

9			**JOINT STRATEGIC ASSESSMENT 2021 - DRAFT SUMMARY REPORT** To consider the report of the Head of Intelligence and Policy (Leeds City Council) that sets out progress in producing the 2021 Joint Strategic (Needs) Assessment (JSA). The production of a JSA on a three-yearly cycle is a joint responsibility between Leeds City Council and the NHS Leeds CCG to inform the Health and Wellbeing Strategy. Specifically, the JSA aims to shape priorities, inform commissioners, and guide the use of resources as part of the commissioning strategies and plans for the city, by understanding the core drivers of health and wellbeing.	17 - 122
10			**HOW HEALTH AND CARE ORGANISATIONS ARE WORKING TOGETHER IN LEEDS TO TACKLE HEALTH INEQUALITIES** To consider the report of the Leeds Tackling Health Inequalities Group that proposes that the Health and Wellbeing Board holds the health and care system to account in making changes to tackle health inequalities and requires organisations to publicly say what has happened and what more is to be done. This paper intends to prompt an open and honest discussion on this topic at the public Health and Wellbeing Board on 16th September.	123 - 134
11			**DIGITAL EXCLUSION** To consider the report of the People's Voices Group that reflects on recommendations made a year ago by the People's Voices Group and views of health and care providers about how they have addressed this key inequalities and access issue.	135 - 182
12			**LEEDS BCF END OF YEAR 2020/21 TEMPLATE AND IBCF UPDATE** To consider the joint report of the Chief Officer, Resources & Strategy, Adults & Health (Leeds City Council) and the Head of Planning & Performance (NHS Leeds CCG) that seeks sign off from the Health and Wellbeing Board of the End of Year 2020/21 Template.	183 - 228

13			**FOR INFORMATION: CONNECTING THE WIDER PARTNERSHIP WORK OF THE LEEDS HEALTH AND WELLBEING BOARD** To note, for information, the report of the Chief Officer, Health Partnerships, that provides a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.	229 - 236
14			**FOR INFORMATION: LEEDS ROUTINE ENQUIRY: GPS AND HEALTH PRACTITIONERS IN 8 GP PRACTICES IN LEEDS- EVALUATION REPORT 2019** To note, for information, the report of the Safer Leeds Safeguarding & Domestic Violence Team, that report that explores data on the short term impact for victims where GPs and Health Practitioners, who have access to a specialist worker, have proactively screened female patients over the age of 16 for Domestic Violence and Abuse (DV&A).	237 - 258
15			**FOR INFORMATION: PUTTING PEOPLE AT THE HEART OF DECISION-MAKING - UPDATE ON PROGRESS IN PLANNING THE BIG LEEDS CHAT 2021** To note, for information, the report of the People's Voice Group that outlines the plans for Big Leeds Chat 2021.	259 - 266
16			**DATE AND TIME OF NEXT MEETING** The next meeting will be held Wednesday 8th December 2021 at 2.00 p.m. (Pre-meet for Board Members at 1:30 p.m.)	

Third Party Recording

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

THURSDAY, 29TH APRIL, 2021

PRESENT: Councillor F Venner in the Chair

Councillors N Harrington and A Smart

Representatives of Clinical Commissioning Group
Dr Jason Broch – Chair of NHS Leeds Clinical Commissioning Group
Tim Ryley – Chief Executive of NHS Leeds Clinical Commissioning Group
Dr Alistair Walling – Chief Clinical Information Officer of Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Victoria Eaton – Director of Public Health
Cath Roff – Director of Adults and Health
Tim Pouncey – Chief Officer, Children and Families

Third Sector Representative
Alison Lowe – Director, Touchstone
Pip Goff – Director, Forum Central

Representative of Local Health Watch Organisation
Dr John Beal – Chair of Healthwatch Leeds
Hannah Davies – Chief Executive of Healthwatch Leeds

Representatives of NHS providers
Alison Kenyon - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Representative of Safer Leeds
Supt. Richard Close – West Yorkshire Police
Jane Maxwell – Area Leader, Communities, Leeds City Council

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

29 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

The Chair thanked her predecessor, Councillor Rebecca Charlwood, for her work as Executive Member for Health and Wellbeing and Chair of the Board.

The Chair welcomed Superintendent Richard Close as a new member of the Board, representing Safer Leeds.

On behalf of the Board, the Chair thanked everyone in Leeds for coming together to respond to the COVID-19 crisis.

30 Appeals against refusal of inspection of documents

There were no appeals.

31 Exempt Information - Possible Exclusion of the Press and Public

There were no exempt items.

32 Late Items

There were no late items.

33 Declarations of Disclosable Pecuniary Interests

There were no =declarations of disclosable pecuniary interests.

34 Apologies for Absence

Apologies for absence were received from Councillor Salma Arif, Sara Munro, Paul Money, Sal Tariq and Anthony Kealey. Alison Kenyon, Jane Maxwell and Tim Pouncey were in attendance as substitutes.

35 Open Forum

No matters were raised on this occasion.

36 Minutes - 20th January 2021

RESOLVED – That the minutes of the meeting held 20th January 2021 be approved as an accurate record.

37 Development of the Left Shift Blueprint

The Director of Population Planning, NHS Leeds Clinical Commissioning Group (CCG), submitted a report that shared the Left Shift Blueprint approach and document with the Health and Wellbeing Board in addition to outlining the progress made with this initiative to date. The Health and Wellbeing Board are asked to sign up to both the concept of the Left Shift Blueprint and the Strategic indicators and support delivery of the plan.

The following were in attendance:

- Jenny Cooke, Director of Population Health Planning, NHS Leeds CCG

- Dr Bryan Power, Clinical Lead for Long Term Conditions, NHS Leeds CCG
- Lindsay Springall, Head of Pathway Integration Long Term Conditions, NHS Leeds CCG

The Director of Population Health Planning introduced the report, and presented a short film 'Mark's Story', part of the 'How does it feel for me?' series produced by HealthWatch Leeds, in which Mark described his experiences of the LEEDs (Learning, Empowering, and Enabling Diabetes Self-Management) Programme – an example of the Left Shift Blueprint in long term conditions and the benefits of investing in structured education.

As part of the ongoing blueprint work, key objectives for the Long Term Conditions team working with partners represented on the Health and Wellbeing Board were set out as follows:

1) Working to facilitate increased healthy lifestyle opportunities; and
2) Increasing referrals into NDPP (National Diabetes Prevention Programme) / Structured Education, which have fallen as a result of the COVID-19 pandemic.

The Clinical Lead for Long Term Conditions described what the Left Shift Blueprint might mean for patients, including:

- Putting people in control of their conditions, and focusing on what matters to people, including developing proactive support plans for self-management with a patients' personalised 'goal' at the centre;
- Reducing health inequalities, by targeting resources to populations at increased risk and adapting approaches and services to suit the needs of different communities;
- Supporting people through social prescribing and more regular reviews of medication;
- Increased options for advice and support at a local community level and fewer repeated visits to hospital.

For clinicians, the impacts of the Left Shift Blueprint were described as follows:

- More integrated working practices, including increased use of digital technologies such as 'Virtual Wards' for a number of services, to reduce the number of admissions;
- Building capacity and capability in primary care settings through more activity in community settings and pharmacies, and increased focus on self-management, meaning better access to services when required;
- Understanding and agreeing health priorities with local communities and targeting resources to those most at risk;
- Shared decision making with patients, working 'with' rather than 'to'.

Members discussed a number of matters, including:

- It was recognised that 80% of an individuals' health is impacted outside of health services, and therefore the benefits of programmes to improve wellbeing and lifestyle, for communities and individuals, are well evidenced;
- Members highlighted the challenge of identifying measures for mental health services, due to the most appropriate approach in certain circumstances being specialist care as quickly as possible, which may be delivered from hospital. Related to this, Members suggested that further consideration be given to incorporating the Left Shift Blueprint into existing mental health measures within Local Care Partnerships;
- Members suggested that the Board schedule further discussions on the shift of resources required to enable better access for disadvantaged groups;
- In response to a query, Members were advised that 25% of participants did not complete the LEEDs course, and that feedback suggested that in most cases this was due to the time commitment required. Members noted the opportunity to reflect on the delivery of such programmes and build on the offer of remote support, to enable more flexibility for patients;
- Members recognised the benefits of focus on prevention and reduced routine patient visits to primary care settings during periods of long waiting times for referrals and treatment as a result of the pandemic.

RESOLVED –

a) That Members comments be noted;
b) That the Board agree to sign up to both the concept of the Left Shift Blueprint and the Strategic indicators;
c) That it be noted that the Board support implementation of the Left Shift Blueprint both in the ways outlined.

38 Joint Strategic Assessment 2021

The Head of Intelligence and Policy, Leeds City Council, submitted a report that sets out initial proposals to produce the Joint Strategic Assessment (JSA), and updates Health and Wellbeing Board on the work that has taken place to date.

The following were in attendance:

- Simon Foy, Head of Intelligence and Policy, Leeds City Council
- Tony Cooke, Chief Officer, Health Partnerships

The Head of Intelligence and Policy introduced the report and delivered a PowerPoint presentation, which set out some of the emerging headlines and lines of enquiry as follows:

- The school age population growing and becoming more diverse - increasingly concentrated in deprived areas. Nationally, 18% of those

under the age of 16 are living in relative poverty, compared to 24% in Leeds, and 38% in Bradford;
- Covid-19 data shows link between deaths and deprivation. Poor living and working conditions increase both exposure to Covid-19 and other illnesses – frontline workers, people unable to work from home, housing-density/condition, use of public transport;
- The Leeds vaccine programme shows similar associations between deprivation, ethnicity and lower vaccine uptake;
- Reduced educational attainment at pre-school and primary, particularly for poorest children, and growing concerns around child and adolescent mental health;
- Prior to Covid-19, there was a long-period of economic growth and expansion, strengths in key sectors, knowledge-based jobs, relatively high-levels of employment. However, since March 2020, trends show stalling growth/low productivity, and many of new jobs in Leeds are low-skilled, low-paid work in consumer services;
- Positive impact of Covid-19 on climate change due to reduced travel and home working, however, there is uncertainty around the medium to long term impact on travel behaviour.

Members discussed a number of matters, including:

- Members identified the experiences of children and young people, particularly the impact of COVID-19 on education and employment, as a key focus moving forward;
- It was noted that further analysis to assess the impact of each of the key themes on BAME, LGBT and gypsy traveller communities should be undertaken;
- Members recognised the significance of the findings and recommendations of the Marmot Review into health inequalities in England '10 Years On' report, and the subsequent 'Build Back Fairer' report, for development of local needs assessments moving forward;
- Members noted the changes to use of transport as a result of the pandemic, largely due to home working, and were keen to understand if these changes were accelerated by the pandemic and likely to remain. Members were advised that it is expected that transport patterns will return to a 'new normal', due to a significant shift in transport modality and a clear focus on active travel. It was also noted that travel behaviour and public transport availability has a great impact on access to employment.

RESOLVED –

a) That Members comments in relation to the proposed approach to the JSA be noted;
b) That a further report be submitted in due course, as the development of the JSA is progressed.

39 2021-26 Future in Mind: Leeds

The Leeds Future in Mind Programme Board submitted a report that presented the 2021–26 Future in Mind: Leeds strategy. This is the plan for Leeds that explains how people are working together to improve mental health and emotional for young people.

RESOLVED – That the 2021-26 Future in Mind: Leeds Strategy be approved.

40 Leeds Maternity Strategy 2021-2025

The Leeds Maternity Programme Board submitted a report that provides an overview of the refreshed Leeds Maternity Strategy (Appendix 1) following the strategic direction provided by the Health and Wellbeing Board in Sept 2020. It is a five year plan for the city explaining how people will work together to improve the health and care services we offer to parents-to-be and new parents, to give babies the best start in life.

RESOLVED – That the refreshed Leeds Maternity Strategy be approved.

41 NHS Leeds CCG Annual Report 2020-21

The Communications Lead, NHS Leeds CCG, submitted a report that sets out the process of developing the NHS Leeds CCG Annual Report 2020-21 as national timescales do not align with the Leeds Health and Wellbeing Board meetings.

RESOLVED –

a) That the process to develop the NHS Leeds CCG draft annual report be noted;
b) That the extent to which NHS Leeds CCG has contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021 be noted.

42 Leeds Palliative and End of Life Care Strategy for Adults 2021-26

The Leeds Palliative Care Network submitted a report that presents the new Leeds Palliative and End of Life Care Strategy for Adults 2021-26.

RESOLVED – That the Leeds Palliative and End of Life Care Strategy for Adults 2021-26 be noted.

43 Leeds Health and Care Financial Reporting

The Leeds Health and Care Partnership Executive Group (PEG) submitted a report that provides a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). This report is for the period ending February 2021, and the forecast year end position at that point.

RESOLVED – That the M11 2020/21 partner organisations financial positions and forecast position at year end be noted.

44 Connecting the wider partnership work of the Leeds Health and Wellbeing Board

The Chief Officer, Health Partnerships, submitted a report that provides a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB).It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

RESOLVED – That the contents of the report be noted.

45 Any Other Business

No matters were raised on this occasion.

46 Date and Time of Next Meeting

The next meeting will be held on Thursday 16th September 2021 at 10.00 a.m.

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Simon Foy / Mike Eakins

Report of: Head of Intelligence and Policy, Leeds City Council

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2021

Subject: Joint Strategic Assessment 2021 – Draft Summary Report

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☒ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

- The production of a Joint Strategic (Needs) Assessment (JSA) on a three-yearly cycle is a joint responsibility of Leeds City Council and NHS Leeds CCG through the Health and Wellbeing Board and informs the Health and Wellbeing Strategy.
- The 2021 JSA takes a life-course approach to the analysis, structuring it through the lens of Starting Well, Living Well, Working Well and Ageing Well. Each section includes a series of initial policy implications drawn from the analysis, alongside the headline findings.
- Headline findings include some of the measurable impacts of Covid-19 on the health of people and communities, making the connections between the virus's impact and existing inequalities. However, the analysis also reflects many of the longer term challenges and opportunities for the city and for people at all stages of life.
- Once the JSA summary report has been finalised, analytical focus will shift to developing a stronger online intelligence platform, adopting the new JSA structure, and providing further opportunities for engagement with detailed quantitative and qualitative insights.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider the JSA draft summary report attached as Annex A, and specifically consider whether the policy implications highlighted fully reflect the headline findings and challenges / opportunities ahead.

- Consider how best to respond to any strategic and commissioning implications of the analysis, in particular those relating the tackling health inequalities and the needs of various communities of interest.

1 Purpose of this report

1.1 The production of a Joint Strategic (Needs) Assessment (JSA) on a three-yearly cycle is a joint responsibility between Leeds City Council and the NHS Leeds CCG to inform the Health and Wellbeing Strategy. Specifically, the JSA aims to shape priorities, inform commissioners and guide the use of resources as part of the commissioning strategies and plans for the city, by understanding the core drivers of health and wellbeing.

1.2 Following the Board's earlier discussion about the emerging findings of the analysis in April, this paper sets out progress in producing the 2021 JSA. The draft summary report is attached as Annex A.

2 Background information

2.1 Our approach to the JSA goes beyond a narrow health needs assessment (although this remains a vital component), by extending the analysis to incorporate the wider determinants of health and wellbeing, and by default informing the 'three key pillars' of the city's overarching ambition – Health and Wellbeing, Inclusive Growth, and Climate Change.

2.2 We have adopted a partnership approach in developing the JSA, establishing a stakeholder 'sounding board' group with cross-council colleagues and partners from the CCG, Third Sector and Universities helping to shape the analysis.

2.3 In light of strong stakeholder input through the sounding board we have developed a life-course approach to the JSA's structure, which uses the lens of life-course stages to frame the analysis. Within this we have also ensured coverage of the three pillars of the city ambition. The structure of the JSA therefore is as follows:

- Introduction / Headline Findings
- 1 – A Changing City: Population Trends
- 2 – Starting Well: Child-Friendly Leeds
- 3 – Living Well (Health & Wellbeing, Thriving Communities, Climate Change)
- 4 – Working Well: Inclusive Growth
- 5 – Ageing Well: Age-Friendly Leeds
- 6 – Implications of the Analysis

2.4 The draft summary report attached at Annex A provides a snapshot based on a wide-ranging analysis of available data. It aims to meet several requirements, these are:

- To inform the forthcoming review of the Health and Wellbeing Strategy.
- To develop analysis and data to guide commissioners, shape interventions, inform evaluations, and support funding bids.

- To provide city-wide strategic insights to understanding progress against city ambitions, framed by the three key pillars, which in-turn should provide a key input into the development of a new city plan.

3 Main issues

Headline Findings

3.5 The ongoing impact of Covid-19 has clearly been a significant factor in the production of the JSA. While holistic analysis of the pandemic's effects is not yet possible in many respects, overall it is clear that the national narrative of exacerbated inequalities, disproportionate impact on older people, and emerging mental health challenges across all ages are absolutely reflected in Leeds.

3.6 A range of complex and inter-related demographic trends continue to shape our population, with a growing number of older people, the profile of young people becoming more diverse and focused in communities most likely to experience poverty, population growth focused in inner-city areas and continued uncertainty on post-exiting the EU patterns of immigration.

3.7 Covid-19 has had a profound impact on the health and wellbeing of children and young people, with the disruption to their education perhaps most obvious. This impact is set against longer-term challenges regarding educational attainment, particularly of more disadvantaged children, the incidence of child poverty and wider concerns regarding the mental health of children and young people.

3.8 Tackling poverty and inequality is central to our approach to health and wellbeing, with the ambition to improve the health of the poorest fastest. The pandemic has exacerbated inequalities, driven by a combination of underlying health conditions, limited scope to follow heathy living opportunities, and exposure to the virus. Poverty is the common factor in all these drivers.

3.9 The pandemic is likely to have also intensified inequalities highlighting weaknesses in our community resilience and rising experiences of loneliness, but it has also shown the best of Leeds communities with people supporting one another and increased collaboration between institutions and stakeholders. How do we hold on to this stronger sense of neighbourliness to overcome underlying challenges and add further support for our established strengths-based approaches?

3.10 Climate change remains the single greatest challenge to global health and Leeds is not immune from its impacts. Achieving net zero carbon ambitions will be incredibly challenging and efforts should focus on four fundamental issues for health: minimising air pollution, improving energy efficiency to reduce fuel poverty, promoting healthy and sustainable diets, and prioritising active travel and public transport.

3.11 Covid-19 has had obvious impacts on the city's economy and labour market with the rapid expansion of home working and acute impacts on hospitality, retail, and local consumer services. The consequences were felt most by young people, women and low earners. However , the city has strong foundations from which to

recover, experiencing economic growth and expansion over the last two decades with a diverse economy, though longer-term concerns regarding low productivity and the nature of recent job growth remain.

3.12 Our older population is growing and becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Older people from diverse ethnicities, cultures and communities of interest who hare a particular identity or experience can also face specific challenges as their established networks and support diminish over time.

3.13 Throughout work the develop the JSA the importance of understanding the specific needs of communities of interest has been a prominent and consistent contribution from stakeholders. The draft summary therefore highlights some specific areas for future focus, including asylum seekers, sex workers and people who are homeless or sleeping rough. Tacking Health Inequalities work is also on the Board's agenda for this meeting and this thread might be something for that group to pick up in the first instance.

Next Steps

3.14 Subject to Health and Wellbeing Board's input and approval, the next steps begin with finalising the summary report. In doing this, a further short summary will be developed drawing from the headline findings, the policy implications and some key statistics needed to produce an easily accessible infographic. This product, which will be no more than ten pages in length, will provide the key information and overview needed for casual readers looking for the headlines, while the full report is available for those who required more detailed insights.

3.15 Analytical focus will then shift to strengthen Leeds Observatory as an interactive, real time intelligence platform, adopting the JSA structure as a revised framework and enhancing opportunities for people to engage with and on the platform, including to capture more lived experience insights alongside existing data sources.

3.16 In moving forward, the existing stakeholder sounding board group will continue to be involved and engaged, reflecting the valuable contribution it has made to this point and the opportunities to further strengthen our collective intelligence capabilities through close collaboration across organisations and sectors.

3.17 The pace of visibility of work to produce a new city plan for Leeds will also increase over the coming weeks, with the JSA being a key input to that process.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 As highlighted in 2.2 the JSA has been produced with the help, support and contributions of a sounding board drawn from the council, CCG, Third Sector and

universities. In addition to this a series of discussion have been held with individual and small groups of third sector organisations to gather insights from them and the communities with which they work.

4.2 Equality and diversity / cohesion and integration

4.2.1 Given its core purpose the JSA naturally helps to identify inequalities, analyse trends and consider their impact on outcomes for people in Leeds. This work will then inform future strategy development as outlined in this report and where appropriate will align to the work of the Leeds Tackling Health Inequalities Group as suggested in 3.13.

4.2.2 However, there are no specific or direct implications for equality and diversity arising out of this report. Future work aligned to the JSA 2021 will be assessed at needed ahead of future reports.

4.3 Resources and value for money

4.3.1 The analysis contained within the JSA 2021 will support strategy and policy development in Leeds, contributing valuable local intelligence to underpin effective commissioning decisions and therefore maximise the impact of resources available across partner organisations.

4.4 Legal Implications, access to information and call In

4.4.1 There are no access to information or legal implications arising from this report.

4.5 Risk management

4.5.1 There are no direct risk implications arising from this report. Any future action taken on the basis, in full or in part, of analysis and insight contained within the JSA will be subject to their own risk assessments as required.

5 Conclusions

5.1 The Leeds JSA is a key part of the fabric of the health and care system and supports understanding of the factors that influence health and wellbeing in Leeds. It also provides good understanding of the assets and needs we have in neighbourhoods across the city.

5.2 The issues and trends outlined provide the ability to work together to understand the choices facing the system and what can be done to support and strengthen positive factors and mitigate less positive ones. Commissioners and policy makers need to consider what further actions they can take to address the current and emerging future challenges highlighted by the analysis, and these factors should be a prominent input into the next refresh of the Health and Wellbeing Strategy.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Consider the JSA draft summary report attached as Annex A, and specifically consider whether the policy implications highlighted fully reflect the headline findings and challenges / opportunities ahead.
- Consider how best to respond to any strategic and commissioning implications of the analysis, in particular those relating the tackling health inequalities and the needs of various communities of interest.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The core purpose of the JSA dictates that it help reduce health inequalities in Leeds. The analysis produced provides an up-to-date picture of strengths, assets needs and trends which can in turn inform the design and delivery of the refreshed Health and Wellbeing Strategy, supporting the vision to improve the health of the poorest the fastest.

Producing up-to-date analysis can help to share the Board's wider work moving forward, alongside that of other partners including Leeds City Council.

How does this help create a high quality health and care system?
The findings of the JSA process can be used to design and deliver more effective services, community led solutions, and to make improvements to the way the health and care system works together for people in Leeds. It is a fundamental evidence base for the Leeds Health and Wellbeing Strategy, and so this JSA is well-timed to inform the renewal of the Strategy in the near-term.

How does this help to have a financially sustainable health and care system?
The JSA again takes a broader view, considering the wider determinants of health and wellbeing and assessing both the needs in the city but also the strengths and assets that exist to meet those needs.

Taking this holistic picture into account will support a more financially sustainable health and care system in the city, which recognises all the drivers of health and wellbeing and equips policy makers, commissioners and providers with the intelligence they need to make better decisions and implement more effective solutions.

Future challenges or opportunities
As highlighted in this paper, there is an intention to grow and develop the JSA digitally, enhancing provision of 'real-time' data and analysis to ensure an up-to-date picture is always available for commissioners and policy makers.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

Appendix 1

Leeds Joint Strategic Assessment 2021

Draft Summary Report

Contents

Introduction and Purpose

What is the Joint Strategic Assessment (JSA)?

The JSA provides a holistic and reliable source of data and analysis about key demographic, socio-economic and health trends in Leeds. It aims to present an up-to-date picture of the issues driving health and wellbeing in the city, providing deeper insights which help us to understand the interrelated nature of the challenges which affect people's lives. The JSA does not attempt to set out the current policy response, rather, its primary purpose is to inform commissioners and policy makers about the future needs of the city to better enable effective strategic planning, priority setting and commissioning decisions – helping to make the most of the resources available, deliver the best possible outcomes for Leeds citizens in a joined-up way, and engage everyone to play their part.

In Leeds we put the wider determinants of health and wellbeing at the core of our JSA, recognising the way factors including the economy, education, environment and housing impact on health outcomes and wider wellbeing over a person's lifetime and are therefore crucial to our ambition to improve the health of the poorest fastest. The JSA also provides valuable insight in assessing the future health and care needs of our changing population, helping to inform change and development in the health and care system. It underpins Leeds's strategic framework including the statutory Health and Wellbeing strategy, our Inclusive Growth strategy and is available to support the future planning of other partners and organisations across the city. From 2021 the JSA will provide a valuable evidence base and context for the agreement of a new city plan for Leeds which describes our shared vision and ambitions for the future.

While much of the JSA is focused on analysing the drivers of need across Leeds, we also adopt the city's asset-based approach to reflect where there are strengths on which we can build. Guiding us in this effort are the voices and lived experiences of people living in Leeds, especially those living in our low-income communities and those facing personal or environmental challenges in their lives.

Producing the JSA during a global pandemic

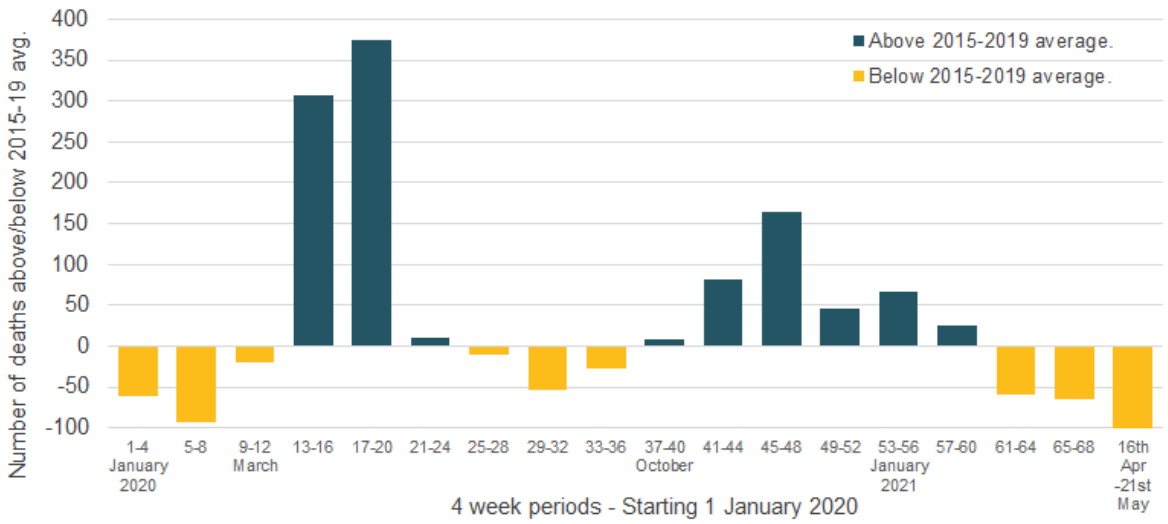
Most of the background research and analysis which has informed the JSA was undertaken in the spring and early summer of 2021 when Leeds, the UK and the rest of the world is still dealing with the Covid-19 pandemic. The pandemic has caused social and economic change on a scale not seen in our lifetimes, and its lasting medium and longer-term effects remain unclear particularly on issues such as mental health and wellbeing.

Producing an accurate analysis of the current and future challenges the city faces in this context is very challenging. Much of the data available is partial in nature or is yet to show the full effects of Covid-19. In other cases, it is too early to draw any conclusions about how Leeds will recover following the pandemic. Therefore, throughout this summary report we have highlighted areas where there should be further lines of inquiry over the coming months to assess the impact of Covid-19, and we will publish further analysis and reporting on the Leeds Observatory.

Despite this ongoing uncertainty, we can offer some analysis of the pandemic's impact with assurance. There are headlines common to places across the UK which we have experienced in Leeds, the most striking of which is clearly the direct impact on human life. Since March 2020 we have seen significantly higher excess deaths as a direct result of Covid-19 when compared to the 2015-2019 average (Figure 1: Deaths in 4-week groupings, variation with 2015-19Figure 1).

As of 30 July 2021, there have been 1,739 deaths recorded in Leeds with Covid-19 on the death certificate, and there have been 90,411 total cases in the city by the same date[1].

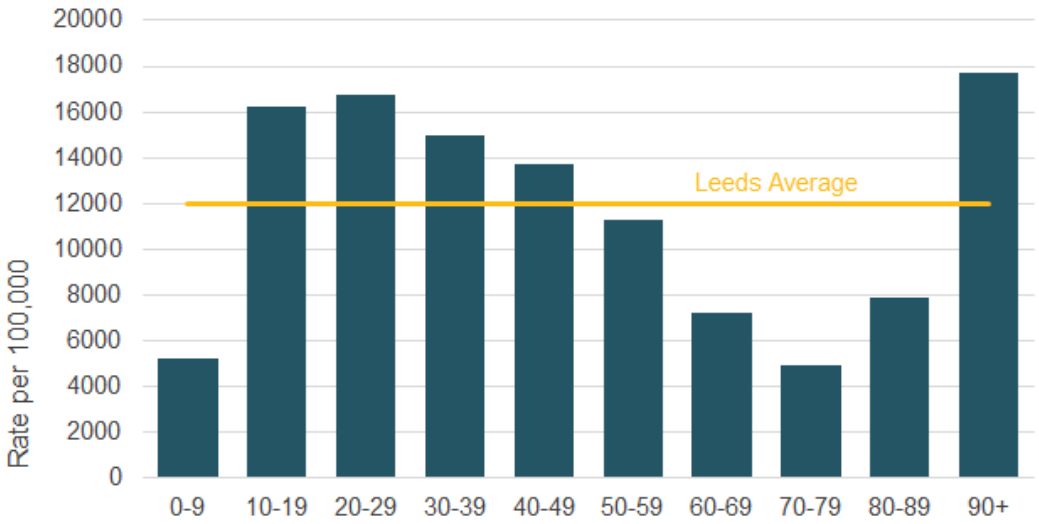
Figure 1: Deaths in 4-week groupings, variation with 2015-19



Source: Leeds Public Health Intelligence, June 2021

Crucial to the purposes of the JSA, Covid-19 has not affected all populations equally. There has been a clear disproportionate impact of the virus on older people. With the exception of the 90+ age group, where the highest number of cases have occurred, case rates have generally been higher in younger populations. Despite this the majority of hospitalisations and 93% of all Covid-19 deaths in Leeds have affected people aged over 60[2].

Figure 2: Cumulative Covid-19 cases in Leeds by age, March 2020 – August 2021



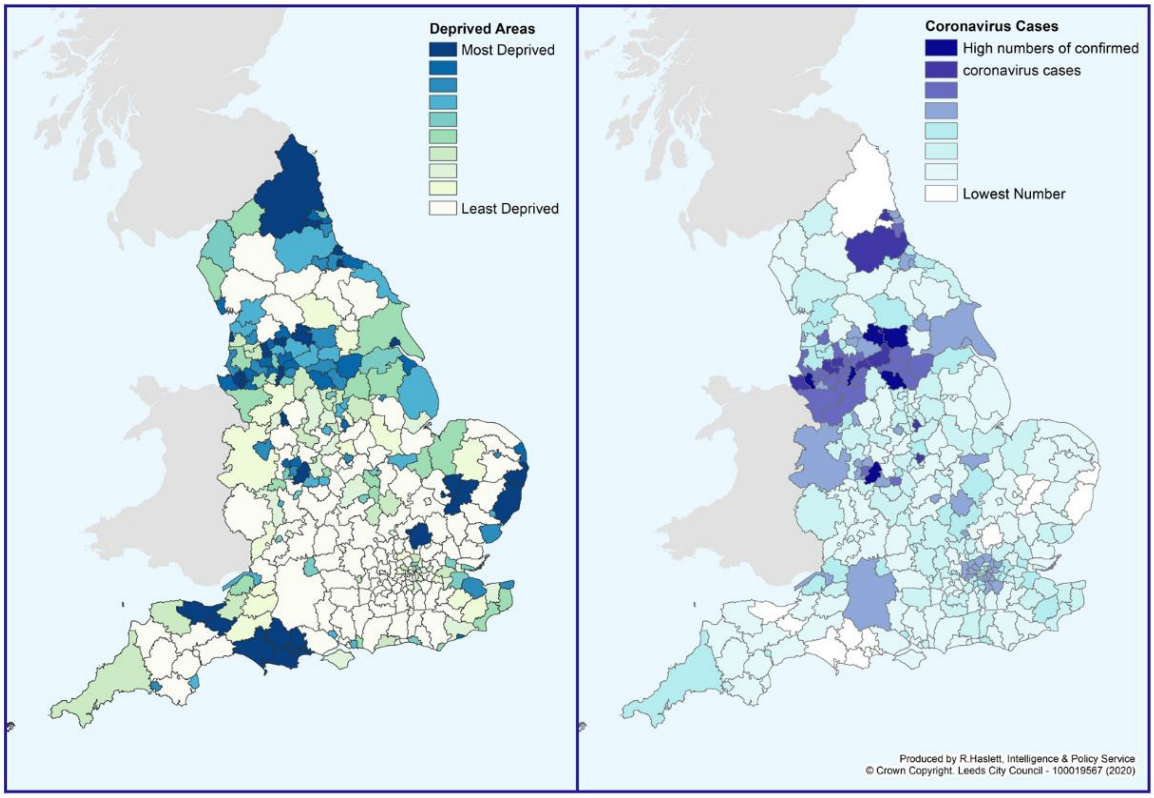
Source: Leeds Public Health Intelligence, August 2021

The virus can also be seen to exacerbate existing inequalities with case rates higher in areas already experiencing disadvantage (Figure 2**Error! Reference source not found.**). Along with more diagnoses there is a higher likelihood of people losing their lives to Covid-19, with mortality rates in the most disadvantaged communities more than double the least nationally and survival rates remaining lower

[1] *GOV.UK Covid-19 Dashboard*
[2] *Covid-19 deaths by age group (Leeds Public Health Intelligence, August 2021)*

after adjusting for sex, age and ethnicity – particularly for those of working age where the risk of death almost doubled[3]. Within Leeds itself these differences are less pronounced in the data, although the mortality rate in the most deprived decile according to the Indices of Multiple Deprivation (IMD) remains higher than the Leeds average and the true impact may be masked by the overall geography of the city.

Figure 3: Index of Multiple Deprivation 2019 and total Covid-19 cases in England

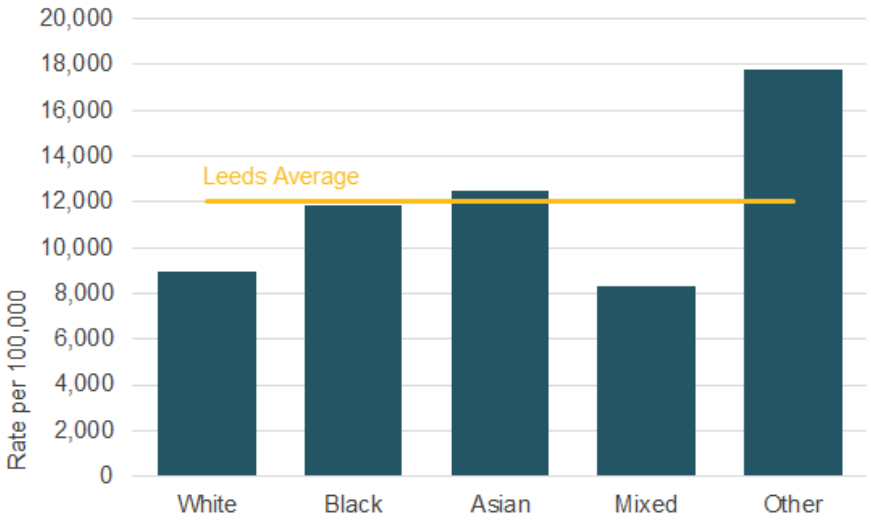


Source: Indices of Multiple Deprivation (2019) and Leeds City Council (2021)

Covid-19 poses increased risk to individuals based on their ethnicity too. In England the highest diagnosis rates per 100,000 population were in Black ethnic groups (486 per 100,000 in females and 649 per 100,000 in males) and the lowest were in White ethnic groups (220 per 100,000 in females and 224 per 100,000 in males). In these cases the increased risk is not specifically related to a genetic vulnerability in minority communities, but instead is likely to be the outcome of structural and cultural economic and societal issues which shape where people live and the jobs they do, resulting in increased exposure and elevated risk for some Black, Asian and ethnic minority communities. Proportionally more people from these communities have also been significantly ill with Covid-19, perhaps exacerbated by the additional issue of higher rates of long-term underlying conditions than in the population as a whole.

[3] *Disparities in the risk and outcomes of Covid-19 (Public Health England, August 2020)*

Figure 4: Cumulative Covid-19 cases in Leeds by ethnicity, March 2020 – August 2021



Source: Leeds Public Health Intelligence, August 2021

Looking at Leeds specifically, the city has also experienced significantly higher case numbers in Black and Asian ethnic groups compared to White ethnic groups. Black African, Other Black, Pakistani and Other Asian ethic groups have been most affected, and while the Indian population has seen a rate lower than the Leeds average it has still been notably higher than for White ethnic groups. The Chinese population in Leeds has experienced very low case rates, perhaps supported by different established cultural norms including regular mask wearing.

More detailed analysis of the ongoing impacts of Covid-19 across all aspects of life in Leeds is contained within the main chapters of this report. We have sought to explore the differential impacts of the disease on the health and economic prospects of people and communities throughout, in addition to presenting analysis about the way the pandemic has affected the behaviours and experiences of the city's population over the last 18 months.

While Covid-19 has undoubtedly had a huge impact on the health and wellbeing of people in Leeds, and aspects of this will continue for some time to come, it is important the JSA does not become solely focused on this. Analysis of the pandemic's impact is contextualised as we consider a wide range of longer-term trends and prominent issues the city faces in the years ahead.

How to use the JSA

This summary report provides an overview of the key issues and implications identified in the latest data and analysis available. It provides a snapshot in time of the headline challenges and opportunities for Leeds, and provides signposts to more detailed data, analysis, themed reports and geographic profiles.

In producing the JSA we recognise the complexity of a city like Leeds. Where localised geographic analysis is included to help understand the issues encountered in different localities and communities, we adopt the most appropriate boundary for the data cited rather than enforcing a single geography across all topics. For example, this might include locally defined geographies such as school clusters

and local care partnerships in addition to ward boundaries, middle super output areas (MSOAs)[4] and lower super output areas (LSOAs)[5].

Structure

The JSA examines health and wellbeing issues, including the wider determinants of health, for the Leeds population at all ages. This summary report therefore groups the analysis into chapters structured primarily around life course stages under the following headings:

1. Population
2. Starting Well – Child-Friendly Leeds
3A. Living Well – Health and Wellbeing
3B. Living Well – Thriving Communities
3C. Living Well – Climate Change
4. Working Well – Inclusive Growth
5. Ageing Well – Age-Friendly Leeds
6. Implications of the Analysis

Deprived Leeds terminology

Part of Section 2: Child-Friendly Leeds and Section 3A: Health and Wellbeing draw specifically on the latest health and wellbeing indicators tracked by the Public Health Intelligence team. This analysis provides an overview of the progress in the city, and where possible separates out city-wide progress and that of those parts of the city most likely to experience multiple factors of deprivation, i.e. those communities identified as 10% most deprived in Index of Multiple Deprivation 2019. In these sections and in this specific context, those communities are identified as 'deprived Leeds'.

Accessibility

The JSA is an evolving product hosted on the Leeds Observatory (observatory.leeds.gov.uk) where you will find further supporting reports alongside a wealth of detailed data and analysis which could not be included in this summary report.

The Leeds Observatory's self-serve capability allows data to be mapped using a range of 'administrative' boundaries. The building blocks for the analysis are usually comprised of the statistical geographies of either LSOAs or MSOAs depending on the availability of data.

This summary report is best read on screen. If you have any queries or require further support accessing the JSA please contact us at leedsobservatory@leeds.gov.uk.

Updates

The JSA is currently undertaken every three years and a summary report produced. Increasingly commissioners, policy makers and providers want access to real-time intelligence about the city which can help them to respond more quickly to changing needs and circumstances at a community level.

Moving forward the JSA will aim to provide this insight in a useful, interactive way through further development of the Leeds Observatory's functionality, with more frequent updates as new

[4] MSOAs are built up from 3-7 individual LSOAs. The average number of people living in an MSOA is 7,000. There are 107 MSOAs in Leeds.
[5] LSOAs typically have an average 1,500 residents and 650 households. There are 482 LSOAs in Leeds.

information becomes available and the inclusion of more real-time dashboards providing key data and analysis in an easily digestible format. This online platform will also enable more effective sharing of qualitative data, case studies and lived experience insights gathered by the council and its partners alongside existing intelligence.

Section 1: A Changing City: Population Trends

Headlines

- In line with national patterns, ageing population trends continue, with the 80+ age group growing fastest.
- The population profile of children and young people is becoming more diverse and focused in communities most likely to experience poverty.
- The birth-rate 'bulge' of the 2010s has fallen back since 2017, though the 8 years of 'bulge' (10,000+) cohorts are now beginning to go through secondary school, with potentially significant mid-term implication for post-16 support and opportunities beyond.
- There are variations in the geography of population change, with growth primarily focused in inner-city communities.
- It is perhaps too early to assess any full impact of exiting the EU on patterns of immigration and/or on some existing communities. However, the pandemic has been an additional factor on masking any more deep-rooted changes.

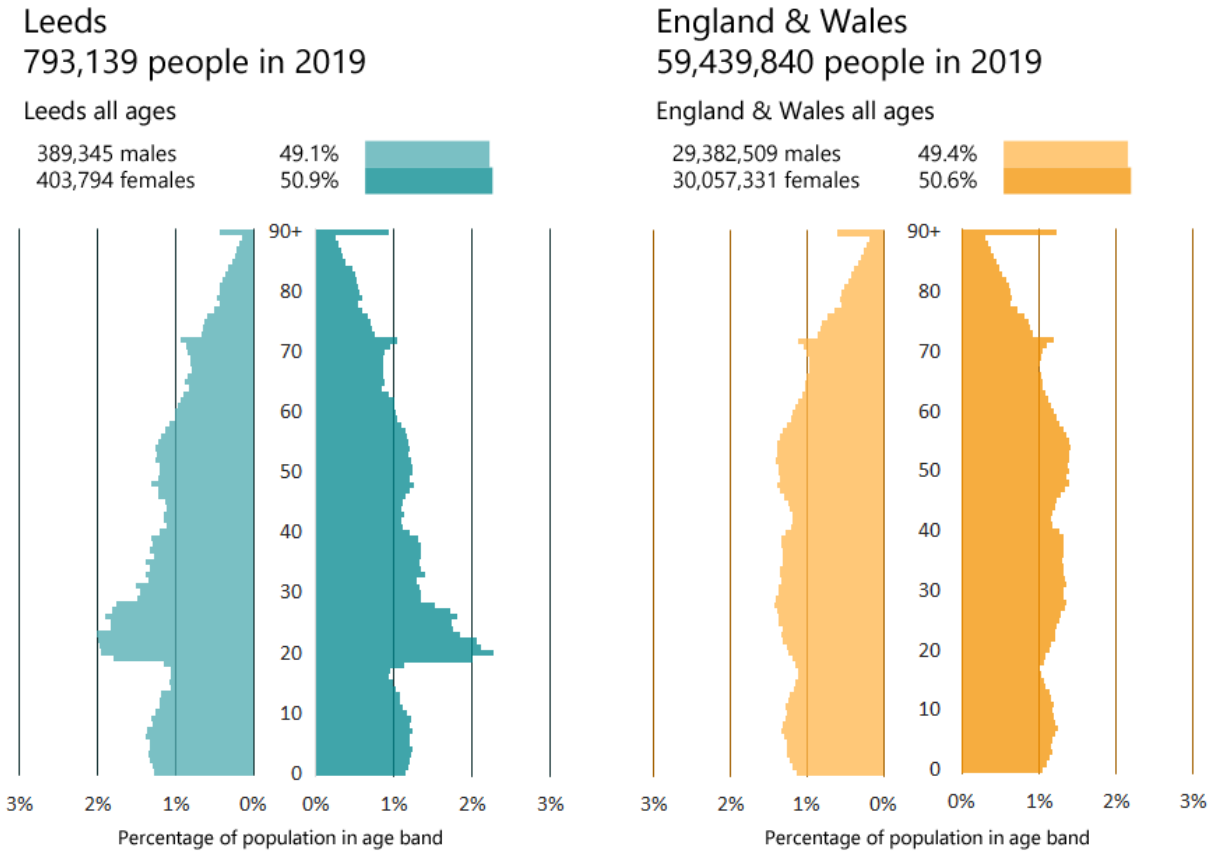
Overview

According to the Office for National Statistics (ONS) mid-year estimates for 2019, there were 793,000 people living in Leeds, up by over 41,000 from the 2011 Census[6]. Given that the Census is now a decade old, GP registrations can provide an additional source of insights into population trends. Data drawn from our Public Health population model (based on GP registrations, but accounting for cross district registrations) suggests the population might be as large as 870,000[7] though care is needed with this figure as duplicate GP registrations can result in over-counting, especially in cities like Leeds with its large student population. That said it is unlikely the scale of the disparity can be fully explained by this over-counting. We await the forthcoming 2021 Census with interest.

However, it is how the composition of our population has changed which is of specific interest, with the GP registration data, birth rates and the results from the annual School Census, all pointing to a far more diverse population.

[6] *ONS Population Estimates 2011 Census Population Count*
[7] *GP ethnicity October 2020*

Figure 5: 2017 Mid-year population estimates for Leeds (teal) and England and Wales (orange)



Source: ONS mid-year estimate of population 2019

The comparative analysis of the city's population highlights both the broad similarities with national trends, but also where the city diverges. The city has an ageing population in-line with national trends. However, it has also seen growth in the population profile of children and young people, which the data suggests is becoming more diverse and concentrated in our inner areas.

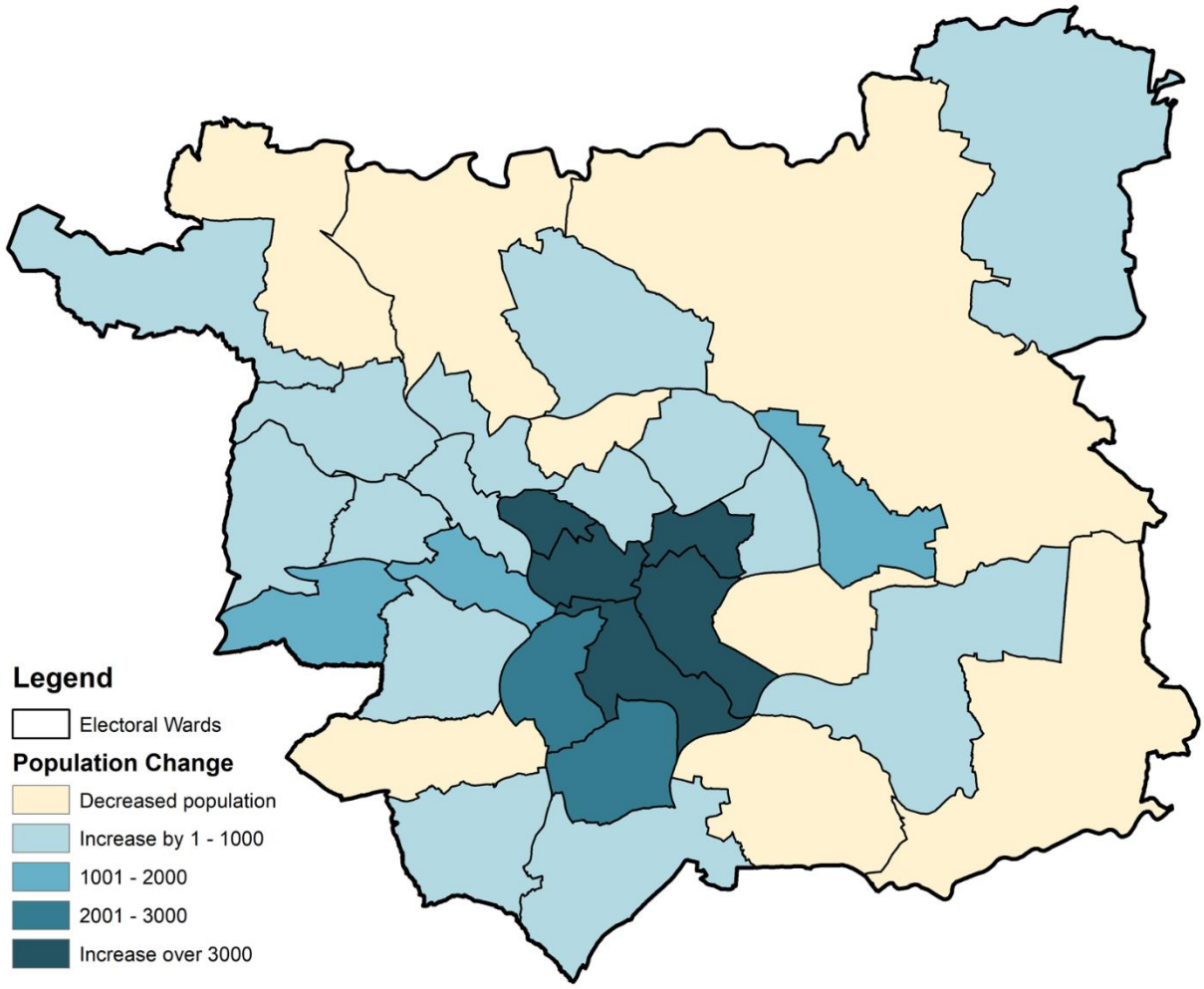
In addition, Leeds has one of the highest student populations in the UK with over around 70,000 students attending the city's universities, with students heavily concentrated in the city centre and Inner West areas.[8]

Population growth centered in our most disadvantaged communities

ONS population estimates, the School Census and GP registrations all point to an expansion in population in our inner-city areas, which are often our most disadvantaged communities. Intelligence regarding the demand for services confirms these often quite rapid demographic changes, not only driven by immigration, but also heavily influenced by the local housing tenure, Figure 6 below illustrates these changes.

[8] HESA Student Population

Figure 6: Population Change by Electoral Ward 2011-2019



Source: ONS Mid-Year Estimates 2011 & 2016

A more diverse population

The city's population has continued to become more diverse since the 2011 Census, in terms of age, countries of origin and ethnicity.

Again drawing on GP records for insights in to how our city is increasingly diverse, the Black, Asian and ethnic minority population represents almost a third of all those registered in 2020, whilst accounting for 19% of the city's population in the 2011 Census. The most notable difference is in the Other White ethnic group, which in the 2011 Census had a population of 23,000, but in the 2020 GP registar stands at 78,000, pointing to the growth in economic immigration primarily from the EU over the last decade. That said most minority groups appear to have grown in population, with the exception of the Carribean (Black and Mixed) and Irish groups which look to have reduced in size (this could be due to identification or disclosure barriers as much as immigration). The White British group also appears to have reduced in size.

Anyone wishing to work in the UK needs a National Insurance Number, analysis of non-British National Insurance Number (NINo) applicants, can be also provide insights into economic migration[9]. The latest data from 2019/20 confirms applications have decreased to the lowest levels since 2011, the extent to which this is due to Covid-19 restrictions or exiting the EU and associated changes to government

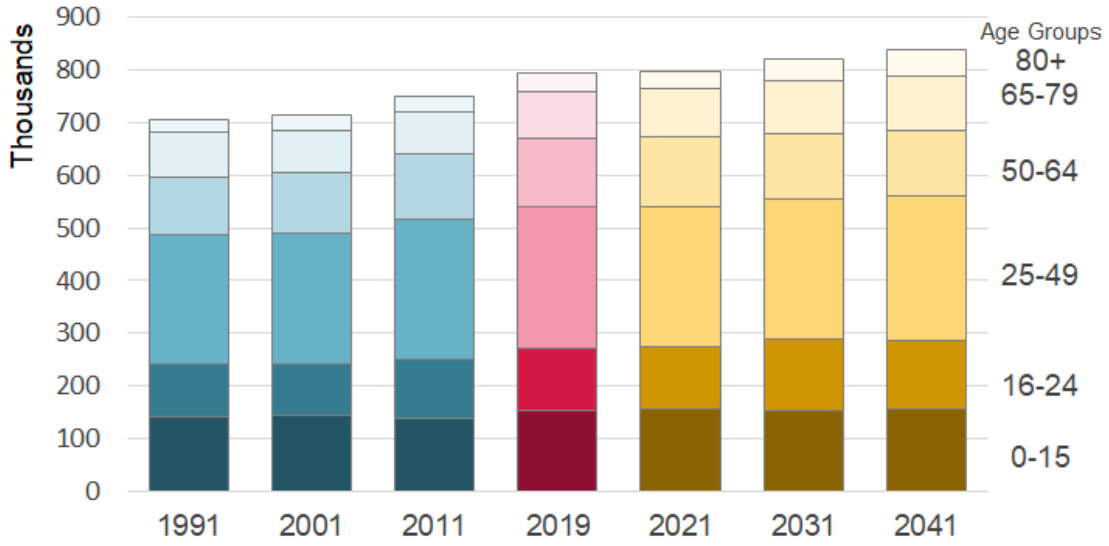
[9] *2019-20 NINO Data Leeds –file includes further core cities and nationality charts*

policy is uncertain, though applications have been on a downward trend since 2016. The largest proportion of applications in recent years have been from Romanian and Polish nationals, though these have seen a significant decline in since exiting the EU.

Population is still ageing

The overriding backdrop to these localised pressures is the wider trend of the city's ageing population. As the baby-boomer generation grows older there will be a range of implications for service provision. The over 50 population has grown by an estimated almost 30,000 between 2001 and 2019, a 12% to 17% increase in each of the 50 plus age groups, much of the city's population growth has been concentrated in these age groups. In terms of future projections to 2041, the 50-59 population is projected to reduce and there will be little change for the 60-69 population, however the 70+ population is projected to substantially grow, with fastest growth amongst the 80+, which is expected to see a 50% increase.

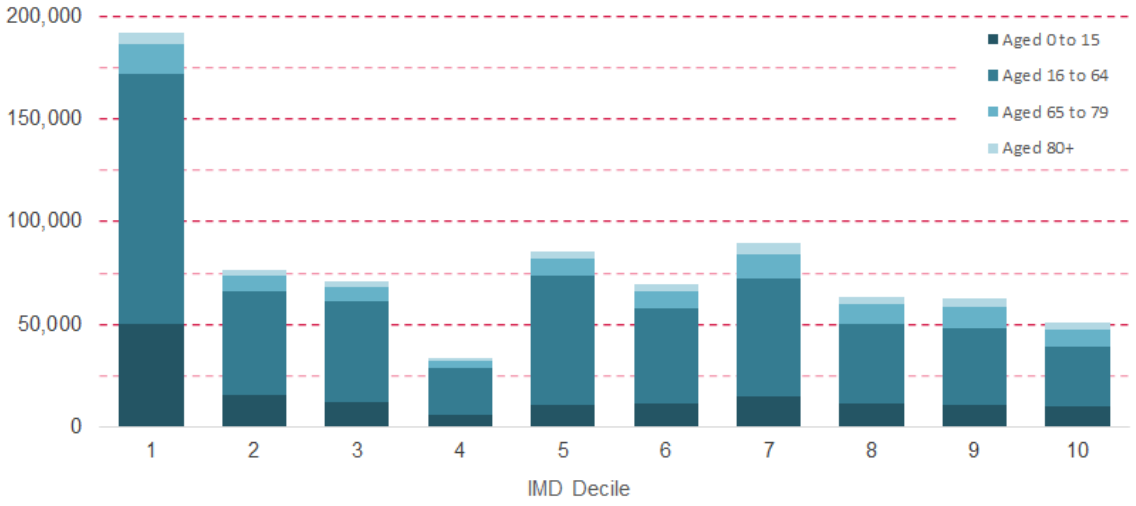
Figure 7: Population of Leeds by age



Source: ONS Mid-Year Population estimates 2019 & Population Projections 2018

The distribution of the city's older population should also be considered. There are currently higher numbers of older people living in the city's outer areas, however this could change as the recent shifts in the composition and spatial concentration of the population work through, resulting in a far more ethnically diverse older population, with a greater concentration in the city's inner areas. Figure 8 below presents the current population profile by age, against the IMD 2019 deciles. This confirms the overall population concentration in our inner areas, which are often those which are most disadvantaged, primarily driven by housing density. However, it also highlights that the single largest over 65 population are also found in these areas.

Figure 8: Age Profile for each Index of Multiple Deprivation 2019 decile

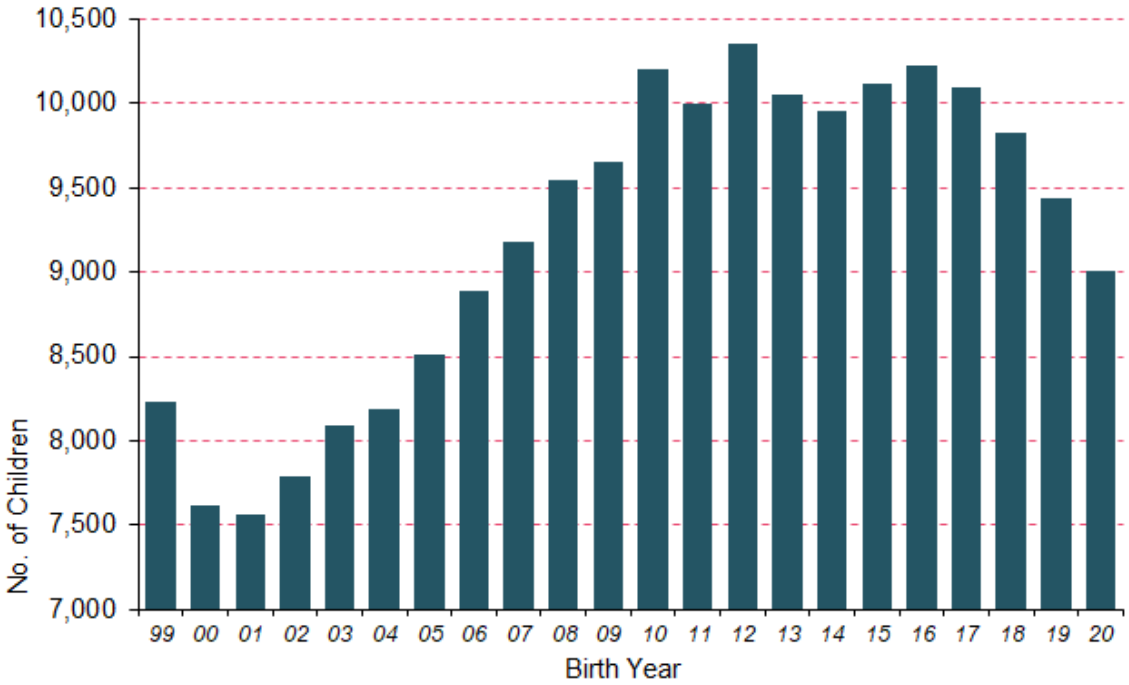


Source: Index of Multiple Deprivation 2019 Mid-Year Population Estimates 2019

More children and young people

The Leeds birth rate increased rapidly from the early 2000s and plateaued at around 10,000 per annum for eight years until 2016. However, the number of births has now fallen consecutively for four years and was 12% lower than 2016 in 2020. Latest intelligence shows that the number of births will be lower still in 2021 (circa 8,400). However, the child population is still growing at a faster rate than the population of Leeds as a whole, but the growth is now concentrated in Secondary school-age groups.

Figure 9: Births within Leeds boundary between 1999 and 2020



Source: NHS Health Leeds / Wakefield / Bradford, contains data within the Leeds boundary only (2021)

The latest ONS projections suggest there will be 15,000 more young people aged between 11 and 19 years old in 2029 compared to 2019. Their data also suggests that this population has been growing faster in our communities most likely to experience deprivation.[10]

Data from the city's schools show major change over the last few years. The proportion of pupils that are Black, Asian and ethnic minority has continued to grow to 36% in 2021. And while, other than White British, the largest broad ethnic groups are Asian, Black, Mixed and White Other; proportional growth has been highest in White Other, mirroring the wider trends driven by economic migration. Between 2010 and 2020, growth has been particularly high within White Eastern European and Gypsy Roma ethnicities. The number of children and young people with English as an additional language (EAL) has increased from 13% in 2010 to 20% in 2021. After English, the main languages spoken are Urdu, followed by Romanian and Polish. Altogether nearly 200 languages are spoken by children studying in Leeds schools.[11] The proportion of school pupils who are eligible for, and claim, Free School Meals has significantly increased since 2018, from 16% to 25% in 2021. Meanwhile the number of pupils who have an Education Health and Care Plan has more than tripled from 824 in 2016 to 3,013 in 2021.

All this shows that while rapidly growing, our teenage population are also becoming more diverse, and the indicators suggest growing more quickly in our more disadvantaged communities. With a backdrop of the Covid-19 pandemic and pressure on resources, our teenage population potentially face significantly growing challenges into the medium-term.

Policy implications

- The city's population has continued to become more diverse, in terms of age, countries of origin and ethnicity. There is a more work to do in understanding and responding to the relationship between ethnicity, deprivation, social mobility and health and wellbeing.

- The city's population is ageing, with the 80+ age group growing fastest. The older population is also becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Future Age-Friendly Leeds work as well as other service provision will need to take account of these factors.

- In terms of young people, the birth-rate 'bulge' of the last decade has fallen back, beginning to be reflected in a fall in demand for school reception places. However, the 'bulge' cohorts are now beginning to go through secondary school, with significant mid-term implications for post-16 education and skills support and routes of entry into the labour market. All this against the backdrop of the economic impact of the pandemic, that has been acutely felt by young people.

- It is too soon to assess any full impact of exiting the EU on patterns of immigration and/or on some existing communities. However, early indications suggest that economic immigration from the EU has slowed, with some evidence of skills and labour shortages feeding through to the local economy and potential longer-term implications for the inclusive growth agenda.

[10] *Census Data Intel*
[11] *Citywide analysis of School Census 2020*

Section 2: Starting Well - Child-Friendly Leeds

Headlines

- The pandemic has had a major impact on children and young people, with the disruption to their education the most obvious. Covid-19 restrictions have led to concerns regarding safeguarding and the disengagement of young people, particularly the most vulnerable.

- Since 2011, the number of children looked after has reduced by 7% in Leeds compared to an 22% rise over that period across England.

- Educational attainment, particularly of more disadvantaged children, is still a significant challenge. Performance at Foundation and Key Stage Two is below regional and national averages, especially amongst disadvantaged children. This performance recovers somewhat by Key Stage 4, where the city's performance (for non-disadvantaged children) is closer to the national average.

- The number of pupils who have an Education Health and Care Plan has more than tripled between 2016 and 2021.

- Child poverty is at the root of many poor outcomes for children and young people and their families. In 2021 almost 24% of children (under 16s) were estimated to live in poverty in Leeds, compared to 19% nationally.

- The population profile of children and young people is becoming more diverse and more likely to live in communities experiencing poverty.

The city has a long-standing aspiration to be a Child-Friendly city, where young people enjoy growing up and achieve their potential to become successful citizens of the future. We want to make a difference to the lives of children and young people who live in Leeds, to have a positive impact on improving outcomes for all children, while recognising the need for outcomes to improve faster for children from disadvantaged and vulnerable backgrounds.

Clearly Covid-19 has had a profound impact on children and young people, with the disruption to their education perhaps most obvious. However, Covid-19 restrictions have also raised very real concerns regarding safeguarding, including issues regarding the disengagement of young people, particularly the most vulnerable, which potentially could manifest in the form of increased involvement in gangs and youth crime, anti-social behaviour and radicalisation. These concerns are accompanied by a broader set of worries regarding the social, emotional and mental health of young people. These worries are exacerbated by the economic impact of Covid-19, where young people have often been the most severely impacted in terms of job losses or furlough as many start their career path in those sectors most affected by the restrictions caused by the pandemic. Although data is still relatively scarce regarding the long-term impacts, clearly this will be a theme for further analysis as new insights become available.

Population

A more comprehensive population overview is set out in Section 1 of the JSA. The population profile of children and young people is becoming more diverse and poorer. The number of births have now fallen consecutively for four years, and was 12% lower than 2016 in 2020. Latest intelligence shows that the number of births will be lower still in 2021 (circa 8,400). However, the child population is still growing at a faster rate than the population of Leeds as a whole, but the growth is now concentrated in Secondary school-age groups.

The latest ONS projections suggest there will be 15,000 more young people aged between 11 and 19 years old in 2029 compared to 2019. Their data also suggests that this population has been growing faster in our more deprived communities.[12]

The proportion of school pupils who are eligible for, and claim, Free School Meals has significantly increased since 2018, from 16% to 25% in 2021. Meanwhile the number of pupils who have an Education Health and Care Plan has more than tripled from 824 in 2016 to 3,013 in 2021.

With a backdrop of the Covid-19 pandemic and pressure on resources, our teenage population potentially face significantly growing challenges into the medium-term.

Child poverty

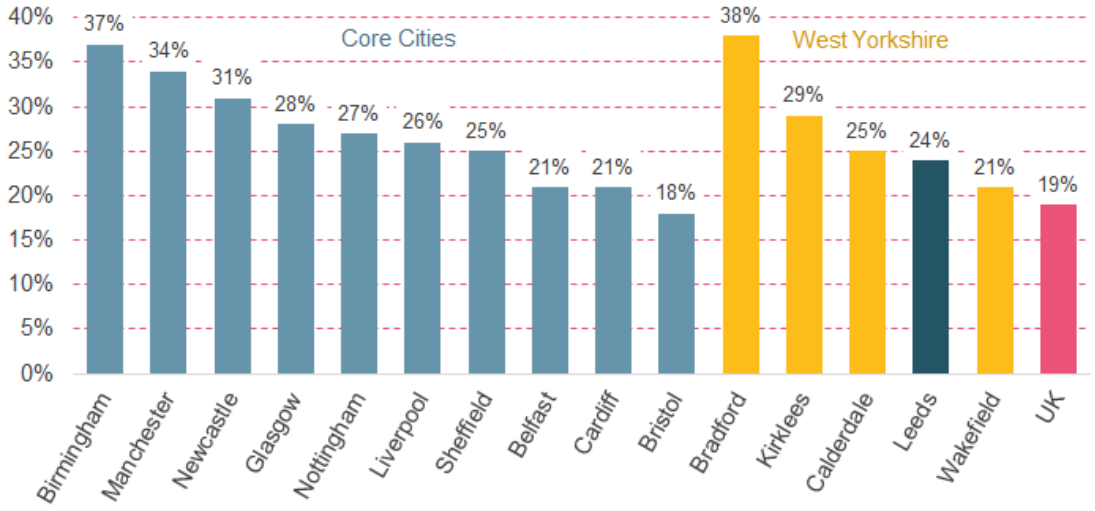
National child poverty data from the Households Below Average Incomes survey (HBAI) for 2019/20 estimates that there are 4.3m dependent children under 20 in Relative Poverty in the UK, after housing costs are deducted from income. This is a rate of 31% of dependent children under 20.
This figure is not available to compare locally. Instead the DWP and HMRC produce an estimate for children in low income families under 16 at national and local levels, before housing costs are deducted from income. This data provides the best indication for child poverty levels across local geographies.

Using this measure, in 2019/20 there were 2.4m children under 16 in relative poverty in the UK, before housing costs are deducted from income. This is a rate of 19% of all children under 16 in the population.

Figure 10 below compares child relative poverty for Leeds against other core cities, West Yorkshire authorities and the UK as a whole.

[12] *Census Data Intel*

Figure 10: Proportion of Children in Child Poverty - March 2021



Source: Department for Education and Leeds City Council

Considering child poverty proportionally somewhat masks the true picture on the ground in Leeds, however. Looking at West Yorkshire, rates of child poverty are significantly above the national average. The rates of children in relative poverty before housing costs are deducted from income in Leeds and Bradford are 24% and 38% respectively. In Leeds this equates to 36,496 children under the age of 16 living in relative poverty. When you consider the administrative boundaries of the two cities, both of which are wide and include notably more affluent outer areas, we can reliably assume rates of child poverty in inner-city areas will be higher still. Bradford (48,100) has the second highest number of children in poverty behind Birmingham, Leeds the fourth highest number and Kirklees (25,553) the seventh most.

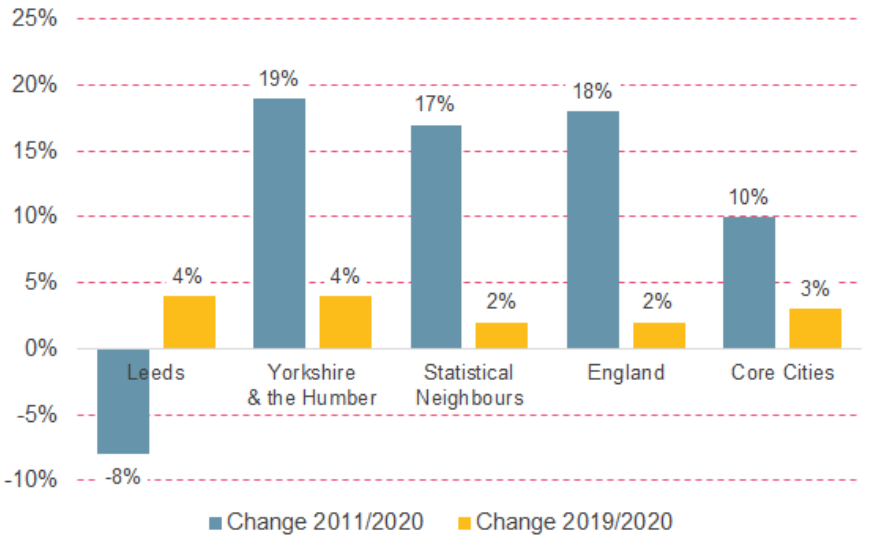
The Leeds child population is also growing fastest in the localities considered most deprived according to IMD. Between 2012 and 2018 to overall Leeds population grew by 4% and the child population (age 0-17) grew by 7%. However, in the 10% IMD's most deprived areas the child population grew by 13%, and in the 3% most deprived it grew by 17%[13].

Safeguarding

Between 2011 and 2020 (the latest nationally available data) there has been a 7% reduction in the number of children looked after in Leeds. Across the same period, the number of children looked after in England rose by 22%. Between March 2020 and March 2021, children looked after numbers fell from 1,346 (80.0 per 10,000) to 1,278 (75 per 10,000). 48 of the 1,278 children looked after are unaccompanied asylum seekers, compared to 60 at the end of March 2020. The 2020/21 national data will be available in the autumn of 2021.

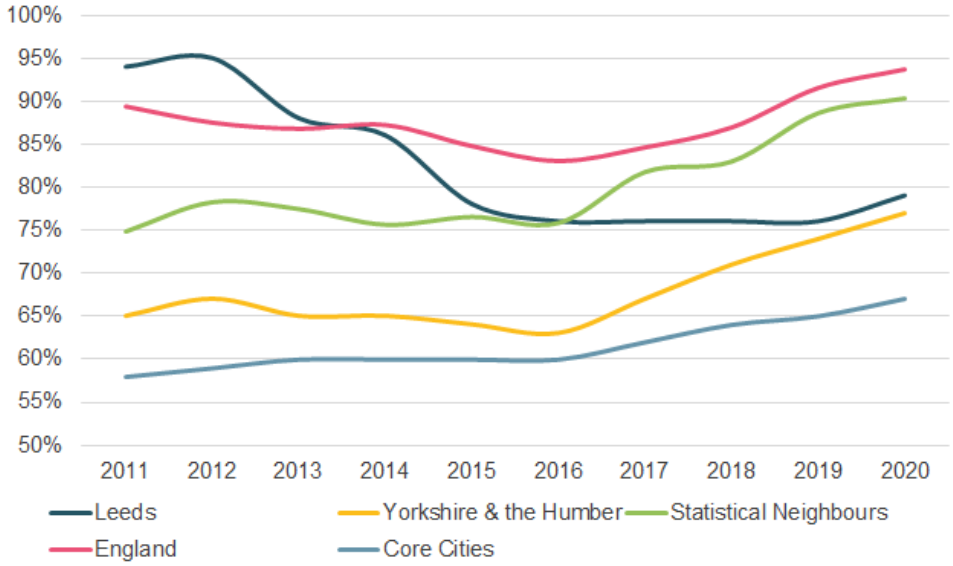
[13] *ONS 2012-18 estimates*

Figure 11: Children looked after at March 2020: Change from 2011 and Change from 2019



Source: Department for Education and Leeds City Council

Figure 12: Children looked after rates per 100k since March 2011



Source: Department for Education, March 2020

At the end of March 2021, 33 per 10,000 Leeds children were subject to a child protection plan (560 children in total). The latest nationally available data covers up to the end of March 2020 when the England rate was 43 children per 10,000.

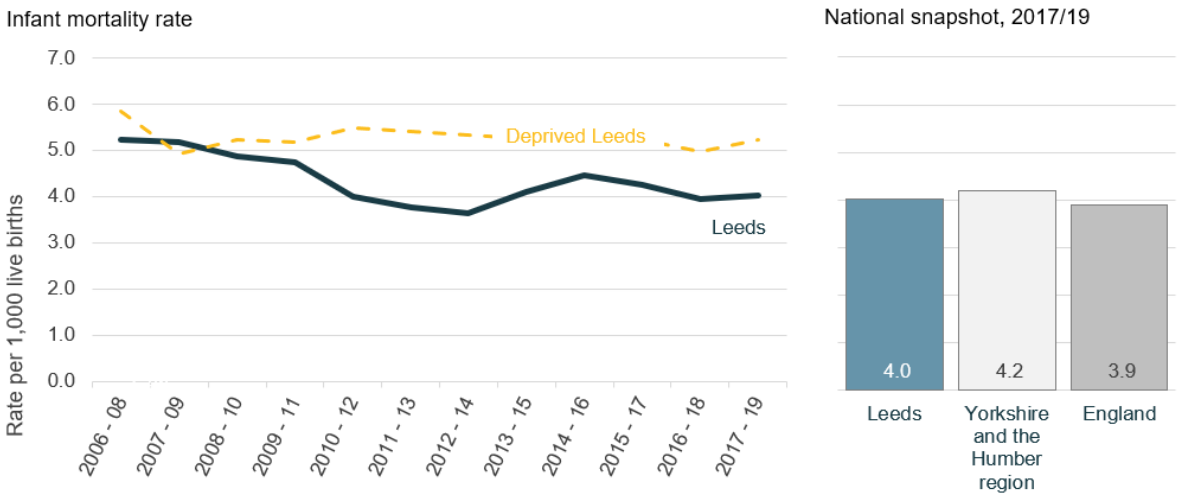
Health

Infant mortality

'Infant mortality' is the death of a live-born baby before their first birthday. Infant mortality rates have seen a gradual downward trend over the period 2006-2019 in Leeds. The gap between deprived Leeds and the city-average has fluctuated but data for the most recent period (2017-19) has shown an increase. For Leeds overall infant mortality rates are close to regional and national averages. The latest

analysis confirms the need to help ensure that parents are well prepared for pregnancy and that families with complex lives are identified early and supported.

Figure 13: Infant Mortality Rate per 1000 births

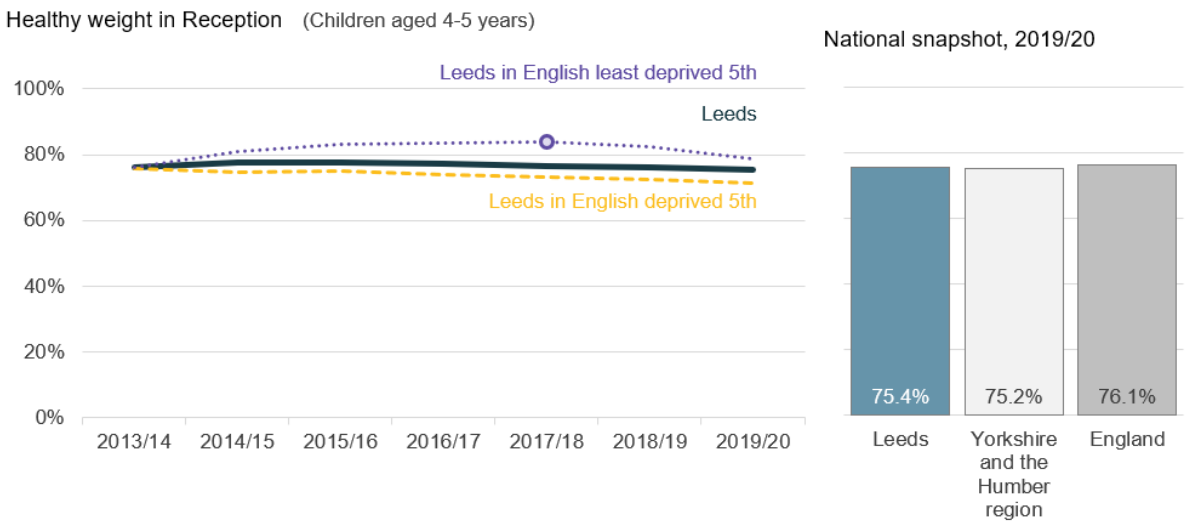


Source: GP registrations and ONS mortality data

Child obesity

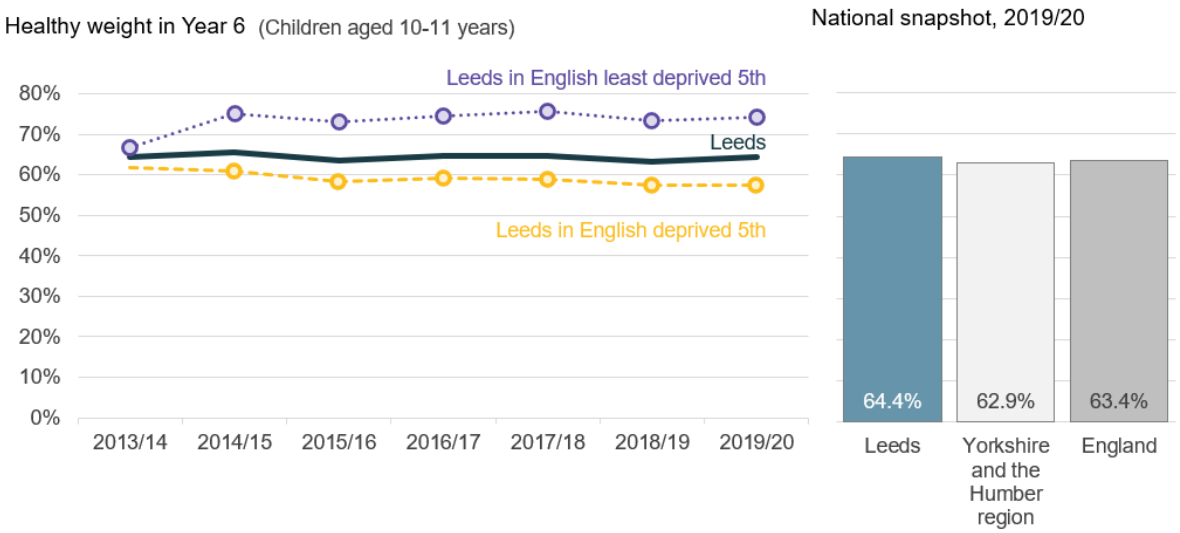
Analysis of healthy weight in children shows a gap between the most and least affluent communities across the city (though 'deprived Leeds' and 'least deprived Leeds' in this data set equates to the most and least deprived 20% according to IMD 2019, as opposed to 10% in the rest of the analysis). The gap has slightly narrowed in recent years, although this is due to faster reduction in health weight in more affluent communities, rather than an improvement in low income areas. The gap grows further as children get older, although Leeds also does increasingly slightly better than regional and national averages too.

Figure 14: Obesity % Healthy Weight in 4 to 5 year olds



Source: NHS National Child Measurement Program dataset

Figure 15: Obesity % Healthy Weight in 10 to 11 year-olds



Source: NHS National Child Measurement Program dataset

Activity levels

The Active Lives survey undertaken by Sport England shows us that in 2019/20, Leeds children were generally more active than the West Yorkshire average, with a higher proportion classed as active (av. 60+ mins of activity per day), and a lower proportion classed as less active (av. Less than 30 mins activity per day). Using the same metrics, Leeds children are less active than the England average.

Figure 16: Children's levels of activity – Academic year 2019-20

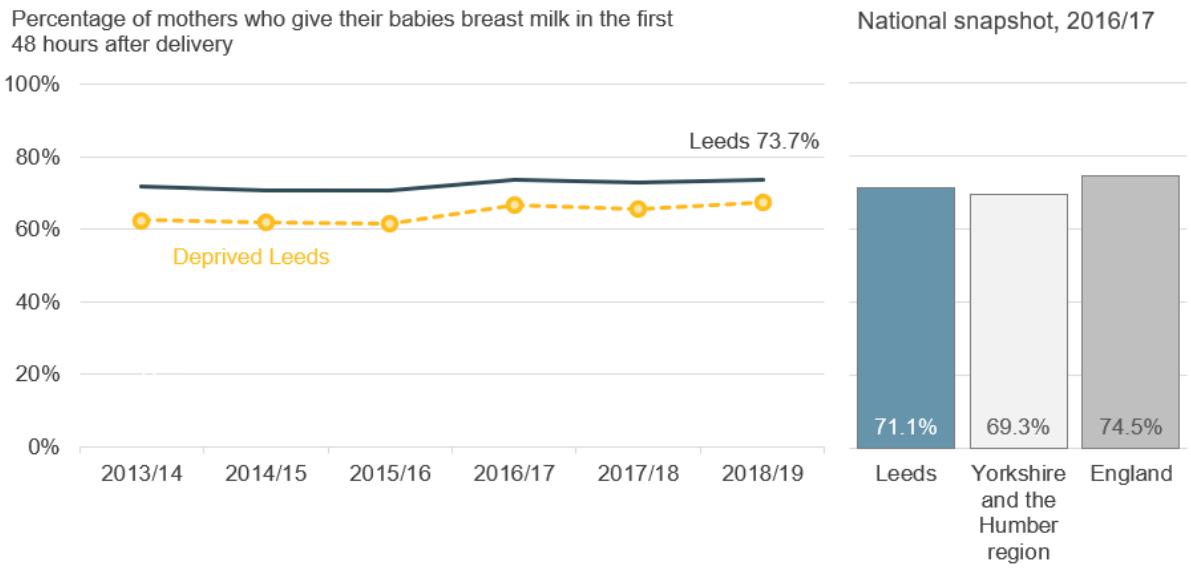
Source: Sport England Active Lives Survey 2019/20

Breastfeeding

Breastfeeding initiation rates in Leeds are lower than national rates but have increased since 2014; and improvements have been observed in deprived Leeds. Breastfeeding continuation rates (6-8 weeks) are better in Leeds compared to national rates, although have dropped a little since 2013/14 and no improvement in deprived Leeds. The White population in Leeds has the lowest breastfeeding

initiation and continuation rates of all ethnicities. Young mothers are also much less likely to initiate breastfeeding.

Figure 17: Breastfeeding Initiation rates



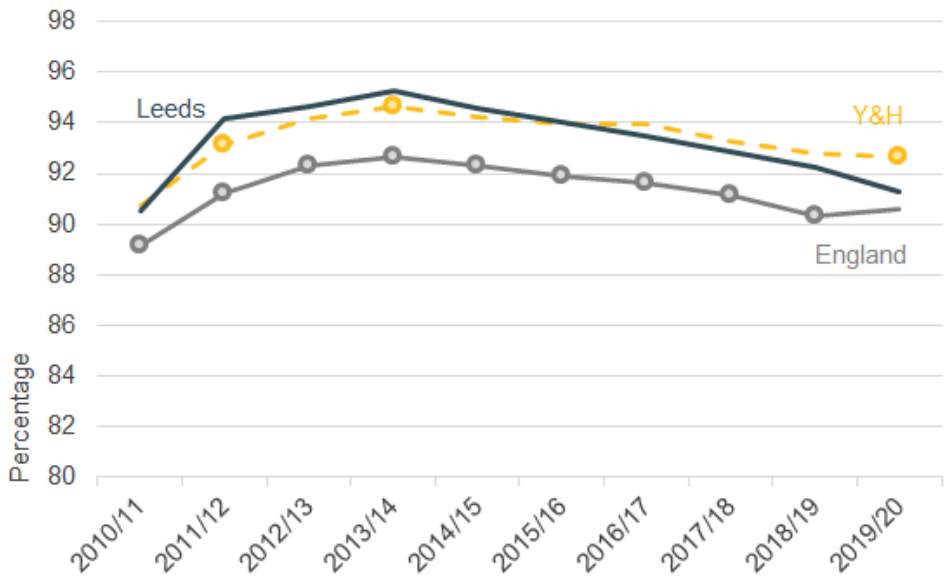
Source: Public Health England Child and Maternal Health Profile

Vaccinations

The Leeds Measles Mumps and Rubella (MMR) immunisation level does not meet recommended coverage (95%). However, the city is still performing better than England overall.

By age 2, 91% of Leeds children have had one dose, higher than the England average. By the age of five, only 87% of Leeds children have received their second dose of MMR vaccination which, while not on target, is still just higher than the England rate of 87%.

Figure 18: MMR vaccination coverage – one dose for 2 year-olds

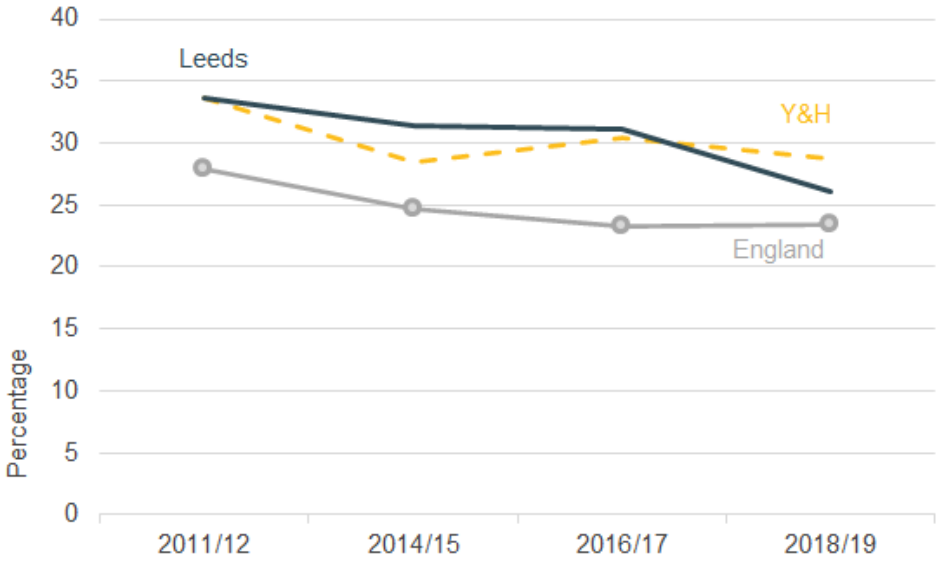


Source: Public Health England Child and Maternal Health Profiles

Oral health

Dental health is marginally worse in Leeds than England with more than a quarter (26%) of Leeds 5 year-olds having experienced dental decay compared to 24% in England.

Figure 19: Percentage of 5 year-olds with experience of visually obvious dental decay

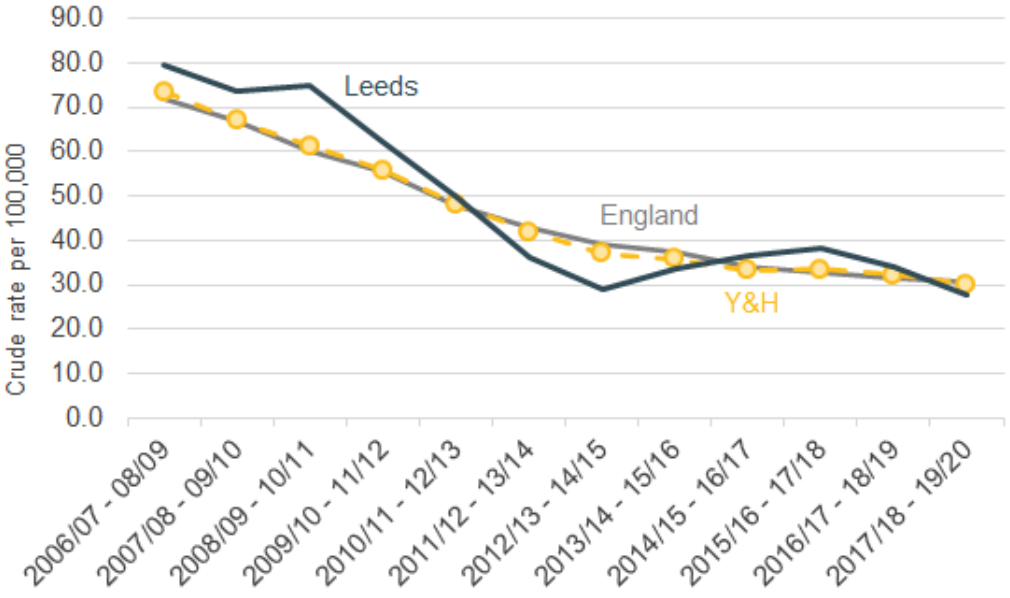


Source: Public Health England Child and Maternal Health Profiles

Young people and alcohol

Nationally, the rate of hospital admissions of children and young people for conditions wholly related to alcohol is decreasing and this is also the case in Leeds. The admission rate in the latest period is similar to the England average.

Figure 20: Admission episodes for alcohol-specific conditions under 18s



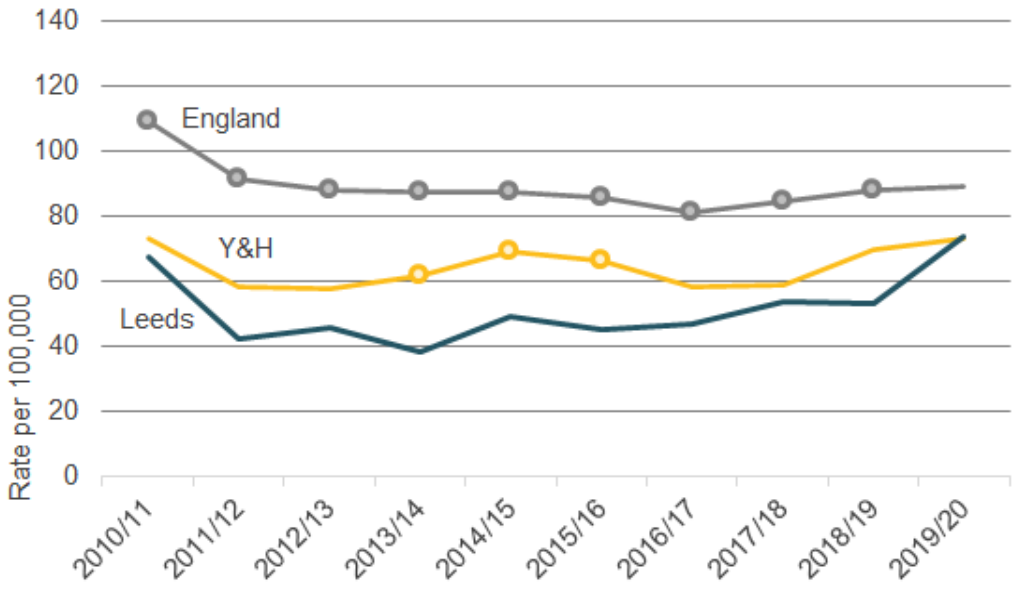
Source: Public Health England Child and Maternal Health Profiles

Mental health

Nationally, the rate of young people being admitted to hospital as a result of self-harm is increasing. This is not the case in Leeds, where there is no significant trend, although the latest admission rates are worse than the England average. Nationally, levels of self-harm are higher among young women than young men.

When considering mental ill-health overall, the Leeds rate of child inpatient admissions for mental health conditions at 73.8 per 100,000 is better than the England average, although it has risen more sharply in recent years. This data of course does not capture in full the broader mental health and wellbeing of young people across the city.

Figure 21: Hospital admissions for mental health conditions under 18s



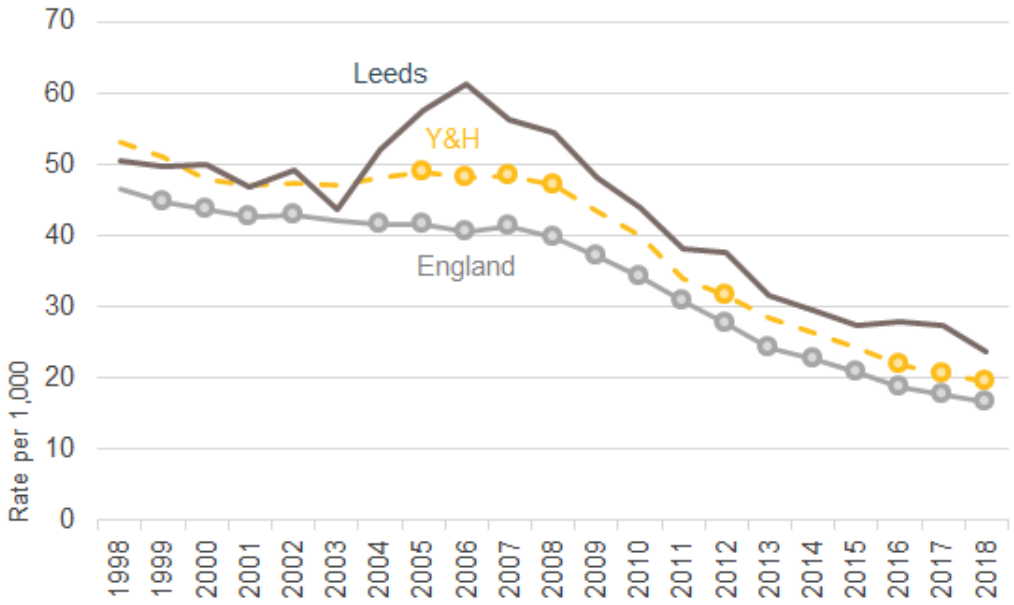
Source: Public Health England Child and Maternal Health Profiles

Sexual and reproductive health

There are approximately 10,000 births per year in Leeds - a third to women residing in deprived Leeds. There has been an increase in the proportion of births to Black, Asian and ethnic minority women since 2009, with ethnic minority groups overrepresented in deprived Leeds. There has also been an increase in births to non-British born mothers.

In 2018, approximately 24 in every 1,000 girls aged under 18 in Leeds conceived. This is higher than the national and regional rates; with the majority of births being to mothers in deprived Leeds.

Figure 22: Under 18s conception rate



Source: Public Health England Child and Maternal Health Profiles

12% of women smoke while pregnant. Smoking in pregnancy rates are higher in Leeds than national rates and are significantly higher amongst women who are under 18 years old at time of delivery – with no improvement since 2014.

Education and learning

Covid-19 has had a significant impact on children and their learning, including no national assessment prior to key stage 4 (GCSE). Young people taking GCSEs and A-Levels have received teacher-assessed grades in place of national examinations and there has been some increase in grades. National analysis assessing the differential impact of these changes on groups of young people suggests most previous gaps have remained constant, although they have widened slightly for free school meal eligible children and those from Gypsy Roma Traveller backgrounds. Further analysis assessing impacts in Leeds will follow. As a result of these unique factors, data used for the JSA is predominantly up to 2019.

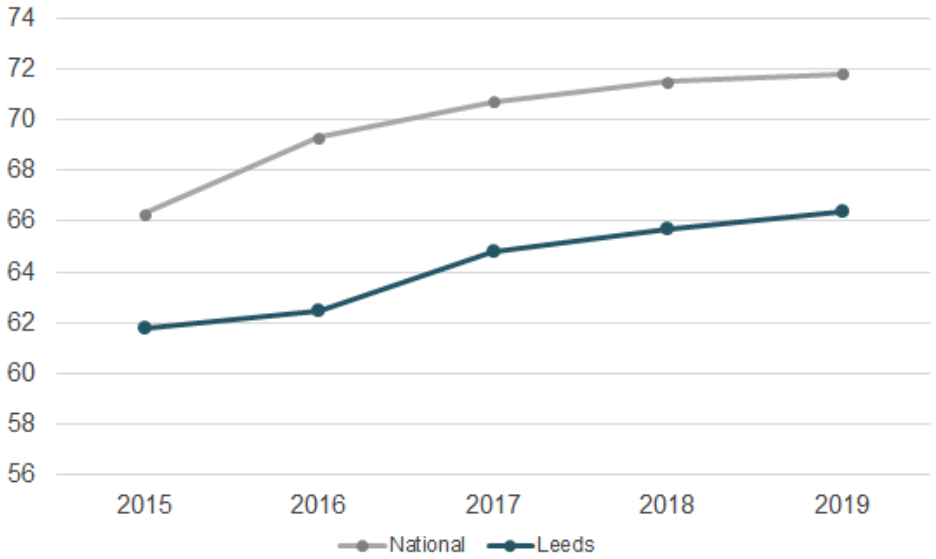
Leeds has a longstanding gap between more and less advantaged children achieving their potential, particularly at pre-school and primary, and particularly for our most disadvantaged children. These issues are very likely to have been exacerbated further by Covid-19. Overall, however, at the key nationally monitored stages of 2 and 4 Leeds children as a whole make reasonable to good progress in learning, comparable to their peers nationally at key stage 2 and above national rates in Leeds secondary schools.

Early years

There have been some encouraging improvements in the proportion of children achieving the expected level in the early learning goals, and the mean average total point score for the lowest attaining 20% of learners is improving consistently and is now above national rates. In 2019, 66% of Leeds children achieved a good level of development, up slightly from 2018. However, against this indicator, Leeds remains behind national levels, but the gap has closed from 6.8 points in 2016 to 5.4 points in 2019.

Children are measured across 17 early learning goals (ELGs) and it is determined whether their skills are 'emerging', 'expected standard', or 'exceeding'. In Leeds, the percentage of children 'exceeding' is consistently above national across all ELGs (except one, which is in line). However, there are more pupils in Leeds than national in the 'emerging' category for 'reading', 'writing', 'numbers' and 'shapes, space and measures'. This indicates that, despite Leeds children having some of the highest attainment nationally, there is also a significantly high level of low attainers.

Figure 23: Early Years Foundation Stage Profile – children achieving a good level of development (2015 to 2019)



Source: Department for Education and Leeds City Council

Key stage 2

Results at the end of Key Stage 2 focus on a child's attainment and progress in maths, reading and writing. Writing is based on teacher assessment, reading and maths on end of key stage tests. 62% of Leeds year 6 children achieved the expected standard in reading, writing and maths, compared to 65% per cent of children nationally.

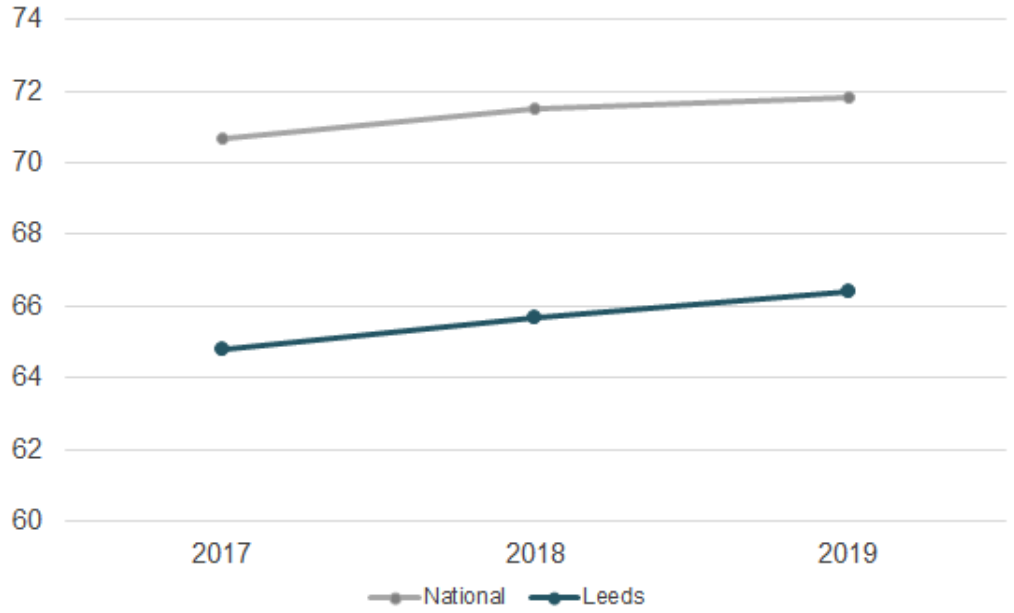
There was a 6% increase between 2017 and 2018 in the proportion of disadvantaged pupils gaining the expected standard in reading, writing and maths. However, this figure remained at 45% in 2019, still 6% points below the national level for disadvantaged pupils. There remains a gap of 26% in attainment between disadvantaged and non-disadvantaged pupils in Leeds, six points greater than the national gap between these cohorts.

Key stage 4 and beyond

Headline measures at key stage 4 are based on the results of eight GCSEs or equivalent, including English and maths. The overall achievement is known as Attainment 8. In 2019, the average Attainment 8 score per pupil in Leeds was 45.1, which is slightly higher than in 2018 when it was 44.8. The gap to national narrowed slightly, from 1.8 points in 2018 to 1.6 points. Disadvantaged children in Leeds perform less well than their non-disadvantaged peers, gaining an average point score of 35.4, compared to 49.4. This is also below the national figure for disadvantaged pupils which stands at 36.8.

42% of Leeds pupils achieved a strong pass in English and maths (grade five of higher) in 2019, very slightly higher than in 2018. The national average for 2019 was 43%.

Figure 24: Key Stage 4 – pupils achieving a strong pass (2017 to 2019)



Source: Department for Education and Leeds City Council

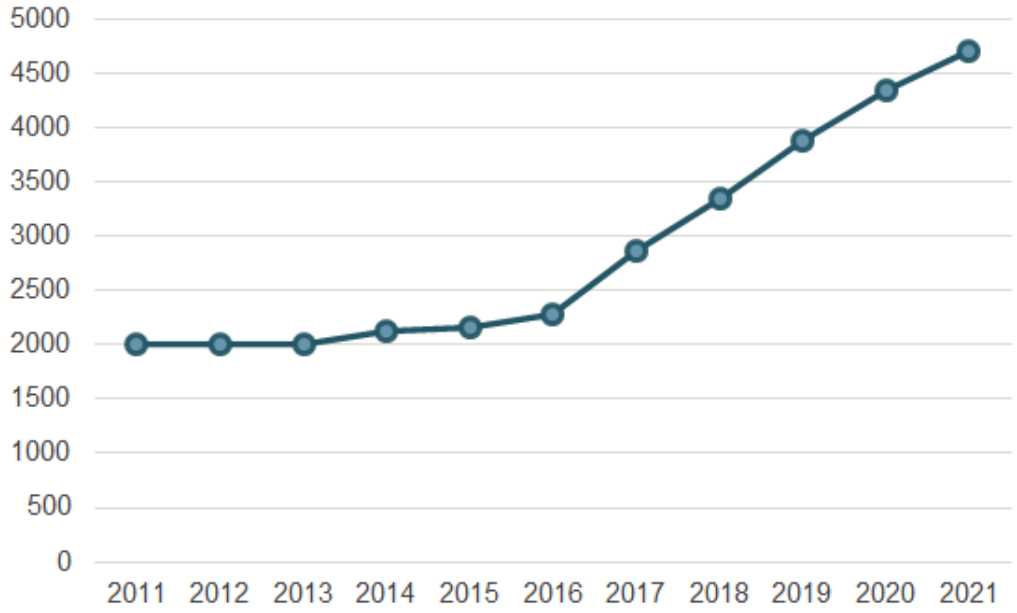
At age 19 when young people are moving into adulthood, marginally over half of Leeds young people achieved a level 3 qualification in 2019, 7% lower than nationally. For level 2 marginally over three quarters achieved this level of qualification, 5.5% below national rates. For young people who were eligible for fee school meals at 16, 51% attained a level 2 qualification in 2019 and 25% Level 3. This reflects in Leeds gaps are wider for our less advantaged pupils as measured by FSM eligibility, evident at all ages.

Support for children with special educational needs

Leeds has an inclusive model, reflected in how funding is directed to schools, which contributes to lower rate of children having Education and Health Care Plans (EHC plans) relative to other local authorities, especially in the primary years. Just over 2% of the school age population attending school has an EHC plan, compared to 3% in Core Cities and almost 4% across England.

Leeds like England is seeing significant increases in EHC plans. In January 2021, the number of plans maintained by Leeds City Council was 4,689, an increase of 350 on the previous year (or 8%). Growth is continuing and by June 2021 numbers had risen to 4,952.

Figure 25: EHC plans maintained by Leeds City Council, 2011 to 2021



Source: Department for Education SEN2 returns, January 2021

Leeds maintains a lower proportion of EHC plans in younger age groups than national averages and comparators – 2% for under-5s and 24% for ages 5-10. The reverse is true for older young people, with the 24% for 16-19 old and 14% for 20-25 both higher than national and comparators. The largest proportion of EHC plans in Leeds are within the 11-15 age group in 2021 (35%).

16% of all pupils who attend a primary school in Leeds are recorded as having a special educational need, 1% of whom have an EHC Plan. For secondary schools in Leeds 1% of secondary school pupils have an EHC plan and 12% are recorded as SEN support, 13% in total. The overall number of secondary school pupils with SEND has grown by 26% since 2016.

In Leeds maintained schools the most common type of need for those with an EHC plan is Autistic Spectrum Disorders and for those with SEN support Speech, Language and Communication needs. This is reflected in Leeds primary schools where the most prevalent SEN primary need is speech, language and communication needs at 41%, an increase in proportion for the past four years and greater than national and comparators. Social, emotional and mental health is the most prevalent SEN primary need in Leeds secondary schools at 25% of the cohort, this includes being the most common need for those with an EHC plan followed closely by autism. Considering SEND primary needs against deprivation some needs such as speech and language and moderate learning difficulties are weighted to more disadvantaged areas, other needs like autism spectrum disorder are reflected more evenly in all communities.

School attendance during Covid-19

School attendance has been severely disrupted due to Covid-19, with rates varying significantly in line with national regulations:

- Attendance was just below 2% from March to May 2020 as school was open to only children of key workers and vulnerable children.
- Attendance rose to 17% in June and July 2020 with school open to a small number of additional year groups.

- With school open as normal, attendance at the start of the 2020/21 academic year was 83%, affected by the collapse of 'bubbles'.
- Attendance fell again to 20% in January 2021 when lockdown was reimposed.
- Since March 2021, attendance has risen back to 85%, although Covid-19 absences continue to affect this figure.

In the autumn term 2020/21 the number of school enrolments in Leeds that missed at least one session due to a Covid-19 related absence was 66.8%[14]. DfE analysis suggests an overall Leeds school absence rate of 5% plus an additional 9% due to Covid-19. For England, it was 5% and lower Covid-19 additionality of 7%. Leeds overall absence rate inclusive of Covid-19 was in line with the region. For autumn 2019 the Leeds absence rate was 5%.

Policy implications

- Covid-19 has had a major impact on children and young people, with the disruption to their education and concerns regarding safeguarding and disengagement, particularly the most vulnerable. However, it is perhaps the mental health of our young people that is of greatest concern. Although on Leeds rates on indicators like child inpatient admissions for mental health conditions are below national averages, they have risen more sharply in the city in recent years. Responding to the mental health challenges increasingly facing young people will be a key challenge going forward.

- Closing the educational attainment gap for the children and young people most likely to be experiencing poverty and disadvantage remains a significant challenge. Promoting positive engagement with education for young people and their families from the outset and strengthening pathways to continued education, skills development and employment opportunities are all likely to be needed.

- Linked to the point above, child poverty is at the root of many poor outcomes for children and young people including education, health and wellbeing and even routes into care, and factors influencing the scale and severity of child poverty in the city are broad-based. Strengthening linkages between interventions and strategies aimed at young people and our wider approach to inclusive growth will be vital in working to realise the full potential of our young people.

[14] *School Census*

Section 3A: Living Well – Health and Wellbeing

Headlines

- Even prior to the Covid-19 pandemic, tackling poverty and inequality was central to our approach, with evidence of an intensification of inequalities, often based in our most disadvantaged communities and an increasing requirement for us and partners to respond more collaboratively.

- The pandemic has exacerbated inequalities, with data establishing a link between number of deaths and deprivation, driven by a combination of underlying health conditions including smoking, obesity and limited opportunities to follow healthy-living, and exposure to the virus, for groups such as key workers, those unable to work from home, those in low income or multi-generational housing and those more reliant on public transport. Poverty is the common factor in these drivers.

- The health-wealth gap risks becoming wider in the wake of Covid-19. Poverty and financial insecurity, employment, our homes and the places we live and the air we breathe, all affect physical and mental health directly. They also affect behaviours like being physically active, smoking, having a poor diet and drinking too much.

- Over recent years, the influence of wider determinants of health and wellbeing have come under sharper scrutiny, regardless of the pandemic. The 2019 study, *Health Equity in England: The Marmot Review 10 Years On*, identified a range of concerns, which are mirrored in the JSA analysis.

- A particular concern is the stalling of improvements in life expectancy for people living in low income areas and growth in mental health issues across all communities.

- The proportion of adults reporting mental health issues increased during the pandemic, with some groups particularly affected including: young adults and women; shielding older adults; adults with pre-existing mental health conditions, and Black, Asian and ethnic minority adults.

- These mental health impacts are likely to continue as the economic impact of the pandemic manifest themselves, with concerns about job security and debt levels likely to increase.

Our ambition articulated in the city's Health and Wellbeing Strategy is that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'. Even prior to the Covid-19 pandemic, tackling poverty and inequality was central to our approach, with evidence of an intensification of inequalities, often based in our most disadvantaged communities and an increasing requirement for us and partners to respond more collaboratively. The pandemic has exacerbated these long-standing and deep-rooted inequalities, with more and more data establishing a link between the most severe impacts of the pandemic and deprivation, driven by a combination of underlying health conditions including smoking, obesity and limited opportunities to follow healthy living, and exposure to the virus, for groups such as key workers, those unable to work from home, those in low income or multi-generational housing and those more reliant on public transport. Poverty is the common factor in both these drivers.

More than ever, realising our ambition requires improvements in all factors that support healthy lives: the social determinants - particularly employment and skills; living conditions - such as housing, air quality, access to green space; and healthy living - including physical activity levels, food choices, alcohol intake and smoking.

Immediate and direct health impacts of Covid-19

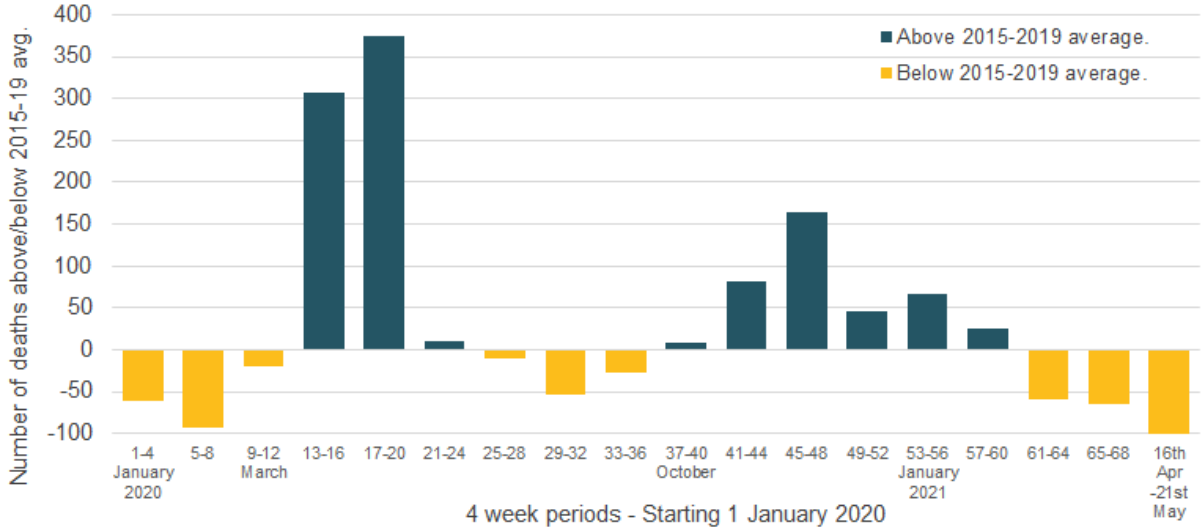
As stated in the Introduction to the JSA, producing an accurate analysis of the current and future challenges the city faces in this context is very challenging. Much of the data available is partial in nature or is yet to show the full effects of Covid-19., this is particularly true of health data, often with a delay in the availability of meaningful data. However, in terms of the immediate and direct health impacts of Covid-19, a wide range of primarily national analysis has been undertaken. In June last year Public Health England (PHE), published the findings of its review into how different factors such as age, sex and ethnicity affect Covid-19 risks and outcomes. Analysis undertaken by our Public Health team during the pandemic over the last year also drew some similar conclusions[15]. Both pieces of work confirmed that the virus' impact mirrored existing health inequalities and, in many cases, increased them further, identifying those groups seemingly at most risk, specially:

- Older People - the largest disparity found was by age, of people diagnosed with Covid-19, those who were 80+ were seventy times more likely to die than those under 40.
- Men – deaths of those diagnosed with Covid-19 are higher in males than females.
- People from disadvantage areas - mortality rates from Covid-19 in the most deprived areas according to IMD were more than double the least deprived, for both males and females.
- Those from Black and ethnic minority communities - death rates from Covid-19 were highest among people of Black and Asian ethnic groups.
- People in low-paid or low-skilled occupations - security guards, taxi drivers, chefs, care workers and bus drivers are the occupations with the highest death rates involving coronavirus.
- People with underlying health conditions - among deaths with Covid-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia.

The operational strain on health and social care have also seen significant analysis, with daily reports and regular dashboards produced to inform our collective response. Since March 2020 we have seen significantly higher excess deaths as a direct result of Covid-19 when compared to the 2015-2019 average (Figure 26). As of 14 June 2021, there have been 1,629 deaths recorded in Leeds with Covid-19 on the death certificate, and there have been 66,650 total cases in the city by the same date[16].

[15] *COVID-19 Health Inequalities: Summary of Evidence and Recommendations, Leeds PH Team*
[16] *GOV.UK Covid-19 Dashboard*

Figure 26: Deaths in 4 week periods in comparison to average deaths 2015 - 2019



Source: Public Health Intelligence

Longer-term trends – the health / wealth gap

Since the 2018 JSA, the impact of wider determinants of health and wellbeing have come into even sharper focus, notwithstanding the pandemic. The 2019 study, *Health Equity in England: The Marmot Review 10 Years On*, commissioned by the Health Foundation to mark 10 years on from the landmark Marmot Review highlighted a range of concerns:

- people can expect to spend more of their lives in poor health.
- improvements to life expectancy have stalled and declined for the poorest 10% of women.
- the health gap has grown between wealthy and deprived areas.
- place matters - living in a deprived area in the North of England is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy can be nearly five years less.

The 2018 JSA mirrored many of these finding. The analysis set out in this section of the 2021 JSA again seeks to examine progress against a range of indicators over time, and also provides valuable baselines from which to assess progress, identify specific concerns, identify further lines of enquiry, and perhaps most importantly explore and strengthen links with the wider determinants of health and wellbeing. We will publish further analysis and reporting on the Leeds Observatory as it becomes available.

The health-wealth gap risks becoming wider still in the wake of Covid-19. Poverty and financial insecurity, employment, our homes and the places we live and the air we breathe, all affect physical and mental health directly. They also affect behaviors like being physically active, smoking, having a poor diet and drinking too much.

Life expectancy

Figure 27: Female Life Expectancy (Life Expectancy Sharing)

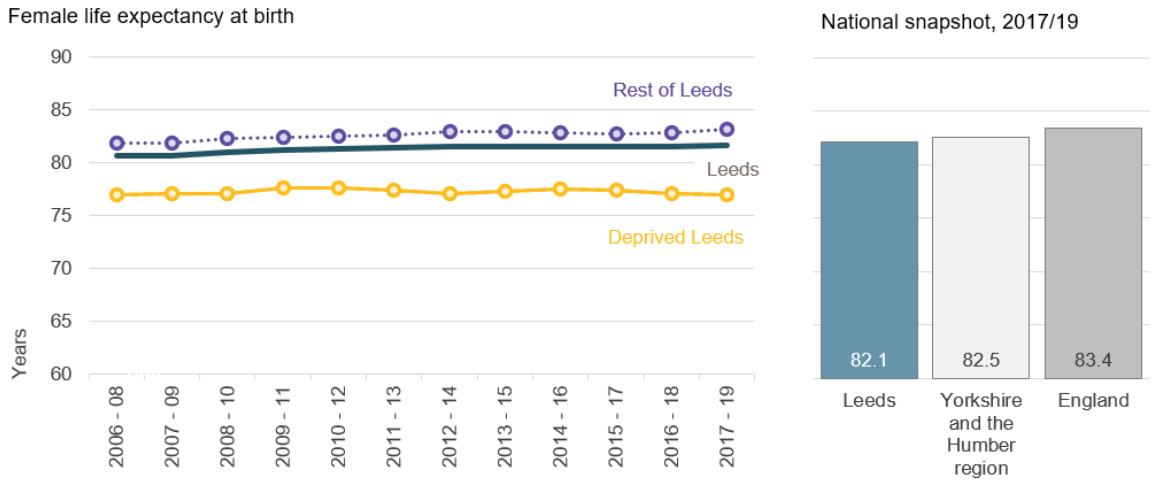
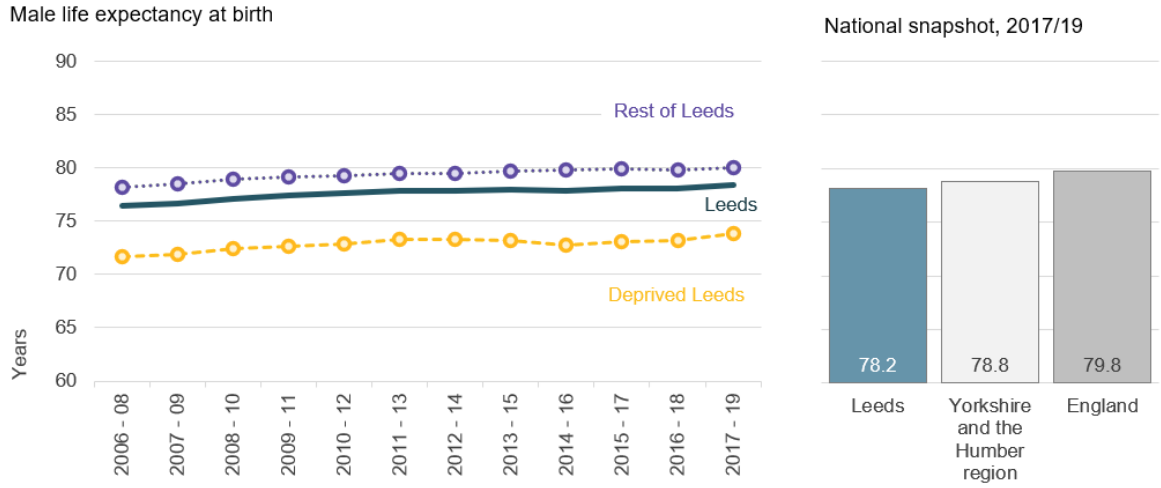


Figure 28: Male Life Expectancy (Life Expectancy Sharing)



Source: GP registrations and ONS mortality data

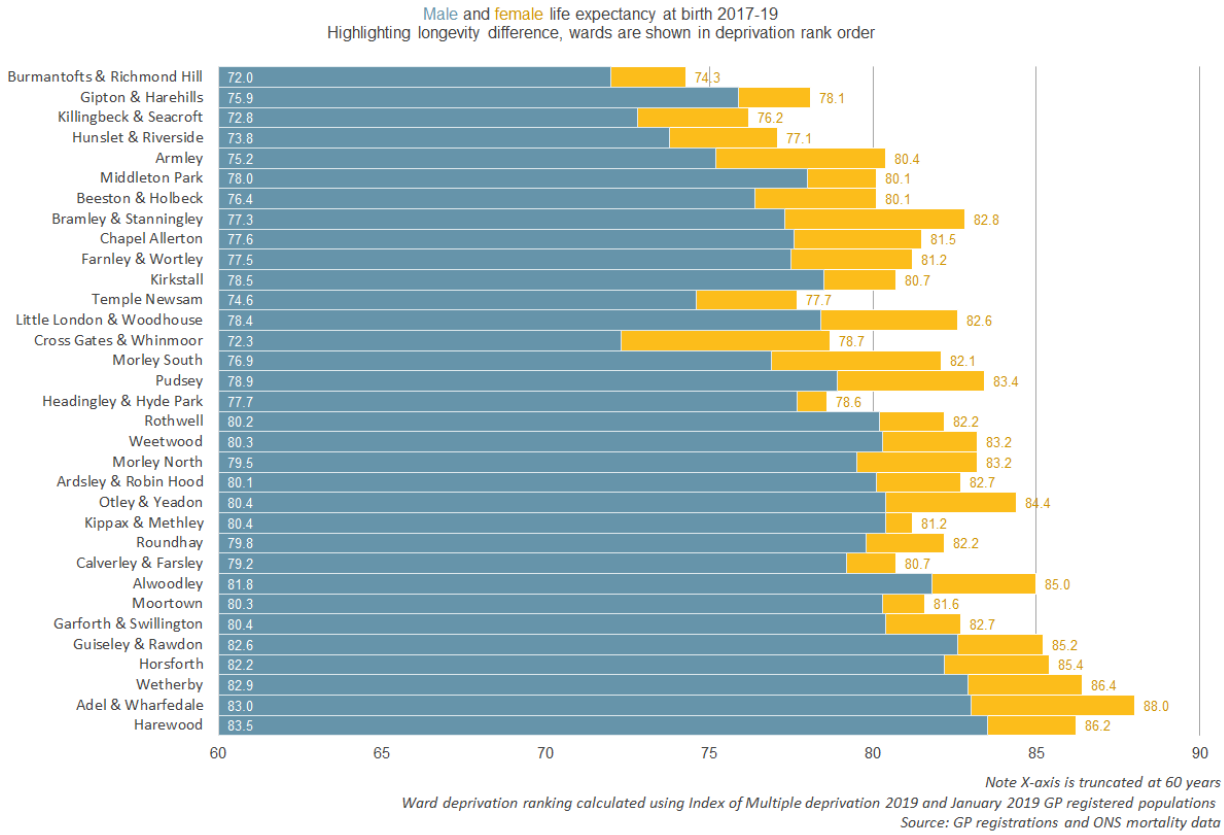
Female life expectancy has stagnated in recent years, with the gap between deprived Leeds and the city average widening in the decade up to 2019. In deprived Leeds, the life expectancy at birth figure appears to have fallen back slightly in recent years, however, none of these changes are classed as statistically significant. In terms of wider comparisons, Leeds lags regional and national averages for female life expectancy.

Male life expectancy has also remained constant in Leeds. Though life expectancy in deprived Leeds has seen a slight uplift since 2016-18. Once again none of these changes in deprived Leeds is statistically significant. Looking more widely, male life expectancy in Leeds also lags regional and national averages.

Figure 29 below highlights the variations in life expectancy by ward across the city. It highlights the gap in life expectancy between of some of our most and least affluent areas as illustrated by a difference in life expectancy of 12 years for women and 11 years for men, between the ward of

Burmantofts and Richmond Hill in the inner city, and that of Adel and Wharfedale in the outer area. It is also important to note there will be differences in life expectancy within ward areas.

Figure 29: Ward / deprivation inequalities Male/Female



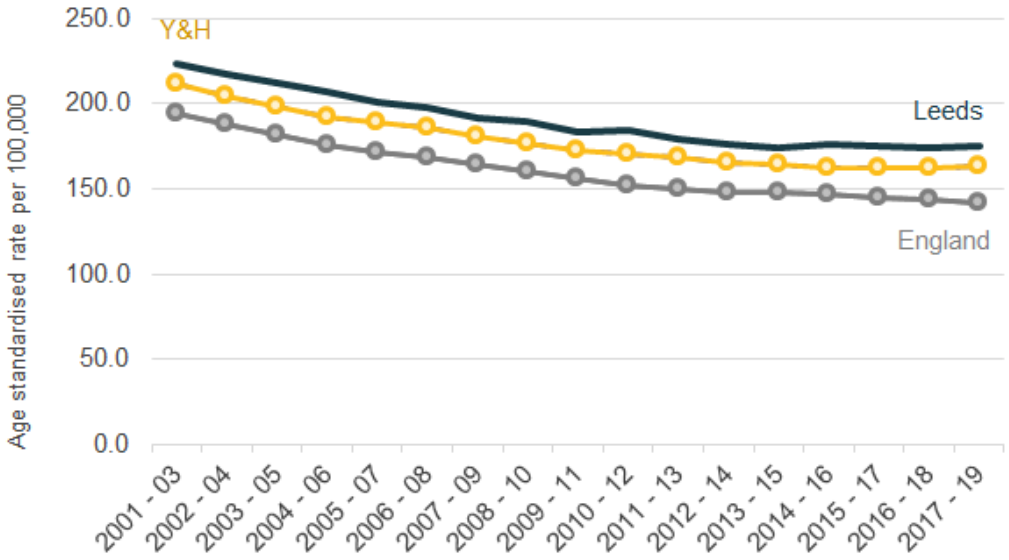
Source: GP registrations and ONS mortality data

In summary, the widely reported recent slowing in life expectancy gains at a national level are reflected in the latest data for the city. The data also confirms the stubborn gap in life expectancy between our most deprived and least deprived communities emphasizing the need to improve the socio-economic conditions in our most challenging communities.

Preventable mortality

Preventable deaths are a measure of the success of Public Health interventions where deaths could have been prevented. Preventable mortality saw a steady decline at local, regional and national levels in the period up to 2019. The extent to which the direct and indirect impact of the pandemic has influenced this trajectory is not yet clear.

Figure 30: U75 mortality rate from causes considered preventable



Source: Public Health England (based on ONS source data)

Suicide rates

Rates for persons (the rate for all people rather than male and female separately) show the clearest picture. The inequality gap is quite pronounced, though it appears to have closed in recent years. Clearly the socio-economic impact of the pandemic has clearly had some profound impacts on mental health. It is uncertain what extent these pressures affect suicide rates. Care needs to be taken in looking at Female rates of suicide due to the low numbers, However, male suicides, due to the larger number are more statistically reliable.

Figure 31: Suicide Rate (persons) FT is age standardised per 100,000 - Leeds

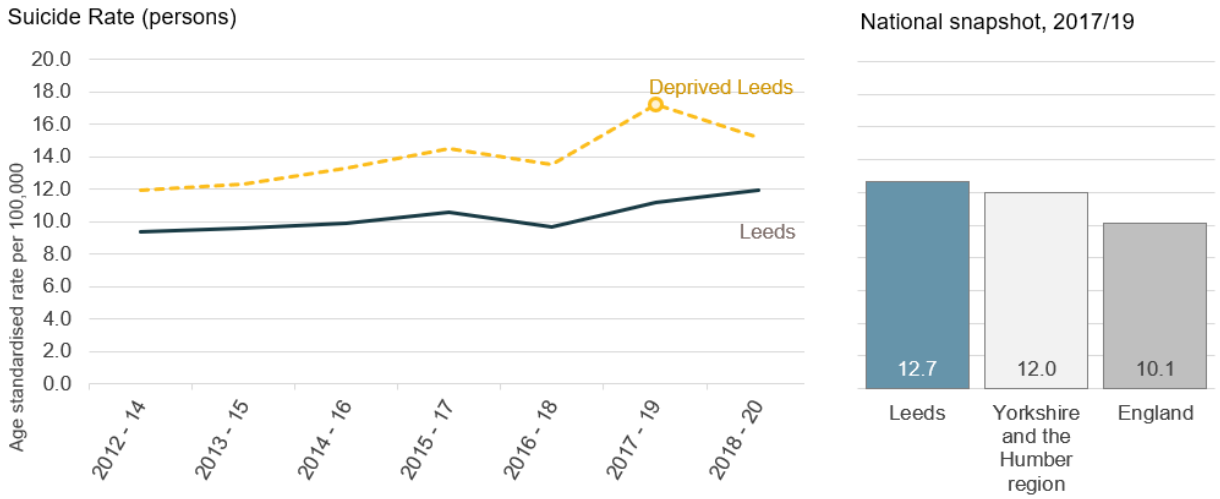
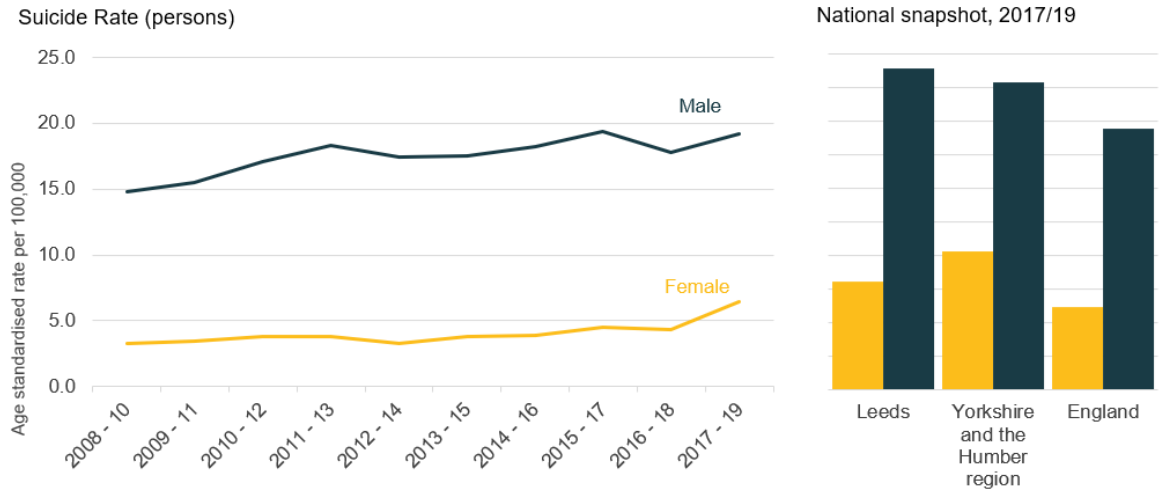


Figure 32: Suicide Rate (persons) FT is age standardised per 100,000 - Male/Female

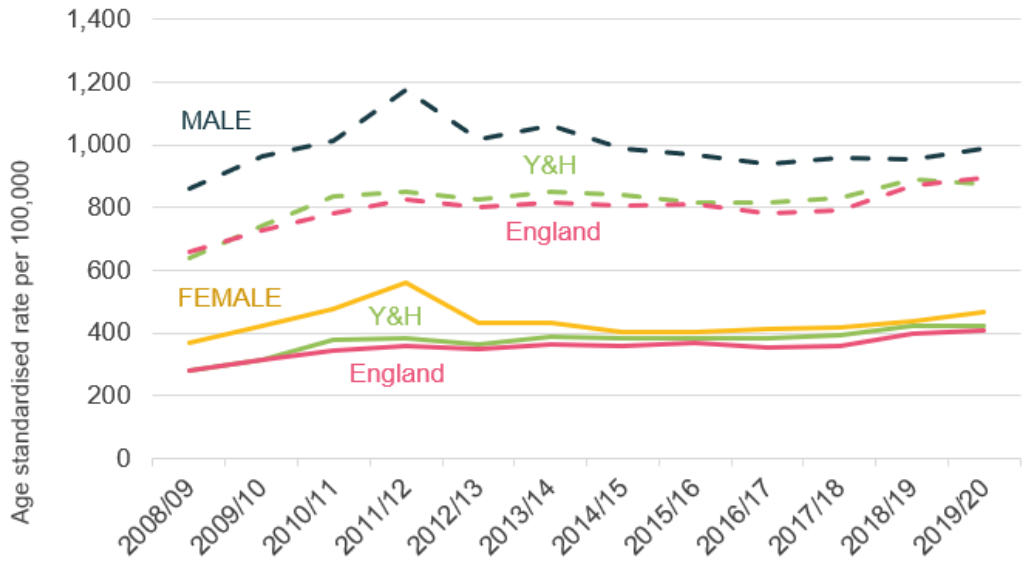


Source: LCC PHI GP data and ONS mortality

Alcohol related admissions

Alcohol related admissions as represented by hospital admissions have picked up over the last few years, with rates for males are far higher than for females. Leeds remains above regional and national averages though the gap is closing.

Figure 33: Rate of alcohol SPECIFIC admissions to hospital per 100,000

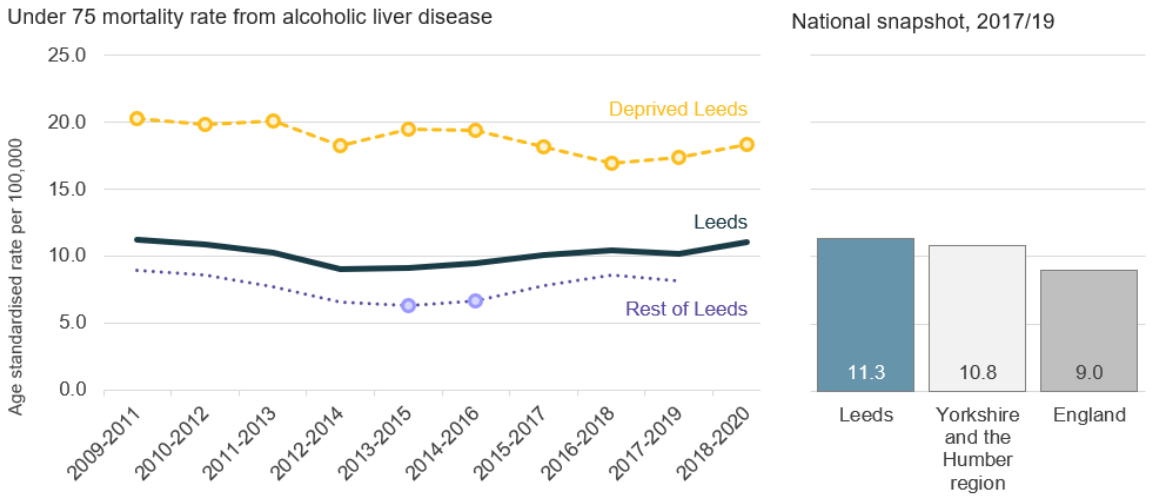


Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Liver disease mortality

The gap between deprived Leeds and the city average for liver disease mortality has narrowed over recent years, with a decline in rates in deprived areas and a slight increase in the overall Leeds average. City rates are above regional and national averages.

Figure 34: Alcoholic liver disease mortality, under 75

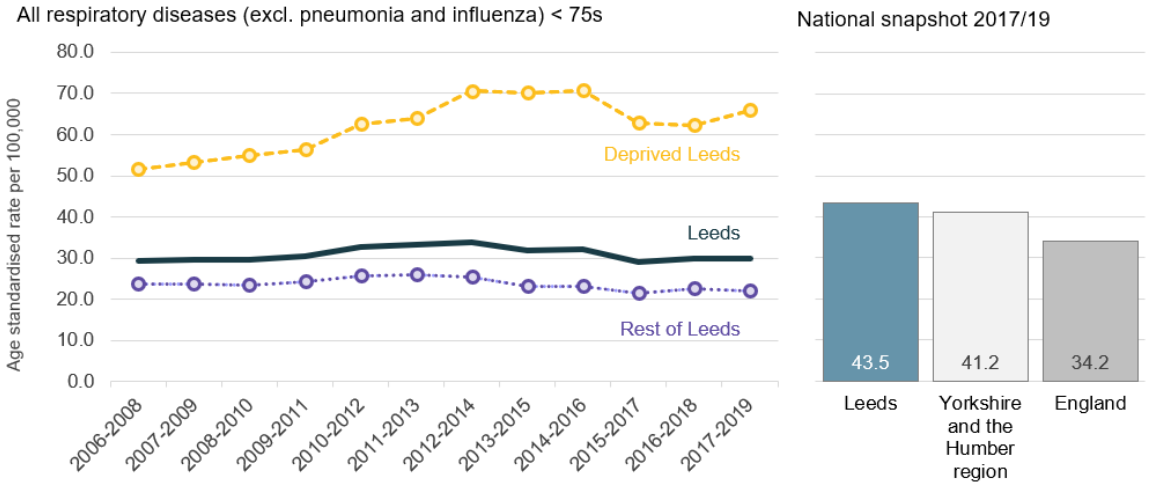


Source: LCC PHI GP data and ONS mortality

Respiratory disease mortality

Respiratory disease mortality is much higher in deprived Leeds than the Leeds average, and is growing again. This inequality gap is related to factors such as smoking, workplace and air quality.

Figure 35: Respiratory mortality U75

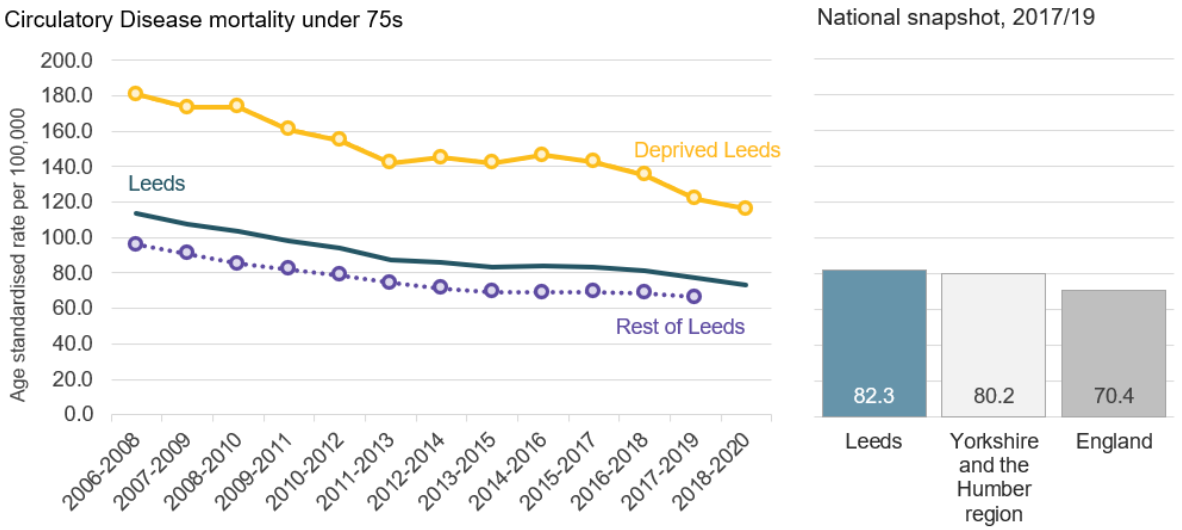


Source: LCC PHI GP data and ONS mortality

Circulatory disease mortality

Circulatory disease has seen a steady downward trend, most noticeably in our communities experiencing deprivation, with a closing of the gap between the overall city average. However, rates remain above regional and national rates.

Figure 36: Circulatory Disease Mortality U75

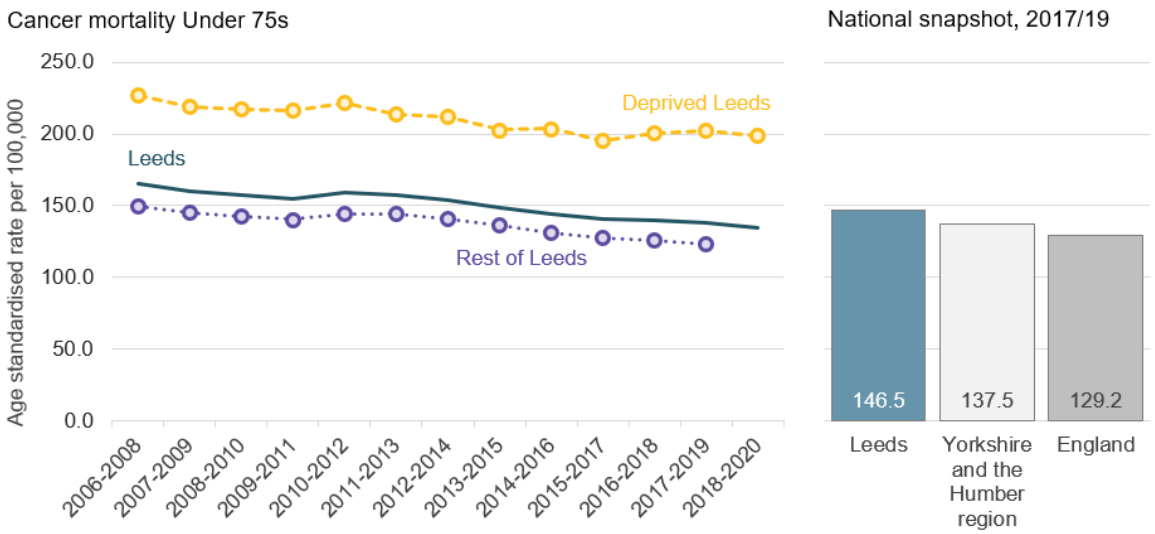


Source: PHI and Annual Population Survey (APS

Cancer mortality

Again, a downward trend for cancer mortality, although the 'deprivation gap' is not closing. Leeds rates are significantly above regional and national averages.

Figure 37: Cancer Mortality U75

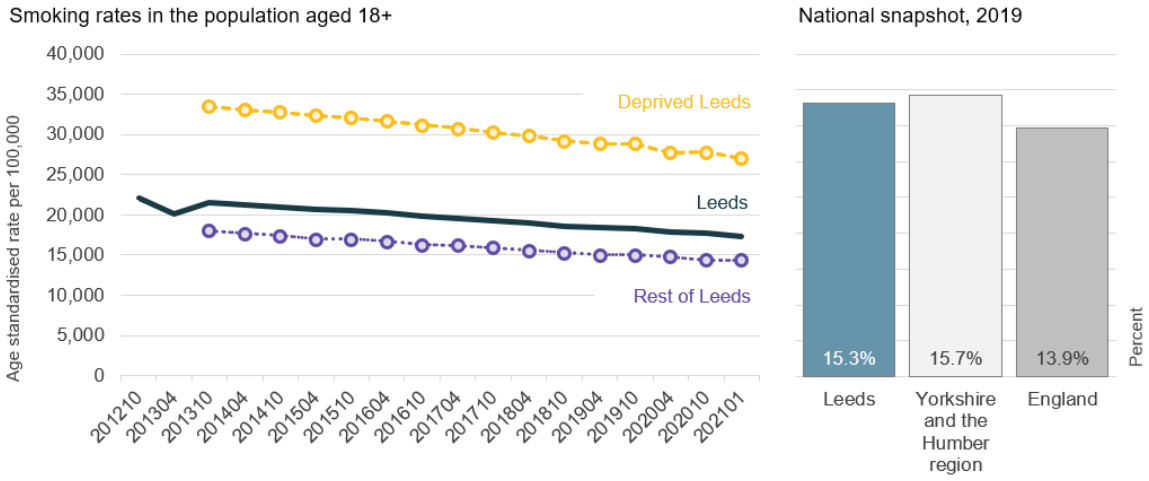


Source: PHI and Annual Population Survey (APS

Smoking prevalence

Leeds prevalence according to PHE, and using the ONS mid-year estimate population, figures shows Leeds to be very close to the regional rate and not significantly higher than England. The trend is generally downward for Leeds with the 'deprivation gap' narrowing.

Figure 38: Proportion of Adults over 18 that Smoke

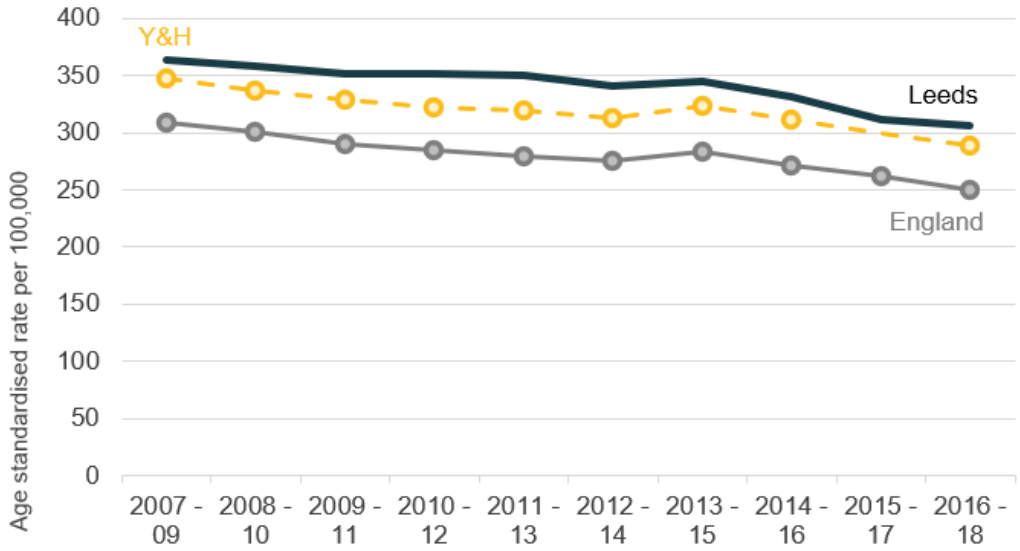


Source: PHI and Annual Population Survey (APS)

Smoking attributable mortality

Because of the lower smoking prevalence there has been a slow reduction in mortality from smoking attributable deaths across all geographies.

Figure 39: Smoking attributable mortality aged 35+

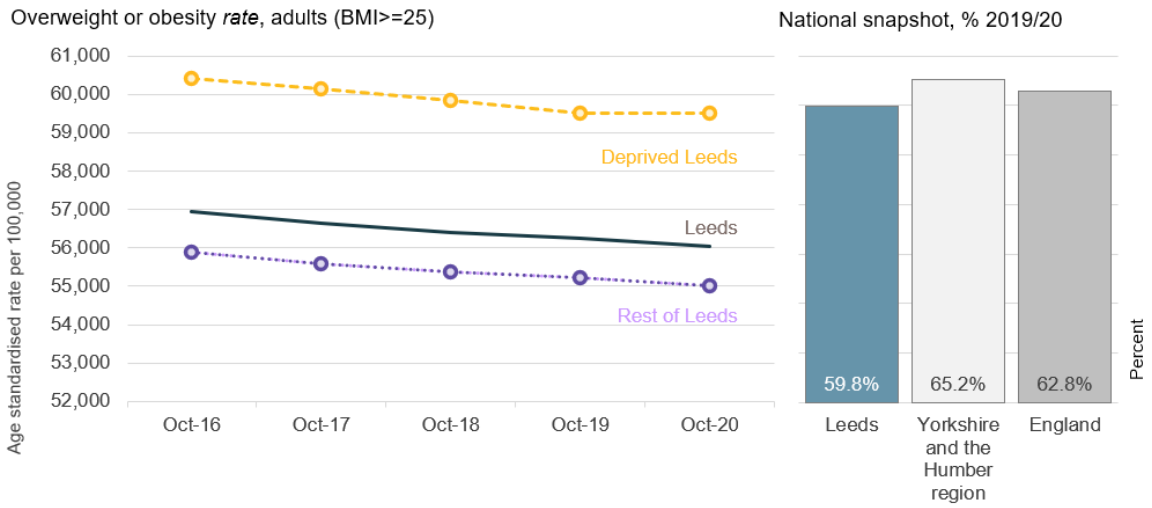


Source: Public Health England

Obesity

Levels of obesity as measured by those adults with a BMI over 25, city-wide rates have seen a decline in recent years, with rates in Leeds now well below regional and national rates. However, the rates for deprived Leeds have remained fairly constant, leading to an increase in the 'deprivation gap'.

Figure 40: Excess weight in adults % of Adults who have a BMI of over 25

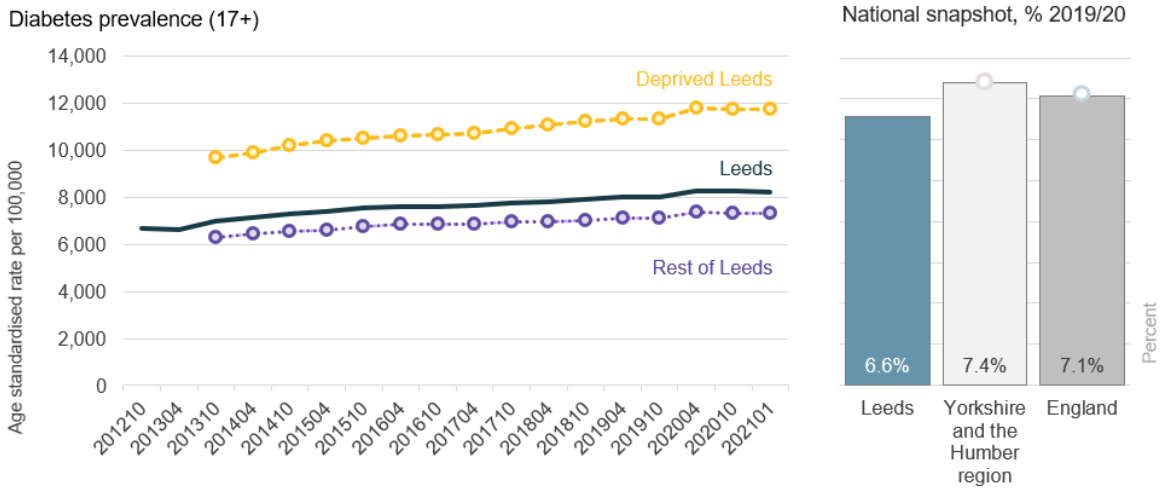


Source: Leeds PHI and GP data

Diabetes

The incidence of diabetes in Leeds is also below regional and national rates. However, rates are increasing across the city and are now more in line with modelled estimates, with a significant 'deprivation gap' remaining.

Figure 41: Diabetes Directly Age Standardised Rates 17+

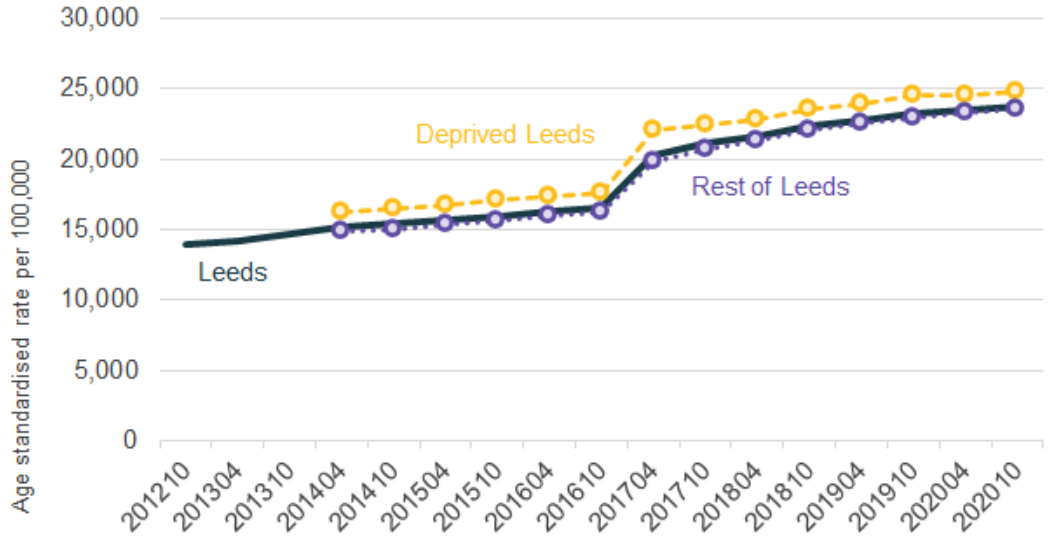


Source: Leeds PHI and GP data

Mental health

Table xx reflects the growth in mental health issues in recent years, across all communities in the city. The data is largely for the pre-pandemic period, and in-line with wider national evidence, the incidence of mental health issues has grown across all areas.

Figure 42: Common mental health issues prevalence (all ages)



Source: Leeds PHI and GP data

According to the most recent analysis by the ONS[17], the proportion of adults aged 18 and over reporting a clinically significant level of psychological distress increased from 21% in 2019 to 30% in April 2020, although rates have been 'up and down' in nature during the pandemic, coinciding with the periods of national lockdown and high Covid-19 cases followed by easing of lockdown and reducing cases. Key symptoms include anxiety, depressive symptoms, loneliness, sleep and stress.

However, the overall trends mask variations within the population. The analysis shows that the mental health and wellbeing impact of the Covid-19 has been different for different groups of people:

- Young adults and women have been more likely to report larger fluctuations in self-reported mental health and wellbeing than older adults and men.
- Older adults who were recommended to shield were more likely to report higher levels of depression, anxiety and loneliness.
- Adults with pre-existing mental health conditions also were more likely to have increase in mental health issues during the pandemic.
- Although there is less data available, Black, Asian and ethnic minority adults were more likely to report higher levels of depression and anxiety, with Bangladeshi and Pakistani men reporting the largest declines in mental health.

These mental health impacts are likely to continue as the economic impact of the pandemic manifest themselves, with concerns about job security and debt levels likely to increase.

[17] *Covid-19: mental health and wellbeing surveillance report, ONS June 2021.*

Policy implications

- The relationship between poverty and inequality, and poor health and wellbeing outcomes is well understood. The pandemic has exacerbated this negative correlation. Loosening the relationship will need to continue to be a primary focus of our combined efforts, from prevention and promotion/enabling of more healthy living, to tackling wider determinants such as employment, education, housing and the environment, and improving access to health and care.

- The proportion of people experiencing mental health issues increased during the pandemic, with some groups particularly affected such as: young adults and women; shielding older adults; adults with pre-existing mental health conditions, and Black, Asian and ethnic minority adults. This trend is set against a backdrop of an increasing recognition of wider mental health challenges, including loneliness and social isolation. Clearly it will be important to continue to focus on reducing mental health inequalities, improving mental health across all ages, and working to promote flexibility, integration and responsiveness in service provision.

- A common theme, across all sections of this report, is stronger integration of strategies and interventions aimed at both addressing key challenges, but also better realising opportunities. This is particularly true in promoting health and wellbeing, where those factors, often described as key determinants, influence options, choices and patterns of behaviour, which in turn shape health and wellbeing outcomes. Building on the collaborative strength of our Covid-19 response will be vital here, both between agencies and the third sector, but also within communities.

Section 3B: Living Well – Thriving Communities

Headlines

- The pandemic is likely to have intensified inequalities across the city and highlighted the very dynamic and multi-faceted challenges often seen in our most disadvantaged communities. The council and partners need to respond more collaboratively – particularly at each end of the age-spectrum.

- The pandemic has shown the best of Leeds communities with people supporting one another, but it has also highlighted some weaknesses in our community resilience and rising experiences of loneliness. How do we hold on to this stronger sense of neighbourliness to overcome underlying challenges?

- National estimates of 'relative poverty after housing costs' when applied to Leeds equate to almost 175,000 people living in relative poverty.

- More recently we have seen growth of in-work poverty, with an estimated 74,000 working age adults across the city being from working households and living in poverty.

- Over recent decades, there has been a fall in overall levels of crime, a trend that looked to be starting to level-off before the pandemic. During the peak Covid-19 restrictions there were significant reductions in crime. However, there are growing concerns regarding domestic violence and abuse during the pandemic, as well as incidences of anti-social behaviour in some localities.

- Up to 70,000 Leeds citizens have typically volunteered in the city each year, but numbers have dropped through the pandemic and confidence levels remain low in some communities.

Leeds is a growing and richly diverse city with people of different ages, backgrounds, cultures and beliefs living and working alongside each other. To build thriving communities we need strong local leadership rooted in partnership; we need to value and promote the voices of local people; we need to increase community conversations to resolve problems and conflict locally; and we need to continue to raise aspirations, creating better links to social and economic opportunities for everyone.

Thriving communities are resilient, aware of their challenges but also their strengths and assets, with strong community infrastructure and local people being more engaged and empowered to overcome their own challenges and reduce unnecessary dependence on public services. Never more so have we seen the strength and perseverance of our communities than over the last 18 months. The Covid-19 pandemic has brough real emotional and financial hardship to too many families, but it has also seen Leeds' community spirit come into its own – truly the compassionate city in action.

The pandemic threw a spotlight on stubborn and long-standing inequalities in the city, with data increasingly establishing a link between direct health impacts and deprivation, driven by a combination of underlying health conditions: including smoking, obesity and limited opportunities to follow healthy living; and exposure to the virus: for groups such as key workers, those unable to work from home, those in low income or multi-generational housing and those more reliant on public transport. Poverty is the common factor in both these drivers.

Socio-economic inequality

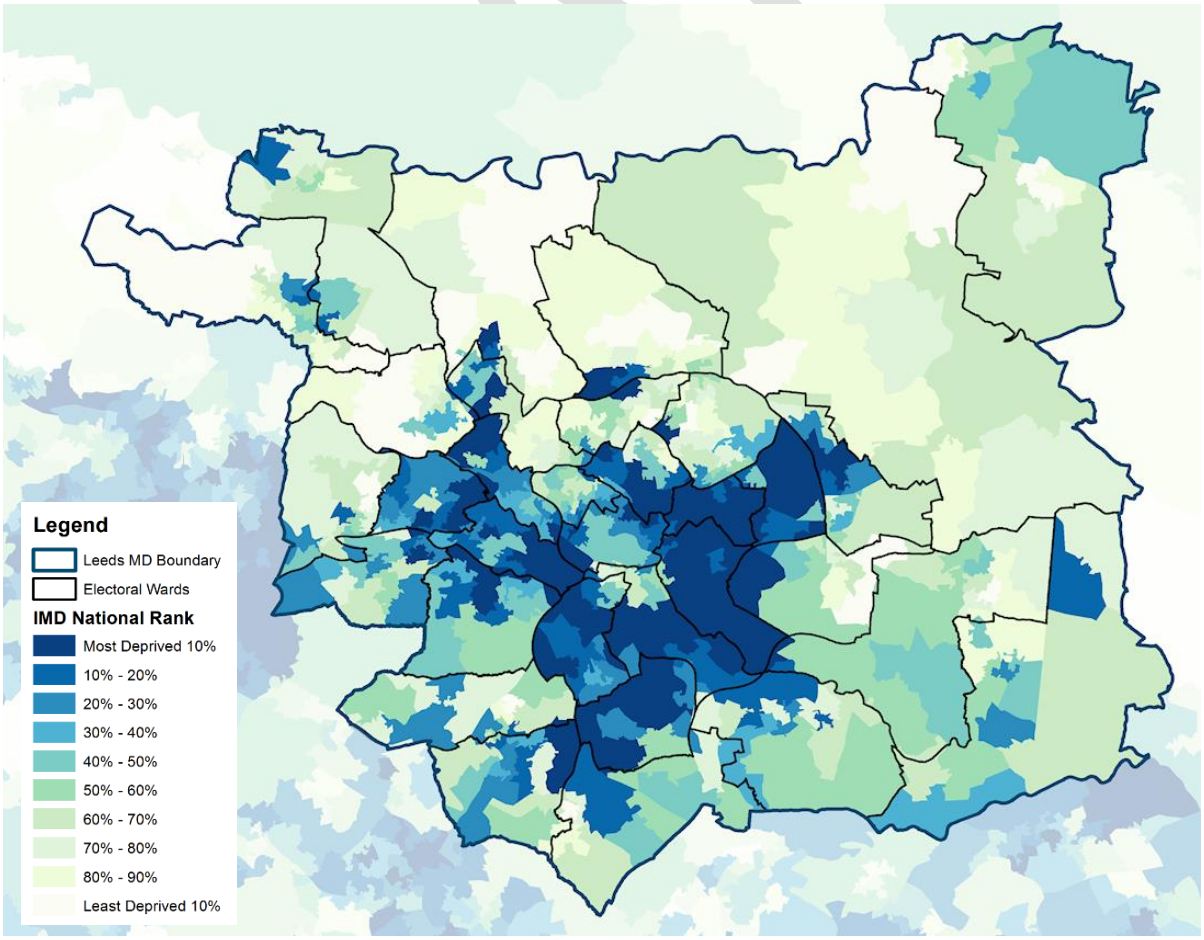
Leeds' diversity is reflected across all its communities and neighbourhoods, with a rich tapestry of cultures and identities being a strength of the city and a key part of its story over decades. There is diversity in the physical identity of Leeds neighbourhoods too, with the city's wider geography, industrial heritage and economic development influencing the sharp distinctions in housing mix and connectivity seen in different parts of the city.

This combination of factors – physical, societal, cultural and economic – also drives many of the stubborn underlying inequalities experienced in Leeds. Often these can be seen on both a geographical and individual or community-centred basis, both of which result in poorer health outcomes for some parts of the population. This is illustrated by the city's model for considering health inequalities contained within the Leeds Tackling Health Inequalities Toolkit.

Geography of inequality

The divergence of economic characteristics – driven in part by Leeds' geography – is arguably the most prominent factor in understanding inequality in the city and is perhaps more pronounced than in other core cities. Using IMD 2019 to illustrate the divergent economic wellbeing of the city highlights that although there are concentrations of relative deprivation, there are significant areas of the city which are relatively affluent.

Figure 43: Index of Multiple Deprivation 2019



Source: ONS – Indices of Deprivation 2019

Analysis across a range of indicators suggests that there was some slight intensification in the concentration of the most deprived and least deprived neighbourhoods across the city since the IMD 2015. However, the pattern of relative deprivation is long-established, with wider analysis of child poverty, educational attainment, health and wellbeing, housing and debt in the city also showing that the same areas are the focus of disadvantage and poverty in Leeds.

Communities of interest

Not all inequality or disadvantage can be seen through a geographical lens, however. This is perhaps most pertinent when examining health inequalities – the unfair and avoidable differences in health across the population, and between different groups in society. While there may be concentration of health inequality in some of the city's low income communities, individual factors remain crucial.

To support better understanding of the health needs of the whole Leeds population, specific assessments are undertaken for communities of interest – groups of people who share a particular identity or experience – more at risk of experiencing poorer health outcomes. Needs assessments have been undertaken for Black, Asian and ethnic minority people, Gypsies, Travellers and Roma groups, people who are pregnant, women and others – all of which can be found on the Leeds Observatory. An assessment of the needs of people with sensory impairment will follow in the coming months.

Throughout work compiling the JSA it has become evident further assessments may be required for more communities of interest, including but not limited to:

- Asylum seekers and refugees
    - There are no accurate figures on the total number of people seeking asylum or refugees living in Leeds. Approximately 850 asylum seekers are supported by the Home Office in Leeds at any one time, but Leeds Asylum Seekers Support Network (LASSN) advises based on their experience that this is far below the true size of this community in the city, with many no receiving support or accommodation from the Home Office. Third sector destitution services in Leeds work with at least 500 asylum seekers per year who receive no official support and therefore do not appear in Home Office figures.
    - The health needs of refugees and asylum seekers are well-documented[18], including untreated communicable diseases, poorly controlled chronic conditions, maternity care, and mental health and specialist support needs. In addition a sizeable minority continue to experience physical injuries and trauma from mistreatment and torture.
    - Asylum seekers and refugees can face additional barriers to accessing or receiving suitable health care as a result of language barriers, poverty, impact of existing trauma, or if they have no recourse to public funds in the UK.
- Sex workers
    - While there are no accurate local figures, there are estimate to be more than 70,000 sex workers in the UK[19]. Between 2014 and 2021 a 'managed approach' model had been in operation in part of Leeds to help meet specific challenges of street-based sex work, including the health and wellbeing of sex workers. This approach has now ended.

[18] *Unique health challenges for refugees and asylum seekers - Refugee and asylum seeker patient health toolkit - BMA*
[19] *Prostitution (parliament.uk)*

- Sex workers are at increased risk of ill-health, experiencing violence and substance misuse and can face additional barriers in accessing health care through fear or discrimination[20].

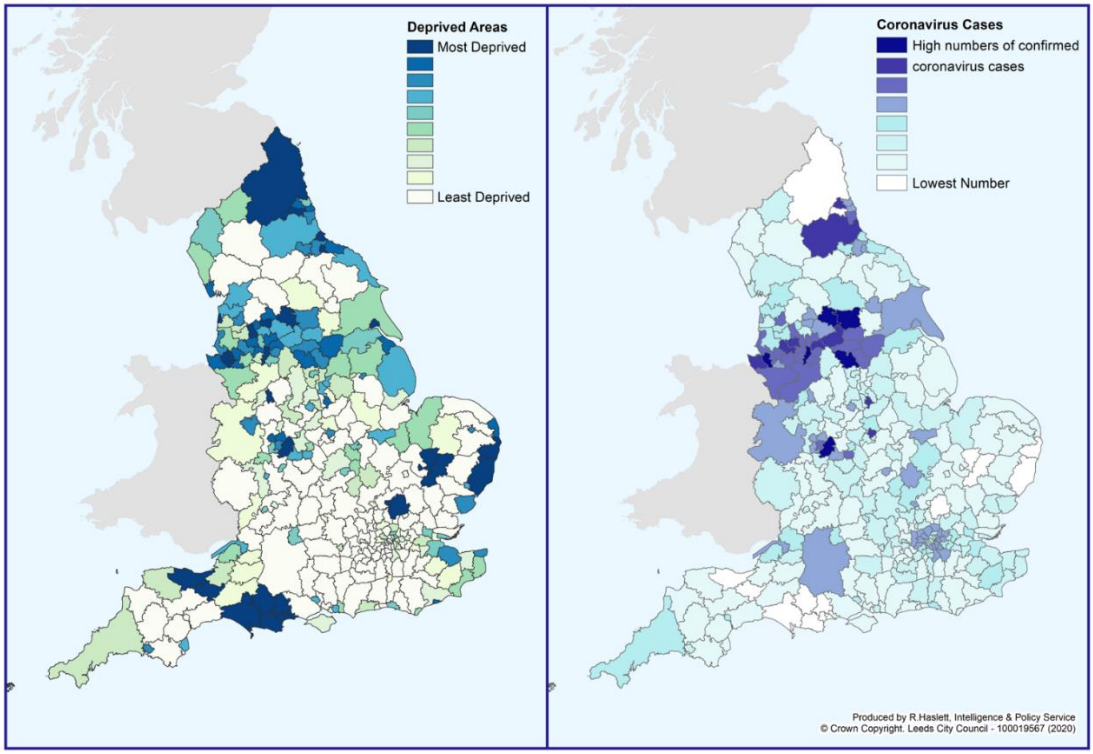
- People who are homeless or sleeping rough
  - According to MHCLG there were 1,523 households in Leeds either homeless or at risk of being so[21]. Through the Covid-19 pandemic the council provided emergency accommodation for over 1,000 people either sleeping rough or at risk of doing so.
  - Homeless people, especially those alone, are likely to have complex health needs including inter-related mental health, drug misuse and alcohol dependency challenges. They are also at increased risk of injury, pneumonia, tuberculosis, dental problems and hypothermia[22].

There may also be a need to expand further on a wider range of health needs for some population groups already partially considered, for example the LGBTQ+ community.

Poverty

Poverty underpins a range of poorer outcomes for people and families, a pattern we have seen exacerbated through the pandemic. Figure 44 illustrates the strong correlation between relative disadvantages and the impact of Covid-19 clearly, using the Index of Multiple Deprivation data from 2019, mapped against the rates of Covid-19 in local authority areas in the autumn of 2020.

Figure 44: Index of Multiple Deprivation 2019 and Total Covid-19 Cases Autumn 2020



Source: Indices of Multiple Deprivation (2019) and Leeds City Council (2021)

[20] Covid-19: Health needs of sex workers are being sidelined, warn agencies | The BMJ
[21] Statutory homelessness, local authority tables (MHCLG, July 2021)
[22] 22.7 HEALTH AND HOMELESSNESS_v08_WEB_0.PDF (local.gov.uk)

Poverty affects individuals, families and neighbourhoods in multiple ways, and it impacts people at different times in their lives. Child poverty is at the root of many poor outcomes for children, young people and their families. According to the latest poverty and child poverty figures released by the DWP in March 2021, for the period 2019/20, 36,500 children under 16 are in 'Relative Poverty before Housing Costs'[23], a rate of 24% in Leeds. Above the national rate of 19%, but similar to that of the rest of West Yorkshire, with the exception of Bradford, where the rate is 38%.

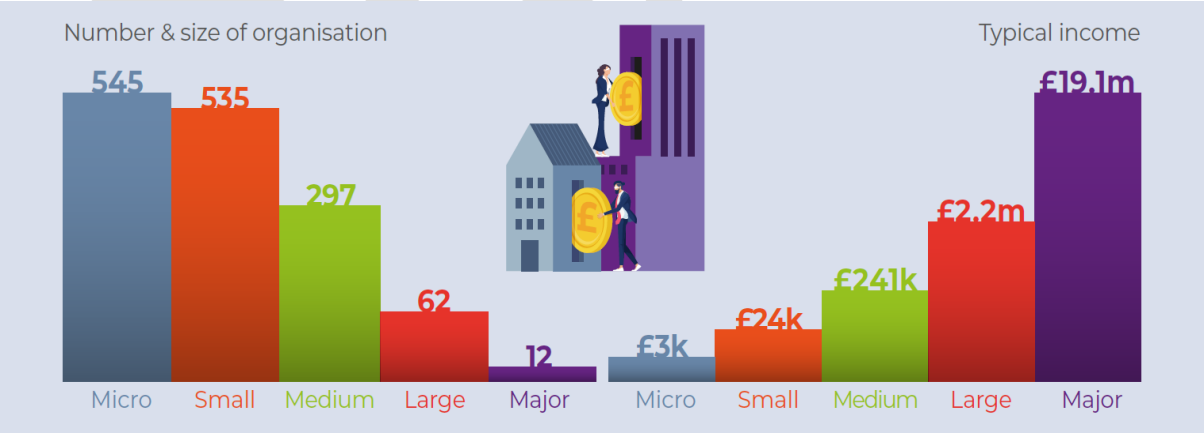
More broadly, taking the Government's national estimates for 'relative poverty after housing costs' and applying them to Leeds, a national average of 22% equates to almost 175,000 people living in relative poverty in Leeds.[24] In addition the Inclusive Growth analysis confirms growth of in-work poverty for some people in recent years, estimating that over 74,000 working age adults across the city are from working households and in poverty.[25]

Data from the Leeds Food Aid Network suggests that almost 42,000 people accessed a foodbank during the 2019/20 period, an increase of almost 24% on the previous year.[26] Fuel poverty levels have been reducing over time, the latest data from 2018 estimated that 10% of Leeds households were in fuel poverty (35,000 households), around 2,000 households fewer compared to the previous year. The city's rate follows the national average.[27]

Leeds' vibrant third sector

There are over 1,500 registered charities in Leeds and more than 2,000 other informal, emerging or un-constituted third sector organisations. In total almost 10,000 people work in the Leeds third sector, supported by volunteers estimated to number between 40,000 and 70,000. Around one third of the registered organisations are working directly in health and care related contexts, while more than three quarters have impacts related to the wider determinants of health[28].

Figure 45: Leeds Third Sector organisations by size and typical income



Source: Forum Central – State of the Leeds Third Sector (2021)

Many of the micro and small organisations operating in the city will have no paid employees, and few if any volunteers. They are often very local, community-based and run entirely by the trustees. Those involved in running organisations will very often have lived experience of the issues on which they're focused, representing a vast network of specialist expertise based in communities and perhaps often

[23] *Leeds Poverty Fact Book*
[24] *Relative and Absolute Poverty*
[25] *In work poverty*
[26] Food poverty
[27] Fuel poverty
[28] State of the Third Sector in Leeds (Forum Central, 2020)

being underutilised. These organisations are key elements of the community infrastructure on the ground in places across Leeds, although the pressure they face due to their limited capacity can make direct engagement with them by larger organisations or public bodies challenging.

Third sector organisations are the backbone of the city's asset-based approach to community development. Community Care Hubs, Neighbourhood Networks and ABCD Pathfinder organisations have all become embedded in their local areas are represent national best practice methods for involving and supporting citizens and communities, and all have been crucial to the city's response to Covid-19. Their presence in communities also develops and improves access to physical spaces for the benefit of the community.

Covid-19 has presented the Leeds third sector with significant challenges, responding to increased need in their communities and with fewer volunteers (71% of organisations in Leeds experiences a drop in volunteers during 2020) able to support their work. Their financial health has been hard hit too, with more than a third of organisations not expecting to be financially sustainable in the medium term[29].

Community resilience

In Leeds, we take an asset-based approach in our communities. We want communities to recognise and be connected to the things, people and places locally which can support them in their day-to-day lives, empowering individuals and communities to overcome challenges independently, resolve local conflict and support one another, reducing the need for top-down public service interventions.

Throughout Covid-19 we have seen great examples of community resilience with people coming together to look after their neighbours, distribute food, or act as virtual befrienders for people experiencing isolation. But we also know there has been a pandemic of loneliness, with associated impacts on mental health most significantly affecting younger age groups, people who are separated or divorced, and those already experiencing depression or greater emotion regulation difficulties[30].

There are three important pillars required for people to build up their independence and thereby collectively their local community resilience: having support from family; being an active participant in their community; and benefitting from friendship and social connection.

Family support

Not everyone has access to family support, and we've seen through the pandemic that living in a single person household can significantly increase the chances of feeling lonely[31]. Based on figures for Yorkshire and Humber, we can estimate that around 110,000 people in Leeds are living alone[32]. Figures are rising, the ONS estimates that by 2039 nearly 1 in 7 people will be living alone in the UK with people in middle age and older people most affected[33]. More than a quarter of women who live alone today are aged 45-64[34].

In the absence of family support, other social ties and community engagement become increasingly important.

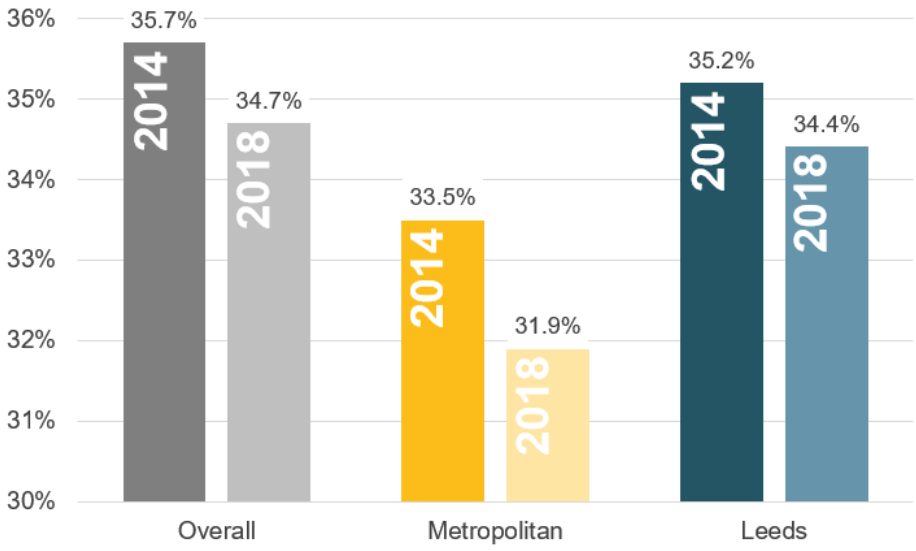
[29] 16-December-Leeds-Third-Sector-Resilience-Survey.pdf (doinggoodleeds.org.uk)
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7513993/
[31] ONS Opinions and Lifestyles Survey, April 2021
[32] Calculated from ONS Labour Force Survey – Households by size and region, 2015-2020
[33] The cost of living alone - Office for National Statistics (ons.gov.uk)
[34] The-State-of-Ageing-in-2019.pdf (ageing-better.org.uk)

Civic participation

People being actively engaged in the success of their local area is a good indicator of how connected they feel to their places, communities and the people around them. There are no reliable measures of civic participation for Leeds, so here we look two proxies – local election turnout and prosocial volunteering.

Voter turnout from the two most comparable recent local elections shows a slight reduction in Leeds from 35% in 2014 to 34% in 2018, similar to and following the trend across England and higher than the average across Metropolitan areas. Turnout dropped further in 2019 to 31%, however this took place alongside European Parliamentary elections that had not been expected to take place, which may have affected overall levels of confidence.

Figure 46: Total percentage election turnout at comparable local elections in England



Source: Leeds Data Mill and the Electoral Commission

The majority of third sector organisations in Leeds rely on volunteers and the expertise of their trustees to deliver their services, with very few organisations with incomes under £500k registering more than one full time equivalent employee. However, providing a more detailed understanding of the scale and value of volunteering activity is more challenging due to the wide variation of roles volunteers fulfil, and the fact that volunteering rates fluctuate. Forum Central estimate that in normal times there are between 40,000 and 70,000 people volunteering in Leeds each year[35] and other estimates include that 14% of adults in Leeds volunteered at least twice in 2018/19[36].

Throughout the pandemic volunteer rates have fallen with 35% of organisations not active with volunteers by May 2020. However, the picture is mixed with large number of new volunteers engaging, some for the first time, through new schemes being established to support pandemic response[37]. Restoring and growing previously established volunteering route and redirecting new volunteers into those routes is a shared policy challenge moving forward.

[35] *State of the Third Sector in Leeds (Forum Central, 2020)*
[36] *Active Lives Adults, November 2018-19*
[37] *Third Sector ResiliEnce in West Yorkshire & Harrogate (wyhpartnership.co.uk)*

Social connections

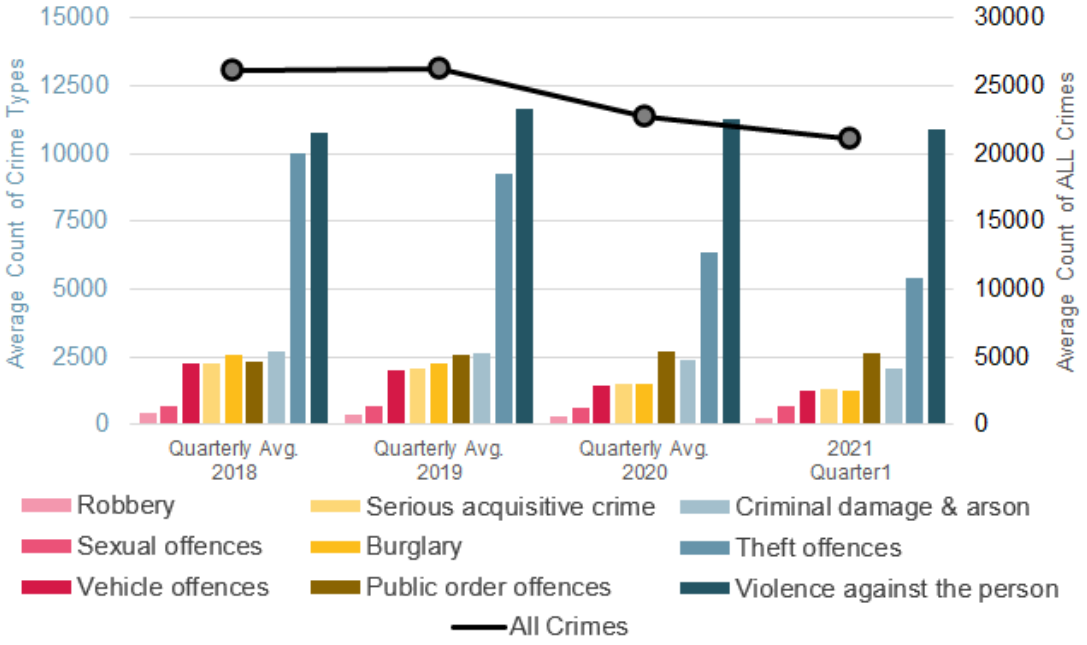
Good social connections are crucial to health and wellbeing, help to reduce loneliness, protect mental health, and encourage people to be more active in their daily lives. We have an ambition in Leeds for everyone to have good friends. Targeted interventions – like Linking Leeds social prescribing service – try to support better social connection for people across the city to improve health and wellbeing.

Our ability to measure social connections is very limited and seeking mechanisms to gain greater reliable insight on this issue should be an intelligence priority moving forward. The national Community Life Survey estimates 66% of people meet up with a family member or friend at least once a week, and 85% communicate by phone or video call. It also estimates that 93% of people have someone they can call if they want to socialise[38]. However, if we apply those figures to Leeds that leaves around 40,000 adults without a solid social network.

Safe communities

Making all our communities safe for everyone remains a central priority. The pandemic has both influenced patterns of crime and disorder, and people's perception of safety and security. However, the West Yorkshire Police and Crime Commissioner 'Your View' survey responses to March 2020[39] reported that 84% of Leeds respondents felt 'safe' or 'very safe' in their local area, with Leeds feedback was the second most positive within West Yorkshire area. Over recent decades, there has been a fall in overall levels of crime, a trend that looked to be starting to level-off before the pandemic.

Figure 47: Crime rates per quarter for Leeds, January 2018 to March 2021



Source: data.police.uk, 2021

Immediately following Covid-19 there were significant reductions in acquisitive crimes including robbery and burglary, and although they have gradually increased since crime rates remain lower that pre-pandemic levels.

[38] *DCMS Community Life Survey 2020/21*
[39] *Due to impacts of COVID pandemic, the OPCC survey has been put on hold since the March 2020 update*

Levels of violent and sexual crime initially reduced following Covid-19 lockdown, but soon returned to similar volumes as previous years after a few months. This category of crime is the highest recorded in Leeds, and crime rates are higher than both regional and national averages.

Levels of drug related offences have been slightly above previous year's following lockdown restrictions; this is partly due to proactive policing and increased visibility / reporting of drug dealing at times when street footfall was low. With on-line shopping and social engagement becoming more common during lockdown and restriction periods, there have been increases around on-line criminality, with emerging new approaches linked to health and delivery services being used in phishing emails and fraud.

Digital inclusion

The pandemic also highlighted the differentials in access to our increasingly digital world, both in terms of the tools and infrastructure, but also the skills required to exploit them, these differentials are another facet of the broader inequalities some communities, families and individuals face. The nature of the lockdowns we have experienced has seen the risk of people being cut off from vital public services increase, unable to access online consultations or support without external assistance. But furthermore, its seen people become disconnected from friends and family, increasing risks of isolation and leading to growing concern about safeguarding those who may be more vulnerable.

Lloyds Bank Consumer Digital Index 2021[40] shows that 30% of people in Yorkshire and the Humber have very low digital engagement, slightly higher than the national average. Applying these figures to Leeds would mean around 150,000 people who are completely offline or only using the internet in a very limited way.

Healthwatch Leeds[41] have identified eight factors which make people particularly likely to experience digital exclusion: poverty, age, literacy and communication preferences, skills and motivation, precarious lifestyles, privacy, disability and specific conditions, trust in IT. Broader factors such as the home environment can also make it difficult to find the space and safety to access healthcare, or to disclose needs to a medical professional securely[42].

Housing

Housing has a huge impact on a person's quality of life. Usually the largest monthly expense and therefore a definitive factor in financial security, the quality and suitability of homes is also a major driver of mental and physical health, and a crucial factor in the efforts of people working to overcome challenges in their life such as those relating to recovery from drug or alcohol abuse.

According to the 2017 Strategic Housing Market Assessment (SHMA), there are almost 350,000 dwellings in the city. The mix of housing tenure has changed significantly over the last two decades. The significant growth of the private rented sector is a key trend which brings with it associated challenges, particularly at the low cost end of the market where housing conditions can be poor. The SHMA estimates the private rented sector accounts for at least 20% of the housing stock.

The private-rented sector across Leeds is complex. In Harehills and Chapeltown, there is a concentration of private-rented houses with a significant number of transient, often migrant,

[40] 210513-lloyds-consumer-digital-index-2021-report.pdf (lloydsbank.com)
[41] Digitising-Leeds-Risks-and-Opportunities-For-Reducing-Health-Inequalities-in-Leeds.pdf (healthwatchleeds.co.uk)
[42] Digital-inclusion-report-October-2020.pdf (healthwatchleeds.co.uk)

households. In contrast the private rental market in Headingley, Hyde Park and adjacent areas has traditionally been driven by demand from student households, resulting in considerably higher rents. In the City Centre, the rapid growth in the numbers of apartments developed since 2001 has created a new private rental market attracting yet another range of occupiers.

Like most large cities, Leeds has a substantial amount of older housing, which tends to be concentrated in more deprived neighbourhoods. What sets Leeds apart from other places, though, is the large amount of back-to-back housing still in use across the city. Most of the 19,500 back-to-backs in Leeds are in the private-rented sector and were built before 1919. As a result, many of them are in poor condition, particularly in relation to their energy efficiency. The concentration of this type of housing, combined with the significant expansion of the private rented sector has a major impact on large areas of the inner city.

The imperative to provide enough suitable housing for the Leeds population has been brought into sharp focus by the Covid-19 pandemic. The city has had success providing emergency access accommodation to 1,018 people either sleeping rough or at risk of doing so through the Everyone In initiative, ensuring there is somewhere safe for them to shelter and self-isolate if necessary. While at this stage only a short-term measure this has been a life-saving intervention and presents a landmark opportunity to re-examine nationally how we support those rough sleeping.

Wider pressures on housing have been felt by a majority of people – whether that's through limited or no access to a garden or outdoor space during lockdown, a lack of suitable indoor space for home workers or children home-schooling, or vulnerability to Covid-19 caused by overcrowded living conditions especially in multi-generational households. Emerging from the pandemic there are early signs of changing demand in the housing market as people who can look to expand their living space following the lockdown experience. The longer-term effects of the pandemic on the housing market remain unclear but will at least in part depend upon wider economic forces and changing workplace practices.

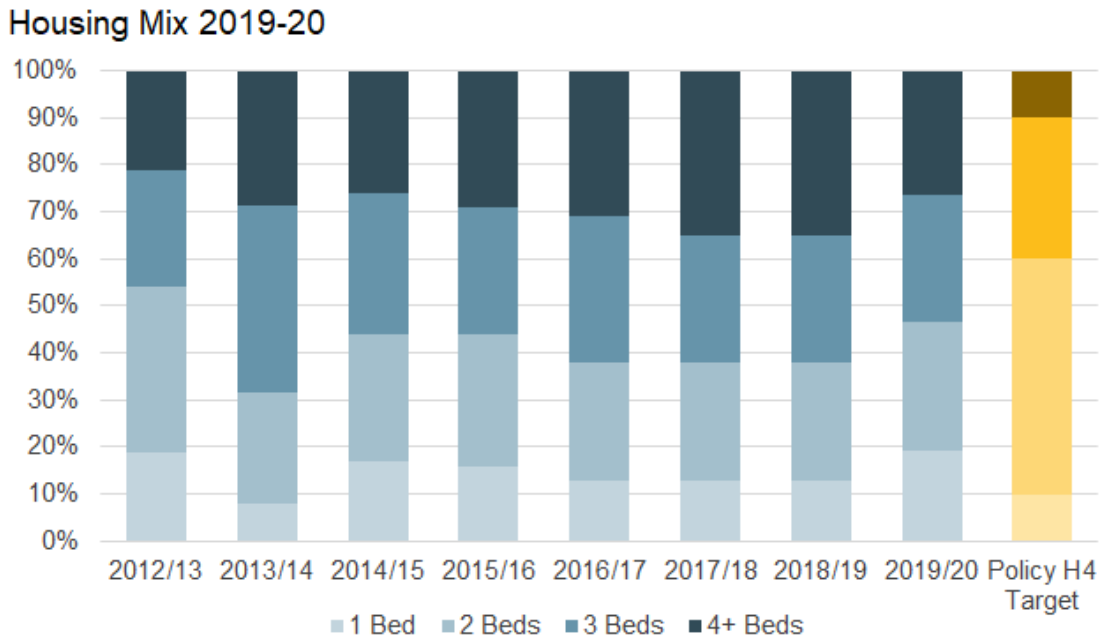
Housing delivery

Providing the new homes required in a large and growing city like Leeds is an ongoing challenge. Doing so sustainably and in a way which creates thriving communities even more so. Leeds continues to perform well overall, building a net 3,386 new homes in 2019/20 including 58 units for older people and exceeding the core strategy target for the year. These are positive delivery numbers and despite the pandemic we should remain optimistic about this continuing.

The mix of those new properties is important in creating sustainable communities, ensuring families are able to secure the size of property they require. In Leeds this means 80% of homes built should be either 2 (50%) or 3 (30%) bedroom, according to adopted core strategy targets.

There continues to be a housing mix challenge in the city with an over provision of 1 bedroom and 4+ bedroom homes and an under provision of 2 bedroom and 3 bedroom homes. This is in part driven by a high proportion of development taking place in the city centre, where 1 and 2 bed apartments are predominantly delivered including as part of student accommodation schemes. However, Figure 48 shows that even when city centre schemes are excluded the overall picture of housing mix remains challenging. In 2019/20 while there was a small reduction after four years of expansion in the growth rate of the city's largest homes, we still saw completion of 23% fewer 2 bedroom and 19% more 4+ bedroom units than targeted.

Figure 48: Housing Mix 2019/20 – proportion of all new housing by beds (excl. city centre schemes)



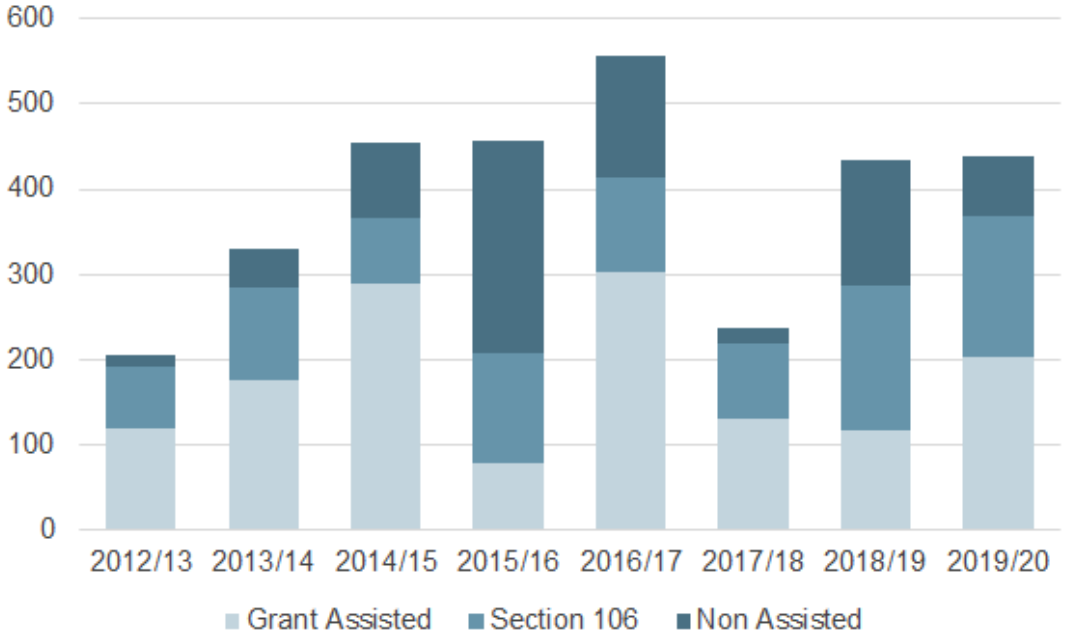
Source: Policy H4 Implementation Note (Leeds City Council, August 2020)

Affordable housing development

There were more affordable homes delivered in Leeds in 2019/20 than in the previous two years and with 439 completions, slightly more than the 434 expected annually. However, the overall target for the year was 1,200 homes as a result of an existing backlog of delivery which will continue to roll forward.

Part of this overall shortfall can be explained by the relatively poor contribution of Section 106 affordable units, caused largely by the proportion of student housing schemes within the completions as these do not require affordable housing. It is forecast that once more market housing is delivered, now supported by an adopted Site Allocations Plan, contributions from Section 106 will increase. We are also increasingly seeing examples of sites being delivered by partners with 100% affordable housing and we expect this to continue in future years.

Figure 49: Affordable housing units delivered in Leeds from 2012/13 to 2019/20



Source: Reported as part of MHCLG Local Authority Housing Statistics (Leeds City Council, 2021)

Housing costs

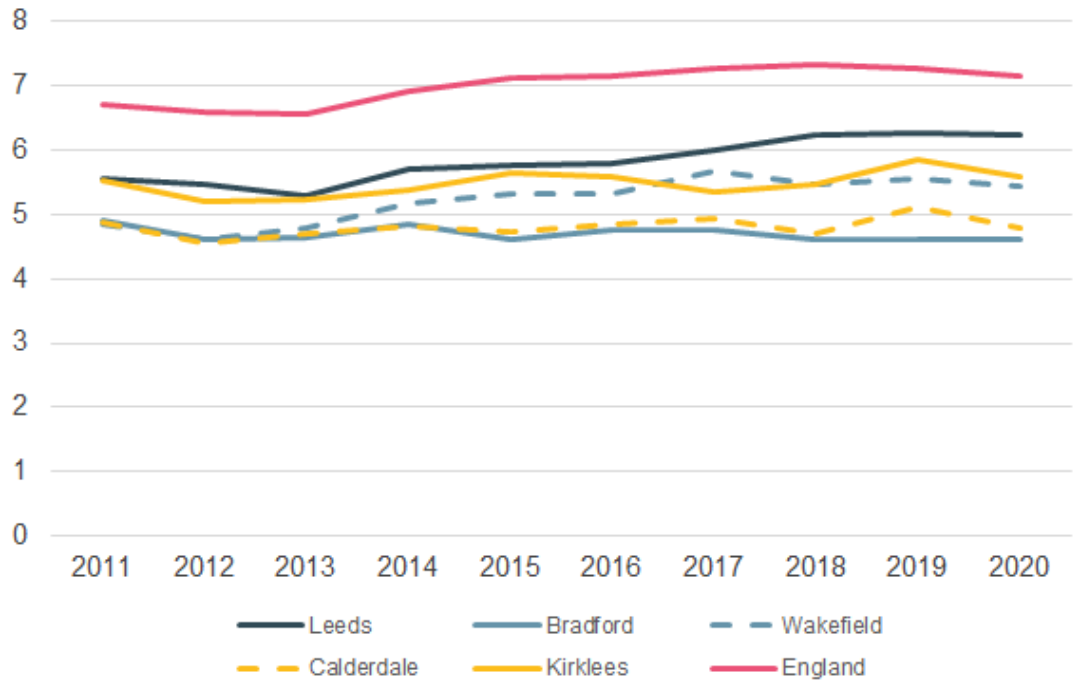
In most households housing costs are the single largest monthly expenditure and their affordability therefore has a significant impact on household financial security. On average private renters spend the highest proportion of their income on their housing costs, 33% in 2018/19. In the same year that compared to 27% for those in housing association homes, 26% for council tenants and 18% for those buying with a mortgage[43].

The affordability of housing is of growing importance with evidence suggesting there is a continuing, often growing gap between the income of families and individuals and the cost of housing, both in terms of access to mortgages and the cost of the rented sector. When looking at the affordability of housing for those with earnings in the lowest quartile annually (Figure 50**Error! Reference source not found.**), we see a long term upward trend in housing costs across Leeds as a multiple of earnings – from a recent low of 5.28x in 2013 to 6.25x in 2020.

While the affordability ratio is still well below the national average (skewed by higher housing costs in London and the South East) the gap is narrowing and we also see Leeds gradually diverging from the other West Yorkshire authorities, some of which have seen a broadly flat trend over the same period.

[43] Section 1 (publishing.service.gov.uk)

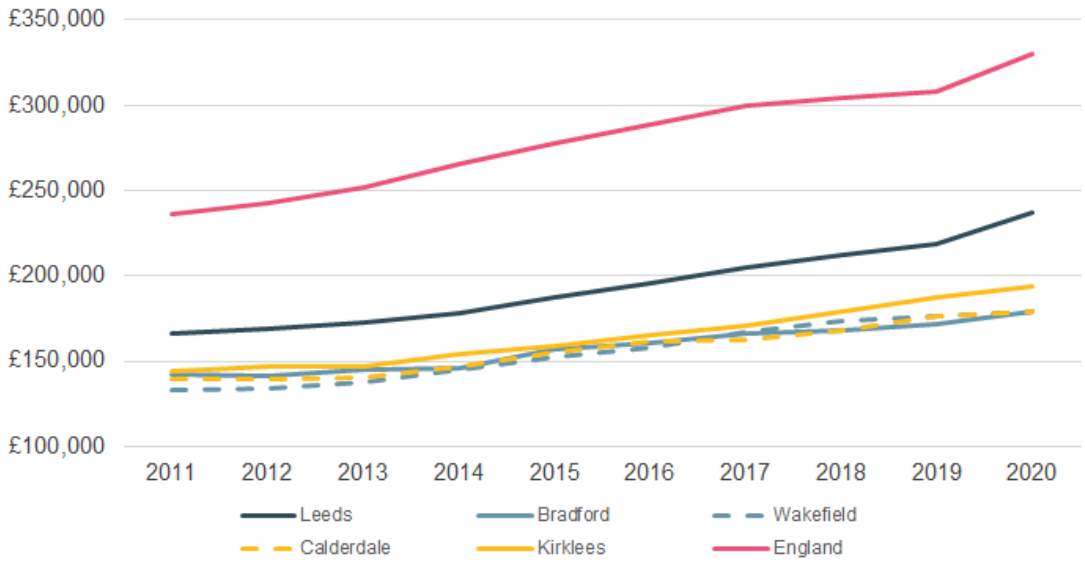
Figure 50: Ratio of lower quartile house price to lower quartile gross earnings



Source: House price to workplace-based earnings ratio (ONS, March 2021)

There is a similar picture when we look at overall house prices (Figure 51), with increases in Leeds closely tracking the England average while clearly remaining lower in absolute terms. The other West Yorkshire authorities have seen slower growth in house prices since 2019 and therefore there is a gradually widening gap in affordability across our region.

Figure 51: Average house prices in West Yorkshire and England, year-end 2011 – 2020



Source: Mean house prices for administrative geographies (ONS, June 2021)

In the rental market, housing costs in Leeds are also considerably higher than in our neighbouring authorities. Figure 52 demonstrates that for an average family seeking to rent a two-bedroom property today, they're facing roughly 23% higher costs than in Wakefield, 25% higher than in Bradford, 30% higher than in Calderdale and 31% higher than in Kirklees.

Figure 52: Median monthly rents (2020/21) for two-bedroom properties in West Yorkshire

Source: Private rental market summary statistics in England (ONS, June 2021)

The reasons underpinning this difference in affordability between Leeds and the other West Yorkshire authorities across all housing markets are complex and multi-faceted, but one likely contributor is the under provision of mid-sized properties across the city discussed earlier in this chapter. We had seen a local evidence over many years that the structure of the Leeds housing market can act as a barrier to upward progression for many families, with neighbouring districts such as Wakefield increasingly offering more affordable housing options within easy commute of workplaces in Leeds. We are likely to continue to see migration from Leeds to Wakefield and Bradford in particular along the M62 corridor as a result of these conditions. Longer-term impacts of insufficient affordable housing supply – both for purchase and rent – require further consideration, especially in terms of the impact on younger individuals and families seeking to get onto and then progress up the housing ladder in Leeds.

Policy implications

- The pandemic has highlighted the importance of community assets and personal connections in building community resilience and ability to respond to challenges, with the worsening mental health of people of all ages coming to the fore. Future policy will need to account for ensuring the sustainability of the city's third sector to support co-design of interventions, strengthen social infrastructure across the city, and bring people together to guard against the emerging rises in community tension often driven by national factors. Intergenerational activities are crucial in achieving this.

- Housing costs are continuing to rise and become unaffordable for low income families, exacerbated by a scarcity of the mid-sized homes sought by growing families and older people looking to downsize within their community. This continues to have knock on impacts for social mobility and risks locking more families into smaller, poorer quality housing at the lower end of the market with associated health, wellbeing and educational implications.

- The spatial concentration of older housing, particularly back-to-backs, much of it in poor condition, particularly in relation to their energy efficiency, combined with the significant expansion of the private rented sector has a major impact on large areas of the inner city.

- Leeds' rich diversity is a strength of the city, but it also reflects the different and changing needs of parts of the population. Future analysis and policy development should be more responsive to the circumstances of communities of interest as well as communities of geography and condition-specific considerations, to support efforts to overcome long-term, entrenched barriers to good health and wellbeing for everyone in Leeds.

Section 3C: Living Well - Climate Change

Headlines

- Climate change remains the single greatest threat to global health and Leeds is not immune from its impacts.

- Achieving net zero carbon ambitions will be incredibly challenging and efforts should focus on four fundamental issues for health: minimising air pollution, improving energy efficiency, promoting healthy and sustainable diets, and prioritising active travel.

- Covid-19 has had a significant impact on all modes of transport – public transport, active travel, car-usage – initial hopes of revolution are fading but could the pandemic period signpost to an alternative model?

- There is significant uncertainty regarding future habits and choices – linked in part to pandemic recovery, home-working and the potential changing geography of employment.

- The fundamental challenges around making a just transition towards a greener, more sustainable economy and society remain, with future fiscal environment, Government policy and patterns of consumer choice and behaviour all being key.

We are committed to making Leeds carbon neutral by 2030. We will do this by reducing the council's carbon footprint and helping other organisations and individuals to do likewise, by reducing pollution and improving air quality, by building sustainable infrastructure and promoting active travel, and by promoting a less wasteful low carbon economy.

Climate change can feel like an abstract concept to many people in Leeds, but on the ground its impacts are already being felt with more frequent flooding incidents and an increase in the number of very hot days threatening the wellbeing of citizens at both ends of the age spectrum. We want to be a city which is tackling poverty and inequality, and the negative effects of climate change and poor air quality tend to affect the already disadvantaged most both in Leeds and around the world.

The scale of the challenge we face is huge, requiring a long-term global effort which drives technological advances alongside structural change in our economy and society. Large cities like Leeds can play a key role in embracing this change in the context of Covid-19 recovery – creating green jobs and developing more sustainable systems of travel. In doing this, we will focus most on the factors highlighted by Sir Michael Marmot as having the greatest impact on population health and wellbeing: minimising air pollution, building energy efficient homes, promoting sustainable and healthy food, and prioritising active and safe transport[44].

Carbon emissions

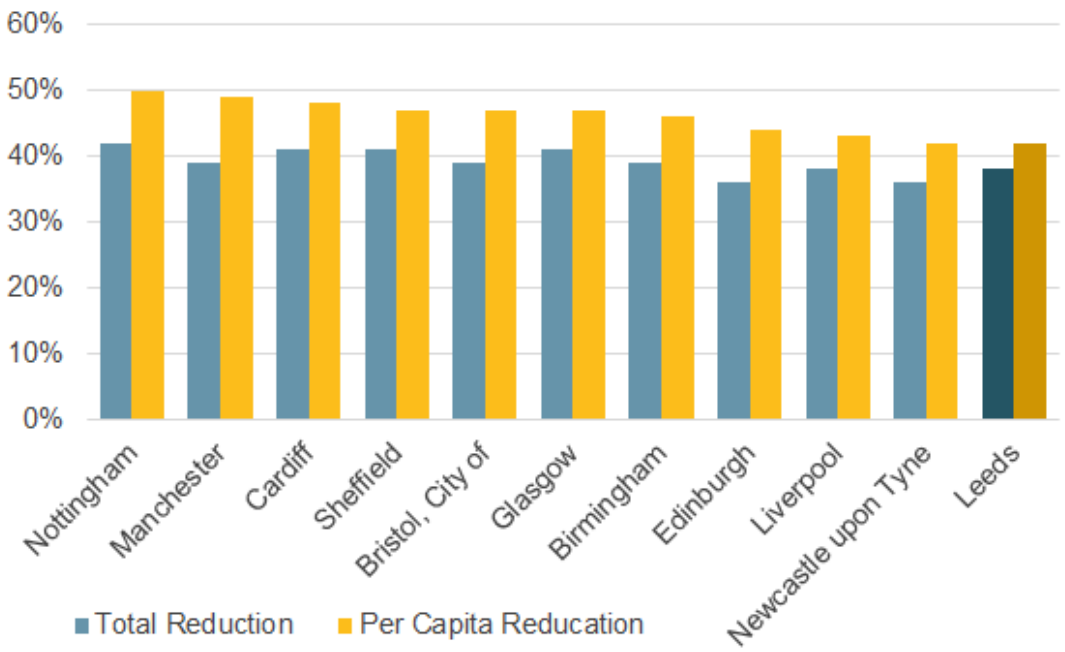
At the heart of our fight against climate change and its impacts is the imperative to limit increases in global average temperature to no more than 1.5 °C. Scientists estimate the world can emit no more than approx. 420 giga (i.e. billion) tonnes of greenhouse gases between 2018 and 2050. Leeds Climate

[44] main-report.pdf (instituteofhealthequity.org)

Commission has calculated Leeds's share of this on a per capita basis to be around 42 mega (i.e. million) tonnes – this therefore is the city's overall science-based 'carbon budget'.

Since 2005 all the UK Core Cities have reduced their overall carbon emissions by around 40%, with Leeds hovering very slightly below the average. On a per capita basis, accounting for population change, Nottingham and Manchester perform most strongly having halved their emissions (50% and 49% respectively). Leeds has performed slightly less well and along with Newcastle has reduced emissions per capita by the least amount, although the city has still achieved a 42% reduction. Leeds Climate Commission estimates this to be a cut from 6.8 mega tonnes to 3.95 mega tonnes.

Figure 53: Reduction in carbon emission for UK Core Cities, 2005 to 2018

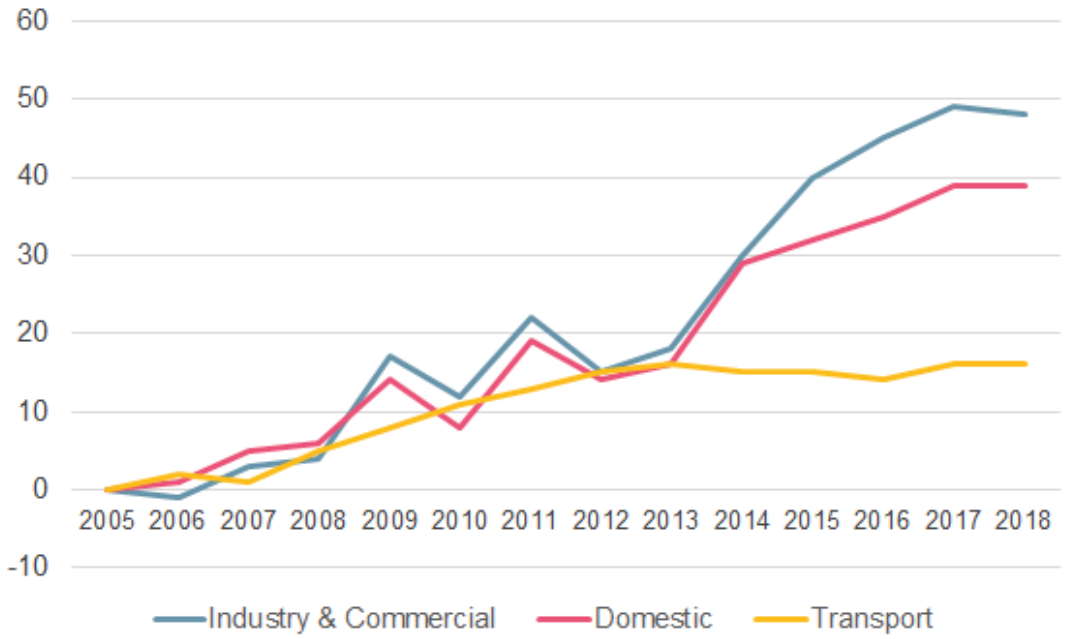


Source: Department for Business, Energy and Industrial Strategy

This suggests a much deeper and faster rate of emissions cuts are needed and have produced a roadmap containing five-yearly budgets. This shows a 70% cut relative to 2005 levels will be needed by 2025, rising to a 97% cut by 2040, to achieve a 100% cut by 2050[45]. Strong focus on transport will be needed to achieve this by overcoming the relatively flat progress Figure 54 shows over the last decade.

[45] Microsoft Word - Leeds Carbon Roadmap v4.docx (leedsclimate.org.uk)

Figure 54: Leeds CO2 savings by type and year, 2005 to 2018

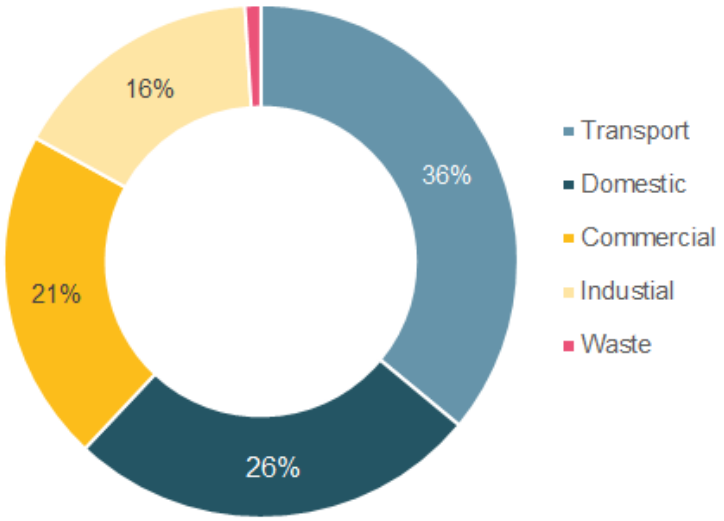


Source: Department for Business, Energy and Industrial Strategy

The council itself, as an anchor institution with a large workforce and broad responsibilities, is a significant contributor to the city's emissions. Key sources of the council's emissions include street lighting, buildings and fleet – including the large 'grey fleet' as a result of workforce travel. To support the city's climate ambitions, the council has already acquired the largest local government electric vehicle fleet in the UK, committed to halve the energy required for street lighting by transferring to LED and to replace gas in our city centre buildings with district heat.

However, given the scale of the challenge clearly the council acting alone – or even alongside other anchor institutions – won't be enough. Taking account of existing commitments, and working within the powers and resources currently available, we will not make sufficient progress to move the city to a net zero position by 2030. Figure 55 indicates the relative contributions to emissions of different sectors.

Figure 55: Sectoral contributions to CO2 emissions in Leeds in 2017

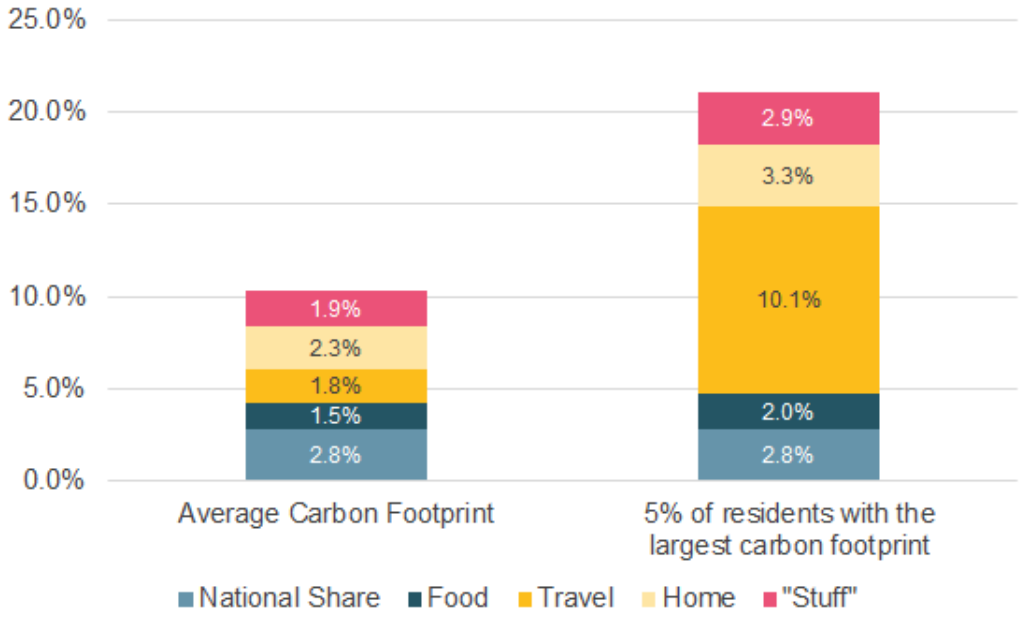


Source: Leeds Climate Emergency Update (Leeds City Council, January 2020)

Leeds City Council partnered with the World-Wide Fund for Nature (WWF) to better understand the average carbon footprint of residents. Based on data from 2100+ residents, it is estimated that the median carbon footprint of Leeds residents is approximately 10.1 tonnes of carbon dioxide equivalent (CO2e) every year whilst the mean is 11.38 tonnes. Both figures are significantly lower than the WWF's estimated 13.56 tonnes CO2e average.

Notably, one twentieth of Leeds' residents have a median annual carbon footprint double that of the average resident. More than 80% of this difference is related to emissions from travel.

Figure 56: Carbon footprint breakdown of residents with an LS postcode, according to WWF data (CO2e)



Source: Leeds Climate Emergency Update (Leeds City Council, January 2020)

Air quality

Air pollution is associated with a number of adverse health impacts. It is recognised as the top environmental risk to human health in the UK, and the fourth greatest threat to public health after cancer, heart disease and obesity. It makes us more susceptible to respiratory infections and other illnesses and often most affects the youngest and oldest in society, alongside those with existing heart and lung conditions. Those communities most affected by poor air quality often mirror those averaging the lowest incomes, thereby exacerbating existing health inequalities.

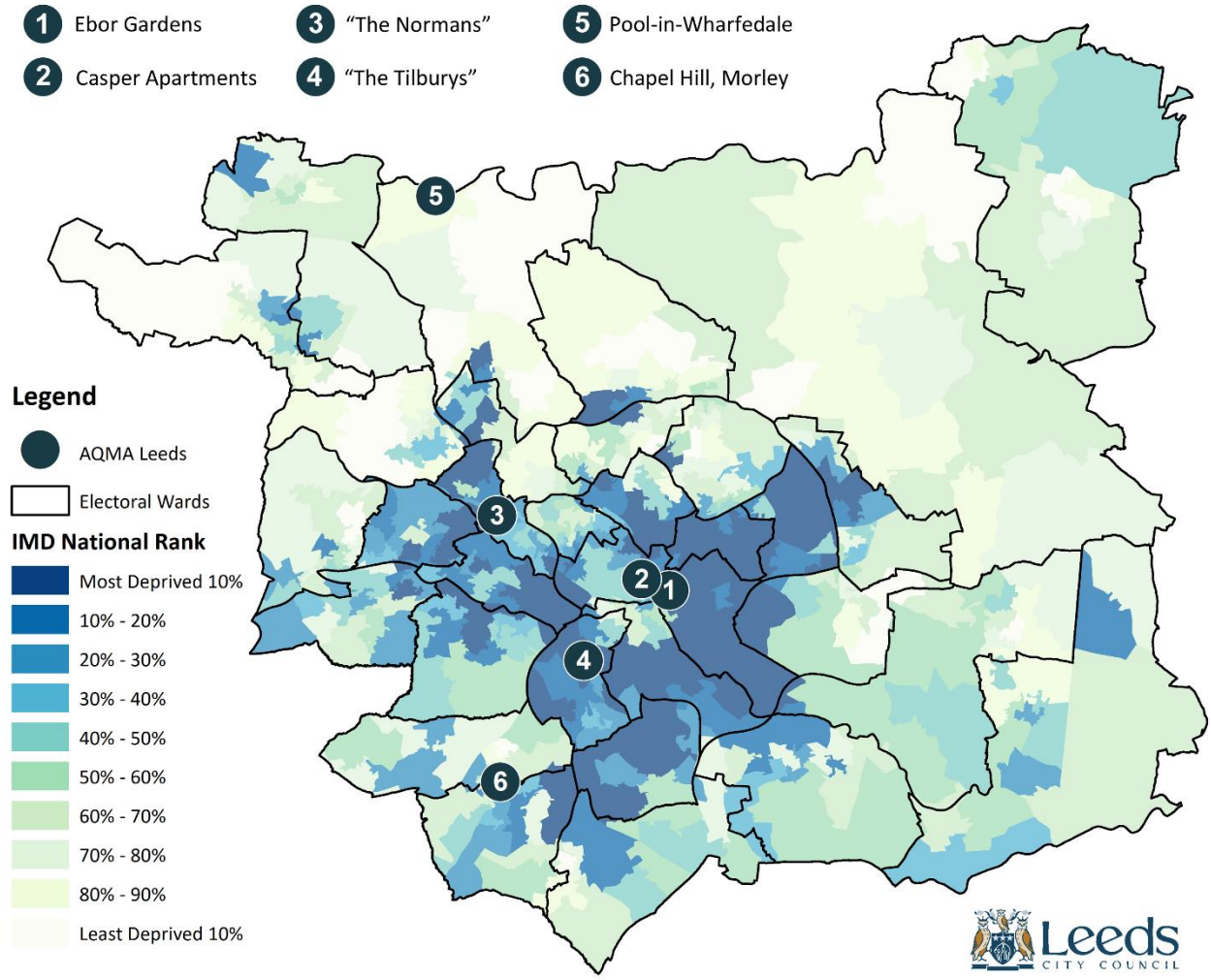
The annual health cost to society of the impacts of particulate matter alone in the UK is estimated to be around £16 billion[46]. It is estimated that up to 36,000 people die early every year as a result of long-term exposure to air pollution. In Leeds, exposure to particulate air pollution is estimated to cause 350 premature deaths annually.

Leeds has six designated Air Quality Management Areas (AQMAs) where levels of nitrogen dioxide (NO2) – mainly coming from vehicle emissions – are closely monitored due to historically high levels. Most of the AQMAs are located in communities with higher levels of deprivation according to the IMD, as shown in Figure 57. While long term trends show an ongoing improvement in air quality, Figure 58

[46] Abatement cost guidance for valuing changes in air quality (publishing.service.gov.uk)

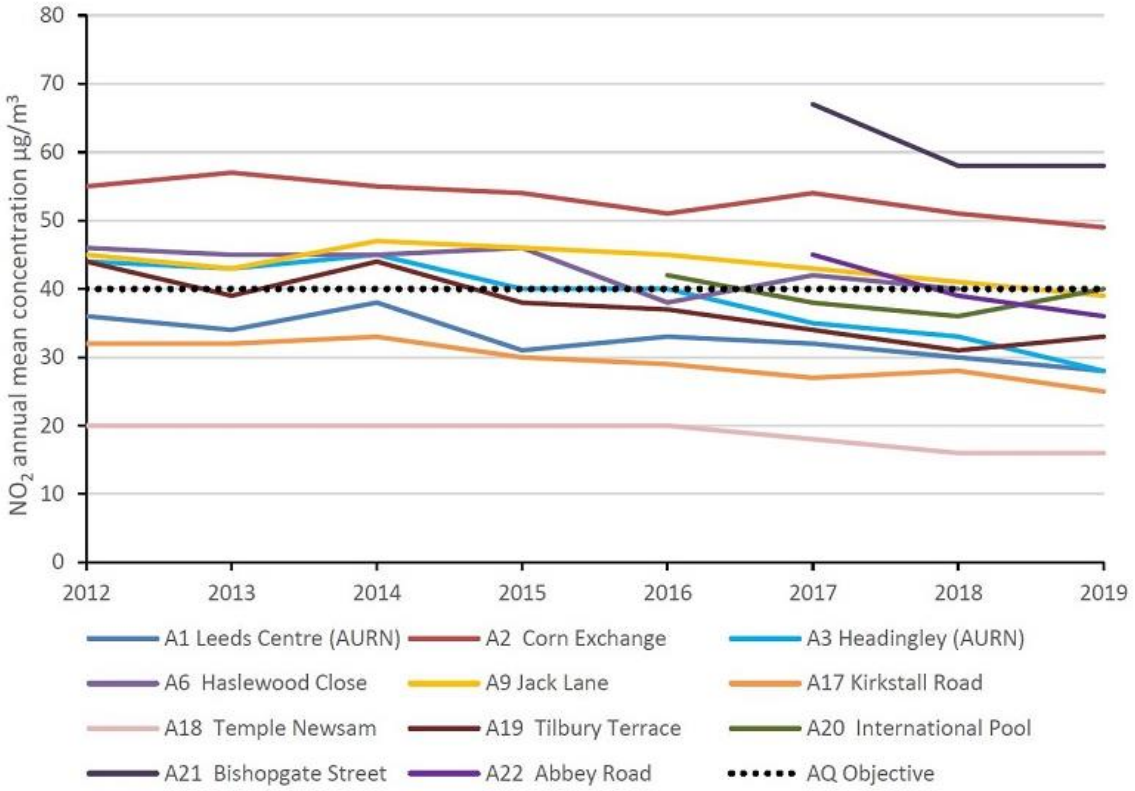
shows that in 2019 there are locations in the city centre, the inner ring road, and within the Pool in Wharfedale AQMA that remain above the annual mean air quality objective for NO2.

Figure 57: Leeds six Air Quality Management Areas compared to IMD national rankings in 2019



Source: Indices of Multiple Deprivation (2019) and Leeds City Council (2021)

Figure 58: Trends in NO2 Annual Mean Concentrations at Leeds Air Quality Stations

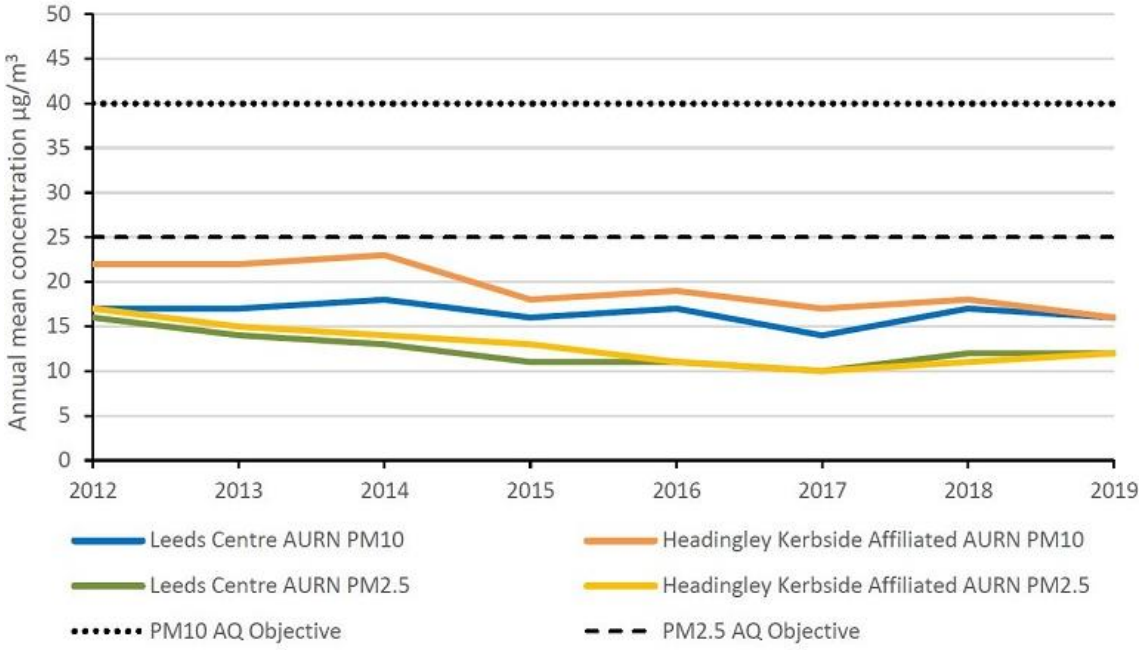


Source: Air Quality Annual Status Executive Summary (Leeds City Council, 2020)

Aside from NO2, the other main pollutants of concern are particulate matter (PM). Sources of PM which most increase public exposure come from road transport; diesel engines; tyre, brake and road surface wear; and the burning of solid fuel such as coal-based 'smokeless fuels' and wood. PM is also emitted from industrial combustion plants and public power generation, and some non-combustion processes such as quarrying. Natural sources can include airborne dust and sea salt from vast distances away.

Monitored levels of particulate matter, both PM10 and PM2.5 are well within UK air quality objectives and are close to the more stringent World Health Organisation guideline levels.

Figure 59: Trends in PM10 and PM2.5 Annual Mean Concentrations at Leeds Centre AURN and Headingley Kerbside AURN sites



Source: Air Quality Annual Status Executive Summary (Leeds City Council, 2020)

Energy efficiency and fuel poverty

Poor energy efficiency increases the demand for fuel, leading to higher household costs and exacerbating the challenge we face to decarbonise the heat network. This in turn increases the likelihood of households falling into fuel poverty, unable to afford the costs of maintaining a warm home.

The links between poor housing, low energy efficiency, fuel poverty and ill health are well established. Cold homes exacerbate problems associated with cardiovascular illness and the onset of stroke or heart attacks, while damp and poorly ventilated homes are associated with a range of respiratory and allergic conditions such as bronchitis, pneumonia, and asthma. Cold homes may also impact on conditions such as rheumatism or arthritis and adversely affect people with poor mobility, increasing the risk of falls and other household accidents. Living in a cold, damp and poorly ventilated home affects mental health – compounded by anxiety about high bills and fuel debt – and is likely to negatively impact the educational attainment of children and young people.

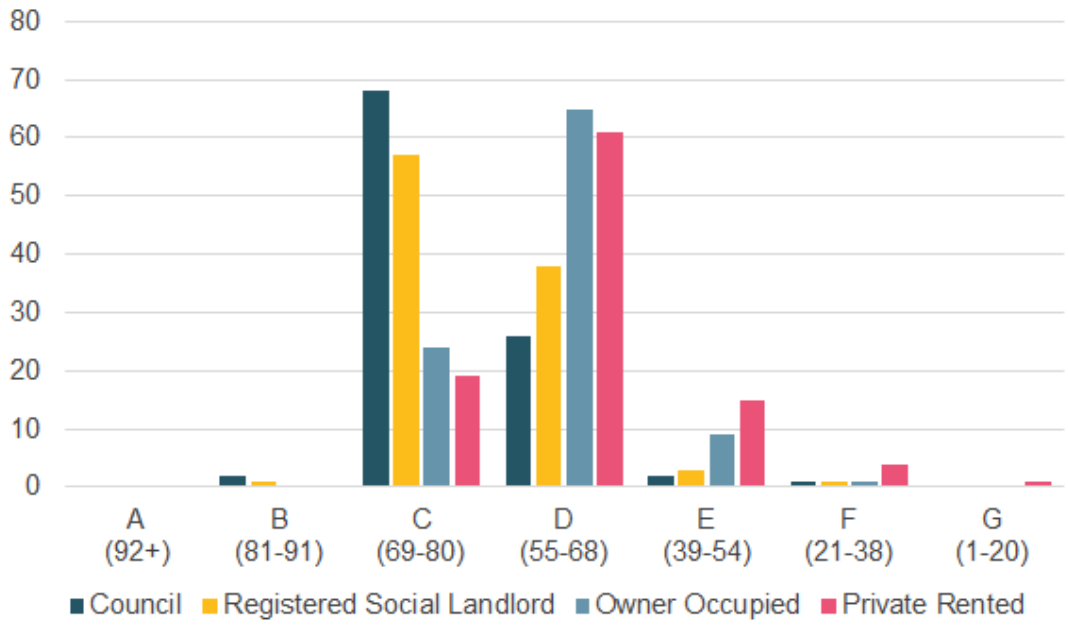
In 2019, 57,529 Leeds households were considered to be in fuel poverty – 17% of all households and a significant increase from 10% in 2018 and 11% in 2017. Whereas the city had closely tracked the national average in the two previous years, the 2019 figures show fuel poverty notably higher in Leeds than the 13% of households nationally[47].

The council's own housing stock, which represents around 16% of the city's total housing, has an energy efficiency rating of C compare to D for housing overall in Leeds. Using the government's Standard Assessment Procedure (SAP) methodology, which is based on the energy costs for heating, hot water, ventilation and lighting minus any savings from installed renewable energy systems like

[47] *Leeds Observatory Data Explorer, Department for Business, Energy and Industrial Strategy, June 2021*

solar panels, Leeds council housing has a higher average rating than owner occupied, privately rented and registered social landlord housing in the city.

Figure 60: SAP rating by tenure for Leeds households in 2018



Source: Calculated using data from MHCLG (Leeds City Council, 2019)

While council housing in the city performs relatively well, privately rented homes are frequently the least efficient of all. The growth of the private rented sector in Leeds has exacerbated these challenges, particularly at the low-cost end of the market where housing conditions generally can be poor. There remains a significant policy for Leeds about how to improve conditions in the city's 19,500 back-to-backs built before 1919, most of which are in the low-cost private rented sector.

Food

The European Commission's Joint Research Centre (JRC) estimates more than a third (34%) of all man-made greenhouse gas emissions are generated by food systems[48]. Yet despite the environmental cost of food production and transportation, increasing numbers of families in Leeds are experiencing food insecurity. While food insecurity in Leeds has been worsening over the last decade, the Covid-19 pandemic has brought this into sharp focus with 63,000 emergency food bags being distributed in the first 6 months of the pandemic.

New research from the University of Sheffield suggests that in January 2021 almost 3% of adults in Leeds experienced hunger because they did not have enough to eat. A further 12% of adults struggled to put food on the table, while 8% were worried about having enough food[49]. Across all three metrics rates of food insecurity were considerably higher in Leeds' neighbouring authorities and in some other Core Cities, although the nature of Leeds' geographical boundaries may be masking the comparative severity of the issue in inner city and low-income communities.

While strong voluntary and community sector presence, along with the council's own involvement, means we have a good anecdotal picture of food insecurity and related issues in Leeds, obtaining

[48] EDGAR-FOOD: the first global food emission inventory | EU Science Hub (europa.eu)
[49] New map shows where millions of UK residents struggle to access food | News | The University of Sheffield

accurate and reliable data remains challenging. Strengthening the local research and intelligence base on this issue will continue to be a policy priority in the coming years.

Transport

Promoting walking, cycling and other forms of sustainable travel has a direct impact on the health and wellbeing of people in Leeds by encouraging healthy active lifestyles, and an indirect impact by reducing the emissions and poor air quality caused by vehicle exhaust fumes. Encouraging more people to leave their car at home more often will be one of the biggest contributors to achieving our net zero ambitions.

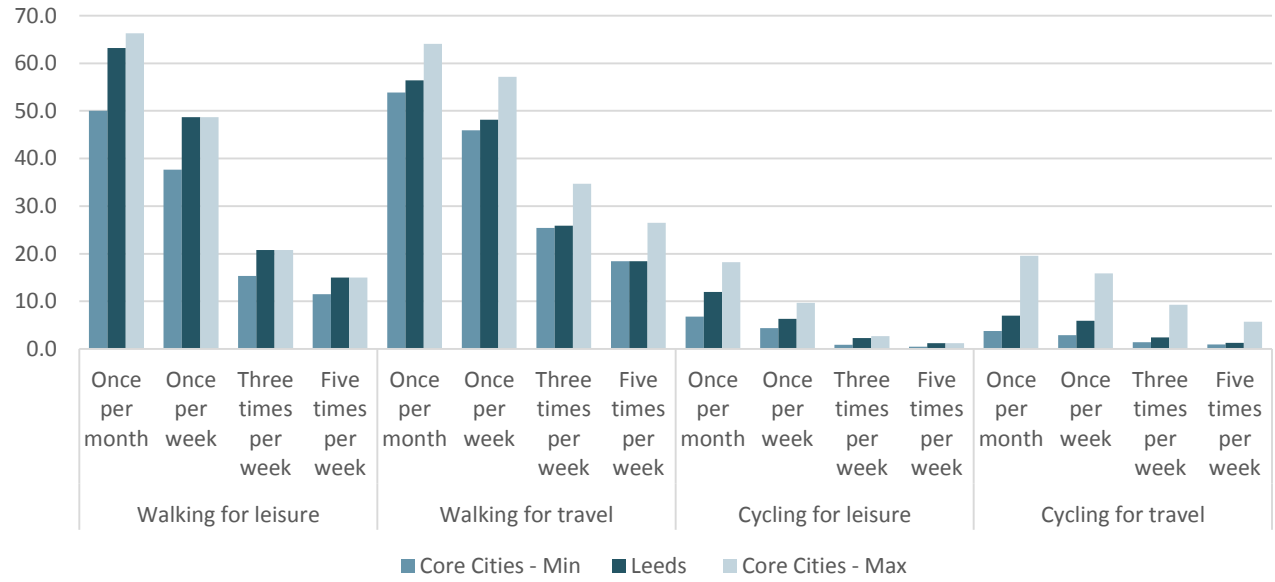
Leeds's legacy as 'motorway city' casts a long shadow but in more recent years there has been significant investment into active travel infrastructure, Leeds Station and other rail infrastructure, park and ride, and pedestrianisation of large parts of the city centre with more to come. All of this is contributing to a healthier, more liveable and sustainable city.

We want to see over-reliance on private cars become a thing of the past as we aim to move people onto the lowest polluting and most sustainable form of transport possible for each journey taken. With 79% of total distance travelled in West Yorkshire being by car, there is more work to do.

Walking and cycling

Walking levels by adults in Leeds are relatively high when compared with the UK's Core Cities. Over the 3-year Sport England 'active survey' period 2016-19, Leeds ranked within the top 5 metropolitan authorities for all walking and the top 6 for walking for travel purposes. This is an improvement from the previous three years reflecting a rise in walking across all frequencies for both leisure and travel.

Figure 61: Leeds and Min/Max Core Cities - walking and cycling frequency 2018-19



Source: Department for Transport/Sport England Active Lives Survey 2019

Although Leeds ranks highest in West Yorkshire for cycling by adults it is lower in the Core Cities ranking. 14% of adults cycle at least monthly, while just 3% cycle five or more times per week.

Compared with the previous three-year period, cycling levels have risen slightly, linked to increased cycling for travel, while leisure cycling has remained unchanged.

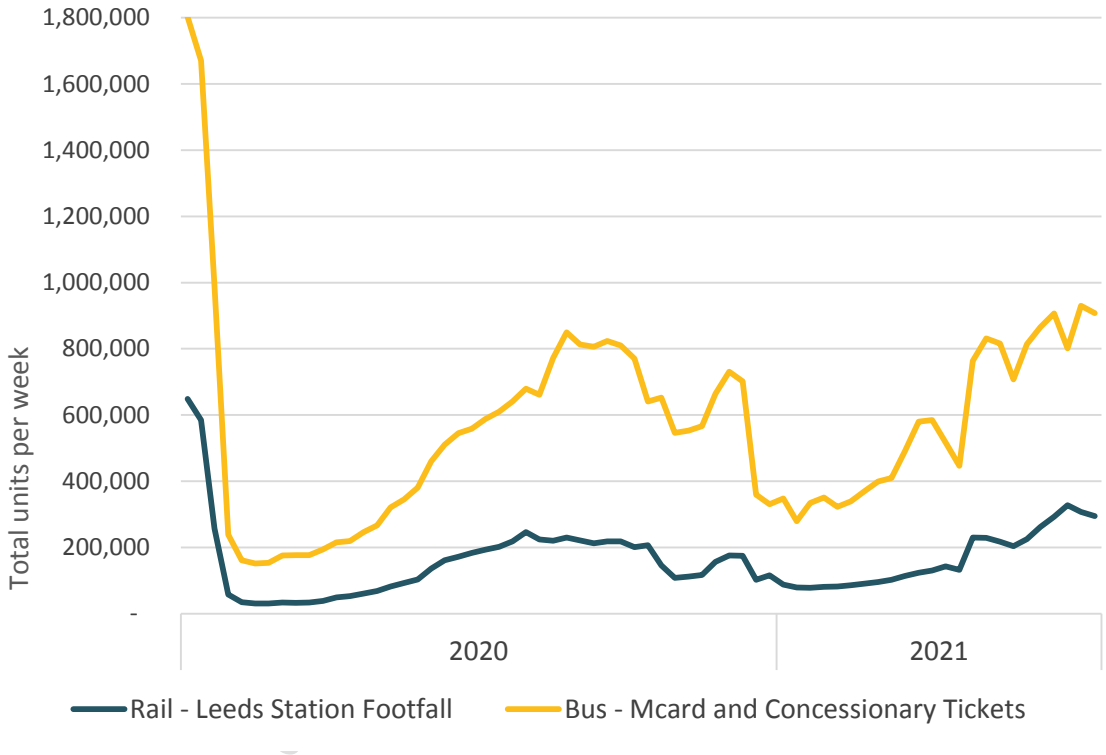
Public transport

As well as providing vital connection for communities and workplaces, public transport can also have great benefits for reducing emissions. Journeys taken by rail and bus not only take cars off the road, they also reduce congestion. As the public transport fleet across the city continues to become greener, with wider use of fully electric vehicles the primary route for this, these benefits will continue to grow.

Recovering and then further growing usage of public transport will be a major public policy challenge of the coming months and years, following unprecedented reductions through the Covid-19 pandemic.

Figure 62 shows bus and rail usage in the city since March 2019. The severe drop off was due to the first national lockdown, and although usage has risen since, it is still well below pre-Covid levels.

Figure 62: Weekly footfall at Leeds Station and Purchase of MCard and Concessionary Bus Tickets



Source: West Yorkshire Combined Authority, 2021

What's clear above is that throughout the pandemic we have consistently seen bus usage recover faster than rail usage. While there is as yet no hard evidence to explain the reasons behind this, we might look to the average user of each form of transport and the ability of people to work from home. Bus usage is often driven by necessity for people with lower incomes, and likely less able to work from home, requiring transport to work or education. The relatively higher cost of rail travel dictates the average train user comes from a relatively higher socio-economic background[50], and is more likely to have spent the Covid-19 pandemic working from home.

[50] Transport and inequality (publishing.service.gov.uk)

Further study of trends as we exit the pandemic will be required to inform future public transport policy discussions.

Access to green space

Parks and green spaces play a role in mitigating climate change by directly helping to reduce carbon dioxide in the atmosphere, reduce the effects of extreme weather events, and build more resilient habitats to help sustain species and food production.

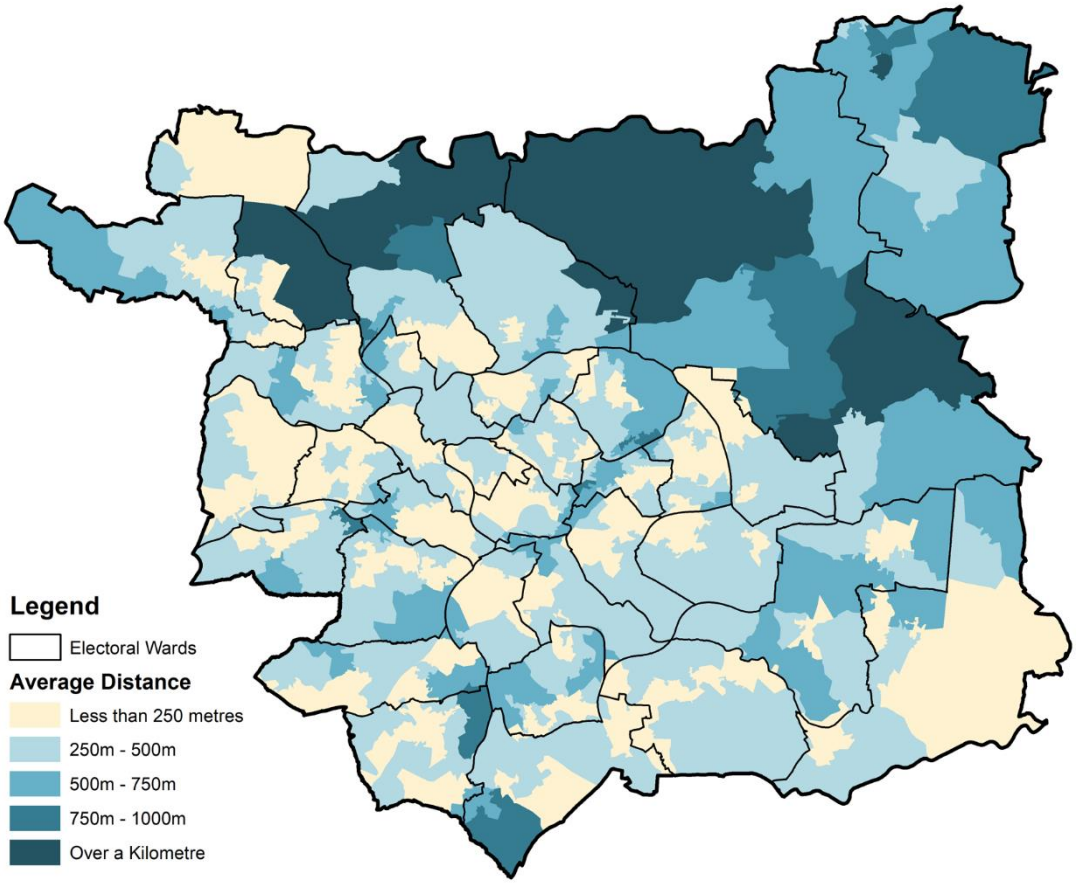
Access to green space is also well evidenced to be associated with positive mental health outcomes, including reduced levels of depression, anxiety and fatigue at all stages of the life course[51]. Fields in Trust found that parks and green space save the NHS an estimated £111m per year based solely on reduced GP visits[52]. However, the benefits are not shared equally as across England low income communities have less available quality public green space with negative health implications for the people who live there.

Leeds has 4,000 hectares of green space including 70 public parks (7 major city parks and 63 local community parks). Leeds parks and green spaces are well visited; research by University of Leeds in 2016 found 91% of residents surveyed had visited a park within the preceding year, with an estimated 45 million adult visits to all Leeds parks and green spaces that year[53]. The main reasons given for visiting a park were closely related to mental and physical health benefits: fresh air, walking, nature and wildlife, to relax and think. Leeds parks are generally seen as very accessible – 96% of people felt their main park is easy or very easy to get to, and 69% visit the park closest to where they live. However, people over 75 or with a disability were significantly less likely to visit a park or green space.

Figure 63 shows a generally positive picture in terms of the accessibility of parks and public green space to communities across Leeds, with most of the city being within 500m and longer distances being largely limited to the outermost areas of the Leeds boundary. There are however fewer accessible public green spaces to some of the lowest income inner-city communities, posing a challenge about how green space is contribution the city's ambition to "improve the health of the poorest fastest".

[51] Improving access to greenspace: 2020 review (publishing.service.gov.uk)
[52] Revaluing-Parks-and-Green-Spaces-Summary.pdf (fieldsintrust.org)
[53] LEEDS PARKS SURVEY: FULL REPORT

Figure 63: Average distance to nearest park, public garden or playing field



Source: Ordnance Survey Open Greenspace

A similar picture emerges when examining access to private gardens. While 85% of properties in Leeds have a garden (96% of houses and 53% of flats), the rates significantly reduce in lower income MSOAs[54].

Policy implications

- Leeds has set a very challenging net zero carbon target in recognition of the contribution the city should make to tackling climate change. While progress has been made, it is clear that to move towards the target bolder and more wide-ranging interventions would need to be developed in the coming years, with the local authority, health system and other anchor organisations carrying responsibility as major contributors to overall emissions.

- Public transport usage reduced to very low levels due to Covid-19 and while it has started to recover, passenger numbers remain far lower than pre-pandemic. Recovery rates are not uniform, with rail usage recovery lagging behind bus usage. Further analysis over the coming months is required to inform future policy decisions, balancing current and future demand for public transport alongside climate change and the need to reduce use of private cars.

- The analysis highlights areas that might be prioritised in efforts to embrace the just transition to a green economy and to create green jobs while tackling long standing social challenges

[54] Access to gardens and public green space in Great Britain - ONS, April 2020

affecting the health and wellbeing of low income families – including reducing fuel poverty by improving energy efficiency, further enhancing access to green space, and over the longer term building a more sustainable food system for the city and wider region.

Section 4: Working Well - Inclusive Growth

Headlines

- Covid-19 has had obvious impacts on the city's economy and labour market. The pandemic exacerbated the inequalities within our communities and had immediate economic consequences with the rapid expansion of home-working and acute impacts on hospitality, retail, local consumer services.

- The repercussions of these factors were felt in the first instance by young people and low earners with knock-on consequences for family debt. Women have also been disproportionately impacted as the often dominate employment in the sectors hardest hit.

- However, the city has strong foundations from which to recover, based on the economic growth and expansion over the last two decades with a diverse, knowledge-based economy, though longer-term concerns regarding low productivity and the nature of recent job growth remain.

- An estimated 413,000 people work in Leeds, of which around three quarters work in the private sector, making Leeds one of the top cities nationally in terms of its private sector workforce. Strong employment growth, pre-pandemic, has maintained the city's employment rate above national and regional averages.

- As the economy recovers, Leeds is likely to continue be the main driver of economic growth for the city-region, with a strong, diverse and knowledge-rich employment base. These strengths, linked to the city's universities and teaching hospitals, are major innovation assets for Leeds. Leeds also performs well in terms of business start-ups, with strong growth in digital and medical technologies, telecoms and creative industries.

- Despite our high levels of employment and doing relatively well in terms of productivity per worker, economic output growth has only been mid-table amongst the core cities in recent years. This could be due to recent employment and output growth being in 'lower productivity' sectors e.g. consumer services.

- There continues to be strong growth in quality jobs associated with digital, health and social care, and professional and managerial roles.

Economic impact of Covid-19

Covid-19 has had profound and immediate impacts on the city's economy and labour market. The pandemic has shone a spotlight on the inequalities within our communities. Prior to Covid-19, tackling these inequalities was central to our approach, our approach to recovery is still guided by our ambitions for a strong economy, a compassionate city, and zero carbon, with tackling poverty and inequalities as the overriding priority.

The city has strong foundations from which to recover, experiencing economic growth and expansion over the last two decades with a diverse economy, with strengths in key sectors and a concentration of knowledge-based jobs. However, immediately pre-Covid-19, like other core cities, there were some

concerns regarding low productivity and that many of the new jobs being created being in relatively low-skilled, low-paid work in consumer services.

The pandemic has had some immediate and obvious effects, with restrictions resulting in an overnight adoption of home-working and a severe impact on hospitality, retail, local consumer services. The city centre saw a major reduction in footfall. The consequences of these factors were felt in the first instance by young people and low earners with knock-on consequences for family debt. Women have also been disproportionately impacted as they often dominate employment in the sectors hardest hit.

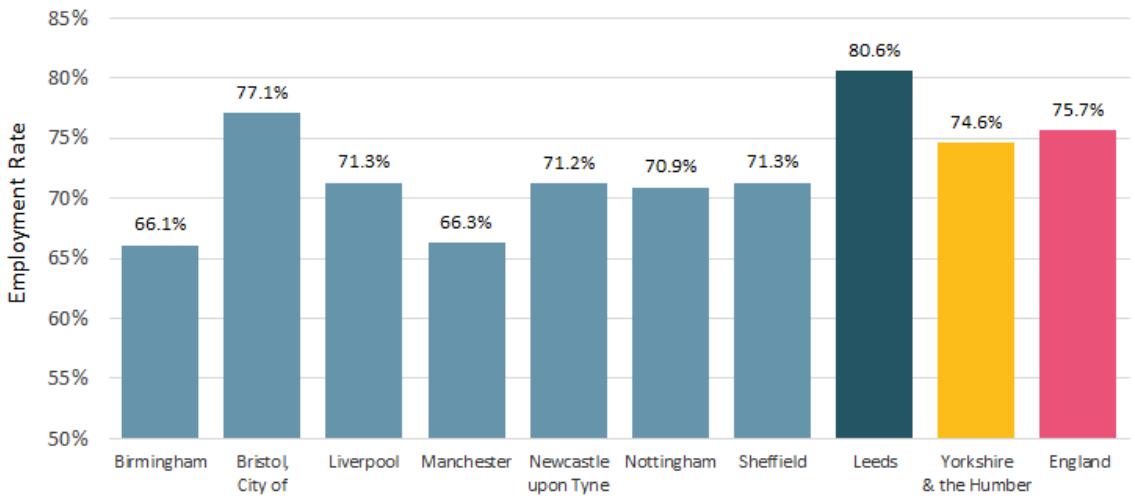
The degree to which these changes on the economy and labour market will be sustained is uncertain. Some believe that the pandemic has simply accelerated changes to patterns and geography of employment that were inevitable, however, there is clearly a latent demand to return to more familiar patterns of employment and leisure, for which Leeds is well-placed to respond. As we move out of restrictions, opportunities to reopen the economy will continue and grow.

Although the full legacy of the pandemic will become clearer as we move forward, as set out above, primary concerns focus on the pandemic's impact on exacerbating inequalities, particularly amongst our most diverse and disadvantaged communities, young people, and women in the labour market.

Employment

Latest ONS estimates suggest that 413,000 people work in Leeds, of which around three quarters are employed in the private sector, making Leeds one of the top cities nationally with a working population employed in the private sector. Indeed, Leeds has witnessed very strong private sector growth since 2010, which in turn has maintained the city's employment rate, with 80% of the working age population in employment, well above regional and core city averages. [55]

Figure 64: Employment Rate – 16-64 – Core Cities – Jan 2020 to December 2020



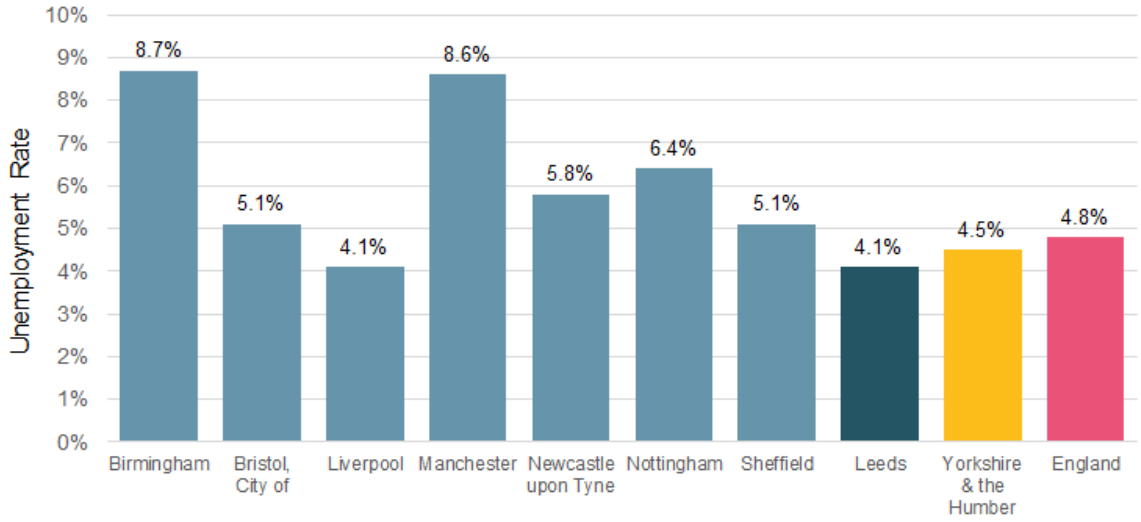
Source: ONS (Annual Population Survey)

This strong employment performance is mirrored in the city's pre-Covid -19 unemployment rate which was consistently below regional and national rates and the lowest of the core cities. [56]

[55] Employment Rate – file includes further charts and data for employment rate by gender, age, ethnicity, occupation and industry.

[56] *Unemployment Rate – file includes further charts and data for unemployment by gender and age.*

Figure 65: Unemployment Rate - 16-64 - Core Cities (January 2020 – December 2020)



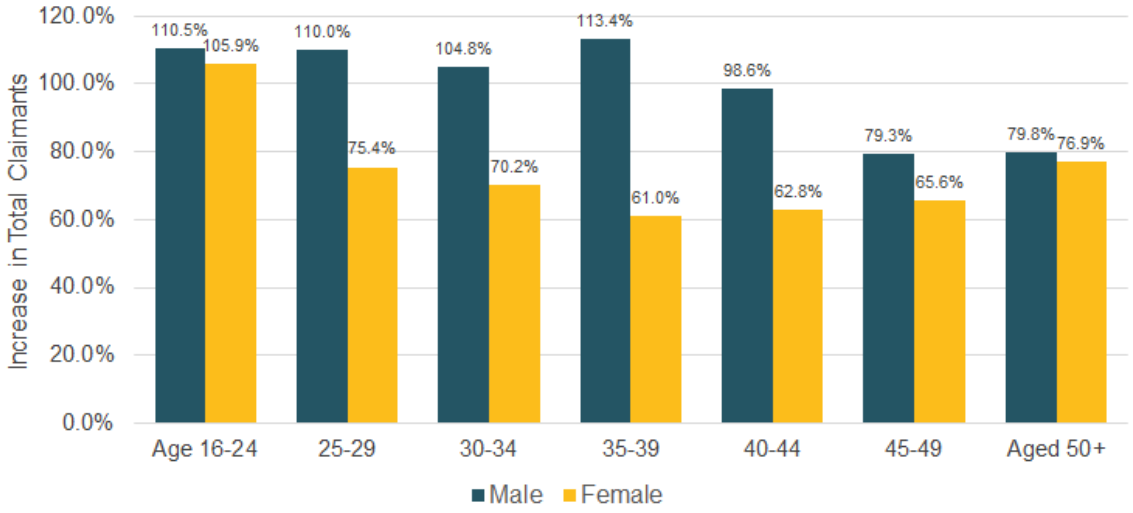
Source: ONS (Annual Population Survey)

Although the official labour market estimates cover the early period of the Covid-19 pandemic, the annual nature of the statistics disguise the effects of the pandemic on employment. Timelier unemployment related claimant counts show claimants in Leeds doubled from 18,000 to 36,000 between March 2020 and April 2021, taking the claimant rate from 3% to 7%.[57]

Although the claimant rate is only slightly higher than regional and national rates and lower than most core cities, Leeds has experienced higher growth compared to regional and most core city counterparts since Covid-19, perhaps reflecting the harder hit on larger, city economies.
The growth in the claimant count, i.e. those in receipt of unemployment-related benefits, appears to have hit the youngest in the labour market most acutely, chiming with wider national analysis and business feedback, which suggests younger people and women in the labour market have been hardest hit by the lockdown. However, the implementation of the furlough scheme might mask some of these impacts on the claimant count (in January 2021, 51,800 employments were still furloughed in Leeds making up 14% of working adults.[58]).

[57] Claimant Count
[58] Coronavirus Job Retention Scheme

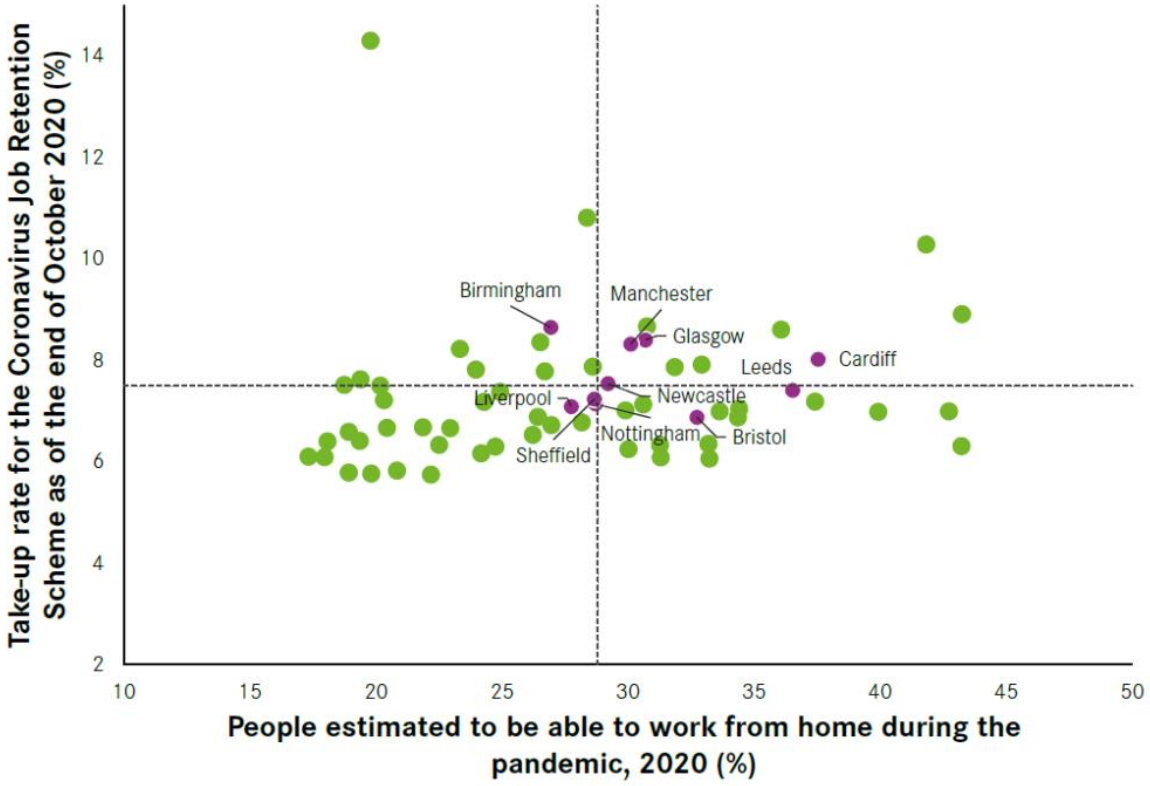
Figure 66: Growth in Claimant Count during the Pandemic by gender and Age (March 2020 to Feb 2021)



Source: DWP (StatXplore)

Leeds has also been perhaps insulated from the worst impacts of lockdown on the labour market, as a relatively high proportion of the city's workforce have been able to work from home. Figure 67 below draws on work undertaken by the Centre for Cities, suggesting Leeds has had a higher incidence of homeworking and low furlough than many other towns and cities. Although this may be a potential issue if homeworking becomes pre-dominant going forward.

Figure 67: Working from home and furlough rates across UK



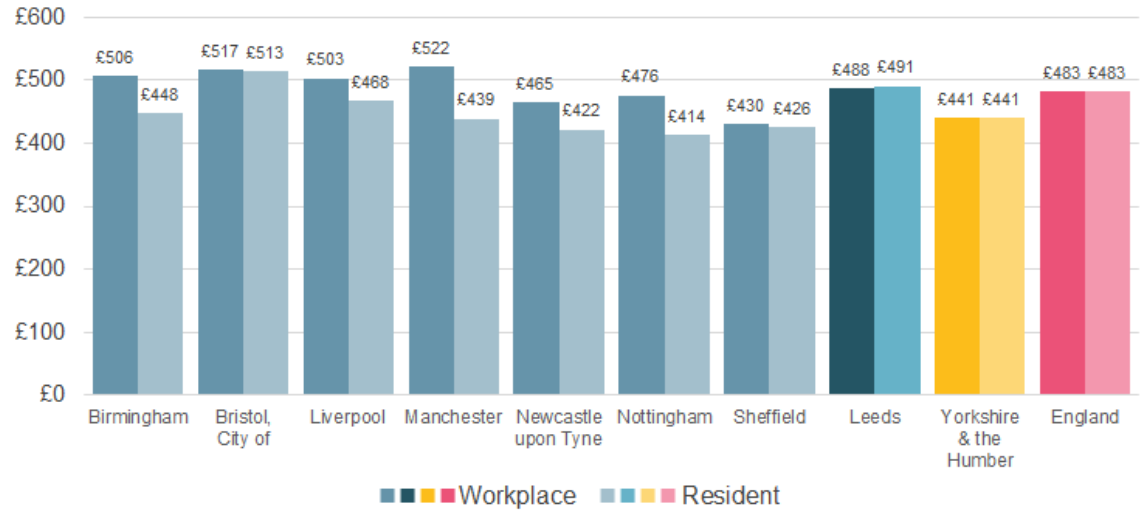
Source: Centre for Cities

Earnings

In many ways the earnings of Leeds workers reflect the relative strength and diversity of the city's economy. Overall, the average weekly earnings for those working and living in Leeds are above the regional average and close to the national average at £488 per week for the workplace population and £491 per week for the resident population. The gap between workplace and resident earnings is low in Leeds compared to other core cities.

While cities like Birmingham, Manchester and Liverpool have higher average earnings for the workplace population compared to Leeds, Leeds has higher earnings for the resident population. Average earnings have been increasing since 2011, with growth for the resident population in Leeds has been higher compared to the workplace population. However, overall, growth in earnings in Leeds appears to have lagged most other core city rates.[59]

Figure 68: Median weekly pay 2020 – ASHE



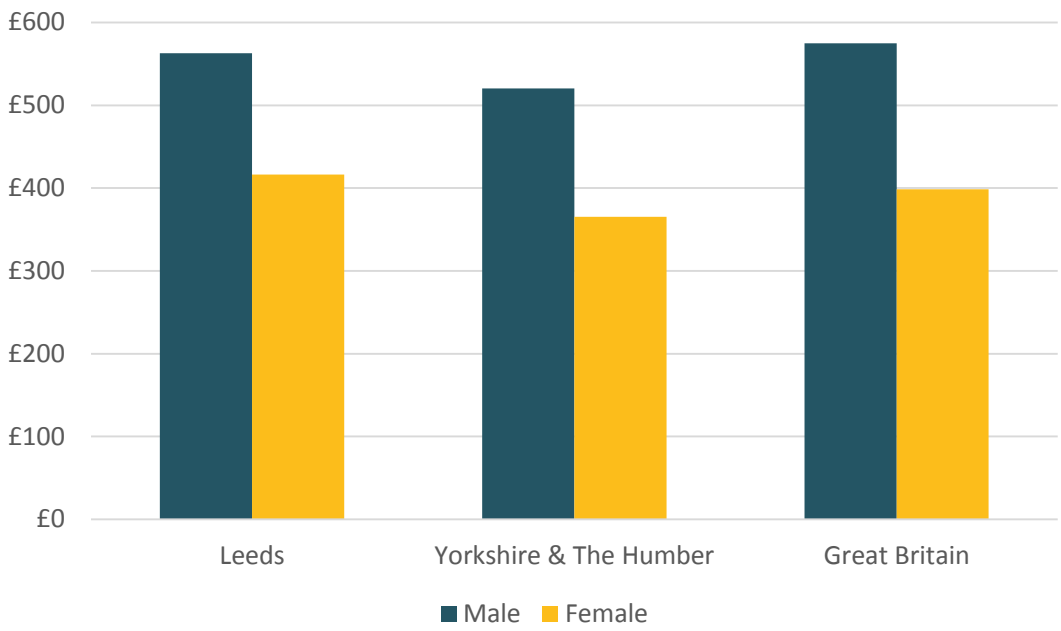
Source: ONS (Annual Survey of Households and Earnings)

However, this relatively strong performance in earnings at a city-wide level masks some significant inequalities in the labour market. This is linked to the expansion of relatively low skilled jobs (see below) and flexible employment practices. It is estimated that around 12,000 people are on zero hour contracts in Leeds, in 2011 only 0.5% of employees were on zero hour contracts this has risen to 3% in 2019.[60] For some people, the city's strong employment rate, rather than providing a route out of poverty, has resulted in a continual struggle to get by, despite being in employment. It is estimated that around 74,000 (14%) working age adults across the city are affected by in work poverty[61]. In addition, an estimated 18% (62,000) of the employed resident population earned less than the Living Foundation's Living Wage in 2020.[62]

In terms of the gender pay gap, Leeds pay gap is slightly less than the national and regional averages, tough the gap remains significant.

[59] Median earnings
[60] Zero hour contracts
[61] In work poverty
[62] Living Wage

Figure 69: Average Weekly Earnings by Gender 2020

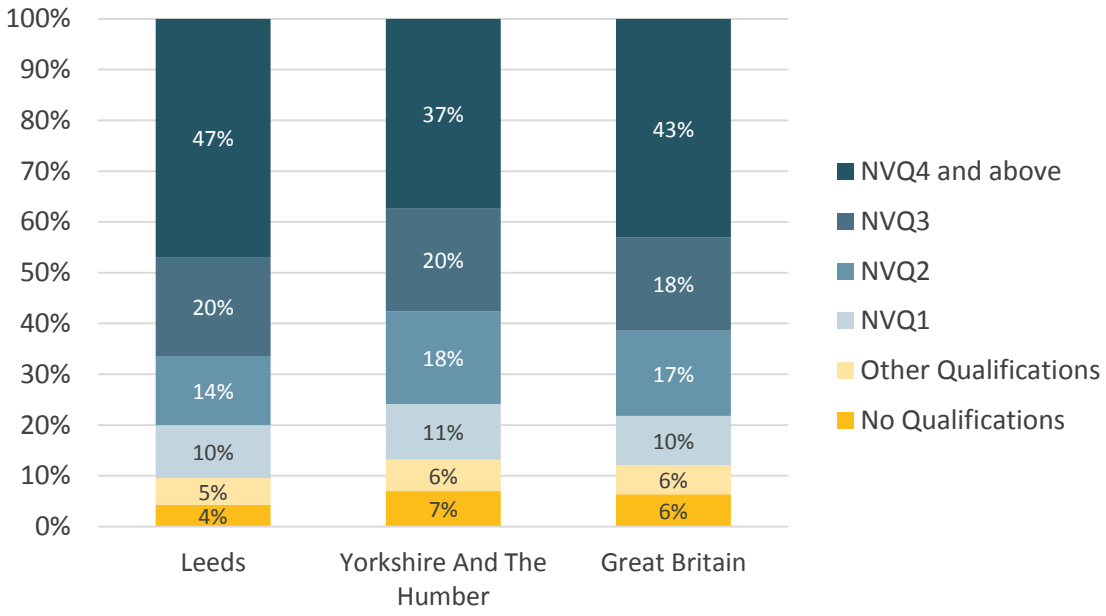


Source: ONS (Annual Survey of Households and Earnings)

Skills and occupational change

The qualification profile of the city's workforce is higher than national and regional averages, with 47% achieving NVQ level 4 or equivalent and two-thirds qualified at level 3 or above. This reflects the concentration of professional and managerial occupations in the city. In contrast to our strong knowledge base, 4% have no qualifications lower than regional and national averages.[63]

Figure 70: Qualifications January 2020 to December 2020

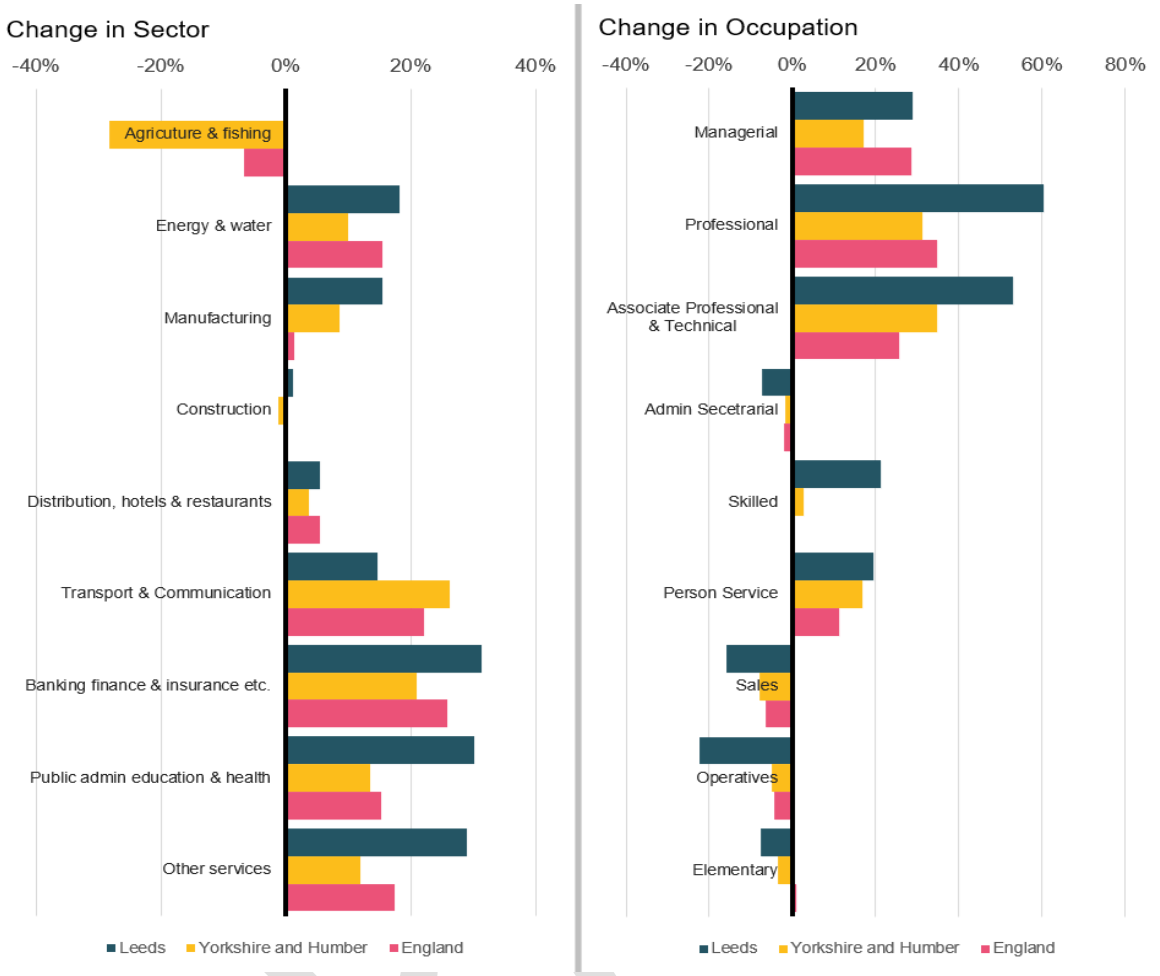


Source: ONS annual population survey

[63] Workforce qualifications

Clearly, the pandemic has had immediate and major effects on the labour market. However, it is the extent to which these effects are a further acceleration of underlying trends that is of interest, where in response, primarily to new technologies, there has been a 'hollowing-out' of skilled and semi-skilled occupations, traditionally in the manufacturing sector, but now increasingly across a wider range of sectors. In recent years this has been accompanied by growth in both high skilled, high valued jobs in the knowledge-based sectors, and lower skilled, lower income jobs often in consumer-services (see Figure 71 below).

Figure 71: Employment Change in Working Sectors and Occupations between 2010 and 2020



Source: ONS (Annual Population Survey)

That said, the last decade has seen strong employment growth, this has been most marked in professional and technical occupations in the city, higher than regional and national growth, the same also for managerial occupations. Skilled and personal services also increased, while sales, operatives and elementary occupations reduced at a faster rate than regionally and nationally.[64]

Looking at employment by industrial sector, banking, finance and insurance services have seen growth, recovering from the effects of the 2008 financial crisis. Public sector employment and jobs in other services have also witnessed strong growth, perhaps driven in part by the expansion in the health sector. Even manufacturing saw strong performance.

Business performance – growth, diversity and productivity

Leeds is well-established as the main driver of economic growth for the city-region, and has key strengths in financial and business services, advanced manufacturing, health and creative and digital industries, with a strong knowledge-rich employment base. These strengths linked to the city's universities and teaching hospitals are major innovation assets for Leeds. Leeds has also performed well in terms of business start-ups in recent years, with strong growth in digital and medical technologies, telecoms and creative industries.

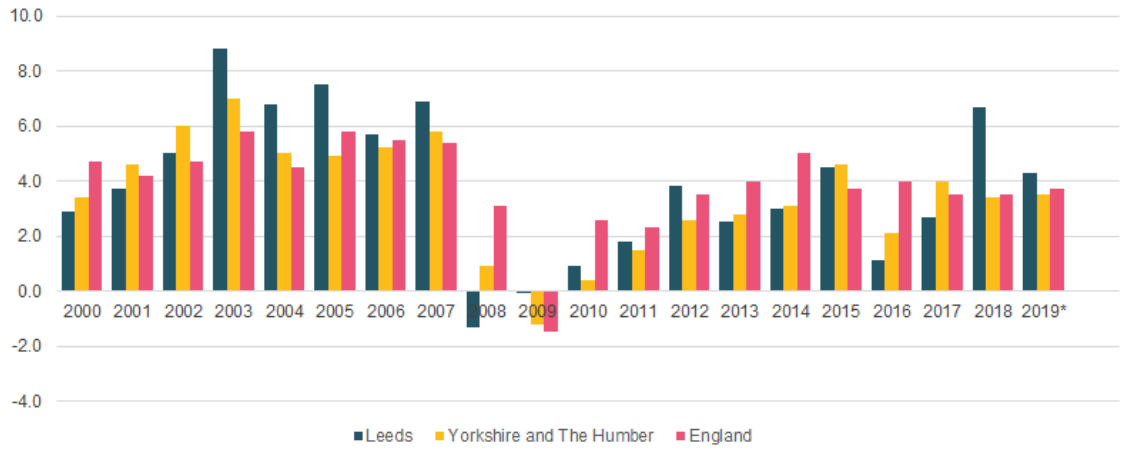
[64] Occupation change

Covid-19 has brought unprecedented changes, accelerating trends around digital transformation, remote working, and the shift from the high street to on-line retail. The extent to which these changes are sustained and develop pose huge questions for Leeds and major cities more broadly, and will need to be a key theme of our analysis. The initial impacts of Covid-19 restrictions were immediate and significant, with home-working, furlough and the changes in consumer patterns resulting in a major drop—off in economic activity in the city centre. Leeds was particularly affected in comparison with our neighbouring economic centres across the city-region, though in-line with other core cities. However, although still early days, economic activity is increasing significantly as restrictions ease, with data suggesting that Leeds' bounce-back is faster than neighbouring localities.

The relative diversity of the Leeds economy has been a key asset in the city's resilience to economic shocks, with the city being able to retain its manufacturing strength as well as consolidate its position as a major centre for finance and business services, during previous downturns. It is likely that this diversity will be a key factor as we recover from the pandemic.

However, as stated above, pre-Covid-19 there were some concerns around slowing growth and low productivity, with a key source of many of new employment being relatively low-skilled, low-paid work in consumer services. Leeds is not alone in these trends, although Leeds does relatively well in terms of productivity per worker (GVA per head), perhaps a reflection of our significant knowledge-based economy, consistently being the strongest performing core city after Bristol. Although it is perhaps more challenging to assess economic performance at a local level, based on available data, the official GVA statistics, suggest our economic output growth has only been mid-table in relation to core cities in recent years, perhaps a hangover from the 2008 financial crisis, since when key sectors particularly in financial and business services have faced prolonged challenges.

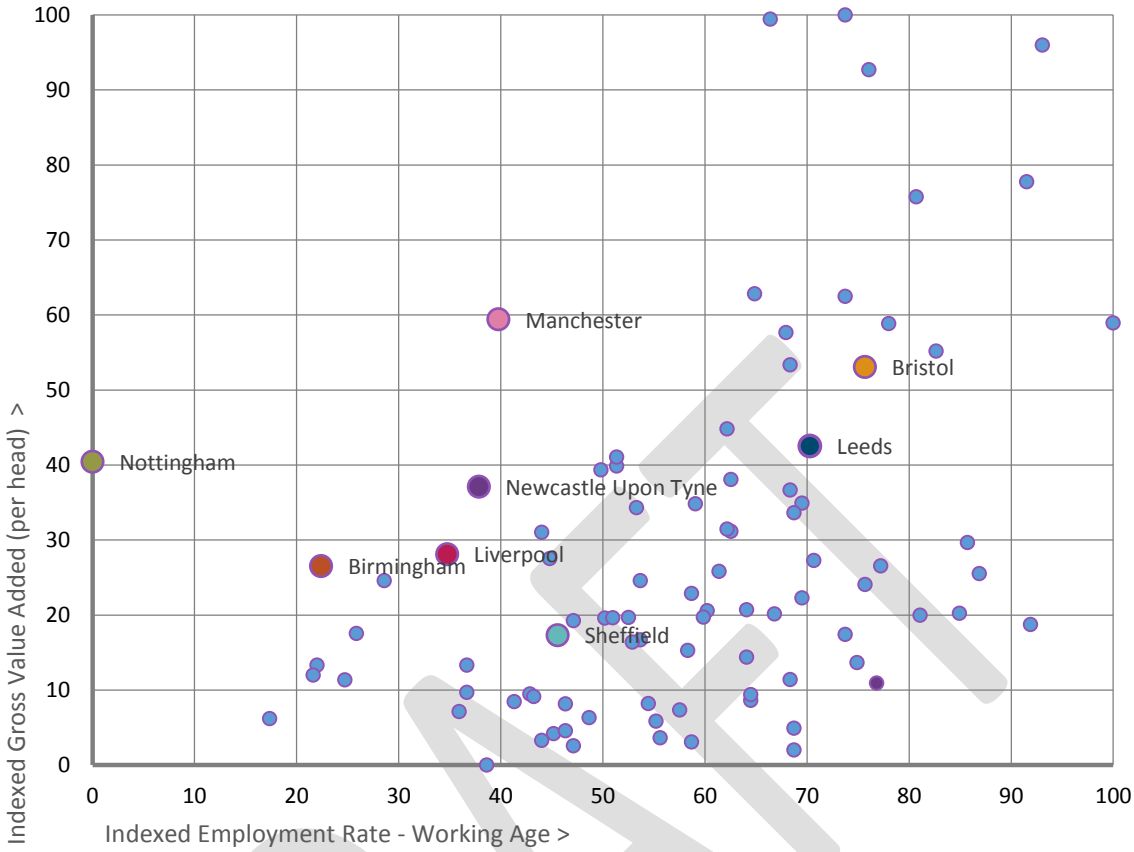
Figure 72: Annual Growth Rate in nominal gross value added (GVA)



Source: Office of National Statistics

Figure 73 below illustrates the relationship between employment and productivity in England's core cities, by indexing employment rates and GVA per head. Bristol performs relatively well against both indicators, Leeds benefits from a strong employment rate, whereas Manchester has relatively strong GVA performance.

Figure 73: Productivity vs Employment – TO DO: update table with latest GVA/Employment data



Source: Nomis, ONS

Policy implications

- Clearly the most immediate challenge is the work to ensure a strong recovery from the impact of the pandemic. As we move beyond the immediate response, longer term recovery and growth against the goals of resetting and renewing the economy. A focus on skills and life-long learning will be a central element here, not only on young people (vital as they are), but also on those people who will need to renew their skills as the world of work continues to change.

- In the longer-term, we will need to build resilience and continue to work with partners and stakeholders in working towards our aspirations to deliver Inclusive Growth - labour market accessibility, business innovation and expanding the green economy are all likely to be key areas.

- More specifically, the pandemic has had some immediate effects, with restrictions resulting in an overnight adoption of home-working and a severe impact on hospitality, retail, local consumer services. The city centre saw a major reduction in economic activity, though some suburbs and satellite towns experienced a mini boom. The consequences of these factors were broadly twofold: in the first instance young people, women and low earners were more likely to be furloughed or at risk of unemployment, as they often dominate employment in the sectors hardest hit; secondly, for a time the economic geography of the city was impacted, with the combination of restrictions, but most notably home-working changing the patterns

of economic activity. The extent to which two broad factors are sustained as we recover is uncertain, though we will need to continue to track these issues.

Section 5: Ageing Well - Age-Friendly Leeds

Headlines

- The 50+ population has grown by an around 30,000 over the last 20 years, future growth in the older populations will be fastest amongst the 80+, who are expected to see a 50% increase.

- It is a widely held perception is that our older population live in the less-disadvantaged, outer areas of the city. However, the largest concentration of the older population is found in our communities most likely to be experiencing deprivation. Changes in housing choice and tenure, together with longer-term demographic trends mean this concentration may grow in future, with potential impacts on service provision.

- The older population is also becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Older people from diverse ethnicities, cultures and communities of interest who share a particular identity or experience, can also face specific challenges as their established networks and support diminish over time.

- At 65 people in Leeds can expect to live half of the rest of their life free of disability or in good health, and half of it with a disability or in poor health.

- Women from the most affluent parts of the city are set to live 14 years longer than those from the least affluent, the gap for men is 12 years. Life expectancy rate for both genders are below regional and national averages.

- There is a link between deprivation and frailty, with the proportion of people living with frailty within the most deprived communities identified according to IMD almost three times higher than those who live in the least deprived.

- Older people have been the most impacted in terms of direct health consequences by the pandemic through deaths, hospitalisations and longer-term health issues. Older people were also more likely to have to shield during national lockdowns and Covid-19 waves, leading to both deconditioning and an increase in mental health issues.

- The number of older people in employment has risen over the last 20 years reflecting the wider trend of an ageing population. This ageing workforce presents both challenges and opportunities, not least how we capture and exploit the experiences, skills and potential of older workers.

- Half of all unpaid carers in Leeds are aged 50+, which equates to almost 40,000 unpaid carers. Women are four times more likely to stop working as a result of their caring responsibilities, which is likely to have an impact on their income and mental wellbeing.

Leeds wants to be a place where people age well: where older people are valued, feel respected and appreciated, and are seen as the assets they are. The opportunities and challenges presented by an ageing population are well-rehearsed, but people in and approaching later life often make a positive contribution to our communities – through the skills and knowledge that they bring, high levels of volunteering, acting formally and informally as community connectors, intergenerational interactions, unpaid caring roles, and through the skills and experience they bring to their workplaces.

Equating ONS national data average household expenditure data and household estimates to Leeds, 50+ aged households could contribute £120 million a week to the economy, however, we also know that many people are ageing with multiple long-term health conditions with inequalities disproportionately affecting the most disadvantaged in our city. Inequalities in older age are cumulative and have a significant impact on a person's health, wellbeing, and independence.

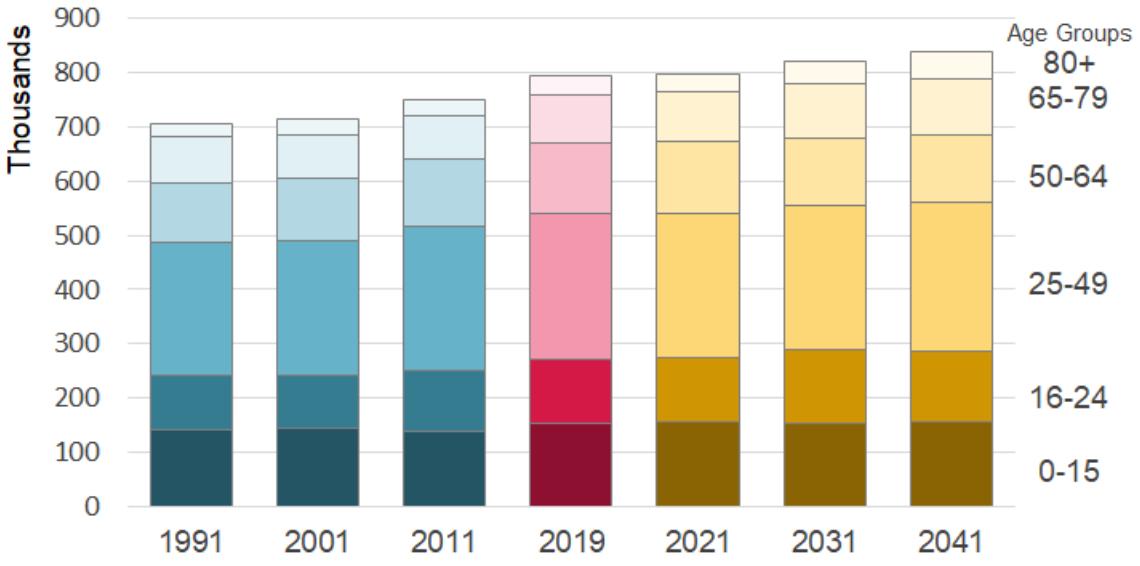
This section draws on data currently being collated in the production of Leeds State of Ageing Report, which will be available on the Leeds Observatory when completed. The report aims to provide data and stories about what it is like to grow older in Leeds, to inform debate and shape priorities. Once completed, the report will be used to refresh the Leeds Age-Friendly action plan.

Demography and housing

A more comprehensive population overview is set out in Section 1, however, the latest 2019 ONS projections estimate that the population of people aged 50+ in Leeds stands at over 250,0000 or a third of the city's population. The gender breakdown is generally equal for the age groups, with the exception of the over 70 age groups, where the proportion of females starts to increase.

In terms of population growth, the over 50 population has grown by an estimated almost 30,000 between 2001 and 2019, a 12% to 17% increase in each of the 50 plus age groups, much of the city's population growth has been concentrated in these age groups. In terms of future projections to 2041, the 50-59 population is projected to reduce and there will be little change for the 60-69 population, however the 70+ population is projected to substantially grow, with fastest growth amongst the 80+, which is expected to see a 50% increase.

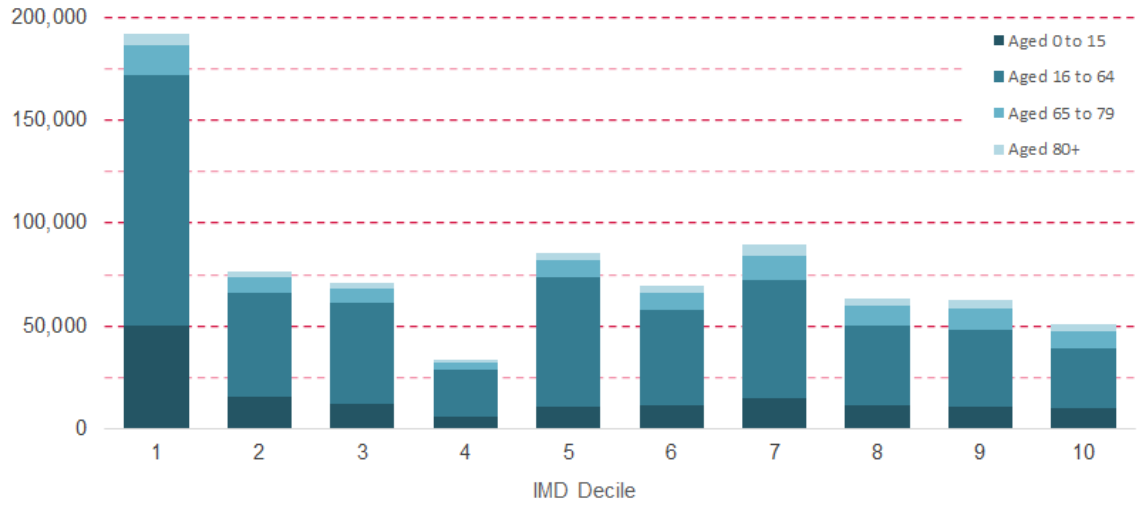
Figure 74: Leeds Population Change (Past and Forecast) 1991- 2041



Source: Census 1991-2011, ONS Mid Term Population Projections 2019

Figure 75 below looks at the distribution of the population by broad age group against the deciles of Index of Multiple Deprivation, with decile 1, being communities likely to be experiencing highest levels of deprivation, and decile 10 the lowest. Although a widely held perception is that our older population live in the less-disadvantaged, outer areas of the city (see below), the largest concentration of the older population is found in decile 1. Given the potential impact on housing choice and mobility outlined below, this concentration may grow in future, with potential impacts on service provision.

Figure 75: Age Profile for each Index of Multiple Deprivation 2019 decile (including 80+)



Source: ONS Mid Term Population Projections 2019/IMD 2019

In terms of diversity, according to analysis based on GP registrations (the population has changed since the 2011 Census) the vast majority of those aged over 65 in Leeds identify as White British (85%), while 12% Black and ethnic minority communities and 3% as Other.[65] The 65+ BME population is made up of a large Other White population (40%), which mainly covers European groups. This is followed by the more settled migrant groups such as Indian (14%), Pakistani (11%) and Black Caribbean (6%). The increasing diversity of our population has been focused on younger people (over a third of school-age young people identify as BME, see Section 2) clearly this will feed through the age-profile going forward.

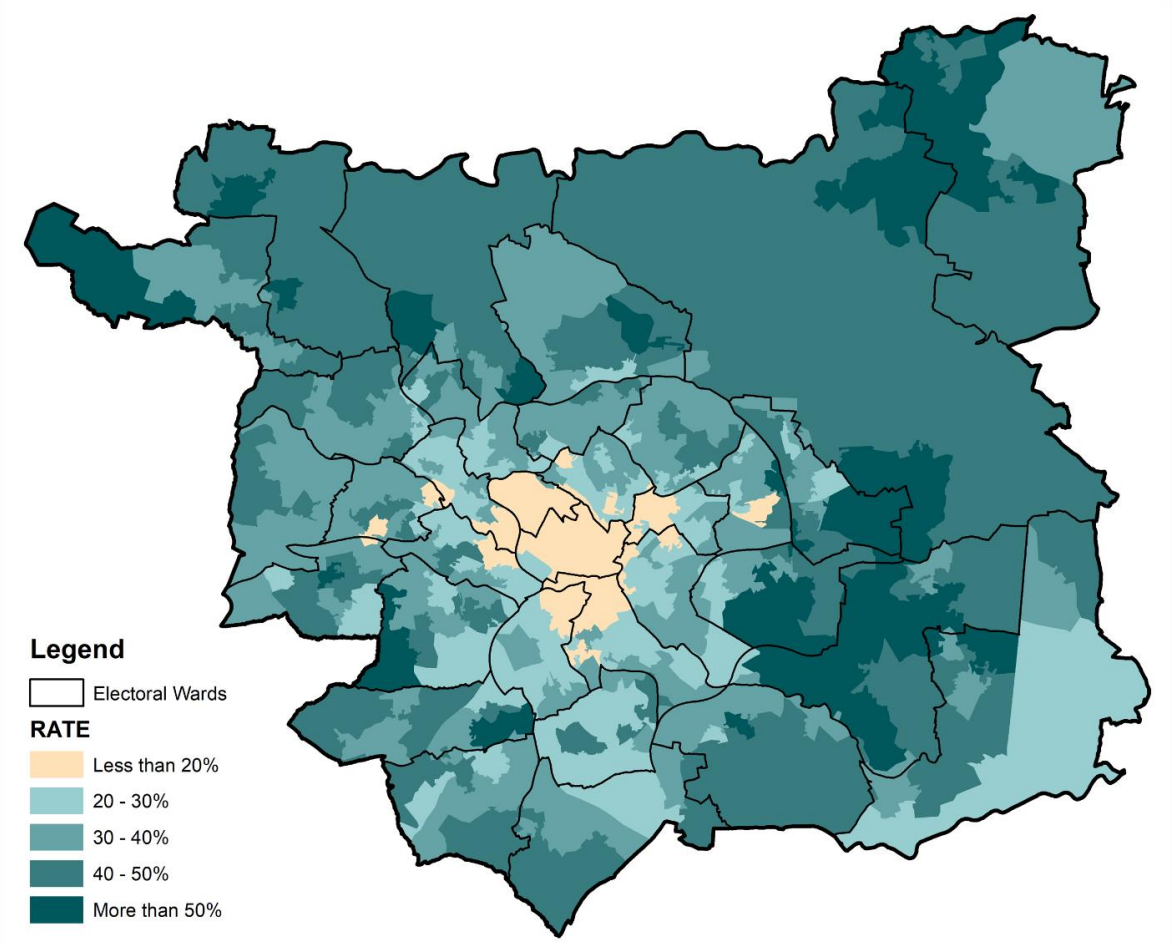
Figure 76 maps the 50+ population across the city and shows that is predominantly based in the outer suburbs of Leeds. This is perhaps a function of how the housing market has functioned over the past decades, with a pattern of younger new buyers entering the housing in relatively modest housing and then being able to 'move up the housing ladder', resulting in the majority of the 50+ households, being owner/occupiers, often in the outer areas.

The extent to which this pattern of housing tenure, and subsequent influence on the geographic age-profile of our population, will continue is uncertain. The shortage of affordable housing and wider growth in house-prices, the expansion of the private rented sector, and limited opportunities for downsizing of existing homeowners within their communities are all factors likely to influence future patterns of housing tenure.

Overall, the vast majority of our older people live in mainstream housing, rather than specialist housing, such as a retirement community or sheltered accommodation.

[65] *Leeds core data: Public Health 2020*

Figure 76: Distribution of 50+ aged population, 2019



Source: ONS Mid-Term Population Projections, 2019

Healthy ageing

Section 3 provides an overview of Health and Wellbeing in the city, however, there are clearly specific issues affecting our older age group and the services they require, with people living longer, but disability free life expectancy decreasing, and the overall proportion of people in the older population growing.

Life expectancy

At 65, on average, people in Leeds can expect to live half of the rest of their life free of disability or in good health, and half of it with a disability or in poor health. Section 3 examined patterns of life expectancy by gender and geography, with some stark findings, women from the most affluent parts of the city are set to live 14 years longer than those from the least affluent, the gap for men is 12 years. Life expectancy rate for both genders are below regional and national averages.

Physical health conditions

Again Section 3 assesses progress against a wide range of indicators. The challenges facing the older age groups in the city , largely mirror those of the wider population, reaffirming the health-wealth gap that risks becoming wider in the wake of Covid-19, with a continued focus required on prevention and support for those with health conditions in those communities experiencing poverty.

Frailty

There is also clear link between deprivation and frailty. The proportion of people living with frailty within the most deprived decile according to IMD is almost three times higher (22%) than those who live in the least deprived decile (8%)[66]. In addition to this, the average age of people with frailty gradually increases from the most to least deprived areas.

People from Black, Asian and Minority Ethnic backgrounds in deprived areas become frail, on average, 11 years younger than those people from a white background in the least deprived areas[67].

Leeds has the highest number of admissions due to falls compared to other cities in the region, and one of the highest rates. The rate of admissions due to falls has generally reduced since 2010, however the numbers have stayed stable since 2012/13.

Mental health

Over 20% of older people (65+) are identified as having a common mental health illness (CMHI) in Leeds, with higher numbers amongst females than males[68], these rates are similar to other core cities according to Public Health England data.

It is widely accepted that the pandemic has had a significant impact on people's mental health, however, PHE data suggests that on average, the mental health and wellbeing of older age groups appear to have been less affected so far during the pandemic, with the impact most acute amongst young people. More broadly, older people aged 60+ have tended to report better mental health and wellbeing during the pandemic. However, these differences in the population's mental health were present before the pandemic.

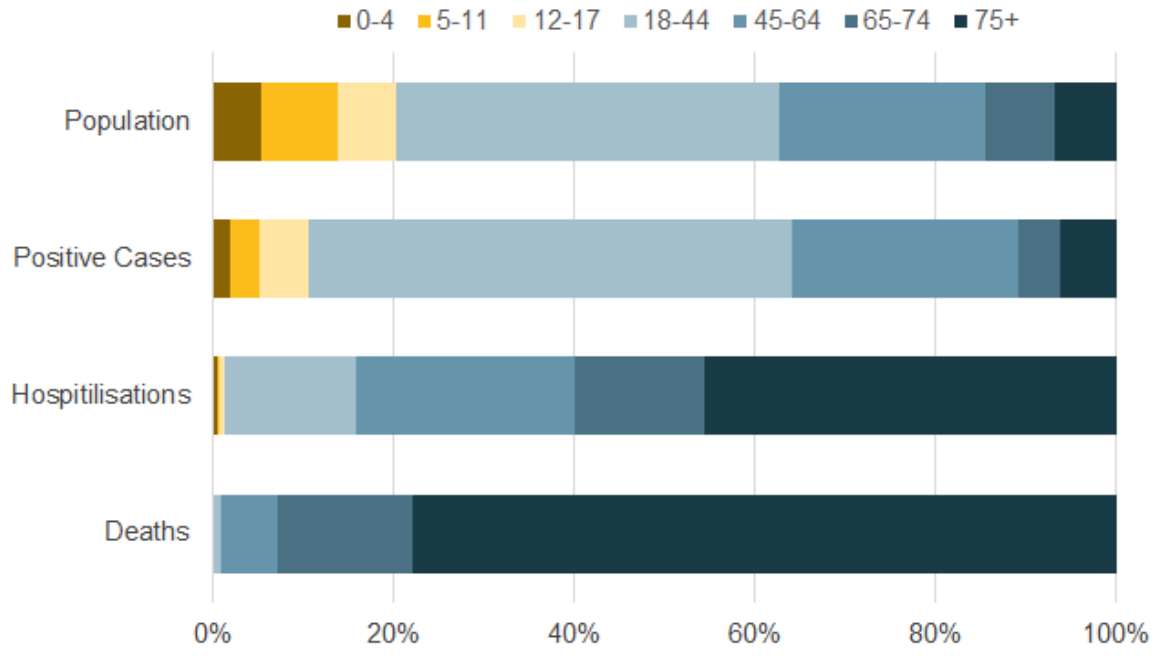
The impact of Covid-19

Undoubtedly older people have been the most significantly impacted in terms of direct health consequences by the pandemic through deaths, hospitalisations and longer-term health issues. Older people were also more likely to have to shield during national lockdowns and Covid-19 waves.

[66] *Leeds Data Model, NHS Leeds CCG 2021*
[67] *Leeds Data Model, NHS Leeds CCG 2021*
[68] *PH Intelligence Team Data, 2021*

Figure 77 below highlights the age differentiation of the health impact of Covid 19 at the peak of the pandemic.

Figure 77: Covid-19 health impacts by age group, Oct-Dec 2020



Source: PHI 2021

However, there have also been economic and employment impacts, according to the ONS Labour Force Survey and local business intelligence employees aged 50+ were more likely to report working fewer hours than usual (including none), than those aged under 50 years, with those aged 65 years and over the most likely to say they had worked reduced hours during the pandemic.

According to national HMRC data, over a quarter of those furloughed are aged 50+, with a third of older workers on furlough thinking there is a 50% chance or higher that they will lose their job when the scheme ends.

Active, included and respected

Loneliness, engagement and mobility are often particularly issues for our older people. Keeping active, connected to family and friends and being valued contributors to their community are all key factors in promoting health and wellbeing.

Active

In terms of physical activity, according to analysis undertaken to support the Get Set Leeds initiative, 65+ year olds self-reported the highest levels of physical activity per week (4.03 days compared to 3.64 days in 45 – 64 year olds); despite 65+ having the lowest levels of self-belief that they can be active and the lowest levels of motivation to be active.

Older citizens also have the highest rates of volunteering (peaking for 65-74 year olds). There are an estimated 40,000 over aged 55+ in Leeds who have volunteered at least once in the last 12 months.

Included

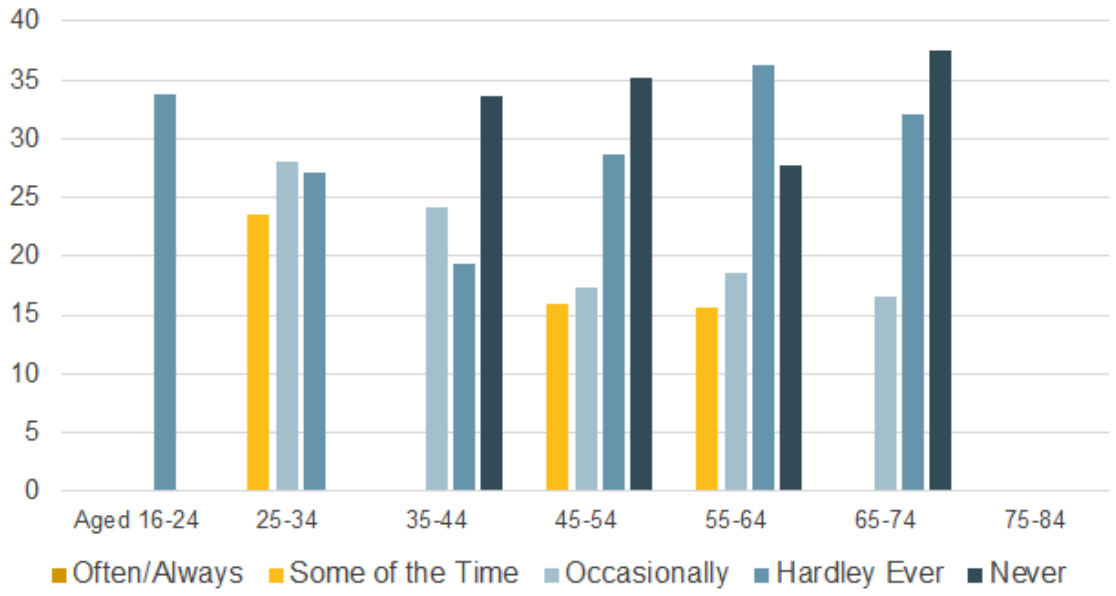
Older people feel more safe where they live, a greater sense of belongingness to their neighbourhoods and are more likely to feel that people from different backgrounds get on and that that they have someone to rely on if they have a serious problem[69]. However, nationally, older people with a long-term condition and those who 'find it difficult to get by' are less likely to feel connected to their community[70] .

The increasing diversity of our older population going forward may also need consideration. People from diverse ethnicities, cultures and communities of interest often have well established identities, social networks and support frameworks, from places of worship, to clubs and social networks. These mechanisms can diminish as younger generations become more assimilated, and as a result, individuals can become more isolated. The ageing Irish immigrant population is an example of how this can play out in the city.

Loneliness

In terms of social isolation, only a small number of older people surveyed in Leeds in the year to November 2020 said they often feel lonely. But only around 1 in 4 people age 75+ said they never felt lonely – as did almost 1 in 3 people age 55-74. These are both lower than the national average.[71] Loneliness is higher in the communities more likely to experience disadvantage.

Figure 78: Loneliness by age group, Leeds 2020



Source: Active Lives Survey, 2020

Mobility and accessibility

The ability to travel is crucial in maintaining independence and staying connected. How older people travel is affected by a variety of factors ranging from the travel options where they live to how safe and accessible places are to their health and deprivation levels.

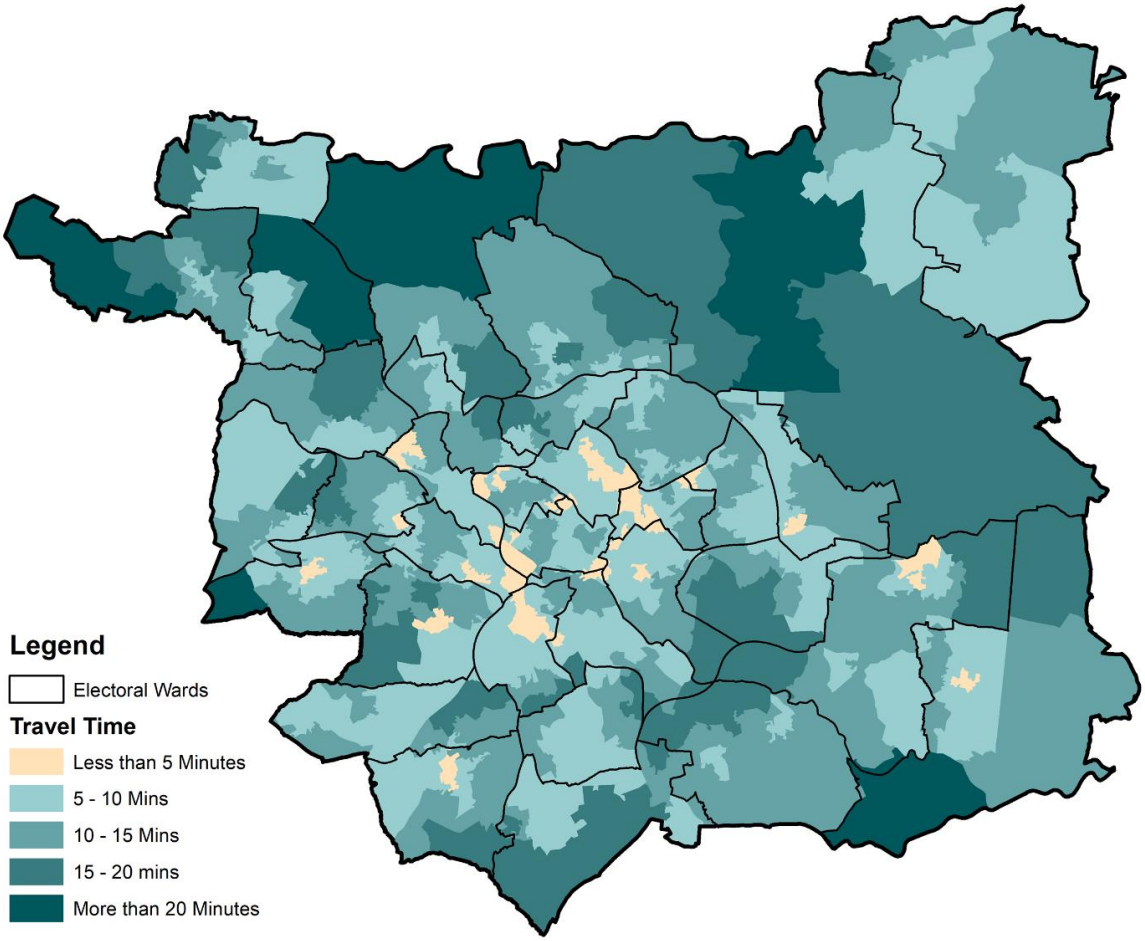
[69] *Understanding Society 2014/15, ONS*
[70] *The Ageing Better NatCen Panel Homes and Communities Study, 2020*
[71] *Active Lives Survey, 2020*

Data for drawn from concessionary bus passes show some inequalities in Leeds. Around two thirds of people aged 60+ own a concessionary travel pass[72]. People aged 60+ living in the city's low income communities are twice as likely to use their concessionary fare pass than those in the more affluent areas. However, it has been estimated that greater proportions of those who live in the most disadvantaged areas of Leeds do not claim a pass that they are entitled to.

Data from WYCA's West Yorkshire Transport Survey shows that people aged 65+ are less likely to have access to a frequent bus within 400m compared to younger age groups. Only 8% of people age 65+ in West Yorkshire live within 400m of a frequent bus. This may be particularly important for women – who are more likely to have mobility issues than men.

Ease of access to essential services, like health services and groceries, becomes increasingly important as people get older. In Leeds, the average travel time by foot or public transport to a food store is 8 minutes, to the nearest hospital is 33 minutes, and to the nearest GP is 11 minutes.[73]

Figure 79: Average travel time to GP by foot or public transport by LSOA



Source: Health & Social Care Information Centre/Dept of Transport

[72] *WYCA, Concessionary Fares Data, 2021.*
[73] *https://www.gov.uk/government/statistical-data-sets/journey-time-statistics-data-tables-jts#journey-times-to-key-services-jts01*

Employment and Learning

Labour market

In Leeds, there are an estimated 121,400 people aged 50+ in employment making up 26% of the workforce[74]. This equates to half of all people aged 50+ that are in employment. The proportion of older people in employment has risen over the last 20 years reflecting the wider trend of an ageing population, locally and nationally. This ageing workforce presents both challenges and opportunities, not least how we capture and exploit the experience, skills and potential of older workers.

The increase in older workers, masks the large number of people who are still falling out of work prematurely. According to the Centre for Ageing Better, regularly identified labour market barriers include ageism in recruitment, lack of flexibility from employers, insufficient support for their health conditions and managing caring responsibilities.

However, as the population continues to age, and many people remain economically active for longer, there will be an increasing need to refresh and develop skills and learning, to reflect the changing nature of work. Although there is limited data on levels of lifelong learning amongst older workers, older people aged over 65 are four fifths less likely to be learning than adults aged under 24[75]. Clearly there is a challenge and opportunity for employers and training providers to respond.

Caring and carers

According to the latest Leeds Carers Health Needs Assessment, half of all unpaid carers in Leeds are aged 50+, which would equate to almost 40,000 unpaid carers. One fifth of all carers are aged 65+ and one third are aged 50-64. As this latter group are of pre-retirement age it may be that a number of those aged 50-64 are managing their caring role alongside employment responsibilities, which could place them under additional stress and pressure, and negatively impact on their own health and wellbeing.

According to Carers UK, women are four times more likely to stop working as a result of their caring responsibilities, which is likely to have an impact on their income and mental wellbeing

Covid-19 has meant that more people than ever are providing unpaid care and are doing so for longer periods of time. The suspension of services such as day clubs and lunch clubs, has meant carers have little chance of a break, even for a few hours per day. The closure of leisure centres and community clubs meant opportunities for social interactions and activities that improve health and wellbeing were more limited. During the pandemic carers were fearful of allowing outside help/carers to enter the home. These impacts will be seen amongst older carers maybe caring for a spouse in their own home or those who provide care to older people:

Policy implications

- The city's population is ageing, with the 80+ age group growing fastest. The older population is also becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile

[74] *Office for National Statistics (2020a), Labour Force Survey. https://www.ons.gov.uk/surveys/informationforhouseholdsandindividuals/householdandindividualsurveys/labourforcesurvey*

[75] *Learning and Work Institute (2019), Adult Participation in Learning Survey 2019.*

of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Future service provision will need to take account of these factors.

- The pandemic highlighted the deep-rooted inequalities in health and wellbeing outcomes. These inequalities are also reflected in how we age, with significant variations in life expectancy and healthy life-expectancy across the city. We also know that many older people are more likely to have multiple long-term conditions with socio-economic inequalities being a key influencing factor. The changing nature of the demography of older people highlighted above may increasingly influence these trends going forward.

- Older people make up an increasing proportion of the workforce, presenting both challenges and opportunities, not least how we capture and exploit the experience, skills and potential of older workers. As the working population continues to age, there will be an increasing need to refresh and develop skills and learning, to reflect the changing nature of work.

- Half of all unpaid carers in Leeds are aged 50+, with an increasing number managing their caring role alongside employment responsibilities, which could place them under additional stress and pressure, and negatively impact on their own health and wellbeing. The pressure on services, exacerbated by Covid-19, has meant that more people than ever are providing unpaid care and/or volunteering and are doing so for longer periods of time, indeed these carers/volunteers are increasingly vital in supporting service provision.

Section 6: Implications of the Analysis (To be developed further)

This section brings together the policy implications drawn from the thematic analysis, it also attempts to identify and link common themes to inform priorities and subsequent strategies and interventions, but also seek to inform a more consolidated and collaborative response. A response that is set against a more intense 'perfect storm' of increasing challenges and resulting service demands, combined with continued pressure on resources, together with raised expectations from service consumers as restrictions ease.

A Changing City: Population Trends

- The city's population has continued to become more diverse, in terms of age, countries of origin and ethnicity. There is a more work to do in understanding and responding to the relationship between ethnicity, deprivation, social mobility and health and wellbeing.

- The city's population is ageing, with the 80+ age group growing fastest. The older population is also becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Future Age-Friendly Leeds work as well as other service provision will need to take account of these factors.

- In terms of young people, the birth-rate 'bulge' of the last decade has fallen back, beginning to be reflected in a fall in demand for school reception places. However, the 'bulge' cohorts are now beginning to go through secondary school, with significant mid-term implications for post-16 education and skills support and routes of entry into the labour market. All this against the backdrop of the economic impact of the pandemic, that has been acutely felt by young people.

- It is too soon to assess any full impact of exiting the EU on patterns of immigration and/or on some existing communities. However, early indications suggest that economic immigration from the EU has slowed, with some evidence of skills and labour shortages feeding through to the local economy and potential longer-term implications for the inclusive growth agenda.

Starting Well - Child-Friendly Leeds

- Covid-19 has had a profound impact on children and young people, with the disruption to their education and concerns regarding safeguarding and disengagement, particularly the most vulnerable. However, it is perhaps the mental health of our young people that is of greatest concern. Although on Leeds rates on indicators like child inpatient admissions for mental health conditions are below national averages, they have risen more sharply in the city in recent years. Responding to the mental health challenges increasingly facing young people will be a key challenge going forward.

- Closing the educational attainment gap for the children and young people most likely to be experiencing poverty and disadvantage remains a significant challenge. Promoting positive engagement with education for young people and their families from the outset and strengthening pathways to continued education, skills development and employment opportunities are all likely to be needed.

- Linked to the point above, child poverty is at the root of many poor outcomes for children and young people including education, health and wellbeing and even routes into care, and factors influencing the scale and severity of child poverty in the city are broad-based. Strengthening linkages between interventions and strategies aimed at young people and our wider approach to inclusive growth will be vital in working to realise the full potential of our young people.

Living Well – Health and Wellbeing

- The relationship between poverty and inequality, and poor health and wellbeing outcomes is well understood. The pandemic has exacerbated this negative correlation. Loosening the relationship will need to continue to be a primary focus of our combined efforts, from prevention and promotion/enabling of more healthy living, to tackling wider determinants such as employment, education, housing and the environment, and improving access to health and care.

- The proportion of people experiencing mental health issues increased during the pandemic, with some groups particularly affected such as: young adults and women; shielding older adults; adults with pre-existing mental health conditions, and Black, Asian and ethnic minority adults. This trend is set against a backdrop of an increasing recognition of wider mental health challenges, including loneliness and social isolation. Clearly it will be important to continue to focus on reducing mental health inequalities, improving mental health across all ages, and working to promote flexibility, integration and responsiveness in service provision.

- A common theme, across all sections of this report, is stronger integration of strategies and interventions aimed at both addressing key challenges, but also better realising opportunities. This is particularly true in promoting health and wellbeing, where those factors, often described as key determinants, influence options, choices and patterns of behaviour, which in turn shape health and wellbeing outcomes. Building on the collaborative strength of our Covid-19 response will be vital here, both between agencies and the third sector, but also within communities.

Living Well – Thriving Communities

- The pandemic has highlighted the importance of community assets and personal connections in building community resilience and ability to respond to challenges, with the worsening mental health of people of all ages coming to the fore. Future policy will need to account for ensuring the sustainability of the city's third sector to support co-design of interventions, strengthen social infrastructure across the city, and bring people together to guard against the emerging rises in community tension often driven by national factors. Intergenerational activities are crucial in achieving this.

- Housing costs are continuing to rise and become unaffordable for low income families, exacerbated by a scarcity of the mid-sized homes sought by growing families and older people looking to downsize within their community. This continues to have knock on impacts for social mobility and risks locking more families into smaller, poorer quality housing at the lower end of the market with associated health, wellbeing and educational implications.

- The spatial concentration of older housing, particularly back-to-backs, much of it in poor condition, particularly in relation to their energy efficiency, combined with the significant expansion of the private rented sector has a major impact on large areas of the inner city.

- Leeds' rich diversity is a strength of the city, but it also reflects the different and changing needs of parts of the population. Future analysis and policy development should be more responsive to the circumstances of communities of interest as well as communities of geography and condition-specific considerations, to support efforts to overcome long-term, entrenched barriers to good health and wellbeing for everyone in Leeds.

Living Well - Climate Change

- Leeds has set a very challenging net zero carbon target in recognition of the contribution the city should make to tackling climate change. While progress has been made, it is clear that to move towards the target bolder and more wide-ranging interventions would need to be developed in the coming years, with the local authority, health system and other anchor organisations carrying responsibility as major contributors to overall emissions.

- Public transport usage reduced to very low levels due to Covid-19 and while it has started to recover, passenger numbers remain far lower than pre-pandemic. Recovery rates are not uniform, with rail usage recovery lagging behind bus usage. Further analysis over the coming months is required to inform future policy decisions, balancing current and future demand for public transport alongside climate change and the need to reduce use of private cars.

- The analysis highlights areas that might be prioritised in efforts to embrace the just transition to a green economy and to create green jobs while tackling long standing social challenges affecting the health and wellbeing of low income families – including reducing fuel poverty by improving energy efficiency, further enhancing access to green space, and over the longer term building a more sustainable food system for the city and wider region.

Working Well - Inclusive Growth

- Clearly the most immediate challenge is the work to ensure a strong recovery from the impact of the pandemic. As we move beyond the immediate response, longer term recovery and growth against the goals of resetting and renewing the economy. A focus on skills and life-long learning will be a central element here, not only on young people (vital as they are), but also on those people who will need to renew their skills as the world of work continues to change.

- In the longer-term, we will need to build resilience and continue to work with partners and stakeholders in working towards our aspirations to deliver Inclusive Growth - labour market accessibility, business innovation and expanding the green economy are all likely to be key areas.

- More specifically, the pandemic has had some immediate effects, with restrictions resulting in an overnight adoption of home-working and a severe impact on hospitality, retail, local

consumer services. The city centre saw a major reduction in economic activity, though some suburbs and satellite towns experienced a mini boom. The consequences of these factors were broadly twofold: in the first instance young people, women and low earners were more likely to be furloughed or at risk of unemployment, as they often dominate employment in the sectors hardest hit; secondly, for a time the economic geography of the city was impacted, with the combination of restrictions, but most notably home-working changing the patterns of economic activity. The extent to which two broad factors are sustained as we recover is uncertain, though we will need to continue to track these issues.

Ageing Well - Age-Friendly Leeds

- The city's population is ageing, with the 80+ age group growing fastest. The older population is also becoming more diverse, as the wider demographic trends are increasingly reflected in our older generation. Although perhaps too early to be definitive, the socio-economic profile of our older population may also be changing, with house-ownership less dominant, and people working longer over a more varied career pattern. Future service provision will need to take account of these factors.

- The pandemic highlighted the deep-rooted inequalities in health and wellbeing outcomes. These inequalities are also reflected in how we age, with significant variations in life expectancy and healthy life-expectancy across the city. We also know that many older people are more likely to have multiple long-term conditions with socio-economic inequalities being a key influencing factor. The changing nature of the demography of older people highlighted above may increasingly influence these trends going forward.

- Older people make up an increasing proportion of the workforce, presenting both challenges and opportunities, not least how we capture and exploit the experience, skills and potential of older workers. As the working population continues to age, there will be an increasing need to refresh and develop skills and learning, to reflect the changing nature of work.

- Half of all unpaid carers in Leeds are aged 50+, with an increasing number managing their caring role alongside employment responsibilities, which could place them under additional stress and pressure, and negatively impact on their own health and wellbeing. The pressure on services, exacerbated by Covid-19, has meant that more people than ever are providing unpaid care and/or volunteering and are doing so for longer periods of time, indeed these carers/volunteers are increasingly vital in supporting service provision.

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Holly Dannhauser and Lucy Jackson

Report of: Leeds Tackling Health Inequalities Group

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2021

Subject: How health and care organisations are working together in Leeds to tackle health inequalities

Are specific geographical areas affected? If relevant, name(s) of area(s):	☒ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This paper has been produced by the Leeds Tackling Health Inequalities Group (THIG), which was established by the Health and Care Partnership Executive Group (PEG) in June 2020. It demonstrates: that we have a strong commitment across our health and care organisations to achieving our Health and Wellbeing Strategy - that the poorest improve their health the fastest; that much has been done to address the widening gap in outcomes; and that we recognise the impact of COVID-19 on health inequalities. It also invites us, as a health and care system, to be honest about where we're not getting it right and to take bolder action where it is most needed.

Our Communities of Interest and people experiencing the greatest health inequalities have told us many times what would make a difference to them and the long-term nature of this work requires consistent commitment to change and for us all to look closely at what we can do differently to help. We all have a part to play. The Health and Wellbeing Board is asked to lead and be accountable for this most important of endeavours.

This paper is focused on the role of the health and care system, and a separate but connected piece of work is taking place focussing on our actions to address the wider determinants of health.

Recommendations

The Health and Wellbeing Board is asked to:

- Hardwire a focus on the role of health and care in addressing health inequalities, as the future Place Based Partnership's (PBP – working title) overriding purpose, and through our organisations, Population Boards, Care delivery and Service delivery group, and wider partnerships, requiring them to publicly say what has happened and what more is to be done
- Lead the culture shift that is required throughout organisations (at all levels) and commit to going further and faster than nationally mandated activity to tackle health inequalities, using the Tackling Health Inequalities Toolkit as a foundation to support our partnership's individual and collective efforts to ensure they have a wider impact than individual actions
- Consistently and systematically establish robust and regular peer to peer support / challenge, including working with the Communities of Interest Network and Allies, to share commonalities and hold each other to account

1 Purpose of this report

In line with its purpose and the vision for Leeds, this paper proposes that the Health and Wellbeing Board holds the health and care system to account in making changes to tackle health inequalities and requires organisations to publicly say what has happened and what more is to be done. This paper intends to prompt an open and honest discussion on this topic at the public Health and Wellbeing Board on 16th September.

2 Background information

Strategy into delivery

2.1 Our vision is to be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The Leeds Health and Wellbeing Strategy has a wide remit because so many factors contribute to our health and wellbeing. The challenge for the Health and Wellbeing Board is to reflect the breadth of the agenda, whilst being specific about the areas we need to focus on to make the biggest difference.

2.2 The Health Foundation reminds us that the greatest influences on our wellbeing and health are factors such as education and employment, housing, and the extent to which community facilitates healthy habits and social connection. Access to health care could account for as little as 10% of a population's health and wellbeing[1].

2.3 In Leeds, we have been taking this 10% more seriously; considering what, as a collective health and care system, we can do to exert maximum, positive influence over the things directly within our remit; for example, the ways we make decisions, how we design and deliver services, the functioning of our organisations; and our wider influencing role as partners in Leeds.

[1] https://www.health.org.uk/publications/healthy-lives-for-people-in-the-uk

The recent context shines a spotlight

2.4 Health inequalities were already worsening, with the gap in life expectancy increasing between communities locally and nationally before Coronavirus. However, the direct and non-direct impacts of COVID-19 have not impacted equally on communities and led to an exacerbation of health inequalities, with wide ranging impacts on both mental and physical health. Meanwhile, Sir Michael Marmot's most recent report[2] reiterates that the economy and health are strongly linked and that reducing health inequalities, including those exacerbated by the pandemic, requires long-term policies with equity at the heart. As such, our health and care sector has a clear role to play.

2.5 The last year has shown the strong assets we have in our local communities and across our health and care partnership and how we can adapt and pull together when it really matters. Tackling health inequalities is the challenge we must meet with this same determination. Our relationships work in our favour but must be nurtured; our communities and Third Sector infrastructure is enviable but needs protecting; our staff are passionate and compassionate but stretched and tired from the pandemic. Meanwhile, the future Place Based Partnership (PBP) arrangements provide a fundamental opportunity to hardwire a focus on the role of health and care in addressing health inequalities as its overriding purpose.

In summary:

- Health inequalities were already worsening before COVID-19
- Our system strengths must be directed to tackle health inequalities
- Opportunity to hardwire health inequalities focus in PBP

Responding as a system

2.6 The Leeds Tackling Health Inequalities Group (THIG) was established in June 2020, formed of representatives of third sector, health, public health, and care organisations. It focuses on the things within the gift of the health and care system. It is not part of the COVID response or reset work, it doesn't replace or replicate existing groups or activity, and does not yet seek a focus on wider determinants e.g. economy or housing (other than the role health and care organisations can take in these areas). It is not responsible for all action on health inequalities but is a key part of our response.

2.7 Members of THIG began this collaboration from different starting points but have worked together to articulate shared outcomes; co-ordinate, steer, and challenge activity; and share and act upon practical learning. The group's approach has always been to ascertain how and where, as a system, we can go further and faster than what is nationally mandated of us.

2.8 This has required an honest process of understanding different perspectives, using assets and expertise, exploring a vast range of qualitative and quantitative data, and interrogating many potential solutions. THIG has achieved a synthesis of multiple, complex views into clear and tangible proposals for meaningful

[2] https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review

change – reaching a place of common understanding, shared ambitions, and practical things to drive action.

In summary:
- THIG focuses on the things within the gift of the health and care system
- Works to ascertain how and where, as a system, we can go further and faster than what is nationally mandated of us
- Reached common understanding, shared ambitions, and practical things to drive action

Bringing health inequalities into the mainstream

2.9 If we are to achieve our ambitions on the scale required, it's now important that this approach is embedded across organisations, teams and system partners, and within our future PBP scoping. To support this process, THIG recommends the 'mainstreaming' of health inequalities across the health and care system.

2.10 THIG has developed a Tackling Health Inequalities Toolkit. This seeks to enable, support, and facilitate colleagues to focus on health inequalities by equipping them with the knowledge and tools to inform and guide their work. Rather than providing all the answers, it is an evidence based and community informed framework within which all partners have the flexibility to operate, generating a range of responses and action determined by staff and communities.

In summary:
- It's no longer about the extra things we can do to tackle health inequalities, but about tackling health inequalities in everything we do
- The Tackling Health Inequalities Toolkit is not the answer, but a resource that equips colleagues with the knowledge and tools to inform their work

3 Main issues

3.1 *What is the Tackling Health Inequalities Toolkit all about?*

What: An interactive resource detailing shared goals, evidence and information, links to external resources, and practical tools. At its core is a description of what we mean by Health Inequalities as well as the 'conditions for change' and 'priorities for action' that provide the fundamental building blocks for all of our health and care system to use as a framework for their approach.

A quick note:
These building blocks do not supersede national requirements, but are areas where THIG has identified we can go further and faster than nationally mandated activity, for example by applying population health management methodologies, adopting robust mechanisms for coproduction with people and communities, and by implementing the same core principles of proportionate universalism (resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need) and equity (allocating what is needed to reach an equal outcome) when using our resources.

Why: Staff have been telling us that they know of and value the city's ambition statement but asked for something that could help to standardise and guide people through putting this into practice. We know from our learning within our population health management programme, focussing on people living with frailty, that having a framework, with flexibility within it, is what works in Leeds.

How: Supporting information and resources, using consistent language, shared by the whole system, helps us as we pursue more work in an integrated way across partners. To help our efforts be unified without being uniform across the health and care system, the Toolkit aims to:

- increase understanding of health inequalities,
- inform thinking and decision making,
- outline shared goals and themes we can all contribute to,
- guide action that can make a real difference to people who experience health inequalities.

Who: for health and care colleagues to focus on health inequalities in their work, it's for: those in strategic and operational managerial roles; those who design and plan service delivery; and those who deliver frontline care.

The toolkit can be accessed at: https://bit.ly/healthinequalitiestoolkit

3.2 *What practical stuff is making a real difference?*

The strength of and connections within our local communities, infrastructure, and organisations means Leeds is well placed to respond to the challenges we face. And our health and care partners are already doing much to make an impact. For example:

- Leeds Asylum Seeker Support Network (LASSN) has provided equipment/phone credit/data to all clients (300) and volunteers (200), to ensure support and information comes at zero cost to people in Leeds who are destitute - no income, nowhere to live, no right to work, bank account, no recourse to public funds. LASSN is also developing specific ESOL tools (with other ESOL providers) for people who find phone calls difficult or impossible.

- A cross-partner initiative has begun to explore creative and practical means of devolving power and decision making, via Local Care Partnerships, so that community-led activity can help tackle health inequalities.

- Leeds Sexual Health is improving access to treatments by increasing patient choice. The new option for treatments to be posted can benefit people living in poverty by removing the cost of travel to clinic, the option to collect treatments from clinics without appointment have improved access for people with chaotic lifestyles or without a fixed address, for whom the postal option or appointment was not preferred. A new clinic for sex workers and other vulnerable groups offers TB screening, Covid vaccination and can also fit IUD contraception as well as sexual health assessment and treatment.

- Covid vaccination planning included understanding which diverse communities had lower uptake of the vaccine from the beginning. This meant that as soon as potential health inequalities were identified, insight work was undertaken with communities and action taken to deliver in alternative community spaces increasing uptake from 30 to 80% in over 80s in those communities. Additional work to address inequity has included: community engagement through door-to-door; vaccine bus; partnership with Leeds GATE, a third sector organisation supporting Gypsies and Travellers to develop a short film to provide accurate information to the community about the Covid vaccine so they could make an informed choice whether to have it https://www.youtube.com/watch?v=dpqM1YcmoxM; engagement with people with Learning Disabilities and their carers; community drop-ins with pop-ups in Trinity and to be held at Leeds Festival.

- The University of Leeds and LCH have been awarded £3.4m funding from NIHR to lead national research into treatment for Long-Covid, which includes addressing health inequalities as one of its key deliverables. By informing policy, practice and research approaches to reducing inequality, the research will enable Long-Covid care to be accessed by those from disadvantaged groups. The research is co-designed by a patient and public advisory group that includes diverse groups and communities to ensure issues of health inequalities and inequities will be taken into account. The qualitative research will be undertaken with a range of disadvantaged and intersecting social groups (women, minority ethnic, deprived, disabled, homeless and Traveller communities). Best practice that is co-designed in this way, with people from a range of communities, is likely to have an impact on practice from the early stages of the project, improving access, experience and outcomes for diverse groups experiencing Long-Covid.

- Last year, Leeds Mental Wellbeing Service (LMWS - a partnership between NHS and 3rd sector providers) identified that although they had a recovery rate higher than the national average, that this was not the same for all communities. As a result of targeted work with Black, Asian and Minority Ethnic communities the service now has higher recovery rates within this group compared with last year, despite the pandemic. They continue to design interventions, in partnership with different kinds of service users, to create a bespoke service for everybody that needs it.

- Improving palliative and end-of-life care for homeless and vulnerably housed people in Leeds has been a priority for Leeds Palliative Care Network with third sector and NHS partners. This work has been shortlisted by the Nursing Times Award 2021 for Team of the Year.

- NHS Leeds CCG have funded several additional small schemes aimed at tackling health inequalities over the last 12 months, working in partnership with local third sector organisations and others. For example:
    - An outreach primary care service for homeless people during the pandemic. This has had the effect of supporting more people into longer term accommodation working alongside partners

- A scheme aimed at mental health in BAME groups in more deprived communities. This included counselling, group discussions and local mental health ambassadors
- A scheme aimed at improving access to primary care services for adults with autism and learning disabilities. This included training for primary care staff and a peer support scheme for 40 individuals

- LTHT has improved its understanding of the impact of health inequalities on demand for and use of the services it provides

PLEASE NOTE: more examples may be included

3.3 *What is proving persistently challenging: aka where can the HWB help?*

3.3.1 Our health and care system wants to be honest about where things could be a lot better because people are telling us that we have a way to go. Throughout March 2021, Healthwatch Leeds led a series of conversations with our communities to answer the question 'what can health and care providers do to play their part in addressing health inequalities?'. The full report can be accessed as part of the Tackling Health Inequalities Toolkit (https://bit.ly/healthinequalitiestoolkt) and the top 10 themes are:

3.3.2 During the pandemic, accessing primary care and GPs has been much harder, especially where face to face appointments are only being offered in "emergency". Although equipment and connections are in place, the confidence, and language

skills, and the persistence to get through when help is needed, means many people give up and turn to A&E/Walk-in solutions.

3.3.3 Data flow and sharing through the system around equality data will improve data quality which is essential to both identifying existing inequity and understanding whether actions taken have achieved the intended outcome. Leeds Community Healthcare Trust (LCH) has been working to increase demographic recording in our own services and the Leeds Informatics Board through Leeds Care Record and the Yorkshire and Humber Care Record are helping to drive this locally, regionally, and nationally. The complexities of enabling structured data to move between systems mean that this work is ongoing.

3.3.4 We need to acknowledge that we are all working within a health and care system that is living with COVID-19, demand is very high, there significant wider impacts of the pandemic for people, and staff are very stretched. Within this context – and because of this context – we need to all still find the capacity and capability to focus on what we need to do as individuals, as organisations, and as Leeds.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement, and hearing citizen voice

4.1.5 The health and care system has been growing its understanding of health inequalities through existing engagement and listening mechanisms, including the system's Big Leeds Chat, Healthwatch Leeds' 'How it Feels for Me' initiative, Leeds GATE's Roads, Tunnels and Bridges report, and many more activities in individual organisations.

4.1.6 The establishment of the Communities of Interest Network has provided a mechanism to share information and hear back from communities in real time. Healthwatch Leeds has led a series of conversations with the Communities of Interest, the findings of which have been developed into a resource, embedded within the Tackling Health Inequalities Toolkit, to inform the work of health and care staff across the system. To support an ongoing improvement to our informed decision making in the city, the Health and Wellbeing Board has launched an Allyship Programme where members of the Community of Interest Network and other Third Sector organisations are partnered with a Health and Wellbeing Board member, offering peer-to-peer support, greater understanding of challenges and solutions, and with a direct link to the Board's work plan.

4.1.7 The Tackling Health Inequalities Group (THIG) brings together representatives from our third sector, health, public health, and care organisations. More recently, members of the Leeds Solidarity Network (LASSN, Basis, Leeds GATE, and Yorkshire MESMAC) have joined THIG. Members have co-created their 'commitment to the work and each other' to ensure that voices are heard, respected, and acted upon. Our partnership principles have also been applied to this work in the following ways:

We start with people	We deliver	We are Team Leeds
For this work, this means…we systematically and deeply listen to people's voices and experiences, especially those who feel the effects of the greatest inequalities	**For this work, this means…**we use intelligence to direct the Leeds £ towards improving outcomes of people, communities and groups who need it the most	**For this work, this means…**we make certain that communities are at the forefront of this work, making best use of mechanisms such as LCPs and clusters

4.1.8 The Tackling Health Inequalities Toolkit aims to share these approaches and embed them widely across the health and care system. Understanding, planning, acting, and evaluating directly with people who experience health inequalities is a fundamental part of our framework. This is one part of hardwiring a focus on health inequalities and an annual assessment tool has been created to support colleagues to consider, report on, and publish what has happened and what more there is to do. It is a recommendation of this paper that the Health and Wellbeing Board holds organisations and our Place Based Partnership to account on this.

4.2 **Equality and diversity / cohesion and integration**

4.2.1 The Leeds health and care system has long contributed to the vision of Leeds being a city where people who are the poorest improve their health the fastest. This paper shows that it is more essential than ever that we renew our focus and energy on tackling health inequalities; this is how we play our part in creating a fairer, more equal Leeds.

4.2.2 Whilst all health and care organisations have a role to play in tackling health inequalities, this paper has explored what is being done (and what more there is to do) on an individual organisation level, as a system, and as an integrated PBP.

4.3 **Resources and value for money**

4.3.1 N/A

4.4 **Legal Implications, access to information and call In**

4.4.1 N/A

4.5 **Risk management**

4.5.1 Risks are monitored and managed on an individual organisational or project basis.

5 Conclusions

5.1 Our Health and Wellbeing Strategy carries a clear vision, but one that is not yet realised. The people of Leeds cannot, and should not, shoulder the burden of unfair and unjust inequality any longer. The widening gap in outcomes must be addressed urgently and with renewed energy. And the health and care system has a clear role to play.

5.2 Our mechanisms for listening to and working alongside communities are strengthening, our individual organisations are ready to take proactive action, and our local partnership arrangements are becoming clearer. These are all opportunities for us to hardwire a focus on tackling health inequalities throughout our system, to be honest about what we're doing and what is still to be done.

5.3 Building on existing strengths, evidence, and collaboration, our approaches have been set out in a Tackling Health Inequalities Toolkit, with a clear framework, guidance, and tools to inform work across the health and care system. This takes us above and beyond nationally mandated activity because we believe that's the right thing and best thing for people of Leeds. It is imperative that this framework is now embedded and used to create a wave of change.

5.4 The impacts of the pandemic cannot be underestimated; our colleagues and services are fatigued and still dealing with the pressures. This context makes it even more essential that we share the responsibility, learn from each other at least and collaborate with each other at best, and hold each other up to be the best we can.

5.5 Our communities keep telling us where we aren't getting it right, but they will also tell us when we make a change for the better. This open, two-way dialogue must be an essential part of what we do and how we do it because it will benefit us all.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Hardwire a focus on the role of health and care in addressing health inequalities, as the future Place Based Partnership's (PBP – working title) overriding purpose, and through our organisations, Population Boards, Care delivery and Service delivery group, and wider partnerships, requiring them to publicly say what has happened and what more is to be done
- Lead the culture shift that is required throughout organisations (at all levels) and commit to going further and faster than nationally mandated activity to tackle health inequalities, using the Tackling Health Inequalities Toolkit as a foundation to support our partnership's individual and collective efforts
- Consistently establish robust and regular peer to peer support / challenge, including working with the Communities of Interest Network and Allies, to share commonalities and hold each other to account

7 Background documents

7.1 The Leeds Tackling Health Inequalities Toolkit: https://bit.ly/healthinequalitiestoolkt

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
This paper sets out how health and care organisations are working together in Leeds to tackle health inequalities and invites a discussion about what more we can do to make a real, positive, long-term change.

How does this help create a high-quality health and care system?
A high-quality health and care system acknowledges and acts on its responsibility to support those who experience the poorest health outcomes. We have the opportunity to consider what, as a collective health and care system, we can do to exert maximum, positive influence over the things directly within our remit; for example, the ways we make decisions, how we design and deliver services, the functioning of our organisations; and our wider influencing role as partners in Leeds.

How does this help to have a financially sustainable health and care system?
This is no longer about the extra things we can do to tackle health inequalities, but about tackling health inequalities in everything we do. Often this will mean re-considering or re-prioritising our existing work and other times it will mean doing something very different. Using the principles of proportionate universalism will help us target our resources where they are most needed and will have the greatest impact.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Wellbeing Board

Report author: Hannah Davies
Tel:

Report of: People's Voices Group

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2021

Subject: Digital exclusion

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Covid-19 pandemic meant that a significant transformation has taken place in terms of how people can access health and care services, with a much stronger focus on non-face to face and digital access. The Communities of Interest network partners have identified digital exclusion as one of the key issues facing communities in terms of health inequalities. This item will look at the recommendations made a year ago by the People's Voices Group and hear from health and care providers about how they have addressed this key inequalities and access issue. Recommendations can also be found in the 2020 report 'Digitising Leeds: Risks and Opportunities For Reducing Health Inequalities in Leeds' which has been included as appendix 1.

Recommendations

The Health and Wellbeing Board is asked to:

- Link with their Communities of interest ally in preparation for this item to understand how digital exclusion is currently impacting on the communities they work with
- Consider and discuss the actions taken as a health and care system towards addressing digital exclusion
- Consider and discuss any additional steps which should be taken

1 Purpose of this report

1.1 The Covid-19 pandemic meant that a significant transformation has taken place in terms of how people can access health and care services, with a much stronger focus on non-face to face and digital access. This item will look at the recommendations made a year ago by the People's Voices Group and hear from health and care providers about how they have addressed this key inequalities and access issue.

1.2 An important part of the Health and Wellbeing Board's Allyship Programme is to ensure the Board's work plan is shaped by the experiences and insight of our Communities of Interest. This paper demonstrates this commitment and seeks to better inform the Board's decision-making processes.

2 Background information

2.1 The Covid-19 pandemic meant that a significant transformation has taken place in terms of how people can access health and care services, with a much stronger focus on non-face to face and digital access and delivery.

2.2 Early on in the pandemic, the People's Voices Group (PVG) started to hear through their various engagement mechanisms (but in particular through the Covid Weekly Check In listening programme) the impact this was having on people, and particularly those facing the greatest health inequalities. A specific PVG working group formed from across all health and care services to bring together the intelligence that we were hearing. In July 2020, the PVG published their first report, *Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds*.

2.3 The report highlighted key stats, factors affecting digital inclusion, positive and negative impacts of the move to remote services, a framework to support organisations in their thinking and planning around this issue, and a set of recommendations for the city and for individual health and care organisations. The main headlines are as follows.

2.4 Current figures show:

- Tens of thousands of adults in Leeds
- 25,000 are not online at all
- 25% of council housing tenants are not online

2.5 Factors which make people particularly likely to experience digital exclusion include:

1. Poverty
2. Age
3. Literacy and communication preferences
4. Skills and motivation
5. Precarious lifestyles
6. Privacy
7. Disability and specific conditions
8. Trust in IT

2.6 Summary of findings:

- Digital is not “one size fits all”.
- Some groups face significant barriers to accessing services digitally.
- People told us they want digital to enhance rather than replace services.
- For parts of the population digital works really well for some interventions, although it is not the best medium for others.
- Some platforms work for some communities and not others.
- Digitisation should take a person-centred approach and needs to be considered in partnership with the Accessible Information Standard requirements.
- There needs to be a city-wide approach to tackle the issues raised.
- People’s experiences of digital are constantly evolving and their changing needs should be understood on an ongoing basis in the planning of services.
- Health and care staff need tools, support, and training.

2.7 Recommendations made for health and care leaders:

1. Use this insight to build on the existing city-wide approach to digital inclusion

2. Develop city-wide metrics to measure how digital inclusion work is progressing.

3. Build digital inclusion into city-wide staff skills development programmes.

4. Consider how the city’s existing physical spaces and resources can be utilised to improve digital access for people who need it most and identify where investment is required to support our poorest citizens first.

5. Continue to extend the role that the third sector plays in providing personalised support to the people in Leeds who are most vulnerable to digital exclusion and what resources they will require to do this.

6. Set local standards and expectations that service users can expect of all providers in terms of use of data.

7. Develop a resource for the public in Leeds around their choices when it comes to using digital services so that a single, consistent approach is developed across health and care organisations in Leeds.

8. Develop a toolkit for frontline staff to support them to understand when digital is the right medium to deliver an intervention and help them understand the issues related to barriers to access.

9. The Leeds Health Observatory to update the JSNA to identify risks to digital exclusion, with the aim of supporting agencies such as primary health care to tailor their approach to local needs.

10. The Leeds Safeguarding Adults Board should consider the implications of digitisation on safeguarding policy and procedures and amend them accordingly.

2.8 Recommendations made for individual organisations:

1. Organisations to draw up their own Digital Inclusion strategy.

2. Share the report with all relevant staff and access how it relates to their work, so that good practice is identified and shared, and proposals for change can be drawn up internally.

3. Consider whether they would be willing to serve as a digital inclusion case study so that their best practice, challenges and positive changes can be shared with organisations and decision makers across the city.

4. Assess how the digital inclusion agenda can progress in tandem with the existing work around the Accessible Information Standard.

5. Identify where: further engagement work is required to gain a deeper understanding of the issues in Leeds and identify actions, patient/service user insights can be gathered on a routine, ongoing basis.

3 Main issues

How has the city responded?

3.1 An action plan was developed by the StaR (stabilisation and reset) group in response to the report as focusing on taking a place-based approach to this issue. Middleton and Beeston LCP was selected to develop this 'blueprint'. Recommendations made by StaR can be seen within appendix 2.

3.2 Additional funding from the CCG was also allocated to ensure that the health focus of the 100% digital team would remain. Over the last year this has included the expansion of digital hubs in the community; continuing to embed digital inclusion within the Personalised care programme; rolling out digital health champions; continuing the dementia pathfinder work and developing digital inclusion networks for specific communities of interest

3.3 100% Digital Leeds is tasked with delivering on some of the recommendations outlined in the report. The 100% Digital Leeds programme is led by a team in Leeds City Council, working with partners to make Leeds the most digitally inclusive city for everyone. The 100% Digital Leeds team acts in a leadership capacity to catalyse, enable and support the process of systems-level change.

3.4 100% digital has a focus on enabling digital health participation and reducing health inequalities and a number of their key initiatives are as below:

- A place-based approach to enable digital health participation, in partnership with Beeston and Middleton Local Care Partnership (LCP) – In direct response to the Healthwatch Leeds 'Digitising Leeds' report, working in partnership with the LCP to develop and test a place based approach to enable digital health participation with the aim of reducing health inequalities, and removing barriers to delivery and subsequent inclusion in digitised health and care services.

Impact and outcomes to date within Beeston and Middleton LCP include:

- 300+ Digital Champions trained across organisations and services working in the Local Care Partnership footprint, across community organisations and health services
- £500,000 of external funding secured for partners working with people locally, to support digital inclusion initiatives including connectivity, devices, staff capacity, and programmes of activity
- Approximately 200 tablets with connectivity provided to digitally excluded people locally, enabling them to access services and develop their digital skills
- Approximately 40 key staff at Leeds Community Healthcare trained to cascade Digital Champions training across the organisation, support services to be delivered in a more digitally inclusive way, improve referrals and work more closely with the third sector. Developing a digital champion network within LCH to embed digital inclusion within the service.

- Digital Health Hubs - The 100% Digital Leeds team partnered with Cross Gates & District Good Neighbours Scheme to launch the first Digital Health Hub in Leeds. Their 1,200 members received support on topics such as ordering repeat prescriptions online, making a GP appointment online or using the NHS app to self–manage their long-term health conditions. This model is now being developed and through the Beeston and Middleton LCP work, six more Digital Health Hubs implemented.

- NHS Widening Participation Dementia Pathfinder – Trialling digital technology with people living with dementia and their carers. Using Voice Technology, Virtual Reality and digital devices to support self-management and improved health outcomes. In a recent evaluation of the Programme, of those who received support: 59% were better able to access/use health information; 65% felt more informed about their health; 51% used the internet to improve mental health and wellbeing; 21% made fewer GP appointments as a result of accessing online information. The 100% Digital Leeds dementia pathfinder project was included in this evaluation.

  The present oversight of this work is through the Digital sub group of the Person Centred care and support steering group chaired by Alastair Cartwright.

What intelligence has been gathered since the first report?

3.5 Since the first report's publication, the PVG subgroup continue to bring together intelligence about people's experiences and, in autumn 2020, a follow-up report was published detailing how individual communities of interest were finding the move to digital, both in terms of challenges and opportunities.

3.6 Digital exclusion was then identified as a key issue again in another Healthwatch Leeds report entitled *What Can Health and Care Organisations Do to Reduce Health Inequalities*? These findings have been included as a qualitative data resource in the Leeds Health and Care Tackling Health Inequalities Toolkit.

3.7 At the Health and Wellbeing Board meeting, one year on from the initial report, health and care partners will be invited to discuss the work that has been going on in their own organisation on this key issue and to consider the next steps.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 This paper has been produced by the People's Voices Group, which brings together involvement leads from across health and care organisations in Leeds to work together as one team. It was set up by the Leeds Health and Wellbeing Board with a shared aim to put people's voices at the centre of health and care decision making in Leeds, and in particular the voice of people living with the greatest health inequalities.

4.1.2 Various engagement mechanisms are outlined throughout the report and have been used to inform this paper and the accompanying resources mentioned.

4.1.3 In preparation for this agenda item Health and wellbeing board members are invited to link with their Communities of interest ally to understand how digital exclusion is currently impacting on the communities they work with.

4.2 Equality and diversity / cohesion and integration

4.2.1 The Communities of Interest network partners have identified digital exclusion as one of the key issues facing communities in terms of health inequalities. This item looks at the recommendations made a year ago by the People's Voices Group and hears from health and care providers about how they have addressed this key inequalities and access issue.

4.3 Resources and value for money

4.3.1 This paper outlines how funding and resources have already been targeted to combat digital exclusion, including several initiatives led by 100% digital to enable digital health participation and reduce health inequalities.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications from this report.

4.5 Risk management

4.5.1 There are no specific risk implications arising from this report.

5 Conclusions

5.1 Communities of Interest network partners have identified digital exclusion as one of the key issues facing communities in terms of health inequalities. Much work has already been done to respond. The Health and Wellbeing Board has committed to being better informed of issues of health inequalities and are asked to consider any additional steps which could be taken.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Link with their Communities of interest ally in preparation for this item to understand how digital exclusion is currently impacting on the communities they work with
- Consider and discuss the actions taken as a health and care system towards addressing digital exclusion
- Consider and discuss any additional steps which should be taken

7 Background documents

- None

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The Communities of Interest network partners have identified digital exclusion as one of the key issues facing communities in terms of health inequalities. This item demonstrates how health and care providers have addressed this key inequalities and access issue and asks what more can be done.

How does this help create a high quality health and care system?
Understanding, planning, acting and evaluating change that matters most to people is an important part of our health and care system's role in tackle health inequalities and helps us function well for all.

How does this help to have a financially sustainable health and care system?
This paper includes examples of how our resources and efforts have been targeted to respond to the challenges we face and asks that we consider what more we can do with our assets to make a difference.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

This page is intentionally left blank

Your healthwatch Leeds

Appendix 1

Digitising Leeds: Risks and Opportunities For Reducing Health Inequalities in Leeds

People's Voices Group

Contents

1. Introduction

The aim of this insight report

The aim of this briefing paper is to highlight people's experiences in Leeds of the move to digitised health and care services during Covid-19 and pre-Covid-19, with a particular focus on hearing the experiences of people with the greatest health inequalities. It intends to help inform a city in which digitised and remote services provide patients and service users with a *wider* range of choice and improved outcomes.

Who is it for?

This insight report is for anybody who has a role in the future design of health and care services in Leeds.

Who is it by?

It has been written by the Leeds People's Voices Group (PVG)[1] chaired by Healthwatch Leeds, which has formed a Digital Inclusion Subgroup in response to the pandemic. The PVG brings together partners from across the public and third sectors in Leeds to work together as one health and care people's listening team with a focus on hearing the voice of inequalities.

The subgroup includes representatives from Forum Central, Leeds City Council, NHS Leeds Clinical Commissioning Group, Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, academic and research organisations and wider third sector partners. (For a full list of members, please turn to Appendix (b) on page 30.) Draft copies of this briefing have been shared within each of these organisations to ensure it is relevant to their digitisation work as they emerge out of lockdown.

[1] The People's Voices Group: https://healthwatchleeds.co.uk/our-work/pvg/

The subgroup's members have each contributed by submitting engagement work conducted locally and nationally to the group's chair. Over the course of its sessions, the subgroup then identified themes from across the various reports, paying particular mind to work with special relevance to Leeds. The collected research has been distilled to create this report. For a list of papers referenced by the subgroup, please turn to Appendix (c) on page 33

Defining "digitisation"

While this paper uses the term "digital inclusion", it refers not just to internet-based modes of communication but to telephone and other forms of contact such as text messaging.

While digitisation has long been on the agenda across the UK, the coronavirus crisis has lent it extra impetus. National government has previously identified four key barriers to digital inclusion[2]:

- access - not everyone has the ability to connect to the internet
- skills - not everyone has the ability to use the internet and online services
- confidence - some people fear online crime, lack trust or don't know where to start online
- motivation - not everyone sees why using the internet could be relevant and helpful

This paper reflects these barriers while also highlighting some of the key findings from engagement work done in Leeds around digital inclusion. At the heart of this city-wide piece of work is a desire to strike the right balance between digitisation and sustainability on the one hand and improved outcomes and reduced health inequalities for the people of Leeds on the other.

[2] https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy
https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is

How digitised is Leeds?

100% Digital Leeds[3] is a Leeds City Council-funded programme designed to lead digital inclusion in the city. As well as working to ensure everyone has the skills they need to improve their lives through digital technology, it is supporting organisations to develop their own confidence and connectivity. Prior to the coronavirus crisis, it identified that:

- 90,000 adults in Leeds are without essential digital skills
- 50,000 are not online at all
- 40% of council housing tenants are not online

2. When do people in Leeds say digitisation works for them?

Lockdown has helped to identify circumstances in which digital access to health and care works well. It has undoubtedly accelerated planned changes towards virtual health and care appointments and presented the city with a great opportunity to get digitised services right.

From what people have told us, digital and telephone access can be helpful when it offers people a quicker, more convenient experience. For example, it might mean that:

- Patients do not have to take time off work to access healthcare, especially when it is routine
- They do not have to travel to their appointment (saving them time and money)
- It is easier to combine caring duties with medical appointments, for example if they look after young children or other loved ones
- People with reduced mobility can access care and information more conveniently

[3] 100% Digital Leeds: https://digitalinclusionleeds.com/

What benefits did people tell us about pre-COVID-19? - A few examples

"Skype is as good as face to face and easier, as there is no sitting in the waiting area"

"I would like a mixture. It's a good to see someone face to face but I would find it more convenient to FaceTime a consultant"

"I work 55 hours per week. I can't take time off easily for appointments. It would be so much better for me to have a Skype or telephone call. I never need examining so it would work just fine for me to do that"

"I'd be ok with technology if I was feeling okay but if my condition was changing I would prefer a face to face consultation"[4]

What benefits have people told us about during COVID-19? - A few examples

"[It was] excellent. I called at 9.30am. Not too long to wait, receptionist asked what the problem was, then they took my number and gave me a time for a telephone appointment at 2.30pm, later in the day."

"Really good video/telephone consultation with GP. Problem diagnosed and prescription emailed to local pharmacy which I was able to collect the same day."

"I was able to speak to a GP via telephone and it was much easier to explain myself than I thought it would be. I hope they continue to offer this after the lockdown as it is hard for me to get out due to mental health problems."

However, we have heard that these advantages are not available to everyone in Leeds. Some people would be excluded from health and care if they were no longer able to access it face to face, and there are junctures in the patient or service user experience where personal contact is felt to be more appropriate.

[4] These quotations are taken from LTHT's engagement report entitled *Listening Week, Outpatient Services, 23rd - 27th September 2019*.

3. When do people in Leeds say they would like a flexible approach to digitisation?

"There should always be an alternative for those without access"[5]

"Digital should be an enhancement to services not a replacement for it."

Digital and telephone appointments don't work for everyone. Sometimes personal circumstances make people more vulnerable to digital exclusion; sometimes digital appointments are suitable at one stage in a person's care but not another. It is crucial that both these elements are taken into account when making decisions about when patients or service users might require flexibility.

From the Digital Subgroup's work, we have identified eight factors which make people particularly likely to experience digital exclusion. They are:

1. Poverty
2. Age
3. Literacy & communication preferences
4. Skills & motivation
5. Precarious lifestyles
6. Privacy
7. Disability & specific conditions
8. Trust in IT

We have not listed these factors in order of importance or prevalence. Of course, in many cases, these factors will intersect and need to be assessed in combination when considering a person's digital needs.

[5] This quotation and those which follow are taken from Healthwatch Leeds' NHS Long Term Plan report and the various Weekly Check Ins it has published throughout the coronavirus crisis.

Poverty

"I don't have a computer and I don't always have phone credit to use internet access"

"I can't afford internet so wouldn't always be able to use. Also not private in libraries or places I can get it free"

People with low or no incomes (and little access to credit) are less likely to have devices, Wi-Fi or data. Those who do have devices are more likely to access Wi-Fi in public spaces such as libraries.

For example, Unique Minds[6] (which supports men from BAME communities, including refugees and asylum seekers) is one organisation which has reported its users not having access to devices during lockdown. Getaway Girls has also noted that its members – girls and young women aged 11 to 25 – sometimes struggle to access data.

During lockdown, 100% Digital has provided grants and equipment loans to third-sector organisations to enable wider digital access. For instance, it loaned six iPads to Arts and Minds (which supports mental well-being through the arts), two of which were handed to service users so that they can join online workshops.

Age

"I would not use it at my age"

Older people are less likely to want or have the skills to access digital healthcare. For example, according to governmental research, over 53% of people who lack basic digital skills are aged over 65, and 69% are over 55.[7]

[6] Comments for all third-sector organisations referred to in this section are taken from Healthwatch Leeds' Weekly Check Ins.

[7] See "Vulnerable and disadvantaged groups", https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy

During lockdown, third-sector organisations in Leeds which specialise in supporting older populations have repeatedly reported a significant number of their service users cannot access digital services but have, in many cases, managed to maintain links via telephone contact. For example, Bramley Elderly Action has adapted to lockdown by keeping in touch with service users by telephone, but it has not moved any services online. Similarly, Community Action for Roundhay Elderly reports that 90% of its service users rely solely on landlines to communicate; and New Wortley Community Centre notes that its older service users tend not to have Wi-Fi or don't know how to use technology.

Sometimes, older people have connected devices but use them for a restricted number of functions (such as, for example, voice calls and text messaging but not video calls). Carers Leeds, for example, has found that many of its older service users are frequent users of WhatsApp.

Literacy & communication preferences

"Can't speak English very well or read and write"

Some insight has indicated that people who leave school with no or minimal qualifications are less likely to access care digitally, but it is unclear whether that is due to purely educational reasons or it is also linked to poverty.

A lack of English language or literacy skills can be a barrier. For example, the Leeds Syrian Community organisation has explained that language barriers are a particularly significant issue for its service users, and Dream Leeds (which promotes social inclusion for disabled people) has expressed concern about how its non-verbal members will access digital platforms.

Computer skills & motivation

"i have access to I Pad but not confident about using it"

"I'm young and tech savvy but there is so much to be said for human connection. I have a good relationship with my GP and I want to continue to see her in person."

Issues around skills and motivation include a general preference for face-to-face contact and a demotivating belief that seeing someone via a screen isn't "really seeing" them. Some evidence has emerged nationally that people aged over 45 and people with lower levels of income are more likely to fall into the "never have, never will" category.[8]

The way digital services are presented to people who would not ordinarily be attracted to them can have an effect on motivation. For example, if video appointments are presented as a lesser means of contact ("we'd like to see you face-to-face but…"), they are more likely to be seen as a downgraded form of service. Similarly, people can be discouraged if feel they are being pushed into a corner to use digital or that the consequences of a digital appointment going wrong would be severe.

Precarious lifestyles

People living in extremely precarious circumstances may only have devices for short periods of time because they may be quickly sold on or stolen (for example homeless people or people with drug and alcohol addictions). Engage housing support, for instance, has noted that some of its service users tend not to answer their phone or change phones often.

[8] See the section entitled "Never have, never will", https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy

Privacy

"I would not like to try book an appointment using a PC in a library; not open all the time, not private enough and no good if you are not well."

Some people don't have the privacy they need to contact health services by phone or digitally. This has been even more the case during lockdown.

People suffering domestic abuse and carers are particularly likely to have reduced privacy in the home. People with low or no incomes are also more likely to be reliant on public Wi-Fi in libraries and so on, and people living in multi-occupancy housing may not have the physical space for a private consultation.

The potential safeguarding implications of this should be considered.

Disability & Specific Conditions

"I don't hear as well through phone/video as I do face-to-face"

"i am totally blind in one eye and from my own experience, using internet is very bad for my eyes"

Disabilities and long-term conditions undoubtedly have an effect on how willing people are to access care digitally.

In some cases, disabilities can make it impossible to use technology without assistance (for example for people with reduced mobility in their hands, people with dementia and, in the case of some platforms, hearing or sight impairments).

Recording communications and accessibility preferences in patient records and ensuring these records follow patients across services is particularly significant to this group. It is worth pointing out that the Accessible

Information Standard sets out an approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, and therefore needs to be fully integrated into any move towards digitisation.

The willingness of people with specific conditions to access services digitally can depend on what stage they are at in their care. For example, people who have been managing their conditions with confidence for many years are generally more willing to have routine consultations remotely, while people who require physical examinations by a doctor are more likely to have reservations.

There are also strong suggestions that face-to-face contact is best when patients and service users need reassurance, extensive explanations or when they are to be told bad news.

The picture for people with mental health conditions is complex. For some, technology can be intimidating and off-putting, while for others, not having to cope with face-to-face contact is an advantage. This demonstrates how important it is that solutions be tailored to individual circumstances and patients and service users be offered a range of choice.

There are some reservations among people with hearing and sight impairments about access care digitally. One key reason for this is a concern that technology will amplify the difficulties this patient group already experiences when accessing care – for example, NHS apps do not provide an option for booking a British Sign Language interpreter, subtitling solutions can be poor and video interpreting needs setting up carefully.

For instance, the Leeds Society for the Deaf and Blind has observed that some members of its community have minimal-to-no technology available to them. It should also be noted that the Leeds Hearing & Sight Loss Service run by BID has been building up a wealth of expertise in the kinds of facilities different platforms offer to people with sensory impairments.

Trust in IT

"It is very complicated and most of the time it doesn't work"

"I am not comfortable with my medical files being online due to all the people hacking and accessing other people's files."

Some people do not trust IT systems to function reliably or that their data will be handled securely. This is sometimes due to past incidents which have affected them or which have appeared in the media.

There is some evidence that certain service users might be less trusting than others regarding technology, notably people from black and minority ethnic backgrounds or with mental health conditions. For instance, Sisterhood (which provides support for women with mental health problems from BAME communities) has found that its members can be reluctant to give out their contact details.

There are also some concerns that certain patient groups would be vulnerable to cyber-crime. For example, Bee Friends (which runs social groups for older people with a learning disability) reports that its service users are particularly reluctant to communicate online because they worry that they would be making themselves vulnerable to scammers by doing so.

The risk of accessing false information about health is also present for all patient groups.

4. Other factors to consider

People living in care homes and assisted living settings

Sometimes, people living in care homes and other settings might be excluded from accessing services digitally by the factors listed above. (They are, for example, more likely to be elderly or living with disabilities and

long-term conditions.) More engagement is undoubtedly needed regarding this population group and digital inclusion, but there are two early findings that need to be taken into account:

- There are some indications that people working in care settings would find it beneficial to help their service users access services online, as this would save time and relieve residences of the need to organise travel for staff and residents.
- At the same time, it is not clear that all staff have sufficient training to support residents to use technology.

Furthermore, a small piece of engagement work by Healthwatch Leeds during lockdown has indicated that, while many care homes say they are facilitating phone and video calls between residents and relatives, some relatives have found that such contact has not occurred regularly enough. This was usually due to a lack of staff capacity or skills, or equipment not working or being used elsewhere.

Questions regarding capacity to make decisions about preferences, data privacy and so on may also be particularly significant to this population group.

Getting the right platforms for the right people

"I would not use digital services if they were only available using a desktop device. My only means of accessing digital services is via my mobile phone so where services are desktop only, it renders the "service" useless."

"Some online platforms have proved useful, particularly those that enable use of emojis etc to respond when communication is difficult [… but] Platforms such as Zoom can be a huge sensory overload for many autistic people"[9]

There are all kinds of reasons why people might prefer some platforms over others, from the functions they allow (such as audio captioning) to how bandwidth-intensive they are and how familiar people are with them. Services' ability to accommodate these preferences has an effect on how accessible they are. Flexibility needs to be built in so services can adapt to users' preferred platform where possible, rather than the other way around.

One example of this is the finding that Leeds Deaf Forum members prefer texting and platforms such as Facebook to other communications tools. Similarly, Zoom does not necessarily offer the best audio captioning tool.

Safeguarding

It is essential that safeguarding processes evolve in step with digitalisation. Consideration needs to be given as to how to enable people who live in an abusive domestic situation or with carers to disclose any concerns.

Similarly, healthcare professionals should be asked whether they have any reservations about their ability to identify safeguarding issues during a telephone or video call. For instance, the Families Together Leeds service run by Family Action has shared its concern that remote support makes it harder for staff to pick up safeguarding issues.

[9] This quote is drawn from Advonet's digital inclusion summary document drawn up during lockdown.

Staff training

Staff's own digital skills and confidence are crucial to the success of online services. Staff need to feel able both to use technology safely and effectively and to support their patients or service users to do the same.

The way staff present digital options to patients can have a significant effect on how the latter perceive them. For example, if staff present a telephone appointment as a second-best option, it is more likely to be experienced that way by patients. It is very important staff feel comfortable with the digital options they offer patients.

Decision-making tool

At our digital inclusion subgroup meetings, LTHT has suggested that a practical tool to guide clinicians through decisions about whether digital services are suitable for individuals could help to boost staff confidence and support frontline workers to think through when digital is the right medium of delivering an intervention.

Digital services require ongoing conversations and support

Giving people the skills and confidence they need to use digital services often takes time and ongoing support. A single intervention to get a person online will not necessarily be enough.

Evolving landscape

The engagement we have seen indicates that people's experiences of digital services are evolving over time. For example, Forum Central has identified, through its conversations with third-sector organisations, that

while people were generally more willing to use digital services at the height of the lockdown, they have not necessarily retained the same motivation once other options have become available. In light of this, it is important that we continue to capture people's experiences so that decision-making is supported.

5. What next: challenges to consider

As part of this work, we have developed a framework to help organisations and the city to think through some of these issues.

The eight key factors provide an initial framework for identifying people likely to be excluded from digital services and are designed to be used as part of a patient-centred process. Each one is the starting point for a conversation with the patient or service user about their needs and preferences. Not being able to afford a device, for example, may be one obstruction to using digital services, but it might also mask several secondary obstructions such as a lack of IT skills or trust in IT.

Just as important as organisations' ability to record patients' preferences is their ability to modify these records dynamically. Thought needs to be given as to how these preferences are checked regularly, but also communicated from service to service via patient records.

Factor	Challenges for health and care organisations	Challenges for decision-making boards	What questions might require more engagement?
Poverty	How can organisations identify patients whose low income would prevent them from buying a device or paying for Wi-Fi or data? What mechanisms are in place for organisations to feed back to the city about the amount of provision required?	What provision is available to give people access to low-cost, high-quality Wi-Fi or data? What provision is available in public spaces to enable people to access Wi-Fi or data privately?	How many people in the city are not able to afford a device?
Age	What can organisations do to support older people who want to use technology (for example signposting to third-sector organisations)? To what extent should organisations consider unfamiliarity with technology to be a valid reason for using face-to-face services only?	What provision is available to help people become familiar with IT and increase their skills and confidence? What role could the community and voluntary sector play in normalising technology and embedding it within older people's social communication networks?	Do we have enough information about young people and digital health and care?
Literacy & communication preferences	How can organisations identify where low levels of literacy	What training is available for people whose lack of literacy	Why are people with lower levels of educational

	affect individuals' ability to use technology? How can organisations record people's preferences regarding platforms? To what extent can organisations adapt to people's preferred platforms?	skills prevents them from accessing technology?	attainment less likely to want to use technology? Is it often linked to, for example, higher levels of poverty?
Skills & motivation	How can organisations ensure staff feel confident and motivated to use technology when appropriate? What can organisations do to direct people to the training they need to use technology? How do organisations present the option of using technology to patients in such a way that it feels like a genuine choice rather than an imposition?	What can the city (including the community and voluntary sector) do to help people improve their digital skills? How do we do this in a way that emphasises the benefits to the user, rather than technology being a chore or an imposition?	
Precarious lifestyles	How do organisations identify patients who live in extremely precarious circumstances?	How can people living in very precarious circumstances be given permanent access to	Which other people might be affected by extreme precarity

		technology without being made responsible for keeping it safe?	(for example family members of people with addictions)?
Privacy	How do organisations identify people whose home environments wouldn't be sufficiently private for a health or care appointment? Can we offer a service flexible enough to accommodate people who may have sufficient privacy at one time of day but not another? What provision is in place to enable people to disclose safeguarding issues if they don't have privacy in the home or are reliant on others to get them online? Do contingency plans need to be drawn up for circumstances in which a person's privacy is breached during an appointment?	What provision is available for people whose homes aren't private places?	Is it more difficult for healthcare professionals to spot signs of abuse when holding appointments digitally?

Disability & specific conditions	How can we identify at what points in their care people are most likely to need reassurance (and therefore face-to-face contact)? Which platforms are most accessible to people with different conditions? (For example, does a particular platform have a suitable captioning service for people who are hard of hearing?)	How do we involve carers and extended families and support them as a city as they assist loved ones with technology? What is the policy for using digital when dealing with compulsory situations like Mental Health Act assessments? How do different organisations work together smoothly when using different platforms? What role can the community and voluntary sector play in feeding back information about disabled people's technology needs and preferences?	Do we need any further information about how specific conditions can affect people's digital access?
Trust in IT	How do we reassure patients that their data is secure; it will not be lost or shared inappropriately; and they will not be spied on? How do we provide patients with the information they	How do we help people tell the difference between reliable and false health information online? Which data protection policies need to be city-wide?	Do staff have all the training and information they need to help service users use the internet safely?

	need about data safety in an easy-to-understand way? How to we develop an opt in / opt out process for people to give informed consent? Should each primary care practice be incentivised to develop their own digital strategy as different approaches will be needed in different communities?	What role can the community and voluntary sector play in familiarising people with technology and educating them about safety?	

6. Summary of findings

- Digital is not a “one-size fits all”.
- People told us they want digital to enhance rather than replace services.
- Digital works for some interventions and is not the best medium for others.
- Some groups face significant barriers to accessing services digitally.
- For parts of the population digital works really well for some interventions.
- Some platforms work for some communities and not others.
- Digitisation should take a person-centred approach and needs to be considered in partnership with the Accessible Information Standard requirements.
- There needs to be a city-wide approach to tackle the issues raised.
- People’s experiences of digital are constantly evolving and the changing needs should be understood on an ongoing basis in the planning of services.
- Health and care staff need tools, support and training.

7. What next: recommendations

This briefing is being shared with senior leaders and key health and care decision-making groups in the city, including the Health and Well-Being Board, Partnership Executive Group, Health and Social Care Gold Command, the Informatics Board and the Health and Care Inequalities group. It is intended to put people’s experiences at the heart of decision making around digitisation in Leeds. We hope it will spark a city-wide conversation and a wider process in which Leeds’ services benefit from higher levels of digitisation while health inequalities are reduced for all citizens.

As referenced in the report, this is a constantly developing landscape and the People’s Voices Group sub-group will continue to work together to hear people’s experiences of the move to digitisation over 2020 and 2021. The group will act as a central point for decision makers to link into and understand people’s real-time

experience and support them to further develop services to respond and adapt accordingly. As part of this, each individual health and care organisation within Leeds is asked to capture people's experiences of digitisation on a routine basis. The group will then produce a quarterly report with the latest insight that we have heard and highlight any gaps where people are experiencing digital exclusion and the impacts it is having on their health and wellbeing outcomes.

Recommendations for health and care leaders

	Recommendation	Lead partners
1	Use this insight to build on the existing city-wide approach to digital inclusion.	Digital Information Service (LCC) working with City Digital Partnerships Team and nominated leads in H&C organisations
2	Develop city-wide metrics to measure how digital inclusion work in Leeds is progressing.	PVG Digital Inclusion group, 100% Digital and other interested partners such as those in academic settings
3	Build digital inclusion into city-wide staff skills development programmes.	Suggest the Leeds Health and Care Academy working closely with 100% Digital and possible national partners including Skills for Health / Skills for Care, the Good Things Foundation and NHS Digital
4	Consider how the city's existing physical spaces and resources can be utilised to improve digital access for people who need it most, and identify where investment is required to support our poorest citizens first.	Digital Information Service: Smart Leeds with Leeds Informatics Board (possibly Inclusive Growth for infrastructure and investment angle)

5	Continue to extend the role that the third sector plays in providing personalised support to the people in Leeds who are most vulnerable to digital inclusion and what resources they will require to do this.	Third Sector Leeds, including Forum Central and Voluntary Action Leeds
6	Set local standards and expectations that service users can expect of all providers. (For example: "Your data will be kept securely and only shared when...") Standards to be agreed by leaders and shared with all organisations.	City Digital Partnership Team in a co-produced way. PVG to support with co-production, plus any other interested partners, for example mHabitat.
7	Develop a resource for the public in Leeds around their choices when it comes to using digital services so that a single, consistent approach is developed across health and care organisations in Leeds.	City Digital Partnership Team working with the PVG Digital Inclusion sub-group.
8	Develop a "toolkit" for frontline staff to support them to understand when digital is the right medium to deliver an intervention and help them understand the issues related to barriers to access.	City Digital Partnership team working with the PVG Digital Inclusion subgroup and Clinical senate
7	The Leeds Health Observatory to update the Joint Strategic Needs Assessment to identify risks to digital inclusion, with the aim of supporting agencies such as primary health care to tailor their approach to local needs.	LCC Policy and Intelligence Team plus other members of JSA cross-city working group, then publish findings on the Leeds Health Observatory
8	The Leeds Safeguarding Adults Board should consider the implications of digitisation on safeguarding policy and procedures and amend them accordingly.	Digital Information Service (LCC) working with City Digital Partnerships Team and nominated leads in H&C organisations

Recommendations for individual organisations (i.e.: hospitals, GP practices, local authority departments, third-sector organisations)

	Recommendation	How to identify that the recommendation has been acted on
1	Organisations to draw up their own Digital Inclusion strategy, taking into account the insight from this report. We would recommend that this strategy includes the findings summarised in section 6.	Report back to Health and Care Inequalities group .
2	Share the report with all relevant staff and assess how it relates to their work, so that good practice is identified and shared, and proposals for change can be drawn up internally.	Feed this information (and changes enacted as a result) back to a) Decision-making bodies b) Potentially the new Health and Care Inequalities group
3	Consider whether they would be willing to serve as a digital inclusion case study so that their best practice, challenges and positive changes can be shared with organisations and decision makers across the city	100% Digital to oversee submission of case studies and share with relevant organisations and decision-making bodies.
4	Assess how the digital inclusion agenda can progress in tandem with existing work around the Accessible Information Standard.	Organisation representatives to feed back their assessments to the Inclusion for All Hub and PVG subgroup.
5	Identify where: a) Further engagement work is required to gain a deeper understanding of the issues (and their scale) in Leeds and identify actions. b) Patient/service users insights can be gathered on a routine, ongoing basis.	Organisations to share findings as widely as possible, including at PVG meetings and decision-making organisation boards.

Recommendations for the People's Voices Group Digital Inclusion Subgroup

	Recommendation	Who
1	To be a central point for people experience intelligence about digital inclusion in Leeds	All PVG member organisations to routinely share the insight with Healthwatch Leeds.
2	To feed into the citywide work to develop system-wide metrics that measure digital exclusion in Leeds	All PVG members
3	To support the development of a number of practical tools: • When digital should be used – a toolkit for frontline workers to understand when digital should be used and issues that need to be considered • A resource for people in Leeds to understand what the options for them are around receiving care digitally • Support the development of a set of standards that people in Leeds can expect in relation to holding of data, etc.	All PVG members, in partnership with health and care organisations and 100% Digital
4	To develop a quarterly report that highlights people's experiences of that quarter and highlights good practice as well as gaps where digital exclusion is being experienced.	The PVG in coordination with Healthwatch Leeds
5	Identify any gaps in hearing the voices of people and commission specific pieces of targeted engagement, potentially using the Big Leeds Chat branding.	Include digital inclusion on the agenda for the Big Leeds Chat meetings and ensure that it features in upcoming initiatives.

8. Appendix

a. 100% Digital Leeds approach

The fundamental principles of the 100% Digital Leeds approach include:

- Convening community- based assets to ensure that no-one is 'hard to reach';
- Working flexibly and responsively;
- Moving to a whole system approach that enables people to independently look after themselves and improve their lives;
- Connecting people to their communities and a wider circle of care and support;
- Co-designing the right interventions with professionals and practitioners, staff and volunteers and people with lived experience.

First and foremost, COVID-19 is a health crisis and the digital response has strengthened the 100% Digital Leeds team's relationships with NHS partners, Leeds Community Healthcare and the third sector to embed digital inclusion within health and care settings.

COVID-19 further highlighted the digital divide through the implementation of video appointments, online consultations and the greater need for patients in the shielded cohort to self-manage health conditions. During the pandemic, 100% Digital Leeds has worked alongside communities to enable more people and organisations to get online. Working together has increased the delivery of Digital Health Champion training, utilised the equipment lending scheme and shared tools and resources to enable health professionals and staff in health and care settings to embed digital inclusion in their approach. Work has been targeted in priority wards and areas with the highest health inequalities.

Support for third sector organisations has included the provision of data, equipment and devices, grant funding, technical support, Digital Champions training, plus advice on how to tackle digital inclusion issues particular to their own organisation.

How 100% Digital Leeds can support the recommendations and next steps for the PVG group

100% Digital Leeds will continue to:

- Deliver Digital Health Champion training with all staff across Health and Care supporting the digital ready workforce programme.
- Support the Digital Health Champion training to be embedded within the Health and Care staff skills development programmes for new and existing staff, increasing opportunities for digital inclusion to be embedded within clinician to patient communication.
- Work with third sector organisations to embed digital inclusion within community settings, adapting a person-centred approach, coproducing digital inclusion to meet the needs of service users.
- Implement and develop the Digital Health Hub model across Leeds partnering third sector organisations with local Health and Care providers.
- Engage with each LCP to develop a localised plan and approach to tackle digital inclusion in supporting health inequalities.
- Use the 100% Digital Leeds evaluation framework to highlight case studies and impact of digital inclusion across Health and Care, and share these across organisations to promote sharing best practice increase tools and resources.

b. Members of the Digital Inclusion Subgroup

Members based in health and care organisations:

- Samantha Hirst (LCHT)
- Neil Maguire (LCHT)
- Suzanne Slater (LCHT)
- Heather Thrippleton (LCHT)
- Joanne Twigger (LCHT)
- Angela Medd (NHS England)
- Sophie Edwards (NHS England & NHS Improvement)
- Leisa Batkin (NHS Leeds CCG)
- Alison Best (NHS Leeds CCG)
- Chris Bridle (NHS Leeds CCG)
- Angela Collins (NHS Leeds CCG)
- Caroline Mackay (NHS Leeds CCG)
- Patricia McKinney (NHS Leeds CCG volunteer)
- Sharon Moore (NHS CCG Leeds)
- Natasha Noor (NHS Leeds CCG)
- Rosemary Horsman (LTHT)
- Krystina Kozlowska (LTHT)
- Caroline Otieno (LTHT)
- Jennifer Wilson (LTHT)
- Sayed Ahmed (LYPFT)
- Amy Hirst (LYPFT)

- Rachel Pilling (LYPFT)
- Helen Thompson (LYPFT)
- Jennifer Fletcher (St Gemma's)
- Clare Russell (St Gemma's)

Members from Leeds City Council:

- Anne Arnold (Health Partnerships Team)
- Kuldeep Bajwa (consultation and involvement officer)
- Rachel Benn (100% Digital Leeds)
- Bebhinn Browne (health improvement specialist)
- Richard Cracknell
- Lisa Gibson
- Hannah Lamplugh
- Hannah McGurk
- Ade Winterburn
- Lelir Yeung

Members from the community sector:

- Wendy Cork (Advonet)
- Karen Fenton (Forum Central)
- Lucy Graham (Forum Central)
- Karl Witty (Forum Central)
- Anna Chippindale (Healthwatch Leeds)
- Hannah Davies (Healthwatch Leeds & People's Voices Group Digital Inclusion Subgroup chair)

- Dex Hannon (Healthwatch Leeds)
- Stuart Morrison (Healthwatch Leeds)
- Jonathan Phillips (Healthwatch Leeds volunteer)
- Karl Proud (Leeds BID)
- Jagdeep Passan (Leeds Involving People)
- Emily Turner (Leeds Women's Aid)
- Lucy Graham (Forum Central)
- Karen Fenton (Forum Central)
- Karl Witty (Forum Central)
- Sarah Fox (Touchstone)
- Jim Leyland (Touchstone)
- Alison Lowe (Touchstone)
- Sally Poyser (Touchstone)
- Iona Lyons (Voluntary Action Leeds)

Members from academic and research organisations:

- Ruth Coulthard (Leeds Academic Health Partnership)
- Roz Davies (mHabitat)
- Amy Rebane (NIHR Leeds Biomedical Research Centre)

c. Bibliography

Advonet, *Digital Inclusion Summary* (2020)

All Party Parliamentary Group on Social Integration, *Social connection in the COVID-19 crisis* (2020)

Brainbox, *Review of insight research that informs changes to outpatient services*

Forum Central, *Communities of Interest reports* (April to June 2020)

Government Digital Service, *Government Digital Inclusion Strategy* (2014)

Health Service Journal, *Patients shun video in favour of telephone and messaging (*May 2020)

Healthwatch Leeds, *NHS Long Term Plan* (April 2019)

LCH, *LR002 –Video Consultation COVID-19 Response* (June 2020)

Leeds CCG, *BSL interpreting in NHS Services* (October 2019)

Leeds CCG, *Safe Haven Engagement* (2019)

Leeds Community Healthcare Trust, *Video consultations – 'Using patient feedback to understand and improve experience' Process Flow* and *Staff Feedback* (2020)

LTHT, *Listening Week Outpatient Services* (23rd - 27th September 2019)

LYPFT, *Keeping in touch with you - What could do the job?* (2020)

National Coordinating Centre for Public Engagement, *What Works: Engaging the public through social media* (November 2018)

NHS Digital, *Digital Inclusion for Health and Social Care* (2019)

NHS England and NHS Improvement, *On-line consultations research* (February 2019)

Office for National Statistics, *Exploring the UK's digital divide* (March 2019)

The AHSN Network, *Patient & Public Involvement (PPI) in a Digital Age*

Use MY Data, *The patient voice in the expanding data world* (November 2018)

VCSE Health & Wellbeing Alliance and Friends Families & Travellers, *Digital Exclusion in Gypsy and Traveller communities in the United Kingdom* (September 2018)

West Yorkshire and Harrogate Health and Care Partnership, Engagement Mapping (May 2020)

Yorkshire and Humber Care Record, *Joined Up Yorkshire & Humber Explaining Population Health Management*

Appendix 2

Recommendations and response from the StaR (stabilisation and reset) group

	Recommendation	Response from StaR
1	Use this insight to build on the existing citywide approach to digital inclusion.	The report has been shared widely with leads of health and care groups in the city and has prompted discussion about the good work already happening, how to build on it and what can be put in place to address gaps. Through discussion at the StAR Group, a time-limited digital inclusion task and finish group was set up to look at a partnership response. This group has representatives from the City Digital Team, 100% Digital, NHS Leeds CCG, Public Health, the Health Partnerships Team and Local Care Partnership (LCP) Team. Through the group, a pilot is being led by the LCP team in Middleton and Beeston around digital inclusion, linked to an agreed funding of £100k for digital inclusion through the CCG as part of the Health Inequalities Framework. Additionally, the City Digital Team have secured £35k to spend on kit to put into the 100% Digital kit library supporting care homes. The CCG has identified £76,000 to expand 100% Digital Leeds' capacity to work with people in a number of rehabilitation pathways, including MSK, stroke and cardio. Beyond the health and care system, 100% Digital Leeds continues to work closely with stakeholders to build on the existing digital inclusion work and impact within the city.
2	Develop city-wide metrics to measure how digital inclusion work in Leeds is progressing.	City Digital are part of the task group set up through PVG to develop a system wide metric to measure digital inclusion along the existing metrics through 100% Digital. A city map to see digital inclusion alongside other indicators such as financial inclusion, health inequalities and so on is in development.
3	Build digital inclusion into city-wide staff skills development programmes.	100% Digital Leeds continue to deliver Digital Health Champion training with staff across Health and Care (including third sector organisations) supporting the digital-ready workforce programme.

		100% Digital Leeds support the Digital Health Champion training to be embedded within the Health and Care staff skills development programmes for new and existing staff, increasing opportunities for digital inclusion to be embedded within clinician to patient communication.
4	Consider how the city's existing physical spaces and resources can be utilised to improve digital access for people who need it most, and identify where investment is required to support our poorest citizens first.	The connectivity stream of the Smart Leeds Programme is all about ensuring the city is connected with super-fast fibre broadband and is ready to exploit new technologies such as next generation 5G mobile. Free Wi-Fi has been rolled out to all Leeds City Council buildings and some city centre locations such as Millennium Square and Briggate and a key part of future work is making sure no one is left behind, including: - Work with government and private sector suppliers to ensure people and communities have access to the best possible broadband speeds. - Equipping more community buildings with free council wi-fi. - Working towards equipping all council houses and flats with access to the lowest priced broadband, e.g. LCC's Homes of the Future project - There are bespoke approaches in LCC's 6 priority neighbourhood areas. For example, in Lincoln Green, all of proposals for development (whether for the health and care element, housing or community) will consider how to make best use of the digital technology available and where possible reduce the digital divide by improving broadband access and access to the hardware to access the internet. The Strategic Estates Group (an enabler to the Leeds Plan) is considering digital connectivity for any new build or refurbishment projects and is aware there should be an explicit consideration to digital inclusion as part of this. For example, the development of a new Burmantofts Health Centre provides some opportunities for which ICT facilities for community use have already been flagged as a requirement of any new health centre in the area. Through the StAR digital inclusion subgroup, the LCP development team is working with 100% Digital, the City Digital Team, GPs and third sector partners to pilot a digital inclusion project in Beeston and Middleton LCPs. This is very much a place-based

		approach, working with communities and local organisations to understand need and what additional resource is required to enable people to access digital services. 100% Digital continues to work with community organisations to get resources to the people who need them, e.g. through their tablet lending scheme.
5	Continue to extend the role that the third sector plays in providing personalised support to the people in Leeds who are most vulnerable to digital inclusion and what resources they will require to do this.	100% Digital Leeds continue to implement and develop the Digital Health Hub model across Leeds, partnering third sector organisations with local health and care providers. 100% Digital Leeds continue to work with third sector organisations building community capacity, equipment lending and training to enable them to provide personal support to people who use their services. Leeds City Digital Team coordinated a digital grants fund to support third sector organisations during the coronavirus pandemic. The third sector is a key partner in LCPs and as such is involved in the Beeston and Middleton digital inclusion pilot.
6	Set local standards and expectations that service users can expect of all providers. (For example: “Your data will be kept securely and only shared when...”) Standards to be agreed by leaders and shared with all organisations.	The City Information Governance Group leads on security standards and informed the Digital Citizen Blueprint. This document brings together a set of standards for how we create and run digital services that meet the needs of our citizens. Wherever possible, existing standards are used rather than creating new ones. There will also be links to the Living in Leeds project through the Leeds Academic Health Partnership. A project lead from LAHP is part of the PVG digital inclusion subgroup.
7	Develop a resource for the public in Leeds around their choices when it comes to using digital services so that a single, consistent approach is developed across health and care organisations in Leeds	Loop (a portal for health information) will provide local information i.e. a diabetes group in LS1. Further, colleagues in the City Digital Team are developing an Apps library for clinically approved apps.
8	Develop a “toolkit” for frontline staff to support them to understand	This is part of the 100% Digital Leeds Digital Health Champion Training which is currently being

	when digital is the right medium to deliver an intervention and help them understand the issues related to barriers to access.	delivered across health and care and with Social Prescribing teams.
9	The Leeds Health Observatory to update the Joint Strategic Needs Assessment to identify risks to digital inclusion, with the aim of supporting agencies such as primary health care to tailor their approach to local needs.	The JSA is being refreshed in context of COVID and we have passed on this recommendation. A link will be made to 100% Digital Leeds work on developing a map showing digital inclusion/exclusion alongside other indicators.
10	The Leeds Safeguarding Adults Board should consider the implications of digitisation on safeguarding policy and procedures and amend them accordingly.	Awaiting response.

Leeds Health and Wellbeing Board

Report author: Lesley Newlove (Project Advisor, NHS Leeds CCG)

Report of: John Crowther (Chief Officer Resources & Strategy, Adults & Health, Leeds City Council) & Rob Goodyear (Head of Planning & Performance, NHS Leeds CCG)

Report to: Leeds Health and Wellbeing Board

Date:

Subject: Leeds BCF End of Year 2020/21 Template and iBCF Update

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

1. Summary of main issues

1.1. Each quarter, there is a requirement to report to NHS England (NHSE) on the performance of the Better Care Fund (BCF) and to report to the Ministry for Housing, Communities and Local Government (MHCLG) regarding the Improved Better Care Fund (iBCF) funding.

1.2. For Q4 2020/21, completion of an end of year template was required and needed to be submitted to NHSE/MHCLG by 24th May 2021. As national timescales do not align with Health and Wellbeing Board (HWB) meetings, we have been able to submit the template to meet the deadline, subject to sign off by the HWB at a later meeting.

1.3. Since BCF plans were not collected in 2020-21 (due to the coronavirus pandemic) the end of year reporting collects information that would normally have been collected during planning. Specifically, this includes collecting information on national conditions, planned and actual income/expenditure, feedback and iBCF fee rates.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to sign off the Leeds BCF End of Year 2020/21 Template attached as Appendix 1 and note the benefits and outcomes of the additional iBCF funding.

3. Purpose of this report

3.1 To obtain sign off from the Health and Wellbeing Board of the End of Year 2020/21 Template.

4. Background information

4.1 The BCF programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. It represents a unique collaboration between: -

- The Department of Health and Social Care
- The Ministry of Housing, Communities and Local Government
- NHS England and Improvement
- The Local Government Association

4.2 The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Long Term Plan. Locally, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

4.3 Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:-

- minimum allocation from NHS clinical commissioning group(s) (CCGs)
- disabled facilities grant
- social care funding (iBCF)
- winter pressures grant

5. Main issues

5.1 The main highlights of the template are: -

- All National Conditions have been met
- Income and Expenditure - outlines the Health & Wellbeing Board level of actual pooled income and expenditure in 2020/21. This includes the mandatory funding sources of the Disabled Facilities Grant, the iBCF Grant, the Winter Pressures Grant and the minimum CCG contribution
- Year End Feedback – this section provides year end feedback on the delivery of the BCF

- iBCF – this section asked for the average fees paid to external care providers

6. Update on schemes funded through iBCF/Spring Budget monies

6.1 The Spending Review 2015 announced the improved Better Care Fund (iBCF). This was recurrent funding and is used by Leeds to fund long term home care, residential placements and to sustain any fee uplifts to our providers. The Spring Budget 2017 announced additional iBCF funding for adult social care over the following three years.

6.2 Leeds agreed to use this non-recurrent three-year funding to fund transformational initiatives that had compelling business cases to support the future management of service demand and system flow and prevent the need for more specialist and expensive forms of care.

6.3 Initially 30 schemes received this non-recurrent iBCF funding with a further 9 schemes receiving funding from a second bidding process held in 2018/19 when an amount of £1.8m of the original additional iBCF funding was identified as being available. This iBCF funding has now ended and Appendix 2 shows the benefits and outcomes of all schemes.

Health and Wellbeing Board governance

Consultation, engagement and hearing citizen voice
Routine monitoring of the delivery of the BCF is undertaken by the Integrated Commissioning Executive acting as the BCF Partnership Board. The BCF Plan has been developed based on the findings of consultation and engagement exercises undertaken by partner organisations when developing their own organisational plans. Any specific changes undertaken by any of the schemes will be subject to agreed statutory organisational consultation and engagement processes.

Equality and diversity / cohesion and integration
Through the BCF, it is vital that equity of access to services is maintained and that quality of care is not compromised. The vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest' underpins the Leeds Health and Wellbeing Strategy 2016 - 2021. The services funded by the BCF contribute to the delivery of this vision.

Resources and value for money
The iBCF Grant allocated through the Spring Budget 2017 is focussed on initiatives that have the potential to defer or reduce future service demand and/or to ensure that the same or better outcomes can be delivered at a reduced cost to the Leeds £. As such the funding is being used as 'invest to save'.

Legal Implications, access to information and call In
There are no legal, access to information or call in implications from this report.

Risk management
No risks identified now that the additional iBCF funding has ended.

Conclusions
Quarterly national returns in respect of monitoring the performance of the BCF will continue to be completed and submitted to NHS England/the Ministry of Housing, Communities and Local Government.

Recommendations
The Health and Wellbeing Board is asked to sign off the Leeds BCF End of Year 2020/21 Template attached as Appendix 1 and note the benefits and outcomes of the additional iBCF funding.

Background documents
None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The BCF is a programme, of which the iBCF grant is a part, spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high-quality health and care system?
The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system?
The iBCF Grant funding has been jointly agreed between LCC and NHS partners in Leeds and is focussed on transformative initiatives that will manage future demand for services.

Future challenges or opportunities
The initiatives funded through the iBCF Grant have the potential to improve services and deliver savings. To sustain services in the longer term, successful initiatives will need to identify mainstream recurrent funding to continue beyond the non-recurrent testing stage.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

This page is intentionally left blank

Better Care Fund 2020-21 Year-end Template

1. Guidance

Overview

This template is for Health and Wellbeing Boards (HWBs) to provide end of year reporting on their Better Care Fund (BCF) plans. The template should be submitted to the BCF team by 24 May 2021. Since BCF plans were not collected in 2020-21, the end of year reporting will collect information and data on scheme level expenditure that would normally be collected during planning. This is to provide effective accountability for the funding, information and input for national partners and into national datasets.

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For an optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (all sheets)

1. On each sheet, there is a section that helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are 'Green' containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete'.
5. Please ensure that all boxes on the checklist tab are green before submission.

Cover

1. The cover sheet provides essential information on: the area for which the template is being completed; contacts; and sign off.
2. 'Question completion' tracks the number of questions that have been completed. When all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to **england.bettercarefundteam@nhs.net**
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2020-21 (link below) continue to be met through the year, at the time of the template's sign off.

https://www.gov.uk/government/publications/better-care-fund-policy-statement-2020-to-2021/better-care-fund-policy-statement-2020-to-2021

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met during the year and how this is being addressed. Please note that where a national condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

The four national conditions are as below:

- National condition 1: Plans covering all mandatory funding contributions have been agreed by HWB areas and minimum contributions are pooled in a section 75 agreement (an agreement made under section 75 of the NHS Act 2006).
- National condition 2: The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation.
- National condition 3: Spend on CCG commissioned out of hospital services meets or exceeds the minimum ringfence.
- National condition 4: The CCG and LA have confirmed compliance with these conditions to the HWB.

Income and Expenditure Actuals

The Better Care Fund 2020-21 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2020-21. Please include income from additional CCG and LA contributions in 2020-21 in the yellow boxes provided.
- Please provide any comments that may be useful for local context for the reported actual income in 2020-21.

Expenditure section:

- Please enter the total HWB level actual BCF expenditure for 2020-21 in the yellow box provided.
- Please share any comments that may provide a useful local context to the reported actual expenditure in 2020-21.

Year End Feedback

This section provide an opportunity to feedback on delivering the BCF in 2020-21 through a set of survey questions which are, overall, consistent with those from previous years.

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2020-21.

There is a total of 5 questions. These are set out below.

Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree

- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2020-21
3. The delivery of our BCF plan in 2020-21 had a positive impact on the integration of health and social care in our locality

Part - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institute for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2020-21.
5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2020-21?

As noted above, these are free text responses to be assigned to one of the following categories from the SCIE Integration Logic Model - Enablers summarised below. Please see link below for fuller details:
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Social care fees

This section collects data on average fees paid by the local authority for social care. This is similar to data collected in Q2 reporting in previous years.

The questions have been updated for 2020-21 to distinguish long term fee rates from temporary uplifts related to the additional costs and pressures on care providers resulting from the COVID-19 pandemic
Specific guidance on individual questions can be found on the relevant tab.

CCG-HWB Mapping

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level.

Better Care Fund 2020-21 Year-end Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Leeds	Yes
Completed by:	Lesley Newlove	Yes
E-mail:	lesley.newlove@nhs.net	Yes
Contact number:	07718 285353	Yes
Is the template being submitted subject to HWB / delegated sign-off?	Yes, subject to sign-off	Yes

Where a sign-off has been received, please indicate who signed off the report on behalf of the HWB?

Job Title:		Yes
Name:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Income	Yes
5. Expenditure	Yes
6. Income and Expenditure actual	Yes
7. Year-End Feedback	Yes
8. iBCF	Yes

<< Link to the Guidance sheet

Better Care Fund 2020-21 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Leeds

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2020-21:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) The CCG and LA have confirmed compliance with these conditions to the HWB?	Yes		Yes

Better Care Fund 2020-21 Year-end Template

4. Income

Selected Health and Wellbeing Board: Leeds

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leeds	£8,286,057
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,286,057**

iBCF Contribution	Contribution
Leeds	£30,710,369
Total iBCF Contribution	**£30,710,369**

Are any additional LA Contributions being made in 2020-21? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Leeds	£2,714,000	Equipment service contribution
Total Additional Local Authority Contribution	**£2,714,000**	

CCG Minimum Contribution	Contribution
NHS Leeds CCG	£58,055,024
Total Minimum CCG Contribution	**£58,055,024**

Are any additional CCG Contributions being made in 2020-21? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding. If you are including funding made available to support the Hospital Discharge Service Policy in 2020-21, you should record this here

Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£58,055,024**	

	2020-21
Total BCF Pooled Budget	**£99,765,450**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2020-21 Year-end Template

5. Expenditure

Selected Health and Wellbeing Board: Leeds

Running Balances	Income	Expenditure	Balance
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£58,055,024	£58,055,024	£0
iBCF	£30,710,369	£30,710,368	£1
Additional LA Contribution	£2,714,000	£2,714,000	£0
Additional CCG Contribution	£0	£0	£0
Total	£99,765,450	£99,765,449	**£1**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£16,497,591	£31,501,652	£0
Adult Social Care services spend from the minimum CCG allocations	£16,803,627	£16,803,627	£0

Checklist

Complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Link to Scheme Type description

					Expenditure								
Scheme ID	Scheme Name	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
421	Contribution to social care demand pressures	Other		This is a contribution to social care	Social Care		LA			Local Authority	iBCF	£21,089,381	Existing
400	Reablement Services	Intermediate Care Services	Reablement/Rehabilitation Services		Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,807,000	Existing
401	Community beds	Intermediate Care Services	Bed Based - Step Up/Down		Community Health		CCG			Private Sector	Minimum CCG Contribution	£9,878,072	Existing
402	Community beds	Intermediate Care Services	Bed Based - Step Up/Down		Community Health		CCG			Local Authority	Minimum CCG Contribution	£1,406,485	Existing
418	Supporting carers	Carers Services	Carer Advice and Support		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,501,709	Existing
403	Supporting carers	Carers Services	Respite Services		Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£278,126	Existing

404	Supporting carers	Carers Services	Respite Services		Community Health		CCG			Local Authority	Minimum CCG Contribution	£353,610	Existing
405	Leeds Equipment	Assistive Technologies and Equipment	Community Based Equipment		Community Health		CCG			Local Authority	Minimum CCG Contribution	£3,070,000	Existing
406	Leeds Equipment	Assistive Technologies and Equipment	Community Based Equipment		Community Health		LA			Local Authority	Additional LA Contribution	£2,714,000	Existing
419	3rd Sector prevention	Other		These are various mental health prevention	Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£5,443,440	Existing
420	3rd Sector prevention	Other		These are various community health	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£505,911	Existing
407	Admission avoidance	Other		Service to ensure people who are admitted to	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£2,800,000	Existing
408	Community Matrons	Other		Provision of community matrons in all	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,600,000	Existing
409	Homeless Accommodation Leeds Pathway	Other		To provide dedicated beds at St George's	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£303,790	Existing
410	Interface Geriatricians	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,000	Existing
411	Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£8,286,057	Existing
412	Social Care to Health Benefit	Other		Funding for social care to benefit health services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£14,203,372	Existing
413	Contingency	Other		Contingency set aside for any NEA shortfall	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£7,500,000	Existing
414	Care Bill	Care Act Implementation Related Duties	Other	To cover the financial costs associated with	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,900,000	Existing
415	Enhancing Primary care	Prevention / Early Intervention	Risk Stratification		Primary Care		CCG			CCG	Minimum CCG Contribution	£2,141,204	Existing
416	Information Technology	Enablers for Integration	Shared records and Interoperability		Other	IT	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£467,050	Existing
417	Former local reform and Community voices	Other		A former social care grant transferred into	Social Care		LA			Local Authority	Minimum CCG Contribution	£150,000	Existing
500	Additional CCG contribution	Intermediate Care Services	Bed Based - Step Up/Down		Social Care		CCG			Local Authority	Minimum CCG Contribution	£550,255	New

600	Winter Pressures	Home Care or Domiciliary Care			Social Care		LA			Local Authority	iBCF	£3,310,729	New
601	Supporting Social Care	Home Care or Domiciliary Care			Social Care		LA			Local Authority	iBCF	£6,310,258	New

^^ Link back up

Scheme Type	Description	
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	

High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	

Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	
Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

Better Care Fund 2020-21 Year-end Template

6. Income and Expenditure actual

Selected Health and Wellbeing Board: Leeds

Income

	2020-21	
Disabled Facilities Grant	£8,286,057	
Improved Better Care Fund	£30,710,369	
CCG Minimum Fund	£58,055,024	
Minimum Sub Total		£97,051,450

	Planned		Actual			
CCG Additional Funding	£0		Do you wish to change your additional actual CCG funding?	No		
LA Additional Funding	£2,714,000		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£2,714,000				£2,714,000

	Planned 20-21	Actual 20-21
Total BCF Pooled Fund	£99,765,450	£99,765,450

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2020-21	

Expenditure

	2020-21
Plan	£99,765,449

Do you wish to change your actual BCF expenditure?	No
Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2020-21	

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Better Care Fund 2020-21 Year-end Template

7. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2020-21
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Leeds

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The main factor that has improved joint working between health and social care this year has been our response to the Covid pandemic. This was made easier because there was already a strong, well established relationship between health and care partners in Leeds due in part to existing joint working to deliver services funded through the BCF.	Yes
2. Our BCF schemes were implemented as planned in 2020-21	Agree	BCF schemes were implemented as planned in 2020-21.	Yes
3. The delivery of our BCF plan in 2020-21 had a positive impact on the integration of health and social care in our locality	Neither agree nor disagree	This year Covid-19 has had more of a positive impact on the integration of health and social care than the BCF however, Leeds' response to the pandemic was more effective because established health and care relationships were already in place.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2020-21	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	One of our successes has been a Therapy Supported Discharge (TSD) pilot which was funded through the iBCF grant. This is an integrated discharge pathway that promotes fluid working across acute and community settings, improving patient flow and outcomes for patients. Integrated working and improved communication have led to a greater understanding of both settings and has enabled patients to be discharged to Neighbourhood Teams earlier saving an average of 3 bed days per patient seen. Due to the success of the pilot (evidenced by data captured) funding has been secured for TSD to be scaled up and integrated into Leeds Teaching Hospitals Trust (LTHT) and all Leeds Community Healthcare Trust (LCH) Neighbourhood Teams. All partners believe progress on this scheme is being evidenced and that the scheme has met the exit strategy outlined in the business plan. TSD also provided appropriate development opportunities to enable the 3 Band 6 Therapists to secure Band 7 positions. At this time the delivery model of the pilot was reviewed in partnership with LTHT and it was agreed that the number of Band 6 Therapists could be reduced to 2 whilst extending the remaining time of the pilot from 3 months to 4.5 months. LTHT also offered to provide 2 Band 6 Therapists (at no additional cost to this project) to work alongside the 2 new Band 6 TSD Therapists. This meant that the LTHT Therapists and the TSD Therapists were doing the same job and they all followed the hospital discharges through from hospital to home - previously the LTHT Therapists managed the inpatients and the TSD Therapists managed the community patients. By merging these roles, a more fluid model was achieved. Joint assessments also took place which increased the knowledge and skills of LTHT staff to work within the community. With all 4 Therapists now performing the same role, a buddy system has been used to aid joint working, supporting each other in their respective working environments.	Yes
Success 2	2. Strong, system-wide governance and systems leadership	In preparation for refreshing the 2020/21 plan to meet requirements a review of the BCF Partnership Agreement (S75) was conducted. Whilst this review was underway, the development of the Mental Health Strategy brought some of the schemes and services in the BCF together and it was agreed that the alignment of the services to the BCF principles should also be reviewed so we could ensure they still aligned to the strategic priorities of the city i.e. integrated commissioning, home first and mental health. Partners have worked together to refresh the BCF and ensure the services within it not only align to current governance structures but that where possible the total amount of spend is now included in the BCF. The BCF is now a better strategic fit linked to Leeds' Integrated Commissioning Framework with clear integrated and functional governance across services.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2020-21	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	2. Strong, system-wide governance and systems leadership	The NHS England changes that see the abolition of CCGs in April 2022 with an increased responsibility held by ICS leaves the clarity of the future of the BCF a risk. We will need to ensure that the legal requirement to have a BCF is held and managed locally at place as services are relevant to our place population. To date there has been no clarity on how this will be achieved in governance terms and how this will fit into our Health and Wellbeing Board arrangements at place.	Yes
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Leeds relies on the Third Sector as a partner to help improve/deliver a lot of Mental Health and discharge services that sit within our BCF but there are a number of challenges facing the Third Sector at a time when demand for services is at an all time high particularly from populations who experience the greatest levels of health inequalities. Challenges include financial sustainability, workforce capacity, increase in demand for services and digital capability.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2020-21 Year-end Template

8. improved Better Care Fund

Selected Health and Wellbeing Board: Leeds

These questions cover average fees paid by your local authority (including client contributions/user charges) to external care providers for your local authority's eligible clients.
The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (including client contributions/user charges). Specifically the averages SHOULD EXCLUDE:
- Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- Any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.

Respecting these exclusions, the average fees SHOULD INCLUDE:
- Client contributions /user charges.
- Fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- Fees that did not change as a result of the additional IBCF allocation, as well as those that did. We are interested in the whole picture, not just fees that were specifically increased using additional iBCF funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:**
1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2019-20 fee as reported in Q2 2019-20 *	Average 2019-20 fee. If you have newer/better data than at Q2 2019-20, enter it below and explain why it differs in the comments. Otherwise enter the Q2 2019-20 value from the previous column	What was your anticipated average fee rate for 2020-21, if COVID-19 had not occurred?	What was your actual average fee rate per actual user for 2020-21? **	Implied uplift: anticipated 2020-21 rates compared to 2019-20 rates.	Implied uplift: actual 2020-21 rates compared to 2019-20 rates.		Checklist Complete:
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£16.66	£16.86	£17.48	£17.65	3.7%	4.7%		Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£587.00	£587.85	£609.60	£611.99	3.7%	4.1%		Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£616.00	£635.27	£661.31	£667.85	4.1%	5.1%		Yes
4. Please provide additional commentary if your 2019-20 fee is different from that reported at Q2 2019-20. **Please do not use more than 250 characters.**		Rate based on full year information rather than data held at Qtr 2. Variable rates are payable based on area so data at end of year is more accurate for average fee rate for 2019/20 rather than that at Qtr 2.					41 characters remaining	Yes
5. Please briefly list the covid-19 support measures that have most increased your average fees for 2020-21. **Please do not use more than 250 characters.**		Covid has not featured in our fee rates - Covid support has been paid separately.					169 characters remaining	Yes

Footnotes:

* "-" in the column C lookup means that no 2019-20 fee was reported by your council in Q2 2019-20

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

CCG to Health and Well-Being Board Mapping for 2020-21

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.4%	87.2%
E09000002	Barking and Dagenham	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.0%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.7%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.7%	3.7%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.2%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	07P	NHS Brent CCG	2.1%	2.0%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000003	Barnet	08E	NHS Harrow CCG	1.3%	0.8%
E09000003	Barnet	08Y	NHS West London CCG	0.2%	0.1%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000003	Barnet	93C	NHS North Central London CCG	25.0%	96.3%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.5%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	1.1%
E06000022	Bath and North East Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	21.0%	98.4%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	78H	NHS Northamptonshire CCG	0.2%	0.6%
E09000004	Bexley	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000004	Bexley	72Q	NHS South East London CCG	12.5%	98.4%
E09000004	Bexley	91Q	NHS Kent and Medway CCG	0.2%	1.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	38.7%	17.5%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E08000025	Birmingham	08C	NHS Hammersmith and Fulham CCG	0.6%	0.2%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.5%	81.8%
E08000025	Birmingham	18C	NHS Herefordshire and Worcestershire CCG	0.7%	0.4%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.7%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.8%	1.8%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.0%	97.7%
E06000009	Blackpool	02M	NHS Fylde and Wyre CCG	2.0%	2.3%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.7%	99.7%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.1%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.0%	96.7%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E08000032	Bradford	02T	NHS Calderdale CCG	0.3%	0.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	36J	NHS Bradford District and Craven CCG	90.5%	98.5%
E09000005	Brent	07P	NHS Brent CCG	89.1%	85.8%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000005	Brent	08E	NHS Harrow CCG	6.0%	4.0%
E09000005	Brent	08Y	NHS West London CCG	4.1%	2.5%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.4%	0.8%
E09000005	Brent	93C	NHS North Central London CCG	1.4%	5.6%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	70F	NHS West Sussex CCG	0.0%	0.2%
E06000043	Brighton and Hove	97R	NHS East Sussex CCG	0.0%	0.1%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.6%	100.0%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000006	Bromley	36L	NHS South West London CCG	0.3%	1.5%
E09000006	Bromley	72Q	NHS South East London CCG	17.2%	98.1%
E09000006	Bromley	91Q	NHS Kent and Medway CCG	0.0%	0.2%
E06000060	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E06000060	Buckinghamshire	06F	NHS Bedfordshire CCG	0.5%	0.4%
E06000060	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E06000060	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E06000060	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.5%	0.7%
E06000060	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.5%	94.9%
E06000060	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E06000060	Buckinghamshire	78H	NHS Northamptonshire CCG	0.1%	0.2%
E08000002	Bury	00T	NHS Bolton CCG	0.7%	1.1%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.4%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.1%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	1.9%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	36J	NHS Bradford District and Craven CCG	0.2%	0.7%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%

E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.7%	96.8%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	3.9%	1.4%
E10000003	Cambridgeshire	26A	NHS Norfolk and Waveney CCG	0.3%	0.4%
E09000007	Camden	07P	NHS Brent CCG	1.2%	1.7%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	1.1%	1.2%
E09000007	Camden	08Y	NHS West London CCG	0.3%	0.3%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.4%	4.7%
E09000007	Camden	93C	NHS North Central London CCG	15.4%	92.1%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.7%	94.9%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.7%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.1%	1.7%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.6%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.2%	0.6%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.2%
E06000049	Cheshire East	27D	NHS Cheshire CCG	51.6%	97.4%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E06000050	Cheshire West and Chester	27D	NHS Cheshire CCG	47.3%	99.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	66.3%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.1%	4.3%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.3%	12.8%
E09000001	City of London	08Y	NHS West London CCG	0.0%	0.2%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	3.4%
E09000001	City of London	72Q	NHS South East London CCG	0.0%	0.3%
E09000001	City of London	93C	NHS North Central London CCG	0.0%	12.7%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000047	County Durham	00P	NHS Sunderland CCG	1.1%	0.6%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	16C	NHS Tees Valley CCG	0.1%	0.1%
E06000047	County Durham	84H	NHS County Durham CCG	96.8%	98.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.6%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E08000026	Coventry	05R	NHS South Warwickshire CCG	0.1%	0.0%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000008	Croydon	36L	NHS South West London CCG	23.9%	93.7%
E09000008	Croydon	72Q	NHS South East London CCG	1.0%	4.7%
E09000008	Croydon	92A	NHS Surrey Heartlands CCG	0.6%	1.4%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.5%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	53.2%	36.5%
E06000005	Darlington	16C	NHS Tees Valley CCG	15.2%	96.6%
E06000005	Darlington	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000005	Darlington	84H	NHS County Durham CCG	0.7%	3.3%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.6%	100.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.6%	0.3%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.5%
E10000007	Derbyshire	52R	NHS Nottingham and Nottinghamshire CCG	0.9%	1.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	15N	NHS Devon CCG	66.0%	99.2%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.7%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	97.0%	97.7%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	11J	NHS Dorset CCG	45.9%	95.7%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	0.9%
E08000027	Dudley	05C	NHS Dudley CCG	91.9%	90.6%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	7.0%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.7%	1.5%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	18C	NHS Herefordshire and Worcestershire CCG	0.1%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	2.1%	1.9%
E09000009	Ealing	07W	NHS Ealing CCG	87.0%	89.7%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.4%	3.3%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.1%	3.5%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	08Y	NHS West London CCG	0.8%	0.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.4%	0.2%
E09000009	Ealing	93C	NHS North Central London CCG	0.0%	0.1%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.2%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	8.7%	7.5%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.8%	7.1%
E06000011	East Riding of Yorkshire	42D	NHS North Yorkshire CCG	0.2%	0.2%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	70F	NHS West Sussex CCG	0.7%	1.2%
E10000011	East Sussex	91Q	NHS Kent and Medway CCG	0.2%	0.7%
E10000011	East Sussex	97R	NHS East Sussex CCG	99.4%	97.5%

E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000010	Enfield	93C	NHS North Central London CCG	21.6%	98.9%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.5%	0.6%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	07H	NHS West Essex CCG	97.2%	19.9%
E10000012	Essex	07K	NHS West Suffolk CCG	3.0%	0.5%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.2%	0.0%
E10000012	Essex	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000012	Essex	08F	NHS Havering CCG	0.4%	0.0%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.1%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.4%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.1%	97.7%
E08000037	Gateshead	84H	NHS County Durham CCG	0.5%	1.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.3%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.5%	98.6%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	18C	NHS Herefordshire and Worcestershire CCG	0.5%	0.6%
E10000013	Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.1%	0.2%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000011	Greenwich	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000011	Greenwich	72Q	NHS South East London CCG	15.2%	99.2%
E09000011	Greenwich	93C	NHS North Central London CCG	0.0%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.1%	92.2%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	1.4%	1.3%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.7%	0.7%
E09000012	Hackney	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000012	Hackney	93C	NHS North Central London CCG	1.0%	5.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.2%
E06000006	Halton	27D	NHS Cheshire CCG	0.2%	1.0%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.5%	1.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.6%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	67.9%	87.0%
E09000013	Hammersmith and Fulham	08Y	NHS West London CCG	7.0%	7.6%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.6%
E09000013	Hammersmith and Fulham	36L	NHS South West London CCG	0.0%	0.4%
E09000013	Hammersmith and Fulham	72Q	NHS South East London CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	93C	NHS North Central London CCG	0.0%	0.2%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.9%	0.0%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.3%	16.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.4%	14.1%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.7%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	4.9%	1.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.2%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.6%	0.6%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	70F	NHS West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	92A	NHS Surrey Heartlands CCG	0.6%	0.5%
E10000014	Hampshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.6%	0.4%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.6%	12.4%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.9%	0.9%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000014	Haringey	93C	NHS North Central London CCG	18.3%	95.9%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	07P	NHS Brent CCG	3.8%	5.1%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.0%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000015	Harrow	08E	NHS Harrow CCG	89.6%	83.9%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	1.9%
E09000015	Harrow	08Y	NHS West London CCG	0.1%	0.1%
E09000015	Harrow	93C	NHS North Central London CCG	1.1%	6.2%
E06000001	Hartlepool	16C	NHS Tees Valley CCG	13.6%	99.2%
E06000001	Hartlepool	84H	NHS County Durham CCG	0.1%	0.8%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.7%	3.1%
E09000016	Havering	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000016	Havering	08F	NHS Havering CCG	91.6%	95.6%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.7%	0.8%
E09000016	Havering	08W	NHS Waltham Forest CCG	0.1%	0.1%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	1.0%
E06000019	Herefordshire, County of	18C	NHS Herefordshire and Worcestershire CCG	23.2%	98.6%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%

E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.8%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.9%	0.2%
E10000015	Hertfordshire	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.0%
E10000015	Hertfordshire	93C	NHS North Central London CCG	0.2%	0.2%
E09000017	Hillingdon	07P	NHS Brent CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.3%	7.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.2%	1.2%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.1%	1.7%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.4%	89.5%
E09000017	Hillingdon	08Y	NHS West London CCG	0.1%	0.0%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000018	Hounslow	07W	NHS Ealing CCG	5.3%	7.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.5%	87.1%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	1.1%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	08Y	NHS West London CCG	0.2%	0.2%
E09000018	Hounslow	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000018	Hounslow	36L	NHS South West London CCG	0.7%	3.8%
E09000018	Hounslow	92A	NHS Surrey Heartlands CCG	0.1%	0.4%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.0%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	1.5%	1.8%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.6%	0.6%
E09000019	Islington	93C	NHS North Central London CCG	15.0%	93.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.4%	2.3%
E09000020	Kensington and Chelsea	08Y	NHS West London CCG	63.8%	91.6%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	36L	NHS South West London CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	93C	NHS North Central London CCG	0.0%	0.4%
E10000016	Kent	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000016	Kent	72Q	NHS South East London CCG	0.4%	0.5%
E10000016	Kent	91Q	NHS Kent and Medway CCG	84.6%	99.4%
E10000016	Kent	97R	NHS East Sussex CCG	0.3%	0.1%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	91.3%	98.6%
E09000021	Kingston upon Thames	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000021	Kingston upon Thames	36L	NHS South West London CCG	11.3%	98.8%
E09000021	Kingston upon Thames	92A	NHS Surrey Heartlands CCG	0.2%	1.1%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.6%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.3%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.6%	1.4%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	36J	NHS Bradford District and Craven CCG	0.5%	0.7%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	87.0%	88.1%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.2%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.7%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.1%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	1.6%	1.3%
E09000022	Lambeth	08Y	NHS West London CCG	0.1%	0.0%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	1.5%	0.9%
E09000022	Lambeth	36L	NHS South West London CCG	1.2%	4.9%
E09000022	Lambeth	72Q	NHS South East London CCG	18.3%	92.6%
E09000022	Lambeth	93C	NHS North Central London CCG	0.0%	0.3%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	14.0%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	29.9%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.8%	0.2%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.7%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	45.0%	12.3%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.3%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.4%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.6%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E10000017	Lancashire	02M	NHS Fylde and Wyre CCG	98.0%	13.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.5%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E08000035	Leeds	15F	NHS Leeds CCG	97.6%	98.7%
E08000035	Leeds	36J	NHS Bradford District and Craven CCG	0.6%	0.5%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	1.6%	1.3%
E06000016	Leicester	04C	NHS Leicester City CCG	93.0%	96.0%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.9%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.0%	4.1%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	52R	NHS Nottingham and Nottinghamshire CCG	0.6%	1.0%
E10000018	Leicestershire	71E	NHS Lincolnshire CCG	0.9%	1.0%

E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.9%	0.8%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	36L	NHS South West London CCG	0.0%	0.2%
E09000023	Lewisham	72Q	NHS South East London CCG	16.6%	98.7%
E09000023	Lewisham	93C	NHS North Central London CCG	0.0%	0.1%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	5.0%	1.1%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	52R	NHS Nottingham and Nottinghamshire CCG	0.3%	0.4%
E10000019	Lincolnshire	71E	NHS Lincolnshire CCG	96.4%	97.5%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.3%	2.6%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.5%	1.0%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.4%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.7%
E06000032	Luton	06P	NHS Luton CCG	97.5%	95.3%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	00Y	NHS Oldham CCG	0.8%	0.3%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.9%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	3.8%	1.4%
E08000003	Manchester	14L	NHS Manchester CCG	91.1%	95.8%
E06000035	Medway	91Q	NHS Kent and Medway CCG	15.0%	100.0%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.4%	0.5%
E09000024	Merton	36L	NHS South West London CCG	14.5%	97.5%
E09000024	Merton	72Q	NHS South East London CCG	0.3%	2.0%
E06000002	Middlesbrough	16C	NHS Tees Valley CCG	22.4%	99.8%
E06000002	Middlesbrough	42D	NHS North Yorkshire CCG	0.0%	0.2%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	78H	NHS Northamptonshire CCG	0.5%	1.3%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.9%	0.8%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	59.5%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	3.9%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.6%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	1.3%	0.9%
E09000025	Newham	08M	NHS Newham CCG	96.6%	96.1%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.3%	0.3%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	72Q	NHS South East London CCG	0.0%	0.1%
E09000025	Newham	93C	NHS North Central London CCG	0.0%	0.2%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.6%	0.7%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.1%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.5%	0.7%
E10000020	Norfolk	26A	NHS Norfolk and Waveney CCG	87.7%	98.6%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.5%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000012	North East Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.3%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.2%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.2%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.8%	96.8%
E06000013	North Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.4%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.5%	98.3%
E06000024	North Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	1.5%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.3%	96.5%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.8%	1.0%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.5%	0.7%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.8%	19.0%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	1.9%	1.2%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	16C	NHS Tees Valley CCG	0.3%	0.4%
E10000023	North Yorkshire	36J	NHS Bradford District and Craven CCG	8.1%	8.3%
E10000023	North Yorkshire	42D	NHS North Yorkshire CCG	99.4%	67.9%
E10000023	North Yorkshire	84H	NHS County Durham CCG	0.1%	0.1%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.1%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.5%	1.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.0%	1.0%
E10000021	Northamptonshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E10000021	Northamptonshire	78H	NHS Northamptonshire CCG	99.0%	94.8%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	84H	NHS County Durham CCG	0.0%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.8%	0.6%
E06000018	Nottingham	52R	NHS Nottingham and Nottinghamshire CCG	33.5%	100.0%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	96.9%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.4%	1.7%
E10000024	Nottinghamshire	52R	NHS Nottingham and Nottinghamshire CCG	64.7%	83.8%

E10000024	Nottinghamshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.6%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.5%	1.8%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.4%	0.3%
E10000025	Oxfordshire	78H	NHS Northamptonshire CCG	0.1%	0.1%
E10000025	Oxfordshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.7%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.2%	96.4%
E06000031	Peterborough	71E	NHS Lincolnshire CCG	1.1%	3.6%
E06000026	Plymouth	15N	NHS Devon CCG	21.9%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.6%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.3%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.3%	1.0%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.0%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.8%	3.2%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.3%	0.3%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.3%	1.6%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.2%	89.5%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.2%	3.0%
E09000026	Redbridge	93C	NHS North Central London CCG	0.0%	0.1%
E06000003	Redcar and Cleveland	16C	NHS Tees Valley CCG	19.9%	98.8%
E06000003	Redcar and Cleveland	42D	NHS North Yorkshire CCG	0.4%	1.2%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.7%	6.8%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.6%	0.7%
E09000027	Richmond upon Thames	08Y	NHS West London CCG	0.0%	0.1%
E09000027	Richmond upon Thames	36L	NHS South West London CCG	12.3%	92.2%
E09000027	Richmond upon Thames	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.5%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.2%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.0%	1.1%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.9%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	10.0%	86.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	71E	NHS Lincolnshire CCG	0.6%	12.5%
E06000017	Rutland	78H	NHS Northamptonshire CCG	0.0%	0.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.3%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.5%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.6%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.5%	88.5%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.4%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.2%
E08000014	Sefton	01J	NHS Knowsley CCG	1.9%	1.1%
E08000014	Sefton	01T	NHS South Sefton CCG	95.9%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.7%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.2%	0.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.4%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.9%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.4%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.3%
E06000051	Shropshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.3%	0.9%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.5%
E06000051	Shropshire	18C	NHS Herefordshire and Worcestershire CCG	0.6%	1.6%
E06000051	Shropshire	27D	NHS Cheshire CCG	0.2%	0.4%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.2%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.2%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.7%	5.7%
E06000039	Slough	15D	NHS East Berkshire CCG	34.3%	93.7%
E06000039	Slough	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	16.9%	99.0%
E08000029	Solihull	18C	NHS Herefordshire and Worcestershire CCG	0.0%	0.3%
E10000027	Somerset	11J	NHS Dorset CCG	0.4%	0.6%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.4%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.8%	1.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.9%	1.9%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.6%
E06000025	South Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.2%	0.6%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%

E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E06000045	Southampton	10X	NHS Southampton CCG	95.1%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	1.9%	1.5%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.6%	1.7%
E09000028	Southwark	36L	NHS South West London CCG	0.0%	0.2%
E09000028	Southwark	72Q	NHS South East London CCG	17.7%	95.9%
E09000028	Southwark	93C	NHS North Central London CCG	0.1%	0.6%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.2%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.4%	2.2%
E08000013	St. Helens	01X	NHS St Helens CCG	91.6%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.4%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	2.9%	1.1%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.9%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	94.9%	23.1%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	05N	NHS Shropshire CCG	0.9%	0.3%
E10000028	Staffordshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	96.1%	23.0%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.7%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	9.2%	3.0%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.7%	0.6%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.5%	0.8%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.6%
E10000028	Staffordshire	27D	NHS Cheshire CCG	0.3%	0.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.7%	96.7%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E08000007	Stockport	14L	NHS Manchester CCG	1.0%	2.1%
E08000007	Stockport	27D	NHS Cheshire CCG	0.4%	1.0%
E06000004	Stockton-on-Tees	16C	NHS Tees Valley CCG	28.5%	99.3%
E06000004	Stockton-on-Tees	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000004	Stockton-on-Tees	84H	NHS County Durham CCG	0.2%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.3%	0.1%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	90.8%	97.2%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.7%
E10000029	Suffolk	07K	NHS West Suffolk CCG	90.5%	29.8%
E10000029	Suffolk	26A	NHS Norfolk and Waveney CCG	12.0%	16.4%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	95.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	84H	NHS County Durham CCG	1.6%	3.0%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.8%	0.2%
E10000030	Surrey	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.7%	7.6%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.3%
E10000030	Surrey	36L	NHS South West London CCG	1.2%	1.6%
E10000030	Surrey	70F	NHS West Sussex CCG	1.4%	1.0%
E10000030	Surrey	72Q	NHS South East London CCG	0.0%	0.1%
E10000030	Surrey	92A	NHS Surrey Heartlands CCG	97.3%	84.1%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	22.8%	4.1%
E09000029	Sutton	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000029	Sutton	36L	NHS South West London CCG	12.7%	97.8%
E09000029	Sutton	72Q	NHS South East London CCG	0.0%	0.3%
E09000029	Sutton	92A	NHS Surrey Heartlands CCG	0.4%	1.8%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.1%	0.2%
E06000030	Swindon	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	24.9%	99.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.4%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	87.9%
E08000008	Tameside	14L	NHS Manchester CCG	2.1%	5.8%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.6%	97.1%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	98.7%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.4%	0.4%
E06000034	Thurrock	08F	NHS Havering CCG	0.3%	0.4%
E06000034	Thurrock	08M	NHS Newham CCG	0.0%	0.1%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000027	Torbay	15N	NHS Devon CCG	11.6%	100.0%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	1.2%	1.1%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	2.6%	2.2%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.6%	94.5%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.7%	0.5%
E09000030	Tower Hamlets	72Q	NHS South East London CCG	0.0%	0.2%
E09000030	Tower Hamlets	93C	NHS North Central London CCG	0.3%	1.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.9%	92.3%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000009	Trafford	14L	NHS Manchester CCG	2.8%	7.4%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.1%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.6%	0.3%

E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.7%	3.3%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.5%	1.4%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.0%	4.7%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.3%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.2%	95.3%
E09000031	Waltham Forest	93C	NHS North Central London CCG	0.0%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.9%	1.4%
E09000032	Wandsworth	08Y	NHS West London CCG	0.9%	0.6%
E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	1.3%	0.8%
E09000032	Wandsworth	36L	NHS South West London CCG	22.0%	93.3%
E09000032	Wandsworth	72Q	NHS South East London CCG	0.8%	3.8%
E09000032	Wandsworth	93C	NHS North Central London CCG	0.0%	0.1%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	1.9%
E06000007	Warrington	02E	NHS Warrington CCG	97.5%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.1%	21.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.6%	30.4%
E10000031	Warwickshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.0%	46.0%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	18C	NHS Herefordshire and Worcestershire CCG	0.2%	0.2%
E10000031	Warwickshire	78H	NHS Northamptonshire CCG	0.2%	0.2%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.6%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	29.7%	97.7%
E06000037	West Berkshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.0%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.0%	1.0%
E10000032	West Sussex	70F	NHS West Sussex CCG	97.7%	97.4%
E10000032	West Sussex	92A	NHS Surrey Heartlands CCG	0.8%	1.0%
E10000032	West Sussex	97R	NHS East Sussex CCG	0.3%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	1.5%	1.7%
E09000033	Westminster	08Y	NHS West London CCG	22.4%	21.6%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	77.6%	70.8%
E09000033	Westminster	72Q	NHS South East London CCG	0.0%	0.2%
E09000033	Westminster	93C	NHS North Central London CCG	0.6%	3.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.5%	2.1%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.3%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.9%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.9%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.2%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.4%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	51.0%	97.8%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.0%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	33.7%	96.9%
E06000040	Windsor and Maidenhead	92A	NHS Surrey Heartlands CCG	0.0%	0.5%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.6%
E08000015	Wirral	27D	NHS Cheshire CCG	0.2%	0.4%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	15A	NHS Berkshire West CCG	32.1%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.5%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.4%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.2%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.9%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.4%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	94.0%	93.4%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.4%	1.1%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	18C	NHS Herefordshire and Worcestershire CCG	74.6%	95.8%
E06000014	York	03Q	NHS Vale of York CCG	59.8%	99.9%
E06000014	York	42D	NHS North Yorkshire CCG	0.0%	0.1%

Produced by NHS England & Improvement using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

Benefits and outcomes of schemes funded from iBCF non-recurrent monies

Schemes have been categorised to show where funding has been mainstreamed to enable the schemes to continue or where they were only for a fixed term and came to an end on or before 31st March 2021. In some cases, system wide discussions are continuing or are required to determine continuity and sources of funding.

Key
Scheme mainstreamed
Fixed Term scheme now ended
Funding discussions continuing/required

SB3	SkILs Reablement Service
Purpose	To increase system flow of patients by placing Case Officers in LTHT and having dedicated Social Work Assistants to support timely exits from reablement where an ongoing service is required.
Expected Benefits	a) An increase in the number of appropriate referrals to SkILs from LTHT – average monthly referrals = 181 b) A reduction in the number of people in transition from reablement – average monthly number of people in transition = 80 c) A reduction in the length of time people are supported in transition by reablement from 4.5 weeks
Outcomes	a) Sept 19 =205, Oct 19 = 205, Nov 19= 241 b) Aug 19 = 45, Sept 19 = 93, Oct 19 = 85, Nov 19= 64 c) 3.7 weeks • SkILs Case Officers were on hospital wards from 12 to 3pm following up customers that the Discharge Teams identified. They talked to patients about the service and how it would support them at home. • Improved service productivity and customer satisfaction

SB7	SWIFt (supporting wellbeing and independence in Frailty) Scheme SB85 continued this work
Purpose	The aim of this service is to work with older people who are living with frailty, socially isolated and with complex issues to improve their quality of life and support them to live independently by: • Helping them to identify ways to build self-confidence and resilience • Providing practical support to help them achieve their aspirations • Ensuring they are accessing the support services they require The service offers targeted, person centred 'wrap around' support.
Expected Benefits	a) Improve the health and wellbeing of older people reducing their risk factors for increasing frailty b) Reduce social isolation and improve support networks for older people to increase resilience

	c) Support a greater number of older people to live independently and safely in their own homes increasing time spent at home and reducing hospital and care home admissions d) Provide person centred support for older people working across the health and social care system complementing existing services e) Improve the wider determinants of health, including economic disadvantage and discrimination
Outcomes	a) 62% experienced an improvement in the health and wellbeing b) 49% experienced an improvement in their social isolation c) 1027 home visits were completed between 1st April 2019 and 31st March 2020 d) 372 action plans were completed between 1st April 2019 and 31st June 2020 e) 12 case studies were submitted for delivery between 1st April 2020 and 31st June 2020

SB8	Customer Access
Purpose	To fully adopt strength based social care, the following changes will need to be put in place this year:- • A new strength based conversation at the first point of contact • Calling customers back as standard after receiving referrals from third party • Increase the use of Leeds care record for data gathering on all email referrals • A new process that includes an increase in mental health referrals at front end and the rolling out of a system that allows Customer Service Officers (CSO) to book into talking points across the city.
Expected Benefits	a) Increase signposting from 53% b) Increase number of customers booked into a talking point at first point of contact from 2 sessions per week in Armley to 2 sessions per week across 13 neighbourhoods
Outcome	a) Signposting = 58% over reporting period b) 45 per month Performance figures indicate that the contact centre is logging less non referral contacts for known customers. This is an indication that failure demand is decreasing.

SB12	Local Area Coordination & Asset Based Community Development (ABCD)
Purpose	The purpose of this scheme is to support communities using local area coordination and ABCD principles to respond to the needs of people who have or may be in need of social care support.
Expected Benefits	a) Improved quality of life for people with low to moderate learning disabilities b) The ABCD pathfinders will help to improve wellbeing and community resilience in the neighbourhoods in which they operate; supporting the rollout of strengths based social work. c) The interdependencies of communities are recognised and strengthened. All members of the community feel welcome including people with learning disabilities.
Outcome	a) Two ABCD pathfinders with a learning disability lens established one hosted by HFT and one hosted by Better Action for Families. They are supporting a

community connector to set up a support group for parents with children with learning disabilities. Working with Aspire CIC to implement asset based approaches in their services. HFT are working with two people with learning disabilities who would like to become community connectors and would like to hold their own social groups and have created a pictorial questionnaire to give out to local residents who attend the courtyard café that provides creative activities for people with learning disabilities. Person with learning disabilities ran a coffee morning for six weeks at New Wortley Community Centre. BAFF held second skills event in local library in Beeston new people have attended this, shared skills and interests. Garforth now have 3 new community connectors with Learning Disabilities. Rothwell Community Connector held the first games group at a local café.

b) We now have 12 Pathfinder sites (13 ABCD Community Connectors as 1 Pathfinder site has two grants) established across Leeds and 13 Community Builders. 1 pathfinder site has Carers Lens focus and 1 Pathfinder site with a Schools and literacy lens. 10 of the Pathfinder sites are funded until 2020 and 2 until 2021. Of these 12 Pathfinders sites we now have 113 community connectors, with 91 activities held by the Community Builders and/or Community Connectors with 688 number of attendees total. The Pathfinder sites have made 336 connections with other organisations to raise awareness about ABCD in their area. Touchstone has delivered 6 ABCD Intro and Bespoke ABCD sessions to over 87 people from organisation such as NHS England, Health watch and Kirklees Council. The last ABCD intro session was online due to Covid19 and we saw a range of local authorities and regional council's such as Stoke Council, Calderdale, Kirklees and regional third sector organisations who are keen to have further conversation and sharing of good practice the ABCD model in Leeds. The team have spoken with 236 individual organisations, attended meeting/briefings/events or been asked to present to influence and share Asset based principles. We are working with a care home to see how they develop strength based practice for staff and sharing of gifts of their residents, this has been paused for now. ABCD Conference was due to be held in March and invited all SLT Directorates across the council with workshops from other directorates in the council that have adapted an asset based approach: Housing, Communities and Environment and Sports and Culture. We delivered ABCD Intro training at the recent TARA conference for housing. Housing Leeds are now creating a 'small sparks' fund for local residents through the Housing Association Panels, we are supporting them in how the process and mechanism will look and how we look at what meaningful measures and positive impact will be captured longer term. Work between the 'Linking Leeds' social prescribing service and how it works jointly with the Community Builders has started.

c) SRG figures 334 (228 new) people currently members of a self-reliant groups in pathfinder areas. Residents in Lincoln Green have created a gardening group called 'collecting together' they're plan is to invite more local residents who are passionate and can share their gardening skills to collectively create greener spaces for all the community to enjoy. Lincoln Green Pathfinder held a participatory budget event called "U Choose Lincoln Green", inviting community residents to come and pitch ideas for their SRG idea to a panel of community members who oversaw the spending of the small parks budget. SRG'S established were: A weekly women's swimming group, A community litter pick and planting session, with a BBQ and family activities, A football tournament, for young people across Lincoln Green and longer term football activities/club ran by residents, A bi-weekly activities programme focused on Women's health and empowerment, A Mother and Daughter social club,

	based on intergenerational learning. The East Street Arts programme has finished and a number of ladies who have attended the group have now decided they would like to run their own craft group to be able to sell some of the work they have created and are in the process of setting up their own self -reliant group. <u>Response to the COVID-19 Pandemic</u> Three of the ABCD pathfinders have become Community Care Volunteer response hubs and two have mobilised their organization in response to the need of residents who they support. For some residents there has been welfare check ups, supporting residents' wellbeing and health. More recently we have seen a shift in Community Builders getting back to focusing on what's strong for people and their associated life, rather than what's wrong and their needs. What has been coming out of a lot of conversation with the community builders is that sense of coming together, many individuals coming forward to offer time, support, money and ideas to help and be part of their community. The Community Builders have shared many examples such as: weekly zoom coffee mornings, street support groups and street bingo. Lockdown projects such as playing music for the community through social media, raising money for NHS Charities Together. Community Builders have been utilising social media platform to share cooking recipes, knitting patterns and adapted easy ready exercise plans. A community connector and her daughter are making weekly Sunday baking videos on YouTube, and the recipes are then put into the play boxes for families to do together, to date there have been 500 mini boxes have been delivered to families in the Seacroft area.

SB13	Dementia (information and skills)
Purpose	To commission improvements to online information about living with dementia in Leeds and to develop further dementia training for social care providers
Expected Benefits	a) More people and carers would be connected to local support to live with the condition, and meet other people who share their circumstances. People with memory problems / family members who search online would find some reassurance that they're not alone with problems and there is help 'out there'. b) More people with dementia would be cared for by staff with appropriate skills and knowledge.
Outcome	a) Website development on hold pending other local developments re. online information (risk of duplication and not joining up effectively) b) In Q3 2019-20 38 people completed the Council's training offer at Skills for Care Tier 2 and 11 managers/senior staff completed the Council's training at Tier 3

SB14	Falls Prevention (links with SB61 Falls Pathway Enhancement)
Purpose	The Falls Prevention programme is targeted at older people living with frailty who are at higher risk of or who have experienced a fall (predominantly those over the age of 65). The work underpins and enhances the Falls Pathway and supports the urgent care and self-management pathways by seeking to reduce the rate of unplanned admissions.
Expected Benefits	a) Clients self-reported an improvement in confidence and reduction in fear of falling

	b) reduction in care home admissions c) reduction in admissions to hospital admitted due to falls related injuries d) Reduction in admissions to care homes; increased independence/less need for care packages.
Outcome	a) Q1 - 85% of participants had an increase in Timed Up and Go scores. Q2 - 72 % of participants had improved their TUG score by week 20 and 65% have improved FES and 65% improved for ConBal. Total number of participants assessed 54. Q3 - 14 participants from the two completed courses finished their assessments. 64% improved their TUG. 79% Improved ConBal. 93% improved FES Q4 - 56 participants from seven completed courses and assessments. 75% improved their TUG. 71% improved ConBal. 70% improved FES b) c) d) Unable to extrapolate from data – being reviewed as part of longitudinal evaluation and cohort comparison.

SB15	Time for Carers
Purpose	To continue to fund the Time for Carers scheme which is a well-established, successful and popular scheme administered by Carers Leeds and which provides unpaid carers with a small grant of up to £250 in order that they can take a break from caring.
Expected Benefits	Increased quality of life for carers Early identification of carers
Outcome	A total of 190 grants have been awarded in 2019/2020 Estimated 110 carers who received a grant also received additional support from Carers Leeds

SB17	Working Carers
Purpose	To provide a funding contribution in order to expand existing and on-going work at Carers Leeds 'Working Carers Project' aimed at working with employers to improve support for carers who are in employment. The funding will also support the project to encourage SME's in Leeds to take advantage of Employers for Carers membership.
Expected Benefits	a) Reducing the disadvantages that carers who give up work to care experience (e.g. loss of income, impact on health and wellbeing, social isolation) b) Reduction in carers giving up work to care through an established network of Leeds employers. c) SME organisations benefiting from Employers for Carers membership
Outcome	a) A range of support offers for employers and working carers has been developed and are in use. b) Network of Leeds Employers is established c) Employers for Carers Membership is confirmed for 2019/2020

SB21	Prevent Malnutrition Programme
Purpose	To fund a programme of work known as the 'Leeds Malnutrition Prevention Programme' that will include:- a) a series of malnutrition campaigns b) the dissemination of resources c) the increased effectiveness and capacity of the older people nutrition training (Improving Nutritional Care & Nutritional Champions) across the health and social care workforce and allied health professionals

	d) the reintroduction of the 2012 'Winter Pressure Project' which included a single point of contact for health and social care professionals who identified an older person to be at risk of malnutrition.
Expected Benefits	a) Number of health and social care staff trained b) Increased nutritional knowledge and confidence within health and social care staff c) Number of older people resources distributed d) Number of calls to single point of contact and outcomes/resolved e) Decrease in admissions and home care requirements due to malnutrition
Outcome	a) & b) Training for health and social care staff; Improving Nutritional Care (older people) courses are booked and delivered by Leeds Community Healthcare. Courses are mostly full with a small number of places allocated to the third sector. Courses evaluate well and are embedded in the training offer by OD. LCC OD have agreed to continue to fund courses for H&SC staff to attend following the completion of the Malnutrition Prevention Programme IBCF funding. Courses link to the Leeds Food consensus, provide an opportunity for staff to share best practice, ask questions and collect resources suitable for their settings. c) **Number of Resources Distributed;** The next hot meal campaign provided opportunities to prompt conversations between staff and volunteers and those who are most vulnerable living in their own homes. Resources along with a staff briefing were provided to H&SC staff, neighbourhood teams, neighbourhood network staff and other third sector providers. The campaign signposts people to the malnutrition helpline and the Leeds food consensus webpage which provides signposting, support and the 8 key questions that can support a conversation around malnutrition. Leeds has recently been awarded the **Sustainable Food Cities Bronze Award** - during the presentation, Leeds was acknowledged for having a wide range of excellent work across the food system. Several projects and initiatives were highlighted as being particularly innovative including the **Next Hot Meal** campaign. **d) Number of calls to single point of contact and outcomes/resolved;** 29 calls received in total – all reported as resolved. Recent resolved queries not reported in previous quarters include; GP/professional queries about signposting and promotion to patients/service users; care home staff asking about dementia and weight loss – advice was provided about the food first approach; a family member asking for advice about dementia and support available; a member of the public asking for advice about quitting smoking and weight loss. Leeds Community Healthcare has agreed to continue to keep the helpline running and will work closely with public health to monitor calls and outcomes. This programme ended in Q2 19/20

SB22	Better Conversations
Purpose	To train health and care staff to have 'better conversations' with the citizens of Leeds and move the conversation to a 'working with' approach.
Expected Benefits	a) Health and Care workforce competent in the skills required to have better conversations. b) People in Leeds are supported to achieve what matters to them c) Decrease in use of services d) A unified approach with health and care partners across Leeds e) Alignment with Leeds Plan outcomes

	f) Alignment with Population Health Management approach and strength based social care g) Providing the culture change required for system integration and city first ambition h) Minimising the costs (financial and personal) of preventable illnesses and dependency, inappropriate admissions and prescribed medications. - Significant savings to the wider social system (Health Foundation) estimates this to be £22M for Leeds. i) To achieve the ambitions within the 5 Year Forward View, the Care Act (2014) and NHS Constitution j) Improved staff engagement, resilience, motivation and job satisfaction. k) Improved recruitment and retention. l) A workforce with the skills, abilities, confidence and attitude needed to deliver services to support sustainable m) Increased capability for people to self-manage n) Increased goals set and achieved by people about what matters to them o) A sense of shared responsibility and risk between public sector organisation and the citizens of Leeds- Changing Leeds
Outcome	a) By the end of December, 1454 staff have been through 128 skills days. As of 19/3/2020 – 1,635 have been through 147 skills days. However COVID-19 has had an impact on Q4 numbers – 4 skills days would have run and a potential of 52 attendees is now no longer viable. b) Data collection has commenced on this element. c) Due to COVID-19, we have had to stop running the skills days. The economic analysis will form part of Yr 3 evaluation d) Wide group of stakeholders across health and care providers. Data collection to be completed via HaCES as of evaluation report. e) Ongoing – at the heart of Personalised Care. f) Workshops delivered to 2 of LCP areas and 2 were planned in February and March (both were cancelled due to COVID-19). g) By the end of December 1454 staff have been through 128 skills days. As of 19/3/2020 – 1,635 have been through 147 skills days. However COVID-19 has had an impact on Q4 numbers - 4 skills days would have run and a potential of 52 attendees is now no longer viable. h) Further economic analysis is built into Year 3 of the evaluation i) This programme is central to the personalised care critical foundation of the LTP j) 4 month surveys - Deployment areas – 2 Non-deployment areas - 24 8 month surveys - Deployment areas – 2 Non-deployment areas - 14 12 month surveys - Deployment areas – 1 Non-deployment areas - 25 Case studies = 3 k) Business Support Officer left the project 10th January 2020. Improvements made within existing team and 2 x BC Assistants promoted to full-time Project Officers – COMMS Lead and Project Lead from 9th March. l) Interim evaluation report from HaCES m) PAMS measurements data no longer collected n) PAMS measurements data no longer collected o) Staff and citizen surveys

SB23	Alcohol and drug social care provision

Purpose	To fund front line drug and alcohol services for residential rehabilitation, Turning Lives Around (formerly Leeds Housing Concern) and spot purchase in order to meet the needs of patients requiring specialist drug and alcohol services.
Expected Benefits	a) Funding alcohol residential rehabilitation (at St Anne's Alcohol Service) b) Funding Carr Beck Service, Turning Lives Around (Formerly Leeds Housing Concern) c) Funding Drug and Alcohol spot purchase
Outcome	a) During 2019/20 a total of 72 people commenced rehabilitation and a total of 77 people left the service including some who had commenced their residential placement the previous year. Of those leaving, a total of 53 successfully completed the full 13 week programme representing a successful completion rate of 69%. Covid-19 had a small impact during the second half of March as some service users chose to leave early and new admissions ceased. All clients including those who did not successfully complete the programme had an aftercare plan in place. For the majority this included ongoing support from the Forward Leeds drug and alcohol service with many engaging in other forms of post rehab support including mutual aid, housing and employment support and statutory services as appropriate. b) The service provides support for women who are alcohol dependent and require support in managing and reducing alcohol consumption and dealing with housing, health and other related needs. During 2019/20 a total of eight clients have been supported with two successfully undertaking a planned move on to other accommodation. One moved to a Council tenancy and the other person moved to alternative supported accommodation. One third move on meets the expected performance target for the 12 month period. Besides help to reduce alcohol consumption, support has been provided as appropriate for other issues such as physical health problems, risk of domestic violence, drug use, self-neglect. Carr Beck continued to support service users remaining with the service throughout the emerging Covid-19 pandemic in Quarter 4. c) This programme provides out of area rehabilitation for drug misuse (there is no residential drug rehabilitation provision in Leeds). It also supports a very small number of alcohol clients, for whom undertaking residential alcohol rehabilitation in Leeds is unsuitable, to access this out of area. During 2019/20, a total of 44 people commenced an out of area placement. Of the 38 who completed or left their placement during the year, 15 did so successfully, 19 unsuccessfully and the outcome of 4 is yet to be confirmed. Covid-19 had a small impact towards the end of the year as some providers closed due to the pandemic which affected admissions and unplanned exits during the second half of March.

SB25	Peer Support Networks
Purpose	To develop a sustainable network of peer support groups across Leeds for people living with Long-term conditions
Expected Benefits	a) Explore whether Breathe Easy Support Groups in Leeds are sustainable b) Do peer Support leaders feel appropriately skilled/confident to sustain groups. Understand why/why not c) Explore if consistent systems in place for holding up to date availability of peer support groups

	d) Peer Support Networks exist / are effective / are sustainable (could be formal / informal / digital)
Outcome	a) We continue to have 5 Breathe Easy groups running. There is a variance in sustainability of individual groups. Sustainable groups have leaders who feel confident and appropriately skilled for the role. CCG are completing a literature review on the Breathe Easy groups. Joint working continues with the Digital Inclusion Coordinator to offer digital training and equipment to peer support leaders. We are also actively exploring digital resources and platforms for these groups. b) We are developing a resource pack that will outline key information to support Breathe Easy group leaders in planning and organising their bi-monthly meetings. In addition, Active Leeds is working some exercise trainers to upskill them. Variance in accessible training and support identified. Informal training package now available and shared which has been further developed by the new Leeds Mental Wellbeing Service and being delivered to first cohort of volunteers in April 2020. There are various organisations that offer training and support for leaders, however, most incur a cost which can be a barrier for smaller grass roots groups. We are currently scoping how the Leeds Peer Support Network (an existing group) can be further developed, including how this network could be a source of free training and resources. c) Leeds Directory has a consistent system in place to hold information on Peer Support Groups; this is promoted within the role. The Neighbourhood Networks Schemes have systems in place such as websites, social media platforms and newsletters. d) There is an existing Peer Support Network in Leeds however this network is not being used to its full potential and further discussions needed for example on how to include more peers to ensure sustainably. Joint working continues with the Digital Inclusion Coordinator to offer digital training and equipment to peer support leaders. We are also actively exploring digital resources and platforms for use by the group leaders.

SB26	Lunch Clubs
Purpose	To continue to fund the Lunch Club small grants scheme for 2018/19 targeted at older people, with the aim of decreasing their social isolation; increase their opportunity to access a nutritional meal and decrease their need for care and support.
Expected Benefits	Lunch Club provision prioritised in deprived, isolated & BME groups Non-prioritised lunch clubs receive contribution Service users (older people) in prioritised wards benefit from an affordable hot meal Maintain or Reduce community malnutrition (underweight recording) Reduced social isolation All lunch clubs are registered with Food Safety team Leeds Establish minimum Food Hygiene Rating for Lunch Clubs
Outcome	Lunch clubs delivered across the city engaged a large number of attendees through the variety of delivery models. Lunch clubs provided colleagues with opportunities to engage older, vulnerable people in a variety of activities including adapted table tennis activities, information on E Coli and preventing infections, Get Set Leeds the physical activity social movement and Seriously Resistant – the campaign helping Leeds to keep antibiotics working.

SB28	TCV Green Gyms

Purpose	To fund Green Gyms where participants are guided in practical activities such as gardening and grounds maintenance. TCV will run four weekly sessions spread across Leeds and two health walk groups. There will also be an extensive programme of outreach and pop up sessions to recruit from the target populations.
Expected Benefits	a) Improved Physical health – target =55 Actual = 52 b) Improved mental wellbeing – target = 55 Actual = 67 c) Maintain or progress recovery – target = 55 Actual = 45
Outcome	We exceeded our recruitment target of 420 volunteers recruited over the life of the project. The Green Gym project saw the 428th volunteer sign up in the final quarter and we worked with our 28th group. We continued to work with the six Green Gym gardening groups and two Green Gym walking groups across Leeds plus a group of residents, Seacroft Community on Top. This latter designed and planted up an area by their local community centre and developed a maintenance plan. We engaged someone to carry out a Listening Project style activity who started to record volunteers talking about how GG has impacted their lives. The IPAQ and Outcome Star evaluations we have demonstrate that over half of Green Gym participants attending 5 times or more increased the amount of vigorous and moderate activity they did, and over 70% increased the number of days when they would walk for at least 10 minutes. This is supported by anecdotal evidence from volunteers who have described finding activity and exercise easier and pushing themselves to do more, and joining other groups of interest as they felt more confident and able. Outcome Star, ONS Subjective Wellbeing and SWEMWBS evaluations show that the mental health of the majority of volunteers has improved and they felt more able to manage it. Over 80% are more satisfied with their lives and are less anxious (pre-Covid-19) and more than 70% feel that their lives are more worthwhile and happy, and they feel more relaxed. Over 60% felt more optimistic and useful, and were able to think more clearly, deal with problems well, feel close to other people and make their own mind up about things. Impact has been seen in an increase in people's social networks and satisfaction with their social lives. Importantly. There have been improvements in how people feel about themselves and how they define who they are.

SB30	Neighbourhood Networks
Purpose	Neighbourhood Network schemes are community based, locally led organisations that enable older people to live independently and proactively participate within their own communities by providing services that reduce social isolation, deliver a range of health and wellbeing activities, provide opportunities for volunteering, act as a 'gateway' to advice/information and other services resulting in a better quality of life for individuals.
Expected Benefits	a) More older people supported by NNS – Target = 26,500 b) Increase in the number of Older People prevented from being admitted to hospital – Target = 650 c) Increase in the number of Older People receiving hospital discharge support – Target = 175 d) Increase in the number of activities delivered to support health and well-being – Target =900
Outcome	a) More older people supported by NNS - Actual = 26,881 b) Increase in the number of Older People prevented from being admitted to hospital – Actual = 6211

	c) Increase in the number of Older People receiving hospital discharge support – Actual = 1405 d) Increase in the number of activities delivered to support health and well-being – Actual = 970

SB31	Leeds Community Equipment Service
Purpose	To increase the BCF funding for Leeds Community Equipment Service
Expected Benefits	Supports the service to deliver the community equipment element of the LCETS Service Specification – Target 97% level 1 and 80% level 2 People are supported to remain at home or return home following admission to hospital or community bed Management of risks related number of people waiting for equipment and the value of that equipment
Outcome	Q3 19/20 97.03% level 1 equipment delivered within 48 hours Q3 19/20 98.04% level 2 equipment delivered within 14 days At the end of Q4 18/19 there were 235 people waiting for equipment with a value of £217,799. The longest delay was 9 months.

SB34	Ideas that change lives Investment Fund
Purpose	To 'top up' the current ITCL investment fund as it is currently oversubscribed. The additional funding will be particularly focused on encouraging the development of social enterprises in more deprived communities and the business support that works alongside the fund will also be refocused to support this.
Expected Benefits	a) DAMASQ is a Syrian organisation that supports migrants, refugees, asylum seekers and older people in east Leeds in a range of ways. This funding will be used to run a six month programme of activities particularly for older and disabled people to improve their life skills and increase their resilience in coping in the modern world. The programme will address IT/social media skills, cooking, finance, fitness and hobbies. b) Fall into Place Theatre delivers drama groups and workshops that are tailored to suit a range of abilities and are accessible for people who have dementia, physical disabilities, and mental health needs. Through drama they seek to improve beneficiaries' wellbeing, self-confidence and social skills, to delay degeneration and increase mental and physical health. Consequently this will enable people to remain independent for longer. They will be working with GPs to determine if people attending their groups are reporting less illness and isolation. c) **PingPong4U** were awarded a contribution towards delivering adapted Ping Pong activities that provides fun, exercise and breaks down social isolation for people in LS7, LS8 and LS9.
Outcome	a) DAMASQ delivered the project but not in the way they had planned as some of their face to face activity had to be moved online due to distancing requirements and lockdown. As one of the elements of their programme was to increase the IT/social media skills of the target group, they were already well placed to help meet the demands of the lockdown. Through delivering the project they have learnt that they want to expand their online offer to older and isolated people to enable more people to be connected. b) As with the other projects, Fall into Place Theatre had to adapt their offer due to the restrictions imposed by government. This organisation was a key

	member of one of the Community Hubs that were created by the council in response to the pandemic. They were instrumental in devising and putting together activity packs for families who were isolating due to the virus. The packs were initially distributed locally with food packages but this increased to citywide distribution as other areas heard about them. The packs were very well received by families who were struggling to find meaningful activities for housebound members of the household. c) PP4U has also had to adapt its offer due to the pandemic but has delivered online tutorials for organisations with an interest in adapted sports. They intend to expand their online offer in future and are selling training packs and equipment to organisations across the city.

SB35	Adults & Health Change
Purpose	The funding is being used to improve the standard of client record keeping and also to ensure a more efficient and effective payment and billing system is in place.
Expected Benefits	a) Deliver additional Income from the recovery of Client Contributions due from both new and existing Clients – Target = £30m 19/20 b) Client Details brought up to date c) Prompt payments and reduced queries from providers
Outcome	a) £30.5m (projected) with a FYE of £30.9m in 20/21. Further savings areas already scoped for future years b) Identified over 1000 records that require cleansing. Programme in place to cleanse those records which will not only allow prompt payment of invoices, but also generate further income. c) Backlogs and time taken to complete financial assessments are reducing and part of the additional capacity now in place will ensure that appropriate reporting arrangements to monitor this are put in place towards the second half of 19/20.

SB37	Assisted Living Leeds – Volunteer Drivers
Purpose	To create volunteer driver posts at Assisted Living Leeds to collect small items of equipment, that do not require any technical ability to disassemble or remove, such as Zimmer frames, commodes, pick up sticks cushions etc.
Expected Benefits	Items of equipment will be collected in a more timely manner
Outcome	Q3 average waiting time for collection = 6 days, value of items collected = £1.5m Collections are now booked with customers when they ring to ask for a collection. These are within 7 days unless a customer asked for a date suitable for them. This means that the service has less failed visits. The average waiting time is now down at 6 days. The service will be developing this service to have areas of the week when they will be collecting. This project is not using volunteers. Commissioners when to tender but there was no bids from the voluntary sector so it was agreed that LCES could employ someone to do this project.

SB44	Intensive Positive Behaviour Service
Purpose	This bid is for an Intensive Positive Behaviour Service which will work intensively with young people with behaviours that challenge and learning disabilities at risk of needing external residential placements, reducing the need for residential placements or emergency hospital treatment and admissions in childhood and adult life.
Expected Benefits	At least 35% increase in the proportion of children with Learning Disabilities and challenging behaviour that remain successfully at home. Improved family functioning. Improved outcomes for children and families in cohort
Outcome	Eight families have been supported by the project, four of whom have received intensive support at home. Two of these families are more recently referred and are in their extended assessment phase. Two cases have been discharged. These are all families who fit the project criteria and were severely challenged in their ability to cope with their child's challenging behaviours. The project workers have built up good relationships with wider agencies and this is strengthening multi-agency working around these families, which was historically considered weak. Wider agencies want to work in partnership with IPBS, although time is a constraint. The project has trained (for example) social workers, Specialist Inclusive Learning Centre's (SILCs) and transport staff to improve understanding of the PBS approach, which has been very well received with some agencies wanting more training and consultation. This is part of the project's strategic objective to change expectations and culture to avoid professionals assuming that this cohort of children will need residential care. Benefits to families include obtaining a fuller understanding of need from a thorough assessment; parents learning and using visual/sensory behavioural tools and understanding behavioural triggers; workers providing a listening ear; parents being believed in terms of the severity of the situation at home; getting the right people round the table to share information and agree consistency in next steps/approaches; access to different support packages; and some parents feeling more hopeful. There are examples where this support has reduced challenging behaviours and changed attitudes to the urgency of need for residential care

SB49	Yorkshire Ambulance Service Practitioners Scheme
Purpose	To fund two Emergency Care Practitioners to be based at the Urgent Treatment Centres who will provide both navigation services and support to minor illness and minor injuries through clinic sessions. To also fund 1 part-time ECP supervisor.
Expected Benefits	a) improvement in 4 hour Emergency Care Standard – target = 99% b) Staff satisfaction rates c) improvement in 15 minute time to assessment – target = 40%
Outcome	a) 99.2% in Q4 b) Improvement on pre rotation comments c) 27% in Q4

SB50	Frailty Assessment Unit
Purpose	To fund a multi-agency frailty service initially in St James' to support a strength based approach to the management of frail people presenting or conveyed to the emergency department and promote the ethos of Home First.
Expected Benefits	a) Reduction in the number of non-elective admissions – target = 1200 over 12 months

	b) Bed Days Saved – target = 2400 days over 12 months c) Number of attendances to Frailty Unit – target = 2000 over 12 months
Outcome	a) 972 b) 1944 c) 1498 Qualitative Benefits • Patients received early Geriatrician input in the Frailty Assessment unit, this not only leads to a better patient journey but increased the number of patients seen within the 14 hour target. • Improved patient journey, providing a considerably better experience not only for patients but for their families and carers. Allowing a multi-disciplined approach to care with input given by families and carers at the point of assessment rather than post admission. • Early clerking of patients and senior review before being admitted to medical wards improves patient experience and results in a clear admission plan on admission which may subsequently positively impact on their length of stay.

SB52	Hospital to Home
Purpose	To fund the Leeds Integrated Discharge Service – a multi-disciplinary team to ensure that where possible admissions into hospital are avoided from A&E and the assessment area. In addition the team works across a number of medical wards to support timely discharge of adult medical patients who have presented to the hospital.
Expected Benefits	Reduction in Non-Elective Admissions Reduced bed occupancy Reduced need for home care (ASC and NHS) Reduced DTOC Bed days associated with Choice Improved A&E Performance
Outcome	This period has seen progress made in finalising the Service Specification and interim Contract for Hospital to Home which will transfer to a service directly commissioned by the CCG with effect from 1 April 2020. The Hospital to Home service is now an established as a component part of both the discharge process within LTHT as well as contributing through its alignment with the Frailty unit to reducing the risk of unnecessary admission. It is worth noting that in the four years that the service has been fully operational Hospital to Home has completed a total of 6293 individual activities with the range of support now offered extending to include pre-discharge 'home comfort' assessments, medication delivery and post-discharge practical support for up to 3 days. The impact of the initial outbreak of Coronavirus has had a direct and significant impact on the Hospital to Home service in this period. The early months of 2020, notwithstanding normal and anticipated winter pressures where comparatively routine, with referrals for the core 'transport and settle' service sustained at manageable levels. However, as the volume of infections increased the hospital trust introduced measures to both treat those who had tested positive and to minimise the risk of harm to people requiring treatment for other conditions. As a consequence, towards the end of this reporting period the volume of referrals received by the H2H service was beginning to decline.

	In response, at the request of the CCG we have extended our support to cover all age groups and increased the number of sites across which the service operates to include the Leeds General Infirmary, Chapel Allerton, Wharfedale, Step-down beds in care homes and The Mount, in addition to St James's Hospital. We have also agreed to accept a small number of referrals for medication prompts from the Reablement Teams within Leeds City Council and for post discharge support for patients with mental health needs being discharged from The Mount. The team have also been making proactive wellbeing calls to check how former patients are doing during the current crisis and offer support where needed. The service has now moved to using minibuses to transport people home rather than our staff using their own cars, as this provides for adequate social distancing and enables us to transport more than one person at a time (whilst ensuring 2m between each passenger). Access to PPE has been a challenge, as is the case everywhere, however the hospital trusts have been supportive and access to equipment has improved. As it stands we have adequate supplies, however, demand for our services has been relatively modest in recent weeks, as a result of the hospitals operating at around 60% capacity, with many routine procedures postponed due to the COVID-19 emergency response. Our PPE requirements will continue to be carefully monitored should we see the widely anticipated increase in referrals. To support any future spike in demand for hospital discharge we have also been allocated volunteers recruited by Leeds City Council in collaboration with Voluntary Action Leeds. We have developed a role profile for these volunteers who will provide additional assistance on the minibuses and assist staff to ensure people are safely escorted whilst being transported home.

SB54	Staffing Resilience
Purpose	Contingency funding for 3 agency Social Workers to cover any exceptional surges in LTHT and out of Leeds inpatient facilities during the winter period
Expected Benefits	The contingency funding will ensure that ASC meets the trajectory around DToCs by ensuring timely assessment and access to funding where required
Outcome	There has been a decrease in delayed transfers of care due to the extra social work posts

SB55	Business Support for Discharge Process
Purpose	To fund additional Business Support in HSW to accommodate the centralisation of all hospital discharges within the HSW service. This additional Business Support will enable Social Workers to smoothly discharge Leeds residents from hospital settings. Business Support provides essential capacity to the Social Work role, and also undertakes quality checks on resource allocation requests
Expected Benefits	Sufficient Business Support capacity to enable Social Workers to smoothly discharge Leeds residents from hospital settings. Business Support provides essential capacity to the Social Work role, and also undertakes quality checks on resource allocation requests. Leeds residents spend less time in inpatient beds, and return home with the appropriate level of support.
Outcome	From October there was an increase in the referrals, assessments & support plans which saw Business Support workloads double along with an increased number of SW staff to support. What we achieved was managing to stay on top of the critical tasks. The posts support improving data quality. Utilising weekly and monthly reporting to capture the required data; Business Support Manager in HSW is able to report any

	issues to the SDM/HoS for action by weekly and monthly reporting to capture the required data.

SB58	Respiratory Virtual Ward
Purpose	To fund a Respiratory Virtual Ward to provide intense respiratory support to a defined cohort of patients in their own home.
Expected Benefits	a) Identify people who can be supported to remain at home – target = 25 patients per month b) To reduce numbers of admissions – target = 25 patients per month c) To reduce length of stay d) Increase numbers of people in the community with an enhanced care plan to manage exacerbation – target = 25 per month e) Improve outcomes reported by individuals and by use of standardised assessment tools f) Improve confidence to self-manage and remain at home reported by individuals/families/carers
Outcome	a) Q3 – 41 patients supported on the virtual respiratory ward. b) Q3 – 21 out of 41 referrals were from community setting d) Since 1st September all patients on the VRW have been supported with a self-management care plan. e) 68% of patients demonstrated an improvement on discharge from the VRW in the COPD outcome measure Service mainstreamed

SB61	Falls pathway enhancement (links with SB14 Falls Prevention)
Purpose	The Falls scheme is predominantly focussed on older people living with frailty people, particularly those with multiple long-term conditions living in their own homes or in care homes. However the increase in diabetes is also having an impact on the risk of falls in younger adults. This work will predominantly affect the citywide Falls pathway, with links to long-term conditions and frailty pathways.
Expected Benefits	a) Support achievement of Sign Up to Safety pledge of 50% reduction in identified harm (falls, medication errors, pressure ulcers) b) Reduction in older people's risk of falling through targeted group exercise programmes and falls risk management interventions resulting in older people maintaining their independence and function c) More consistent, standardised and timely assessment and input to falls risk patients d) Reduction in waiting time for specialist falls assessment e) Closer links with the neighbourhood teams for specialist falls advice and support f) Reduction in pressure on the neighbourhood teams allowing them to provide more timely falls risk assessments and interventions g) Cost savings through the proactive assessment and management of the risk of falls thereby reducing the numbers/level of harm and preventing possible hospital admissions or admissions to community beds or neighbourhood team caseloads (e.g. fractured neck of femur costs £8-20k to health and social care in treatment and rehabilitation) h) Safety Huddles spread across registered and non-registered staff, actively sharing learning to avoid harm

Outcome	The falls enhancements via the iBCF money has not seen a corollary reduction in waiting times as the additional capacity has coincided with a period of demand growth. The waiting list, though, has been generally maintained. Without the additional capacity the waiting list would be significantly worse.

SB63	Transitional Beds
Purpose	To increase the availability of transitional beds in the city of Leeds over the course of the winter period (2017) by utilising the vacant J31 ward in the Beckett Wing at St James University Hospital. To help provide non-acute bed capacity and mitigate the risks associated with the mobilisation period of the new community beds procurement. The aim would be to transfer patients who are medically optimised to this facility for further assessment of need or on-going therapy input. In addition system capacity is constrained during the winter period and therefore this facility will allow capacity for patients to transfer whilst waiting for identified packages of care or longer term placement. Scheme only funded for 2017/18

SB64 & SB65	Trusted Assessors - LGI and SJH
Purpose	The bid for Trusted assessors is to increase the capacity of the Leeds Integrated Discharge Service (LIDS) to enable cover to be extended to wards on the LGI site.
Expected Benefits	a) Reduce the number of delayed transfer of care patients in Leeds – Target <30 per month b) Reduce length of stay – reduce number of stranded patients by 42% by March 2020 c) Increase number of patients referred to reablement service – Target = 14.5% d) Reduction in long term care placements – Target = 18% Nursing Homes, 15% Residential e) Reduce number of MOFD beds in Acute Trust f) Reduce number of patients on sub optimal pathway on discharge – Target = 56% patients on sub optimal pathway
Outcome	a) Actual = 25 – 30 per month b) On target up until November 2019. During the winter period this number has now increased and therefore no longer achieving the trajectory c) 7% increase in referrals Sept 2019 d) Nursing Home = 9% Residential = 8% e) 112 beds remain open f) 41%

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Ryan Rothery (Health Partnerships Team)

Report of: Tony Cooke (Chief Officer, Health Partnerships)

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2021

Subject: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides a summary of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). The report gives an overview of key pieces of work across the Leeds health and care system, including:

- Resilience and recovery plans for the Health and Care system in the city, tackling winter pressures and the impact of the Covid-19 pandemic
- Developing system models for the future of the Health and Care system in Leeds
- Connecting system leaders and 3rd sector partner across the city to continue to tackle health inequalities

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

1 Purpose of this report

1.1 The purpose of this report is to provide a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

2 Background information

2.1 Leeds Health and Wellbeing Board provides strategic leadership across the priorities of our Leeds Health and Wellbeing Strategy 2016-2021, which is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. We want Leeds to be the best city for health and wellbeing. A healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This strategy is our blueprint for how we will achieve that.

2.2 National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change[1]. With good governance, the Leeds Health and Wellbeing Board can be a highly effective 'hub' and 'fulcrum' around which things happen.

2.3 This means that the HWB is rightly driving and influencing change outside of the 'hub' of public HWB meetings. In Leeds, there is a wealth and diversity of work that contributes to the delivery of the Strategy.

2.4 Given the role of HWBs as a 'fulcrum' across the partnership, this report provides an overview of key pieces of work of the Leeds health and care partnership, which has been progressed through HWB workshops and wider system events.

3 Main issues

3.1 The Health and Wellbeing Board convened a development Board to Board session on June 16 2021 and a Board to Board session on July 13. These sessions bring together a larger number of health and care partners (50+) to discuss key strategic topics, share perspectives and progress collective actions to support the delivery of the Leeds Health and Wellbeing Strategy. This approach is unique to Leeds and ensures that everyone is joined up and working towards the same goals for the city and for our citizens.

3.2 In Leeds our health and care system leaders are committed to a city first and organisation second approach at all levels through the following principals of approach:

[1] *Making an impact through good governance – a practical guide for Health and Wellbeing Boards,* Local Government Association (October 2014)

Leeds Health and Wellbeing Board: Development Session (16 June 2021)

3.3 At this session the following areas were discussed:

The kind of Leeds we want to be

3.4 HWB were given an overview of ongoing work contributing to priority 3 of the Leeds Health and Wellbeing Strategy 'achieving strong, engaged and well-connected communities'. The ongoing work presented included:

- The People's Voices Group
    - The group have been working on the development of the Big Leeds Chat 2021, which will be used as a wellbeing check-in across the city through September/October
- Marmot's Build Back Fairer
    - A recommendation has been set for further Marmot discussions to be brought to the Health and Wellbeing Board in early 2022
- The Tackling Health Inequalities Group

Allyship: a Health and Wellbeing Board that leads the way

3.5 The Health and Wellbeing Board Allyship Programme has been uniquely developed for Leeds, with each HWB member being 'allied' with a member of the Communities of Interest Network. Allies were given their first opportunity to connect, share and learn from each other before planning how to continue their relationship in a way that will positively impact health inequalities across the city.

Leeds Health and Wellbeing Board: Board to Board Session (13 July 2021)

3.6 At this session the following areas were discussed:

Health and care system resilience and recovery and plans

3.7 HWB: Board to Board received an overview of the position responding to the COVID-19 pandemic and winter pressures and Covid recovery plans

3.8 During HWB: Board to Board discussions, the wider health and care system through their organisations and existing partnership/board groups agreed the following:

- To ensure public communications provided by services across the city are consistent in their messaging to prevent confusion for residents looking to access appropriate services
- A commitment to release a joint, cross system statement around cautionary mask wearing in response to the relaxation of government Covid-19 guidance
- To continue to deliver the plans outlined in the system resilience and recovery plans

System opportunities with Building the Leeds Way and the Innovation District

3.9 HWB: Board to Board received an overview of the progress made with Building the Leeds Way, including an update on the Leeds Teaching Hospitals Trust estate redevelopment of the existing Leeds General Infirmary site and development of the new Innovation District

3.10 During HWB: Board to Board discussions, the wider health and care system through their organisations and existing partnership/board groups agreed to:

- Provide collective engagement, challenging ourselves on how we are best meeting the needs of the Left Shift Blueprint
- To undergo further work to understand the impact on community and primary care as a result of changes brought about through the Building the Leeds Way programme
- For partners across the system to continue to champion and advocate the Building the Leeds Way programme

Developing the Leeds Integrated Care Partnership (ICP)

3.11 HWB: Board to Board received an overview of the work to date in developing the Leeds ICP

3.12 During HWB: Board to Board discussion, the wider health and care system through their organisations and existing partnership/board groups discussed the following:

- The need to ensure there is clarity on the relationship between the ICP Board, ICS and Leeds Health and Wellbeing Board and other organisational boards
- The need for clarity around delegated authority across specific areas
- Discussion around the key responsibilities of the ICP including:
    - Ensuring integration of services in Leeds in a way that delivers data-informed, personalised, preventative care based around citizen needs
    - The delivery of Leeds ambitions around Population Health Management, the Left Shift Blueprint and tackling health inequalities

Developing the West Yorkshire Integrated Care System (ICS)

4.0 HWB: Board to Board received an update on the work to date in developing the West Yorkshire ICS

4.1 During HWB: Board to Board discussion, the wider health and care system through their organisations and existing partnership/board groups discussed the following:

- The need to ensure peoples voices remain at the centre of the work as it progresses, supported by the People's Voices Group, the Tackling Health Inequalities Group and the Communities of Interest Network
- To consistently give local authorities a voice at the table, particularly due to their financial contributions and support in delivery
- To continue the strong approach already developed across West Yorkshire of subsidiarity and supremacy of place and communities

5 Health and Wellbeing Board governance

5.1 Consultation, engagement and hearing citizen voice

5.1.1 Health and Wellbeing Board has made it a city-wide expectation to involve people in the design and delivery of strategies and services. A key component of the development and delivery of each of the pieces of work for the HWB: Board to Board session is ensuring that consultation, engagement and hearing citizen voice is occurring.

5.2 Equality and diversity / cohesion and integration

5.2.1 Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

5.2.2 Any future changes in service provision arising from work will be subject to governance processes within organisations to support equality and diversity.

5.3 Resources and value for money

5.3.1 Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

5.4 Legal Implications, access to information and call In

5.4.1 There are no legal, access to information or call in implications arising from this report.

5.5 Risk management

5.5.1 Risks relating to each piece of work highlighted is managed by relevant organisations and boards/groups as part of their risk management procedures.

6 Conclusions

6.1 In Leeds, there is a wealth and diversity of work and initiatives that contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021 which is a challenge to capture through public HWB sessions alone. This report provides an overview of key pieces of work of the Leeds health and care system, which has been progressed through HWB workshops and events with members.

6.2 Each piece of work highlights the progress being made in the system to deliver against some of our priorities and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

7 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

8 Background documents

8.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

How does this help create a high quality health and care system?
National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change. The Leeds Health and Wellbeing Board is rightly driving and influencing change outside of the 'hub' of public HWB meetings to ensure that the wealth and diversity of work in Leeds contributes to the delivery of the Strategy. The Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system.

How does this help to have a financially sustainable health and care system?
Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

Future challenges or opportunities
In the wealth and diversity of work there is an ongoing opportunity and challenge to ensure that the Board, through its strategic leadership role, contributes to the delivery of the Strategy in a coordinated and joined up way that hears the voices of our citizens and workforce.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Ryan Rothery
Tel:

Report of: Safer Leeds Safeguarding & Domestic Violence Team

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2021

Subject: Leeds routine enquiry: GPs and Health Practitioners in 8 GP Practices in Leeds, Evaluation Report 2019

Strapline: This report explores data on the short term impact for victims where GP's and Health Practitioners, who have access to a specialist worker, have proactively screened female patients over the age of 16 for Domestic Violence and Abuse (DV&A)

Comms & Engagement:

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

- In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 786,000 men) withwomen much more likely to experience serious harm and homicide.
- Domestic violence has a devastating impact on children and young people that can last intoadulthood. One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood which affects them in many ways.

- Since April 2011 there have been 24 domestic violence related deaths in Leeds including fivechildren who were killed alongside their mothers, coercive control has been a key feature in the majority of these cases

Recommendations

The Health and Wellbeing Board is asked to:

- Consider the role Primary Care Networks could play in ensuring all women over the age of 16 have equitable access to specialist support for DV&A

1 Purpose of this report

1.1 To inform the board of the ongoing work being done with GP practises across Leeds to increase support for those experiencing DV&A across the city

2 Background information

2.1 None

3 Main issues

3.1 Detailed in summary earlier in this report

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 This paper was produced by members of the Leeds CCG Safeguarding team and the Safer Leeds Safeguarding & Domestic Violence team using case studies from people with lived experience to support recommendations

4.2 Equality and diversity / cohesion and integration

4.2.1 The report provides a a data breakdown across multiple ethnicities and communities

4.3 Resources and value for money

4.3.1 The benefits of increased funding from Primary Care Networks in an increase of staffing resources have been outlined in the report

4.4 Legal Implications, access to information and call In

4.4.2 There are no legal, access to information or call in implications from this report.

4.5 Risk management

4.5.3 There are no specific risk implications arising from this report.

5 Conclusions

5.1 Identifying DV&A through routine enquiry does allow for support to be offered to patients at an earlier stage

5.2 Providing GPs and Health Practitioners with DV&A training does increase awareness of the issue and provides Health Practitioners with a platform in which to begin asking patients about DV&A

6 Recommendations

The Health and Wellbeing Board is asked to:

- To consider the role organisations across Leeds can play in supporting people experiencing DV&A

7 Background documents

7.1 None

Leeds Routine Enquiry: GPs and Health Practitioners in 8 GP Practices in Leeds

Evaluation Report 2019

Authors

Michelle O'Keeffe, *Safer Leeds Safeguarding & Domestic Violence Team*

Gill Marchant, *Leeds CCG Safeguarding Team*

Contents

Executive Summary

This report explores data on the short term impact for victims where GPs and Health Practitioners, who have access to a specialist worker, have proactively screened female patients over the age of 16 for Domestic Violence and Abuse (DV&A).

DV&A is a serious problem that includes, but is not limited to, physical, emotional, sexual and economic abuse. Physical signs such as visible injury are often easier to recognise than the emotional and psychological forms of abuse including coercive control and stalking behaviours.

In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 786,000 men) with women much more likely to experience serious harm and homicide.

Domestic violence has a devastating impact on children and young people that can last into adulthood. One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood which affects them in many ways.

Since April 2011 there have been 24 domestic violence related deaths in Leeds including five children who were killed alongside their mothers, coercive control has been a key feature in the majority of these cases. Lessons learned from Domestic Homicide Reviews (DHRs), both on a local and national level have often revealed that victims of domestic homicide have had some contact with their GPs in the lead up to their death. A 2016 Analysis of 24 Domestic Homicide Reviews by Standing Together Against Domestic Violence found just over half of interpersonal homicide reports note that the GP missed opportunities to ask the victim about abuse.

It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures, in fact, evidence suggests that victims want to be asked about their experiences of DV&A and equipping GPs with the knowledge and skills to identify domestic abuse victims, risk indicators and referral pathways can mean earlier interventions for victims and their families.

NHS Leeds Clinical Commissioning Group (CCG) recognises that health services, particularly primary care, are integral to identifying and responding to domestic violence and abuse. The CCG works in partnership with Safer Leeds Domestic Abuse Team, to ensure that all GP practices in Leeds are provided with the skills and knowledge to implement the Leeds Routine Enquiry model with their patients. In 2018 the CCG Safeguarding Team successfully bid for NHS England funding to facilitate:

- The employment of a Specialist DV&A Worker
- Training for GPs and Practice Staff in 8 practices, raising awareness and understanding of Domestic Violence and Abuse (DV&A) including coercive control, how to ask the question and respond appropriately

- Support for Practices to achieve the Safer Leeds Domestic Violence and Abuse Quality Mark
- The development of robust referral pathways and the implementation of the same by primary care.

Due to this funding between April and December 2019 473 patients were asked about DV&A and subsequently referred on to the specialist worker. Of these, 347 were seen by the worker. 49 went on to receive ongoing support whilst the remaining 298 clients were provided with a one off assessment, given advice and information and/or signposted to appropriate agencies that were better able to meet their needs. Following a continuation of funding there are updated statistics from the work of a 21 hour Specialist DV&A worker covering the same practices during the covid-19 pandemic, at the end of this document.

The report recommends that funding should be secured to ensure that all practices across Leeds have access to specialist support, alongside this it is suggested that further analysis of the longer term impact on patients referred to the specialist worker is advised to ascertain if those patients who were making very frequent visits to the GP before getting help have reduced in attendance after being supported by the DV&A Worker. This would help to establish whether, in the longer term, savings to primary care can be identified.

This report comes as the Government's 'landmark' Domestic Abuse Bill[1] returned to parliament for a second reading on 5 January 2021, following long delays. As well as creating the first statutory definition of domestic abuse and 'transforming' the response in the justice system, the bill aims to 'drive better performance in response to domestic abuse across all local agencies and sectors'.

Acknowledgements

Thank-you to all the people who contributed to the piloting and evaluation of the Leeds Routine Enquiry model and to the GPs and Health Practitioners in Leeds involved in this project.

The following practices were crucial in this process:

Armley Moor Medical Practice

Bellbrooke Surgery

Leeds City Medical Practice

Lingwell Croft Surgery

Manor Park

Oakwood Lane Medical Practice

Shaftesbury Medical Centre

Windmill Health Centre

We would also like to thank all the people who took part and allowed us to use their information in this evaluation, Leeds Women's Aid, the Front Door Safeguarding Hub and the 8 practices who took part in this model.

We are so grateful to Anna Sanghera and Lindsey Goodwin our incredibly efficient specialist support workers and huge thanks to Janet Taylor from Leeds Women's Aid/Leeds Domestic Violence Services for all her hard work and continued commitment to the project.

Introduction

In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 786,000 men) with women much more likely to experience serious harm and homicide (HO 2020). In 75% of the domestic abuse-related crimes recorded by the police in the year ending March 2019, the victim was female, and between March 2016 and the year ending March 2018, 74% of victims of domestic homicide were female compared with 13% of victims of non-domestic homicide. (ONS 2019)[2]

Domestic Violence and Abuse (DV&A) is a serious problem. It can include, but is not limited to, physical, emotional, sexual and economic abuse. A physical sign such as visible injury is often easier to recognise than the emotional and psychological forms of abuse including coercive control and stalking behaviours. Abusers may limit access to finances, social contact or what a person may do in order to have control over them.

Domestic violence has a devastating impact on children and young people that can last into adulthood. One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood. *Birchall, J. and Choudhry, S. (2018)*[3] Children who witness domestic violence and abuse will be affected in many ways.

Since April 2011 there have been 24 domestic violence related deaths in Leeds including five children who were killed alongside their mothers, coercive control has been a key feature in the majority of cases. Lessons learned from Domestic Homicide Reviews (DHRs), both on a local and national level have often revealed that victims of domestic homicide have had some contact with their GPs in the lead up to their death. A *2016 Analysis of 24 Domestic Homicide Reviews* by *Standing Together Against Domestic Violence (STADV)*[4] found just over half of interpersonal homicide reports note that the GP missed opportunities to ask the victim about abuse.

It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures; in fact, evidence suggests that victims want to be asked about their experiences of DV&A. *Feder G, Hutson M, Ramsay J and Taket AR (2006)*[5] GPs can play an important role in identifying victims of domestic abuse, particularly where victims are reluctant or unwilling to disclose to other professionals. Equipping GPs with the knowledge and skills to identify domestic abuse victims, risk indicators and referral pathways can mean earlier interventions for victims and their families.

The Report

This report will explore data on the short term impact for victims where GPs and health practitioners, who have access to a specialist worker, have proactively screened female patients for DV&A.

NHS Leeds Clinical Commissioning Group (CCG) recognises that health services, particularly primary care is integral to identifying and responding to domestic violence and abuse. The CCG works in partnership with Safer Leeds Domestic Abuse Team, to ensure that all GP practices in Leeds are provided with the skills and knowledge to implement the Leeds Routine Enquiry model with their patients.

To achieve this end, the CCG Safeguarding Team successfully bid for NHS England funding to facilitate:

- The employment of a Specialist DV&A Worker
- Training for GPs and Practice Staff, raising awareness and understanding of Domestic Violence and Abuse (DV&A) including coercive control, how to ask the question and respond appropriately
- Support for Practices to achieve the Safer Leeds Domestic Violence and Abuse Quality Mark*
- The development of robust referral pathways and the implementation of the same by primary care

The funding allowed 8 practices, selected for this project due to their high number of Multi Agency Risk Assessment Conference (MARAC) patients and/or who have been in involved in a Domestic Homicide Review (DHR), to have direct access to a specialist DV&A support worker who :

- Supported the delivery of DV&A training in partnership with Safer Leeds Domestic Violence Team.
- Supported GPs and practice staff to introduce Routine Enquiry with all female patients age 16+.
- Supported GPs and practice staff following a disclosure of DV&A by a patient.
- Supported patients following disclosure, including the completion of DASH Risk Assessments and referral to MARAC as appropriate.

**The purpose of the Domestic Violence and Abuse Quality Mark is to promote consistent and high quality service provision to women, children and men affected by domestic violence and abuse.*

The Quality Mark for primary health care providers focusses on ensuring a safe and appropriate response to individuals who disclose DV&A.

The Role of the DV&A Support Worker

The specialist DV&A support worker works alongside GPs and practice staff to help them to develop the skills and knowledge required to support and encourage patients to disclose DV&A to their GP or other primary care staff in a safe environment. The specialist worker provides support to patients in each practice one morning or one afternoon per week. She is based within the surgeries and has access to the electronic patient records systems; SystmOne and EMIS, this allows her to update on the patient's records details of any safety/support plan that has been agreed during the assessment. In addition, practices achieving the Safer Leeds DV&A Quality Mark will ensure they promote consistent and high quality service provision to women, children and men affected by domestic violence and abuse.

Aims and Objectives

- Reduce the risk of serious harm and homicide to patients and their children through timely intervention
- Increase awareness of DV&A by practice staff leading to increased awareness in the wider practice population
- Increase GPs confidence in terms of Routine Enquiry - 'asking the question'
- Increase the number of disclosures of DV&A
- Ensure early intervention & Safety Planning
- Improve identification of high risk victims
- Increase number of referrals to MARAC from Primary Care
- Ensure appropriate referrals to other support agencies ensuring a holistic and wrap around approach
- Improve identification of perpetrators and subsequent referral to support agencies.

The Evaluation Approach

In order to monitor the project outcomes, both qualitative and quantitative data is collected through Leeds Women's Aid monitoring processes and numbers of direct referrals to the specialist worker from the GPs and health practitioners. The data includes:

- Total number of patients referred and supported
- A breakdown of the support provided for each case
- Number of referrals signposted (to which agencies)
- Number of client referrals into MARAC by the specialist worker
- Details of any additional issues affecting patients (e.g. alcohol, mental health)
- Demographic details of client
- Number of health practitioners trained on DV&A and routine enquiry
- Number of practices achieved the GP DV&A Quality Mark
- Case studies and feedback from GPs and clients
- Number of referrals by GPs into the MARAC

Data obtained for this report was recorded from **1st April 2019 – 31st December 2019.**

Data analysis

The specialist worker received direct referrals from GPs and practice staff including practice nurses and health care assistants.

Total Number of Clients 1st April 19 – 31st December 19	
Total Referred	**473**
Total who did Not Attend	**126**
Total Seen	**347**

Of these cases referred, 49 clients went on to receive ongoing support with more than one contact with the specialist worker and were opened on the Women's Aid monitoring system, OASIS Reporting. The remaining 298 clients were provided with a one off assessment, given advice and information and/or signposted to appropriate agencies who were better able to meet their needs.

The data information for the 49 ongoing cases are set out below:

Figure 1

The ages of survivors ranged from under 18 to over 70, with the most common age group being 21 - 25 years.

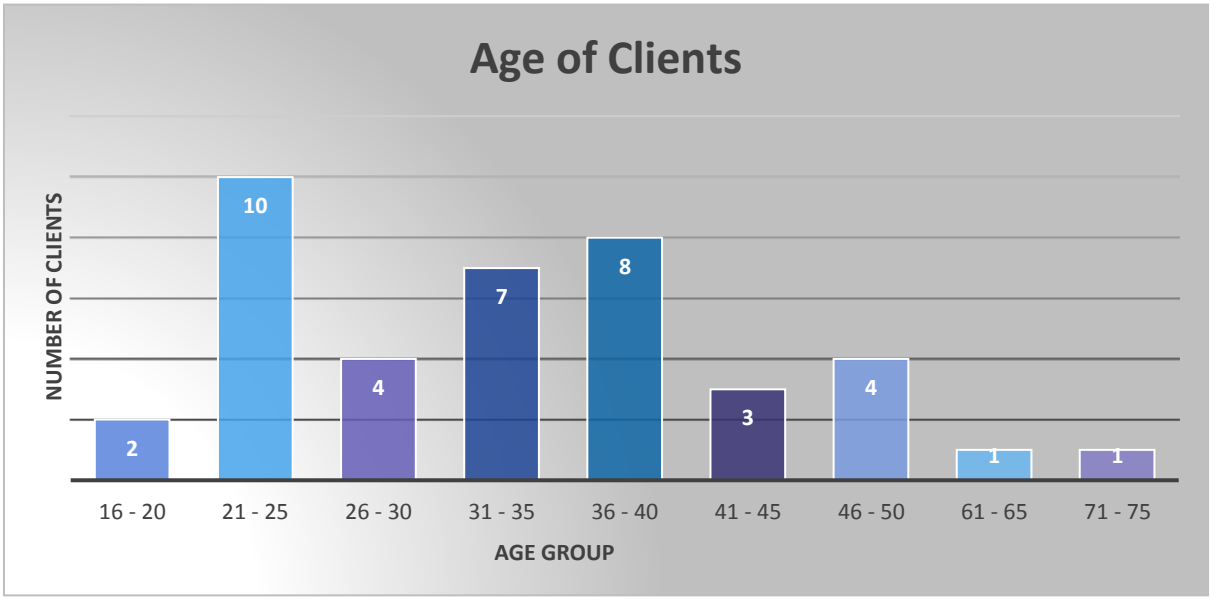


Figure 2

65% of clients were White British.

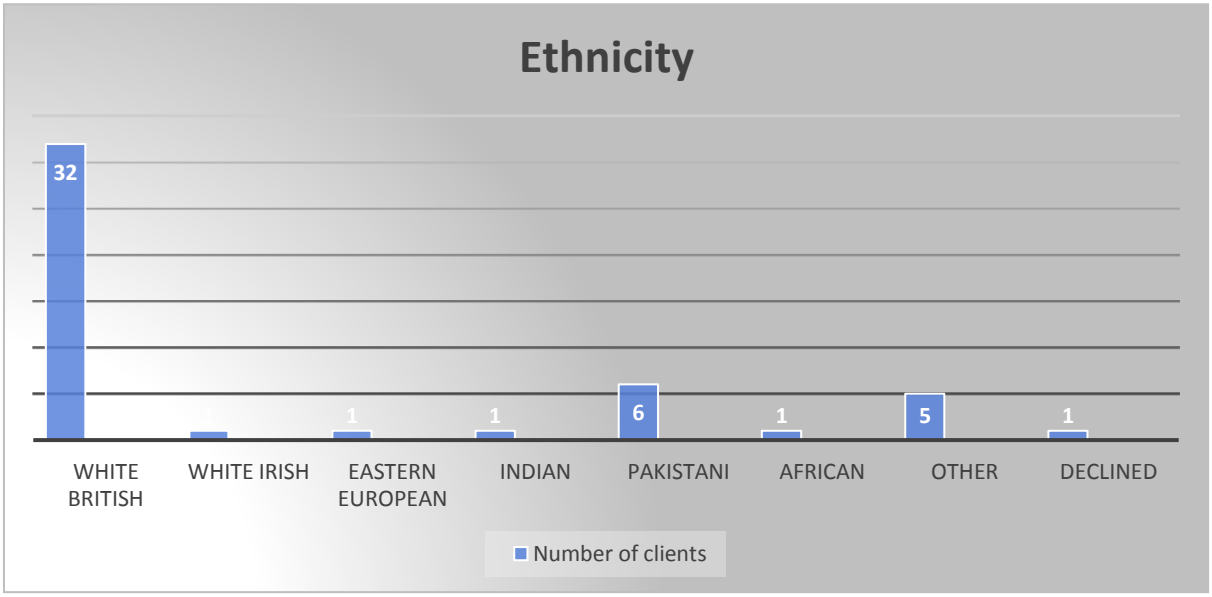


Figure 3

The highest number of children fall into the 0 - 5 age range with children between 6 – 10 years the next highest.

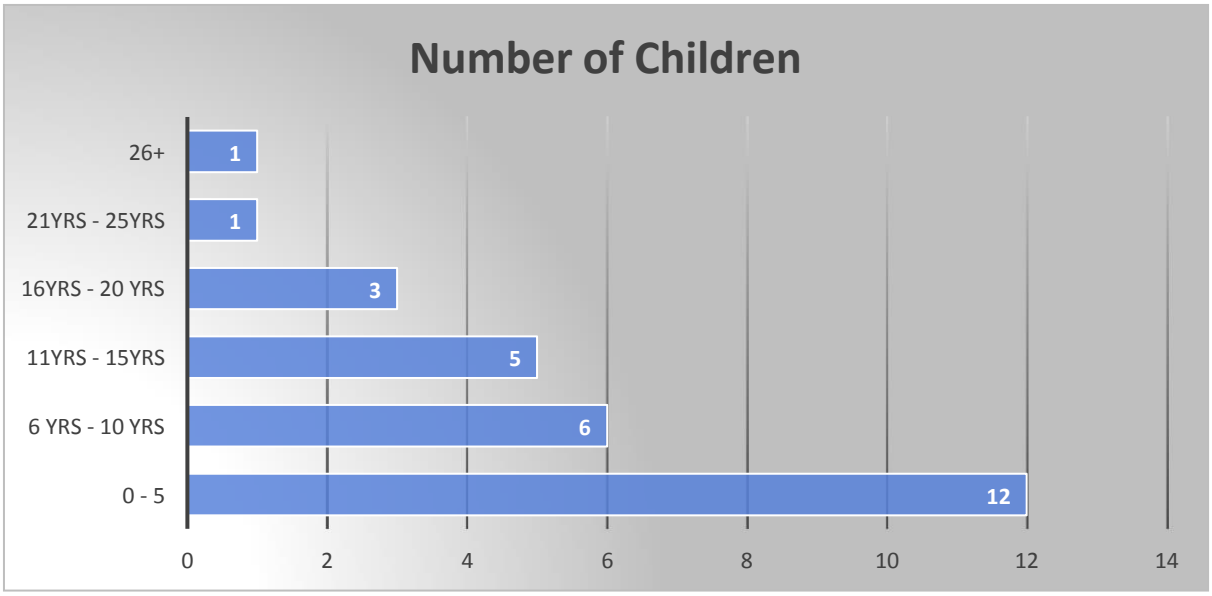


Figure 4

Over half of clients disclosed that they were experiencing emotional abuse with around a third of clients experiencing jealous and controlling behaviours and harassment and stalking. A victim is likely to experience multiple abuse types.

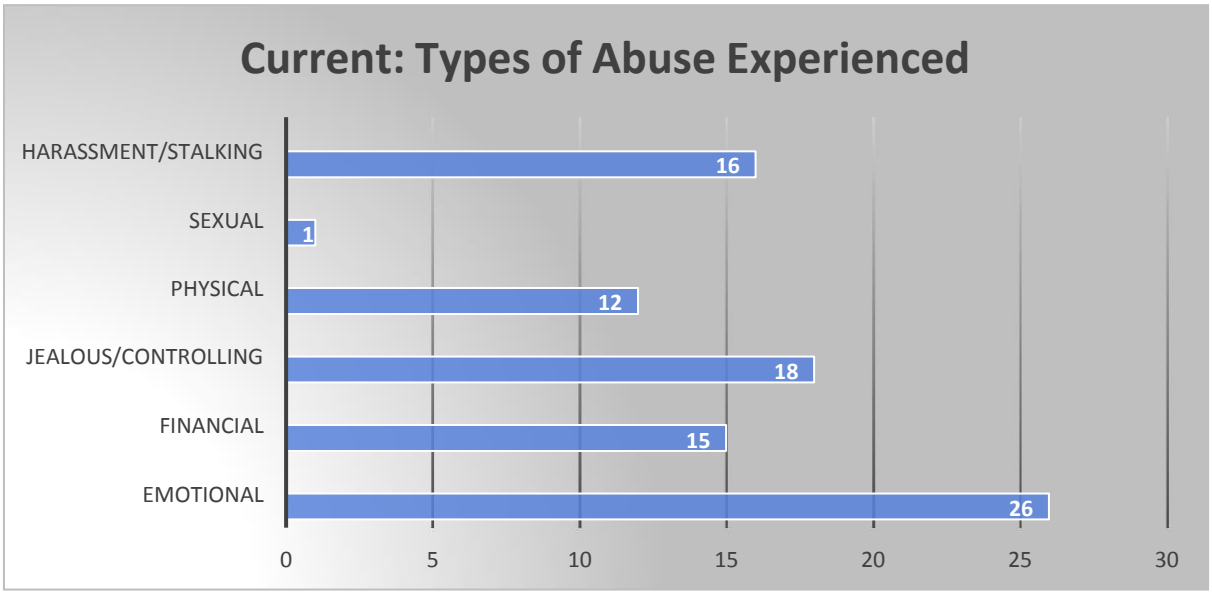


Figure 5

Almost two thirds of clients disclosed that they had felt depressed and/or suicidal at some point in the relationship and just under a third visited their GP with injuries as a result of the abuse.

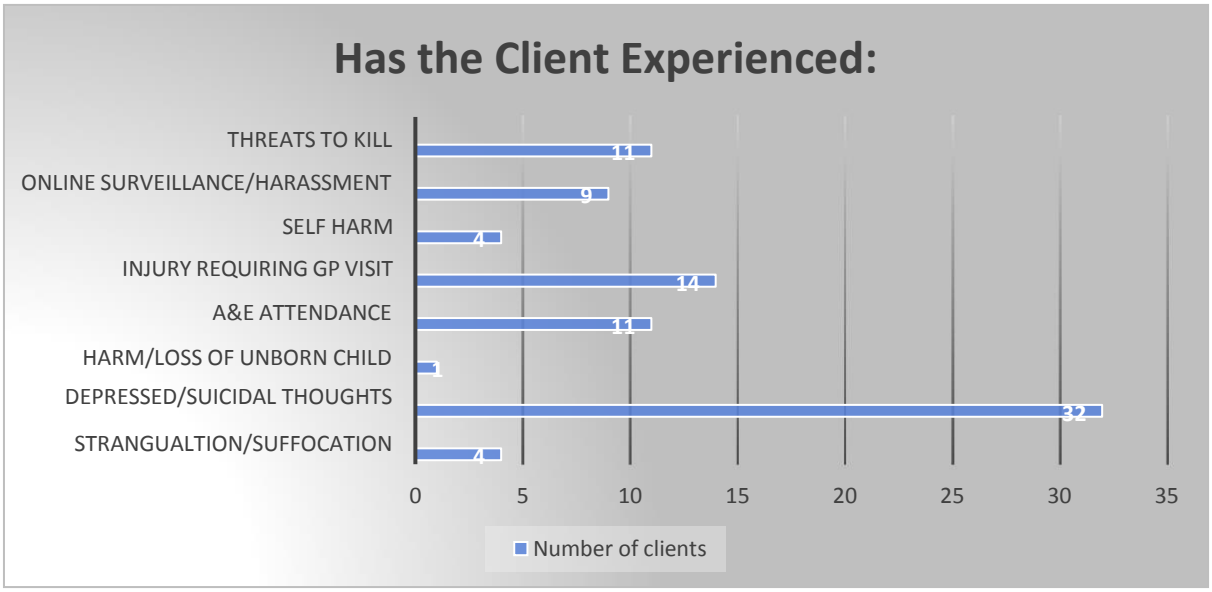


Figure 6

Just under half of all clients accessing support were no longer in the relationship, with some still experiencing abuse from their ex-partner.

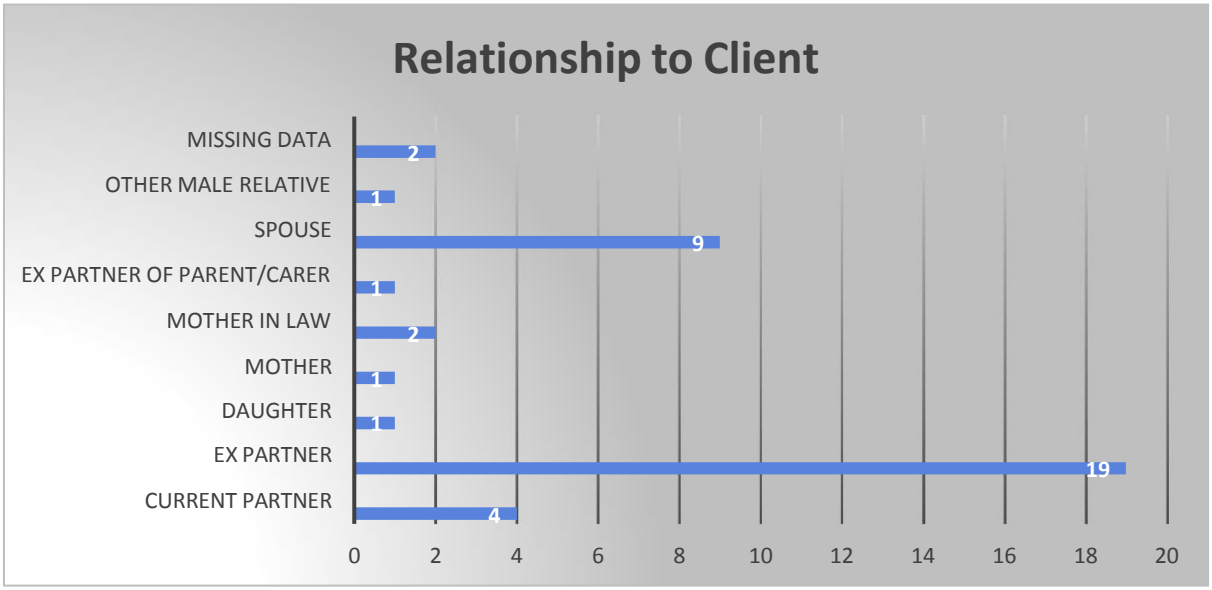


Figure 7

Mental health issues are an overwhelming factor for client's experiencing abuse. The data for drug issues was unclear with 41 stating they had no drug issues and the remaining 8 were recorded as "unknown."

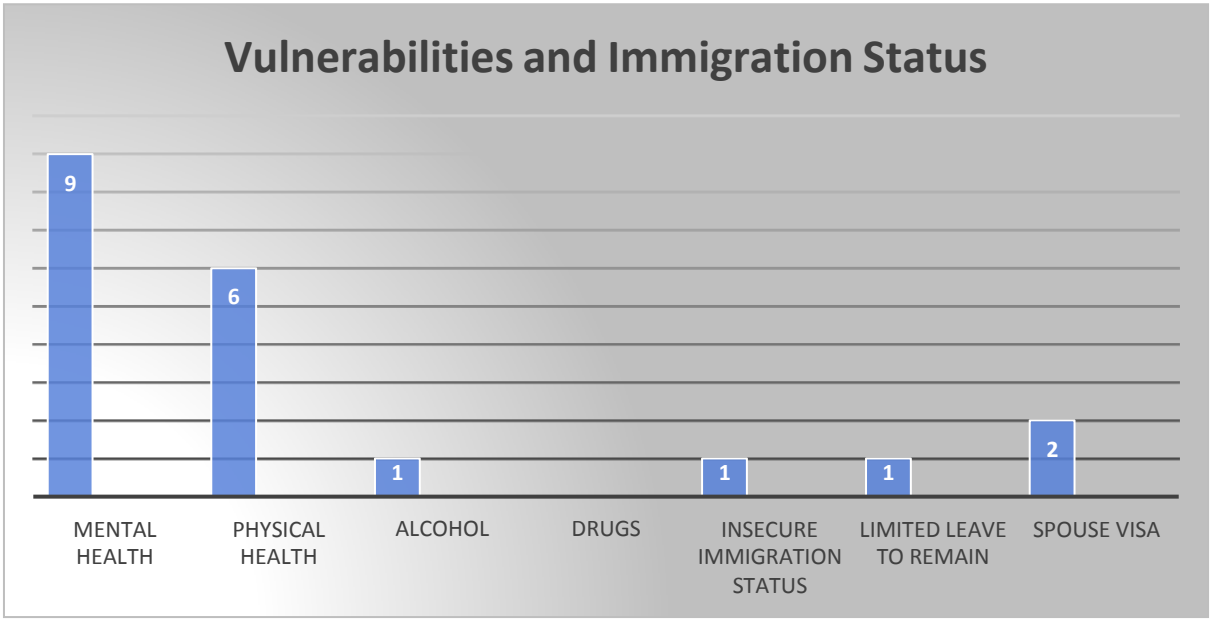
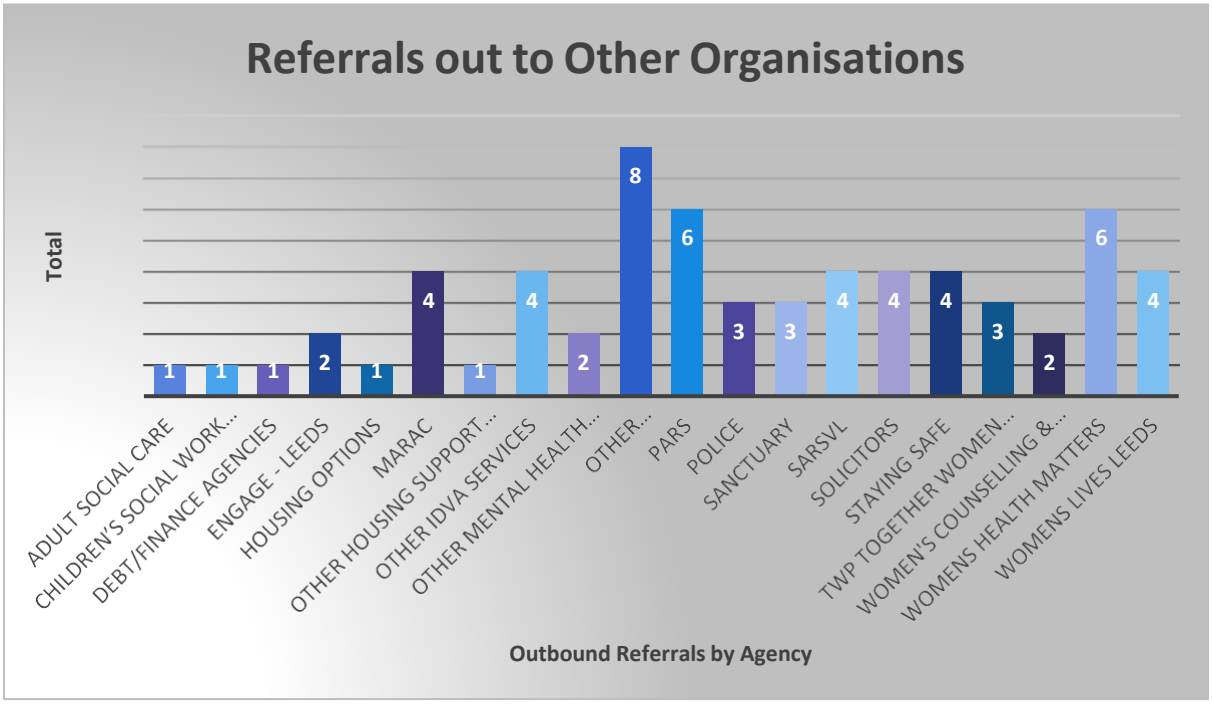


Figure 8

Clients were signposted to a variety of specialist organisations including PARS (Preventions and Recovery Service) and Women's Health Matters for group work. The majority of referrals went into voluntary sector projects.



MARAC (Multi Agency Risk Assessment Conference) Referrals

From April 2019 to December 2019 there were a total of 162 referrals from primary care in to the Daily MARAC. Whilst we are unable to compare this data due to the Oasis Data System did not go live until July 2019, anecdotal evidence suggests that this is a marked increase of referrals from GPs and practice staff.

Staff Training

Over 60 GPs and practice staff received training on routine enquiry, how to ask the question and respond appropriately.

GP Training Feedback

"I will endeavour to ask female patients the direct question relating to domestic abuse and try and get over my discomfort of asking the question. I will look for signs of abuse. Be more attuned to DNA's where abuse may be a factor."

"I feel much more confident carrying out the routine enquiry and have already noticed an increase in my day to day use of the questions."

"Increased effectiveness in enquiring about domestic abuse, increased awareness of when and how to refer cases to safeguarding and MARAC. Useful list of support services for signposting patients. New knowledge about 999 Text register."

"I will ask the question relating to domestic violence as a routine enquiry. Much more awareness and knowledge of the extent of this issue and the effects on the victims."

Case Study

Sarah was referred to the DVA support worker by the GP Safeguarding Lead, however she did not attend the first appointment. It can take time to build up confidence to attend appointments and it took Sarah 3 months and 3 missed appointments before she attended her fourth appointment scheduled by her GP. Sarah shared that she was in an abusive relationship for over 8 years and it was only when she was asked by her GP about DVA that she began to question her toxic relationship. Sarah stated that she was hospitalised whilst she was pregnant as a result of her ex-partner's abuse and went on to say that it was only after talking to her GP that she found the courage to make an application for a Non-Molestation Order against her ex-partner.

The Non-Molestation Order did not deter her ex-partner which led to Sarah experiencing anxiety, she was able to access support with this through the DVA worker within the GP practice.

Sarah disclosed how her ex-partner and his family continued to turn up at her house to emotionally abuse her and how he would encourage his family and friends to stalk and harass her. Sarah shared concerns of how her son was beginning to show worrying signs relating to a fear of groups at school and towards adult men.

Sarah was concerned that her ex-partner and his family knew where she lived and in January 2020 he physically attacked her at the property as she held her son in her arms.

Sarah decided that she wanted to report this incident and the breaches of her Non-Molestation Order to the Police. She also stated that she wanted to access counselling to help enable her to understand and recover from the abuse she suffered at the hands of her ex-partner since she was 16 years old.

Sarah required intensive support which was put in place to support both her and her son. A referral to specialist IDVA (Independent Domestic Violence Advisor) was made to support Sarah with reporting the breaches and incidents to the Police, a MARAC referral was made which led to increased support including a housing support referral and specialist counselling referrals for both Sarah and her son.

Sarah told the DVA worker:

"It feels that a weight has been lifted off my shoulders now I have support, I don't feel as alone. In an environment that I know, I have been offered loads of times to get help, but I could not allow myself to get support as then I would have to admit to myself there was a problem. I don't know if I would have ever got support if the GP had not asked me about domestic abuse as this allowed me to talk about my experiences from me being a survivor as well as a victim."

Sarah's decision to report to the Police led to criminal charges on her ex-partner. She continued to receive support from the IDVA to support her through the court process and to implement safety measures, including additional security to her property. Sarah was awarded Band A plus for housing, which ensures she has priority when bidding on properties. Her son has also demonstrated great emotional development in school and his confidence and interacting with other people continues to improve, furthermore, he has an ever growing support network in school.

Summary

There is little doubt that the added value of a specialist DV&A worker linked directly to GP practices does provide GPs with the confidence to ask about DV&A, knowing that they have a reliable referral route into specialist support. Research shows that GP practices are much more likely to spot signs of domestic abuse and to refer patients after receiving in-depth training.

It is widely acknowledged that victims are more likely to disclose DV&A if they are asked directly, however, as our figures show, they may not take up the offer of support at the first opportunity. Asking for help is not easy. Add into this the insidious nature of coercive control where the abuser will use tactics such as limiting access to money or monitoring all communication, as a controlling effort. This will often erode a victim's self-confidence and self-esteem, making it difficult for them to understand or explain what is happening to them. Furthermore, learning from DHR suggests that the absence of physical violence can often mislead victims and professionals into under-estimating risk. Over half the clients in our data disclosed that they were experiencing emotional abuse with around a third of clients experiencing jealous and controlling behaviours, harassment and stalking.

Mental health was a significant factor among victims in this pilot. Domestic violence and abuse is associated with depression, anxiety, PTSD and substance abuse in the general population. Exposure to DV&A also has a significant impact on children's mental health. In this pilot, the majority of clients had children under the age of 5 years. Mental health issues are an overwhelming factor for client's experiencing abuse. Many studies have found strong links with poorer educational outcomes and higher levels of mental health problems.

Almost two thirds of the clients disclosed that they had felt depressed and/or suicidal at some point in the relationship and just under a third visited their GP.

A recent report by Safe Lives, *Safe and Well*[6] found that people with mental health needs were more likely to have experienced physical abuse, harassment and stalking, jealous and controlling behaviour and in particular, sexual abuse. The report also revealed that people with mental health needs had also visited their GP and A&E more times on average compared to those without. (GP: 5.9 times compared to 3.8 times. A&E: 1.5 times compared to 1.2 times)

A misunderstanding about domestic abuse often prevents professionals from knowing what to do, how to talk about it or where to direct women disclosing abuse. The DV&A support worker offers a unique opportunity for GPs and health staff to access guidance and support and provides a clear referral pathway for victims and their children. GPs and health care staff may not be experts in DV&A, nor do they need to be, the specialist worker is key to providing this service.

Conclusions

Between April and December 2019 there were 473 patients who were asked about DV&A and subsequently referred on to the specialist worker. Of these, 347 were seen by the worker. 49 went on to receive ongoing support whilst the remaining 298 clients were provided with a one off assessment, given advice and information and/or signposted to appropriate agencies who were better able to meet their needs.

Identifying DV&A through routine enquiry does allow for support to be offered to patients at an earlier stage.

Providing GPs and Health Practitioners with DV&A training does increase awareness of the issue and provides Health Practitioners with a platform in which to begin asking patients about DV&A.

Whilst we are relying on anecdotal evidence in relation to MARAC referrals, the fact that the number of referrals from GPs has increased over time suggests that health staff are recognising and responding to cases where there is a high risk of serious harm or homicide.

As demonstrated in our case study, asking about DV&A does provide clear benefits to the patient.

By ensuring better-informed practice, improved responses and support for patients experiencing DV&A, we believe that ultimately lives are changed and quite possibly saved as a result of the implementation of routine enquiry.

What we hope to achieve

To create and maintain an ethos which acknowledges the prevalence of DV&A and encourage both health practitioners and patients to get comfortable talking about it.

To embed good practice and ensure that all GPs and health staff receive DV&A training and support to achieve the DV&A Quality Mark.

Continue to promote and support routine enquiry, further strengthening the clear message that DV&A is recognised as an important health issue, is unacceptable and ensures that patients who do disclose receive an appropriate and timely response.

It is clear that DV&A has become increasingly visible in health settings and is something that requires health professionals to be aware of and act upon.

We acknowledge that routine enquiry is a long term cultural change to working practices and requires leadership and support if it is to be embedded and maintained.

Recommendations

There is currently one specialist DV&A support worker providing support to eight GP practices at an annual cost of £36,916. It is recommended that each Primary Care Network (PCN) in Leeds funds and appoints its own DV&A support worker to ensure that all women over the age of 16 have equitable access to specialist Support

Further research is recommended to review the longer term outcomes for patients that have been referred to the specialist worker. Research should include:

- Has intervention from the DV&A worker improved outcomes in the mental and emotional health of victims and children within the family?
- Has the intervention from the DV&A worker resulted in a reduction in the frequency of visits to the GP?
- Has the intervention from the DV&A worker resulted in monetary savings to Primary Care?

Statistics Update

Summary of Outcomes for cases supported by the GP Drop In Service & closed June-December 2020 - The following figures relate to clients who were admitted to ongoing support from the GP Drop In Service and who's cases were closed between 1/6/20 - 31/12/20

62	Cases closed
92%	completed a programme of support (8% disengaged with the service)
96%	of clients supported received emotional support
84%	of clients supported were advised & supported around their mental health
61%	of clients supported went on to access support relating to mental health
43%	were informed about legal options available to them (both civil and criminal) and chose not to pursue at that time
13%	were supported to report incidents to the police
34%	went on to receive specialist women's and DV support from agencies such as Behind Closed Doors Prevention & Recovery Service (PARS); Support After Rape & Sexual Violence Leeds (SARSVL), Women's Lives Leeds, Shantona
11%	went on to receive additional support from other LDVS/LWA services
26%	went on to receive other support from non-DV agencies – including Engage Leeds, Sanctuary, other mental health support agencies
47	onward referrals were made for clients supported by GP Drop In – to services including Early Help Hub; MARAC; PARS (Behind Closed Doors); Sanctuary; Women's Lives Leeds; Shantona, Women's Counselling & Therapy Service

We should take into account when looking at these recent figures, the devastating impact that the Coronavirus and lock down has had on all of society. With that in mind, it's extremely encouraging that the DV&A support worker has continued to provide support to victims of DV&A, albeit in different ways. Furthermore, the GP, health providers and chemists have remained a safe space for victims to access support during this time.

References

[1]*Home Office (2020) Domestic Abuse Bill 2020: overarching factsheet*

[2]*Office for National Statistics (ONS), Domestic abuse victim characteristics, England and Wales: year ending March 2019*

[3]*Birchall, J. and Choudhry, S. (2018) 'What about my right not to be abused?' Domestic abuse, human rights and the family courts. Published online: Women's Aid*

[4]*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016*

[5]*Feder G, Hutson M, Ramsay J and Taket AR (2006) Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies, Archives of Internal Medicine, 166 (1) 22 –37.*

[6]*Safe and Well, mental health and domestic abuse https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf*

Leeds Health and Wellbeing Board

Report author: Hannah Davies, Adrian Winterburn

Report of: People's Voice Group

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2021

Subject: Putting people at the heart of decision-making - update on progress in planning the Big Leeds Chat 2021

Strapline: Update on plans for this year's Big Leeds Chat events

Comms & Engagement: The Big Leeds Chat is coming to a community near you. This is your chance to talk to Senior decisions makers in health and care, talk to them about what would make your area the best place to be healthy and well. Find out how to take part at www.bigleedschat.co.uk

Are specific geographical areas affected? If relevant, name(s) of area(s):	X Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	x No
Is the decision eligible for call-In?	☐ Yes	x No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	x No

Summary of main issues

Within Leeds we have an ambition, led by our People's Voices Group (PVG), to think about how the voice of people, especially the voice of inequalities, is at the heart of all levels of our health and care decision making.One of the ways that we so this as a joined-up Leeds health and care system is via the Big Leeds Chat. A new and innovative way of hearing from people, bringing decision makers together with people, as one health and care team, going to where people are and listening to what was important to them.This paper outlines the plans for Big Leeds Chat 2021. The paper is provided for information.

The Health and Wellbeing Board is asked to:

- note progress in planning for this year's Big Leeds Chat.
- register to take part in a BLC event.

Purpose of this report

1.1 To inform the Board on progress in planning Big Leeds Chat 2021.

2 Background information

2.1 Within Leeds we have an ambition, led by our People's Voices Group (PVG), to think about how the voice of people, especially the voice of inequalities, is at the heart of all levels of our health and care decision making.

2.2 One of the ways that we so this as a joined-up Leeds health and care system is via the Big Leeds Chat. A new and innovative way of hearing from people, bringing decision makers together with people, as one health and care team, going to where people are and listening to what was important to them.

2.3 This paper outlines the plans for Big Leeds Chat 2021. The paper is provided for information.

3 Main issues

3.1 Detailed in the main paper.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 The Big Leeds Chat is an opportunity to engage with and listen to what matters to local people.

4.2 Equality and diversity / cohesion and integration

4.2.1 We will be prioritising the voices of those living with the biggest health inequalities.

4.3 Resources and value for money

4.3.1 There are no specific resource implications arising from this report.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications from this report.

4.5 Risk management

4.5.1 There are no specific risk implications arising from this report.

5 Conclusions

5.1 There are a series of Big Leeds Chat events taking place in September and October.

6 Recommendations

The Health and Wellbeing Board is asked to:

- note progress in planning for this year’s Big Leeds Chat.
- register to take part in a BLC event.

This page is intentionally left blank

Putting people at the heart of decision-making – update on progress in planning the Big Leeds Chat 2021

Background

Within Leeds we have an ambition, led by our People's Voices Group (PVG), to think about how the voice of people, especially the voice of inequalities, is at the heart of all levels of our health and care decision making.

One of the first ways that we started this as a joined-up Leeds health and care system was via the Big Leeds Chat. A new and innovative way of hearing from people, bringing decision makers together with people, as one health and care team, going to where people are and listening to what was important to them. We asked three simple opening questions:

1. what do you love about Leeds?
2. what do you do to stay well?
3. how do we become the best city for health and wellbeing?

Much of the value of the Big Leeds Chat are the conversations that went on from those opening questions in terms of insight and understanding of how it feels to live, work or visit Leeds from a person's perspective.

The first Big Leeds Chat (BLC) took place in October 2018 at Kirkgate Market and involved all health and care partners and senior leaders coming together to listen to people in the market, with over 500 conversations taking place.

For the next BLC in November 2019 we further developed it to wanting to hear the voice of those people who experience inequalities and from people in their communities too. We included a number of local Big Leeds Local Chats linked to LCPs (Local Care Partnerships) as well as going to community- based settings such as local food banks.

Both of these BLCs resulted in the intelligence being used in a variety of ways including giving direction to the Health and Wellbeing board work programme. But there were also wider benefits in terms of culturally feeling like one health and care team, and also looking like one health and care team. Many senior leaders who can often be one or more steps removed from the front-line were able to gain first-hand insight into what was happening for people, some of who were emotionally moved as a result of what they heard which led to a positive change in their approach to work. There was a strengthened commitment to the importance of people's and community voices being at the heart of our health and care thinking and decision-making.

As we come out of the Covid 19 pandemic, it feels like an appropriate time to be going out to communities to listen to how they are and understand what is important to them as we move forward as a city. There are other drivers as well that we could seek to bring into our conversations with people.

The previous two BLCs told us as leaders how important it was to people that we supported people in Leeds with their **mental health**, as well as **improving access to services**, and the importance of **good quality jobs** on people's wellbeing. We know the impact of living through the pandemic has impacted on us all, and it is likely that all three of these areas have been negatively affected because of it. So, it is timely to have a Big Leeds Chat to allow local people to reflect on their health and wellbeing in a post-pandemic environment, and for senior leaders to hear first-hand experiences of local people.

We also know that people who traditionally live with the biggest health inequalities have been adversely affected by the pandemic, both in terms of geographical communities, and communities of interest. So, having a platform to enable these local people to influence health and care at a local level, through the LCPs, is a key element of LCPs succeeding. Local BLCs are one way in which people's voices are at the heart of community-level decision making.

Whilst we have the opportunity to use online channels to deliver engagement events as part of the BLC, face-to-face events are still the preferred choice for engagement, both because of the quality of conversation, but also so that we can engage with some of the digitally excluded people - especially important as more health and care services have moved to digital platforms as a result of the pandemic.

Big Leeds Chat 2021

The PVG have spent the last few months agreeing the best ways in which to deliver a successful BLC this year, with more consideration given to the risks associated with the Covid-19 pandemic – we want to hear from local people in a safe way. It was agreed that this year the emphasis should be on delivering more smaller BLC events across the city, particularly in communities where people live with the biggest health inequalities.

As such, BLC this year will be delivered as a 'road show', with the aim of delivering one BLC event in each of the **LCP areas** during September and October. Further, to ensure we are listening to the voices of people living with the biggest health inequalities, we will also host BLC events with specific **communities of interest**. We were successful with similar events during BLC 2019, but this year we want to scale those events up, so that we have more events across the whole city.

In addition, we want to put more efforts into hearing the voices of **children and young people** – especially important given the disruption the pandemic has had on their lives. We have been working closely with YouthWatch, and with Child Friendly Leeds, to develop BLC events that are targeted at CYP and are delivered in a way that works for that audience.

Finally, this year we are exploring options for a **digital event**. Whilst one of the key benefits of the BLC has been the face-to-face contact between senior leaders and local people, there is no doubt that acceptance of digital platforms has grown during the pandemic with some communities – therefore we feel this is an opportunity worth exploring. This will be a 'digital festival' type event, with an emphasis on hosting online wellbeing events and classes; attendees will then also be encouraged to take part in a 'chat'.

Given the past 18 months, we feel it is important to give people the opportunity to 'debrief' about their experiences of living through the pandemic. Therefore, this year we have decided to slightly change the three questions, and this time will ask:

- How has it been for you over the past 18 months?
- What things would help you improve your health and wellbeing?
- What could make your area a happier and healthier place to live?

It's important to remember, these questions are meant as 'conversation starters' to enable senior leaders and chat makers to have a conversation with people about what matters to them.

Given the current risks associated with the pandemic, and perhaps a reluctance from local people to engage with a big event, it has been decided that for this year the flagship Kirkgate Market event will not take place.

Get involved

Planning for BLC2021 is being led by Healthwatch Leeds and the Health Partnerships Team, with support from the BLC Working Group (a sub-group of PVG) and the LCP Development Team. However, to make the events successful we need volunteers from across the health and care system to take part in the events – especially **senior leaders** and **chat makers**. Without these, the events will not be able to go ahead.

At each BLC event, it is the role of the senior leaders to listen to local people – to listen to their experiences during the pandemic, to listen to their experiences of using health and care services, and to listen to what matters most to them in maintaining a healthy (or healthier) life. It is these discussions that provide senior leaders with important insight to inform the way they go about their day jobs.

The role of the chat maker is to support the senior leaders in those discussions, and to make a record of those conversations. This is an essential role on the day and is key to ensuring we have some intelligence to evaluate after the event. Anybody who works in health and care can be a chat maker, and the BLC provides an opportunity to develop your own knowledge of what it feels like for our local people right now.

All volunteers will be provided with an online pre-briefing session and the materials you need to support you to successfully hold 'chats' with members of the public.

As explained, there are numerous events taking place this year, and we need your support to make them a success. **If you can volunteer some of your time, please email blcontour2021@gmail.com or call 0113 898 0035.** Once you have registered to take part as a senior leader or chat maker we will contact you with available dates and locations of events, and you can choose one that works best for you.

Post BLC 2021

After we have hosted all BLC 2021 events, all the qualitative insight collected through the chats will be collated and analysed. A report will be produced in early 2022 which highlights the key

themes that have emerged, as well as providing recommendations. This report will be made available on the Big Leeds Chat web pages, and will be shared with key decision-making bodies, including the Health and Wellbeing Board and the Partnership Executive Group.

Report authors

Hannah Davies, Chief Executive Healthwatch Leeds, and Chair of the People's Voices Group.
Adrian Winterburn, Partnerships Communications, Engagement and Marketing Manager.