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Report of Director of Public Health

Report to Executive Board

Date: 21 April 2021

Subject: Leeds Covid-19 Vaccine Health Inequalities Plan

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes	☒ No
Has consultation been carried out?	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Will the decision be open 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

1. Main issues

- We are committed to reducing infection, serious disease and deaths from the Covid-19 virus in communities who have been disproportionality affected, so that no one is left behind as the city starts to recover. We also know the same communities historically have lower uptake of vaccinations and continue to be at greater risk of exposure at this time. This report provides an update on the Leeds Covid-19 Vaccination Programme's approach to mitigating inequalities and ensuring underserved populations have access to the Covid-19 vaccine our communities through the *Leeds Covid-19 Vaccine Health Inequalities Plan*.

2. Best Council Plan Implications (click here for the latest version of the Best Council Plan)

- Covid-19 continues to have a hugely significant impact on all areas of the Best Council Plan, with the economy, employment, education, community resilience and health and wellbeing all detrimentally affected by the pandemic, which will undoubtedly limit progress towards our ambitions and present long-term challenges for the city. In relation to severe illness and death this has particularly impacted on older people and recovery will be part of our Age Friendly Leeds Action Plan.
- While challenging, the vaccine programme is our light at the end of the tunnel. It will save lives, improve health and enable us to gradually re-open the parts of our economy that are currently struggling and/or closed.

- Through the 'Team Leeds' approach, with Leeds City Council being an equal partner in the design and delivery of the programme, it is an example where we are living our ambition to be a compassionate and caring city to everyone in Leeds.

3. Resource Implications

- The direct funding of the vaccination roll out programme is from the NHS. This is already covering funding for specific initiatives such as the roving vaccine model. There is now the announcement that there will be additional funding to support addressing health inequalities which will be available to each Integrated Care System. Clinical Commissioning Groups will be asked to develop a plan in collaboration with the local community, agreed with the local Director of Public Health, detailing how they intend to utilise the initial funding and outline any additional longer-term strategic and systemic engagement required to address local needs.

Recommendations

Executive Board is asked to:

- Provide feedback on the contents of the report and our ambitions.
- Note the Director of Public Health as the senior responsible officer for the Leeds Covid-19 Vaccine Health Inequalities Plan.
- Continue to support the commitment of all Directorates in delivering Leeds Covid-19 Vaccine Health Inequalities Plan.

1. Purpose of this report

1.1 The purpose of this report is to provide an overview of the Leeds Covid-19 Vaccination Programme's *Leeds Covid-19 Vaccine Health inequalities Plan* and how we are going further to increase uptake across all communities of Leeds as a compassionate and caring city reducing inequalities.

1.2 Recognising the pace the work is developing and changing to meet local needs, a supplementary appendix will be published closer to the meeting providing the latest position.

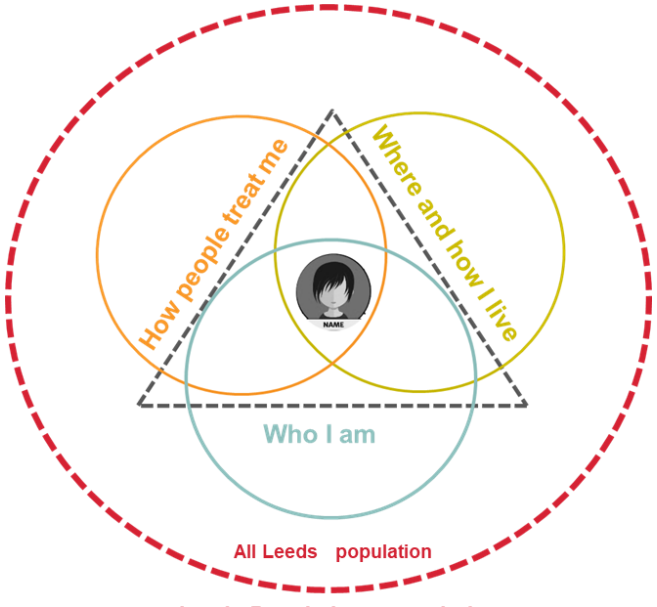
2. Background information

2.1 Leeds City Council has been working in partnership to respond to the citywide challenges posed by Covid-19 on communities, which is covered in further detail under *Item 10: Update on the Coronavirus (Covid-19) Pandemic: Response & Recovery Plan*. These challenges are hugely significant and have resulted in radical changes to service delivery and new pressures on staff. The people of Leeds have responded magnificently, but we are all too aware of how important it is for a return to a semblance of normality and to begin our journey of resetting to a fairer and more equal Leeds through tackling poverty and reducing inequalities.

2.2 The vaccination programme is our light at the end of the tunnel as part of this longer journey of recovery. It will save lives, improve health and enable us to gradually re-open the parts of our economy that are currently struggling and/or closed.

2.3 In Leeds to date, over 200k Covid-19 vaccines have been delivered including first and second doses. It is a testament to the strength of partnership working in the city. The Leeds Covid-19 Vaccination Programme is a partnership rooted in the 'Team Leeds' approach involving the full range of local partners with the Executive Director of Operations, Leeds Community Healthcare as the Senior Responsible Officer. This includes all NHS Trusts, Leeds City Council and the third sector, as well as HR, intelligence and communications leads.

2.4 It includes a range of programmes in place covering key areas such as logistics, workforce and communications meaning Leeds has been able to move at pace. Across the whole programme there is the need to ensure we are fulfilling the statutory duty of the Equalities Act and that everyone with protected characteristics has an equal opportunity to access the vaccination. In addition to this, the programme also has a specific programme focussing on mitigating inequalities and ensuring underserved populations have access to the Covid-19 vaccine in Leeds (see Appendix 1 for scope).



2.5 Local experience and insight from communities as well as national evidence shows that certain population groups and communities have been disproportionately affected and impacted by Covid-19. There have been a number of national reports describing these impacts, most notably '[Build Back Fairer: The Covid-19 Marmot Review]' by Public Health England and Sir Michael Marmot. This highlighted the risk of broadening health and social inequalities as a result of Covid-19, particularly those related to mental health, poverty, education, employment and housing status, all of which have been impacted by both the pandemic and our necessary response (lockdown, etc.).

2.6 We have a Leeds Covid-19 Vaccine Inequalities Plan (see Appendix 2 for the plan on a page) which forms a central part of the Leeds Covid-19 Vaccination Programme. The plan focuses on improving uptake in areas of deprivation and in groups at risk of illness and mortality from Covid-19 infection. The approach is based on three main programmes to ensure that no one is left behind:

- Primary Care Network (PCN) Health Inequality Vaccine Plans
- Improving equitable access through roving mobile provision and targeted vaccine provision for inclusion groups
- Community engagement working with local communities

2.7 Our experience from previous vaccination programmes, insight from our communities and national evidence is being used to shape our approach. One that is asset based working with people and communities to ensure that the vaccination programme is targeted and uptake maximised in areas of deprivation and by groups who are at increased risk of illness and mortality from Covid-19 infection.

2.8 The Covid-19 Vaccination Health Inequalities Group reports to the Covid-19 Vaccination Programme Steering Board.

3. Main issues

3.1 In Leeds, we already know that there are inequities emerging through the uptake of Covid-19 vaccinations to date:

- The previous pattern in higher age groups of a higher proportion of white people having a 1st vaccine compared to BAME is now also seen in 70-74 and Clinically Extremely Vulnerable (CEV) groups. However, trends over time do show in a narrowing of the gap in vaccine uptake between ethnic groups, and between people living in more or less deprived parts of Leeds for the initial priority groups.
- In JCVI (Joint Committee on Vaccination and Immunisation) groups 2 to 4 (all those 80 years of age, all those 75 years of age and over, all those 70 years of age and over and clinically extremely vulnerable individuals) over 94% of the white population have had a 1st vaccine compared to 75% in BAME.
- A greater proportion of people decline vaccination in BAME groups than White. The difference is greatest in older age groups (11.7% vs 1.9% for over 80s)
- Similar issues have been seen with people with severe mental illness and people with learning disabilities (except for those with learning disabilities in the CEV group which is the same as those without learning disabilities). However, positively, 86.5% of people with dementia have had a 1st vaccination, which is higher than those without dementia (80.8%), driven by higher rates of vaccination for people with dementia in CEV group.
- For deprivation we are also still seeing a gap between the most and least deprived (deciles 1 and 10):
    - Between 8-10% in groups 80 years of age and over and aged 70-74.
    - This gap increases to over 26% in the CEV group the gap.
    - The gap in older populations has reduced, the gap in the CEV group has increased slightly

3.2 The Leeds Covid-19 Vaccine Health Inequalities Plan is clear in its aim, objective and its principles to tackle these inequities:

Aim: Mitigating inequalities and ensure underserved populations have access to the Covid-19 vaccine in Leeds.
Objective: To ensure that vaccine is targeted and uptake is maximised in areas of deprivation and by groups most at increased risk
Principles: • Co-produce actions based on local, national insight and evidence • Deliver the vaccine through building confidence in culturally sensitive ways to meet the needs of diverse populations and age friendly principles • Ensure interventions identify and support those individuals considered 'vulnerable' and underserved. • Be diligent in the consideration of people with protected characteristics and follow equality guidance. • Reflect the needs of the local community, the social excluded and socio-economically disadvantaged and those with protected characteristics. • Be action focussed and responsive to identified needs.

3.3 To deliver on our aim and objectives we have a focused set of work streams.

Primary Care Network (PCN) Health Inequality Vaccine Plans

3.4 Public Health has been working in partnership with Primary Care Networks (PCNs) (groups of general practices working together with health and care partners to better support their local communities) from the most deprived areas of the city to develop bespoke health inequalities plans to respond to community needs; Armley, Beeston, Burmantofts, Richmond Hill & Harehills, Bramley, Wortley and Middleton Park, Chapeltown, Middleton, Seacroft and York Road.

3.5 This has resulted in some good practice examples of PCN led targeted work to develop a community outreach offer to increase vaccination uptake in low uptake areas:

- Drop in clinics at the Bilal Centre will be supported by PCN staff and community leaders.
- Workshops organised for Local Care Partnerships (LCPs) to identify barriers and interventions to support the development of tailored plans to increase uptake.
- Developing an offer for PCN's to support proactive conversations with patients who are hesitant to taking up the offer of the vaccine.
- Workshops booked to plan outreach with LCPs, PCNs, partners and communities.
- Working with frontline staff to support people who have refused a vaccination to build confidence and provide facts.
- Housing colleagues are phoning residents who have refused a vaccination to support them in making an informed choice.

Improving equitable access through a roving vaccine model and delivering a vaccination approach for inclusion groups

3.6 Through our 'Team Leeds' approach, Leeds and York Partnership NHS Foundation Trust (LYPFT) is providing leadership and clinical governance supported by LCC, NHS Leeds Clinical Commissioning Group (CCG), Leeds Community Healthcare NHS Trust (LCH) and community leaders for our roving vaccine work stream. This will deliver a rapid, responsive, roving model in the coming weeks. This approach will be supported by community engagement activity including door knocking and community awareness raising with support from PCNs, local third sector partners, LCC Communities Teams and LCC Public Health.

3.7 The roving vaccine model has three different approaches:

- **Vaccination bus with dedicated vaccine team**: 2 LCC buses have been identified and refitted to provide this service. LYPFT lead this model supported by partners, using Public Health data and local intelligence to inform where to site the facility, and how the model can be developed. This model will:
  - Offer vaccine to those who missed it in the first 4 cohorts
  - Provide a proactive offer running at the same time as the current eligible vaccine offer
- **Pop up facility in a community venue** (i.e. church, community centre, etc.).
- **Roving vaccination team**: Delivering vaccinations in specific areas and settings with agreement from Sheltered Housing to explore a bus / team providing roving service in these settings.

3.8 In addition to the roving model, we have a dedicated inclusion approach driven by a local NHS, PCN, LCC and third sector partnerships to build on the positive work achieved through the pandemic. The approach will include providing a targeted vaccine offer to rough sleepers, sex workers, Gypsy and Travellers, emergency accommodation users at St George's Crypt, refugees and asylum seekers and people living in residential accommodation including women experiencing domestic violence and residential alcohol detox services.

Community engagement working with local communities

3.9 Community Engagement Plans have been developed in areas of deprivation working with community champions, third sector, faith leaders, LCPs, and building on existing community networks. This includes:

- Contact with approx. 50 organisations in the city who work with underserved communities (e.g. gypsies and travellers; sex workers; homeless people, drug users) to develop the most accessible and acceptable model for them to access the vaccine. This will also include ongoing work to provide information ahead of JCVI guidance allowing groups to be eligible.
- Promotion of prevention messages, in areas of high case rates to now include vaccine facts to increase confidence.
- Consideration of 'women' only vaccination clinics.
- Developing a Community Champions Network working with 75 Community Champions who will be part of organised local listening events, receive key messages to share with the wider community, etc. Discussions have already taken place with local African communities and churches alongside clinicians.

3.10 These three programmes are underpinned by a number of supporting work streams to ensure that the Leeds approach is evidence based, driven by the data as well as local insight, supported by training provision for the wider workforce and highly effective and joined up communications approach.

Increasing confidence training

3.11 Development of a training package for the wider workforce focusing on raising awareness, increasing confidence and providing vaccine facts from a trusted source. This includes:

- Digital resources including a wealth of information of vaccine facts and addressing hesitancy.
- Further 'Want to Know more' sessions and a digital resource including a filmed version of the training.
- Roll out program continues with sessions being delivered to Retirement Life staff with support from LCC Public Health Older People's Team.
- Facilitated sessions with asylum seeker hotel residents and staff.
- Training being used by LCC to build confidence for all staff.

Communications

3.12 An engaged and targeted communications approach, which includes:

- Digital and print campaigns based on NHS information amended for local communities. Vaccine information can be found on https://www.leedsccg.nhs.uk/health/coronavirus/covid-19-vaccine/
- Identifying and working with the workforce where there is hesitancy.
- Webinars to address vaccine hesitancy including one specifically for African communities.
- Developing behavioural insight work focusing on younger people.
- A photography project as part of Leeds Making History.
- Developing South Asian arts and drama communications.
- Planning in preparation for Ramadan.
- Media work taking place on Urdu speaking channels.
- Working with local schools to develop lamp post banners and local art work to support the roving approach.
- Working with Street Games and Together Youth.
- Tackling hesitancy in those who are eligible & in younger cohort with a twofold impact of younger demographics and influencing the older eligible population.
- Work is ongoing to co-produce resources and understand behavioural insight with agencies.
- Working with churches' Facebook pages. This includes promoting messaging for black and ethnic minority communities and Eastern European communities in Burmontofts, Richmond Hill & Harehills.

Data & Intelligence

3.13 To inform the targeting of actions, the combined Public Health Intelligence and NHS Leeds CCG Business Intelligence Teams are working together to provide weekly reports of vaccine uptake by different communities and within different PCNs.

Led by the evidence base

3.14 To develop the programme both insight and intelligence have been used. Leeds Academic Health Partnership (LAHP) supported this work through a review of local and national insight to increase vaccine uptake with groups most at risk. This highlighted the need for outreach (taking the vaccine to people) and for messages to be delivered by trusted people (e.g. GPs and local community leaders) in trusted places and for the messages to be co-designed. We are continually collecting further insight from commissioned services, PCNs, community groups, and Healthwatch Leeds to ensure the plan is agile and responsive to local needs.

Equality/Inequality Impact Assessment

3.15 All work streams have Equality Impact Assessments embedded (see Appendix 3: EDCI Screening Form for more information), in addition to the overall EIA for the whole programme.

4. Corporate considerations

4.1 Consultation and engagement

4.1.1 Through the insight report led by Leeds Academic Health Partnership and the work of Healthwatch Leeds there has been ongoing consultation with the programme. As the initial groups were older people, Leeds Older Peoples Forum have been a key member of the Vaccination Health Inequalities Group. Elected members continue to play a key role in engaging the public, particularly in encouraging neighbourliness, volunteering, and encouraging people to play their part in minimising spread of the virus. Elected members are also part of the Local Care Partnerships where the awareness sessions and targeting of additional approaches are discussed.

4.1.2 Engagement with stakeholders has continued and in many cases have been strengthened and work led by Healthwatch Leeds has been central in capturing and responding to citizen voice on the impact of the Covid-19 pandemic and vaccination programme.

4.2 Equality and diversity / cohesion and integration

4.2.1 As highlighted throughout this report, minimising the impacts of the pandemic on the most at risk is central to our response and recovery planning and at the heart of the Covid-19 Vaccine Health Inequalities Plan.

4.3 Council policies and the Best Council Plan

4.3.1 The updated Best Council Plan 2020-2025 reflects the current Covid-19 context, while maintaining the three pillar priorities of inclusive growth; health and wellbeing; and climate change, under the overarching priority of tackling poverty and inequalities. Covid-19 continues to have a hugely significant impact on all areas of

the Best Council Plan, with the economy, employment, education, community resilience; age friendly and health and wellbeing all detrimentally affected by the pandemic, which will undoubtedly limit progress towards our ambitions and present long-term challenges for the city.

4.3.2 Our city ambitions, particularly Leeds Health and Wellbeing Strategy, to reduce health inequalities and that people who are the poorest improve their health the fastest is key to guiding the Covid-19 Vaccine Health Inequalities Plan and our recovery, particularly as we begin to better understand the long-term health, social and economic impacts of the pandemic.

Climate Emergency

4.3.3 In line with our city ambitions, responding to the Climate Emergency is a key priority as we move through our response and recovery, with a focus on continuing to improve air quality and work towards a carbon neutral city by 2030. We continue to work to ensure that the Leeds Covid-19 Vaccination Programme is aligned to this approach working across partners, while recognising the importance of maximising the vaccination uptake.

4.4 Resources, procurement and value for money

4.4.1 Leeds is awaiting further information about the funding position for vaccination rollout, as it is clear that this will be a major logistical exercise for local authorities, NHS trusts and their partners. Leeds health and care system will continue to push for full cost recovery for all spend, and an understanding that all aspects of organisational budgets will be impacted as a result of the Covid-19 pandemic and vaccination programme.

4.5 Legal implications, access to information, and call-in

4.5.1 There are no legal, access to information implications from this report.

4.6 Risk management

4.6.1 Risk management for the Covid-19 Vaccine Health Inequalities Plan occurs through the Leeds Covid-19 Vaccination Programme Steering Board with escalation occurring to Leeds Gold Health and Social Care Group as part of the citywide command and control arrangements.

4.6.2 There is also regular reporting through organisational boards and inclusion in their risk registers.

5. Conclusions

5.1 The development of safe and effective Covid-19 vaccinations provides hope for a return to normal life. Across Leeds there has been extensive planning to prepare for a vaccine rollout and ensure that those most at risk are offered vaccinations first. Our ambition is that no one is left behind, and that everyone is able to make an informed choice to take up the vaccine. The Leeds Covid-19 Vaccination Programme has been clear from the outset that we have a duty to ensure that the vaccination roll out mitigates inequalities and ensures underserved populations

have access to the Covid-19 vaccine. The Leeds Covid-19 Vaccine Health Inequalities Plan aims to ensure that the vaccine is targeted and uptake is maximised in areas of deprivation and by underserved groups who are at increased risk.

5.2 However, until such a time that enough of the population is immune, restrictions and social distancing will need to remain in place to keep Leeds safe, which will require continued patience and cooperation of people, who have already made considerable sacrifices over the course of 2020.

5.3 Likewise, the city will continue to work together. Leeds' response to the Covid-19 pandemic and the vaccine programme represents the best of Team Leeds pulling together as partnerships, organisations and as people.

6. Recommendations

6.1 Executive Board is asked to:

- Provide feedback on the contents of the report and our ambitions.
- Note the Director of Public Health as the senior responsible officer for the Leeds Covid-19 Vaccine Health Inequalities Plan.
- Continue to support the commitment of all Directorates in delivering Leeds Covid-19 Vaccine Health Inequalities Plan.

7. Background documents[1]

7.1 None.

8. Appendices

8.1 Appendix 1: Protecting people and communities most at risk

8.2 Appendix 2: Leeds Covid-19 Vaccine Health Inequalities Plan on a Page

8.3 Appendix 3: EDCI Screening Form

8.4 Supplementary Appendix (to be published closer to the meeting)

[1] The background documents listed in this section are available to download from the council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Appendix 1

Protecting people and communities most at risk

In Leeds, we are prioritising working with people who have a greater likelihood of poor health the more of these factors that apply to their lives. This is particularly important during the Covid-19 pandemic when some people have a much greater risk of infection, complications or even death.

I am identified as being at higher clinical risk:
This can be because I have a specific medical condition or a number of conditions. I may have a significantly higher risk than others within this group, and might be shielding.

How People Treat Me on an individual and institutional level:
Some people who experience the greatest inequalities have historically been excluded or marginalised based on how they live, who they love, where they were born, what they look like or who they pray to.

'Communities of Shared Interest' is the collective term used to describe the groups of people who share an identity (for example people with a shared ethnicity) or those who share an experience (or example survivors of domestic violence).

Communities of Shared Interest tend to emerge from experience of exclusion from mainstream communication, thinking or planning. The are a source of vital expertise on planning for inclusion and addressing barriers to inclusion.

Who I am in demographics:
This includes my age, gender, disability, ethnicity, sexuality, religion, faith or beliefs. These are characteristics protected in law.

Where I live and how I live:
What money I have available to me makes a significant impact on my ongoing health. As does the job I do, my education level, who I live with and how we interact. When these are negative, it can have a direct impact on my mental and physical health, and the choices I make about staying healthy.

If where I live has multiple "deprivations" – where more people are likely to have lower incomes, there is poor quality housing or poorer environmental factors – such as noise or pollution. Or if my area does not have a strong community or social infrastructure – this can negatively affect my health.

My legal status also impacts on the health options I have.