Appendix A

Report to Adults, Health and Active Lifestyles Scrutiny Board: 5th October 2021

Title of report:	**Leeds Long Covid Community Services Pathway – The First Year**
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This paper provides an oversight of the Leeds Long Covid Community Service model, the demand, activity and performance of the service and detail of the health inequalities evident from data analysis

1. Background

1.1. Evidence

Evidence shows that a small but significant minority of people who contract Covid-19 continue to experience the effects of the virus months after initially falling ill. This ongoing condition is known as 'Long Covid'. The most common symptoms people report is fatigue, ongoing shortness of breath, muscle pains, chest pains, palpitations, 'brain fog' and anxiety. A wide range of other symptoms have also been reported. Typically, symptoms can fluctuate over weeks, so individuals can seem to be getting better, then get worse again. Most people get better slowly but may need lots of time to rest to recover.

The National Institute for Health and Care Excellence (NICE) have recently published the following case-definitions to define the effects of COVID-19 at different time points:

Acute COVID-19 infection

- Signs and symptoms of COVID-19 for up to 4 weeks.

Ongoing symptomatic COVID-19

- Signs and symptoms of COVID-19 from 4 weeks up to 12 weeks.

Post-COVID-19 syndrome

- Signs and symptoms that develop during or following an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis. It usually

presents with clusters of symptoms, often overlapping, which can fluctuate and change over time and can affect any system in the body.

Post-COVID-19 syndrome may be considered before 12 weeks while the possibility of an alternative underlying disease is also being assessed.

1.2 Prevalence – how large an issue is this?

The Office for National Statistics (ONS) Long Covid Study estimates that 1.5% of the UK population were experiencing self-reported "Long COVID" (symptoms persisting for more than four weeks after the first suspected COVID-19 infection that were not explained by something else) at 1 August, 2021. This equates to 12,807 people in Leeds.

In addition, another recent study from ONS *(Updated estimates of the prevalence of post-acute symptoms among people with coronavirus (COVID-19) in the UK: 26 April 2020 to 1 August 2021)*, released on the 16th September, estimates that 1 in 40 (2.5%) of people who had tested positive for COVID-19 experienced any of the common Long Covid symptoms for at least 12 weeks.

It is acknowledged nationally that it is difficult to get an accurate account of the true prevalence and therefore it is still not exactly clear how common Long Covid is.

1.3 Who is at greater risk of having Long Covid?

Long Covid is more commonly reported among people aged 35 to 69 years, females, people from more deprived areas, those with pre-existing health conditions and among health and social care workers. Some of this difference might be because some groups have had a higher chance of getting an initial Covid infection. Also to note that many people reporting Long Covid had no pre-existing health problems.

The Leeds Long Covid Community Services Pathway was developed following rapid collaboration between NHS Leeds Clinical Commissioning Group, Leeds University, Leeds City Council and NHS service providers within the Leeds system in response to the first wave of covid infections in the early spring of 2020. The service became operational in September 2020. In order to facilitate pathway development a system wide steering group was established to oversee the development of the pathway.

2. Service Model

2.1 Aim of the Service

The aim of the Leeds Long Covid Community Rehabilitation Service is to provide holistic rehabilitation to adult patients in Leeds who are experiencing new and long-lasting symptoms of the Covid 19 infection which are significantly impacting how people function in day-to-day life, to enable them to return to living an independent life.

The service provides timely triage assessment and rehabilitation services to patients in the community, either in their own home, at a specific community-based clinic, or virtually via digital systems. The multi-disciplinary team consists of Physiotherapists, Occupational Therapists, Dieticians, Rehabilitation Assistants and a Psychologist employed by Leeds Community Healthcare NHS Trust. The team are further supported by consultants from the Leeds Teaching Hospitals NHS Trust with specialties in rehabilitation medicine, cardiology and respiratory medicine and a Clinical Fellow.

The service developed pathway guidance for General Practice referral criteria and the investigations to be considered for presenting symptoms prior to referral. This ensures that other potential

pathologies are excluded prior to referral into a rehabilitation centred model of care, managing patient safety.

2.2 Service Description

Referrals are accepted when a person has ongoing symptoms 12 weeks post COVID infection. Following referral, people referred are requested to complete the COVID19 Yorkshire Rehabilitation Scale outcome measure which is used as a Long COVID outcome measure and as a screening tool to identify symptoms and needs at the first stage of the triage assessment with a clinical coordinator. Local clinicians and researchers developed this novel scale for capturing long-term symptoms known as the COVID 19 Yorkshire Rehabilitation Scale (C19YRS). It assesses symptom severity, functional disability and overall health state. This was developed in partnership with patients and is literature's first patient reported outcome measure (PROM) for Long COVID. This scale is now recommended by NHS England and the National Institute for Health and Care Excellence (NICE).

Following clinical triage and taking into consideration the results of the measure, rehabilitation is provided either within a home setting or a clinic setting. The service also offers digital assessment and treatment for those people who can access this offer which has been supported by the Digital Inclusion Team. Further medical screening and diagnostic tests may also take place at this stage. After assessment and discussion at the multi-disciplinary team most people are offered educational groups which are available digitally, ongoing physiotherapy and occupational therapy, referral to psychological support and follow up and review. If ongoing complex needs are identified, further individual treatment sessions are offered with progress evaluated.

At the point of discharge from the service, the person may be offered continued support outside of the specialist team to support ongoing recovery. Examples are community Singing for Breathing groups, Linking Leeds Social Prescribing Services, Leeds Active, Leeds City Council the Nuffield Covid Rehabilitation exercise programme and local peer support groups. Ongoing medical oversight is provided in General Practice.

2.3 Workforce

The workforce comprises a range of administrative, medical, nursing, research, management and allied health professional roles. There is a virtual multi-disciplinary team (MDT) of medical Consultants in Rehabilitation Medicine, Cardiology and Respiratory Medicine a Clinical Psychologist is also a member of the MDT alongside two clinical pathway coordinators who are senior level physiotherapists. There are currently 26.8 whole time equivalent staff and the costs of providing the service is currently £1,164,217. Funding for 2021/22 is allocated from NHS England.

The team has faced enormous challenges in coordinating a pathway and team during the pandemic. The team was recruited at a time when social distancing was the norm in the country and subsequently training and interviews occurred virtually. The usual team introductions and working as well as social interaction to maintain wellbeing was not possible in a face to face format. Despite this, the team have risen to the challenge and continue to support each other virtually. Coming together each week at an MDT as well as team briefings, helps to ensure any concerns whether clinical or personal can be discussed and supported.

3. Service Data and Performance (data point end of June 2021)

3.1 Activity
Table 1.

Caseload			
Number of referrals	Number of discharges	Active on Caseload	Awaiting assessment
988	178	432	408
Waiting Times (weeks)			
Triage	OT	Physio	Dietician
15	11	20	5

3.2 Demographics
Chart 1.

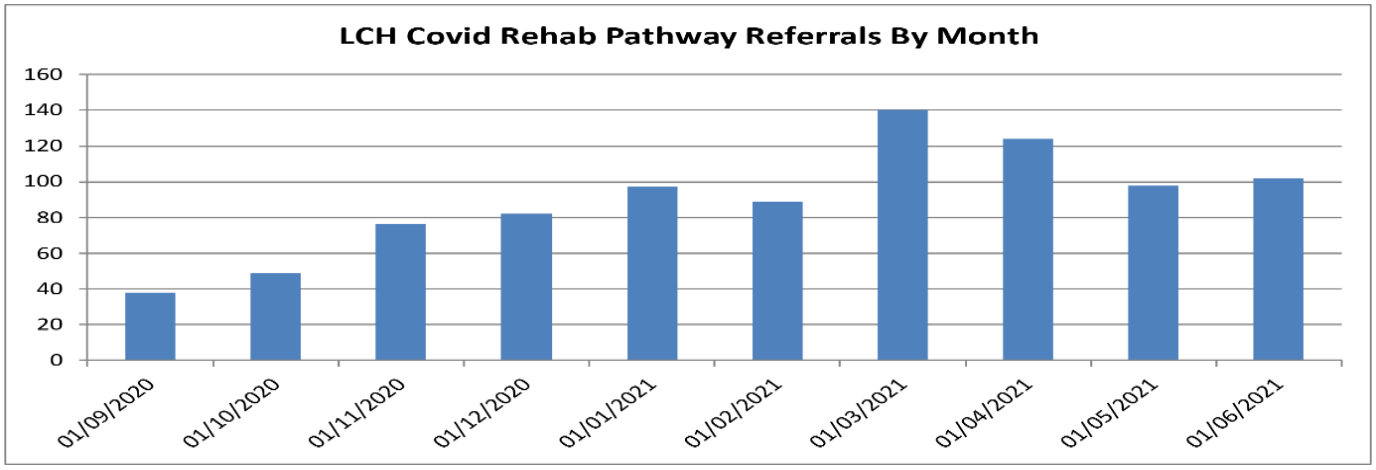
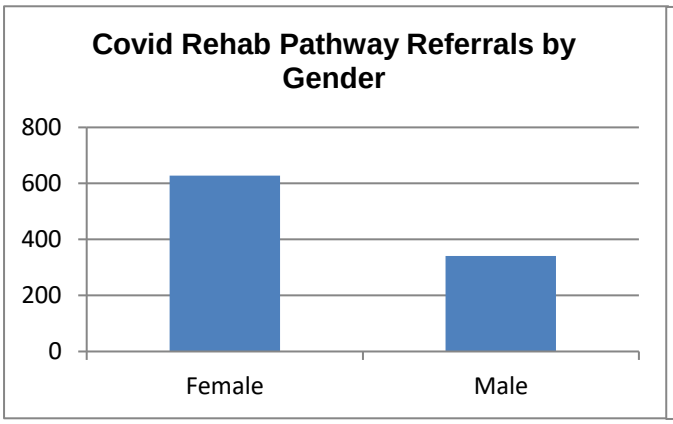
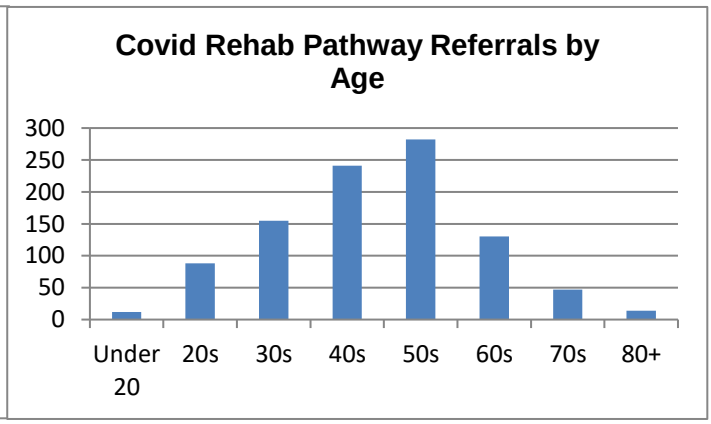


Chart 2.





Average age remains consistent from pathway inception – 49yrs. 65% of people presenting are female. Findings still suggest that Long Covid is higher in those younger age groups compared to the over 60s.

3.3 Presenting Symptoms

- Multi- system condition likely thought due to a form of dysautonomia (a dysregulation of the nervous system) triggered after contracting COVID-19.
- Main symptoms – Fatigue, shortness of breath, cognitive problems (brain fog, memory problems, trouble concentrating and processing/ understanding information), anxiety, Post Traumatic Stress Disorder, gut problems, voice/throat issues, PEM (**p**ost **e**xertional **m**alaise- extreme fatigue after emotional/physical/concentration or stress induced activities), pain – chest/head/muscles and joints.
- Autonomic dysfunction 'poor regulation' leads to other symptoms such as - poor body temperature control / erratic heart rate and blood pressure control / erratic breathing / skin rashes and dizziness.
- Non hospital attenders suffering more with Long Haul symptoms (85% v 15%)
- Post Viral Fatigue is the most common reason people not been able to return to work. Linked to a "brain fog" presentation where patients are describing a fatigue related impaired brain function.
- Relapses seem to be 'cyclical' and fluctuating symptoms from one day to the next making self-management and recovery difficult. This is often due to PEM. Patients often refer to their symptoms and recovery as the 'corona coaster', because of this nature it's difficult discharging patients from the service.

3.4 Clinical Outcomes

Measuring the severity and impact of Long Covid is established research practice within the service. Standardised outcome measures are assessed at baseline and discharge, including the C19YRS, EQ5D (Mental Health Wellbeing Measure), Modified Fatigue Impact Scale, MRC Breathlessness Scale, 30 second sit-to-stand test.

Recent Evaluation of Clinical Outcomes:

- 86% report an improvement in health-related quality of life assessed through EQ5D (EuroQual 5-dimension instrument)
- 66% demonstrate improvement in the Medical Research Council breathlessness scale
- 82% report functional improvement through sit to stand test
- 85% have improved fatigue scores on the Modified Fatigue Impact Scale

3.5 The impact on employment and returning to work

57% of people at point of triage are a combination of not able to work, have lost jobs or working modified hours. We excluded people who are furloughed and those people who have retired from work. As a result, we plan to audit who the team have supported back into the workplace as this is a major part of the Occupational Therapist input. NHSE estimated **15%** of employed people at the point of triage were not able to return to work. Following a site visit where the team shared local evidence with representatives from NHSE, the Leeds team are now sharing data and outcomes in relation to employment with the national Long Covid team.

4. Research and Innovation

Leeds has been successful in securing a £3.4 million research project which has launched in the city to identify the best way to treat and support the one million people in the UK now living with Long-COVID. Led by the University of Leeds and Leeds Community Healthcare NHS Trust funded by the National Institute for Health Research (NIHR), the study aims to create a "gold standard" approach for the treatment of Long COVID. Aims identify best practice in providing services,

ensuring people are supported quickly and receive the right treatments from the right healthcare professionals – in their own home, through their GP or at specialist long-COVID clinics. It will investigate how many people are unable to work due to long-COVID and look at developing a vocational rehabilitation programme to support them back into employment.

5. Health Inequalities

A health inequalities task and finish group was established, consisting of Leeds Community Healthcare, the Clinical Commissioning Group, Public Health, Leeds City Council and the Third Sector to ensure service uptake is equitable according to need. A range of local and national data and intelligence has been collected and analysed to determine if there is any inequity of access to the service or unmet need in communities and to put in place any mitigation actions. It is important to note that, due to how relatively little is known about Long COVID (including prevalence), and limitations and caveats in available data, this is a complex piece to comprehensively produce a clear picture of the situation. Findings from available data are outlined below:

The ONS Long Covid study has produced percentage prevalence estimates of Long COVID by both index of multiple deprivation and ethnicity respectively. We have applied these point estimates to Leeds population data and compared these with service uptake data.

Chart 3. IMD 1 = most deprived

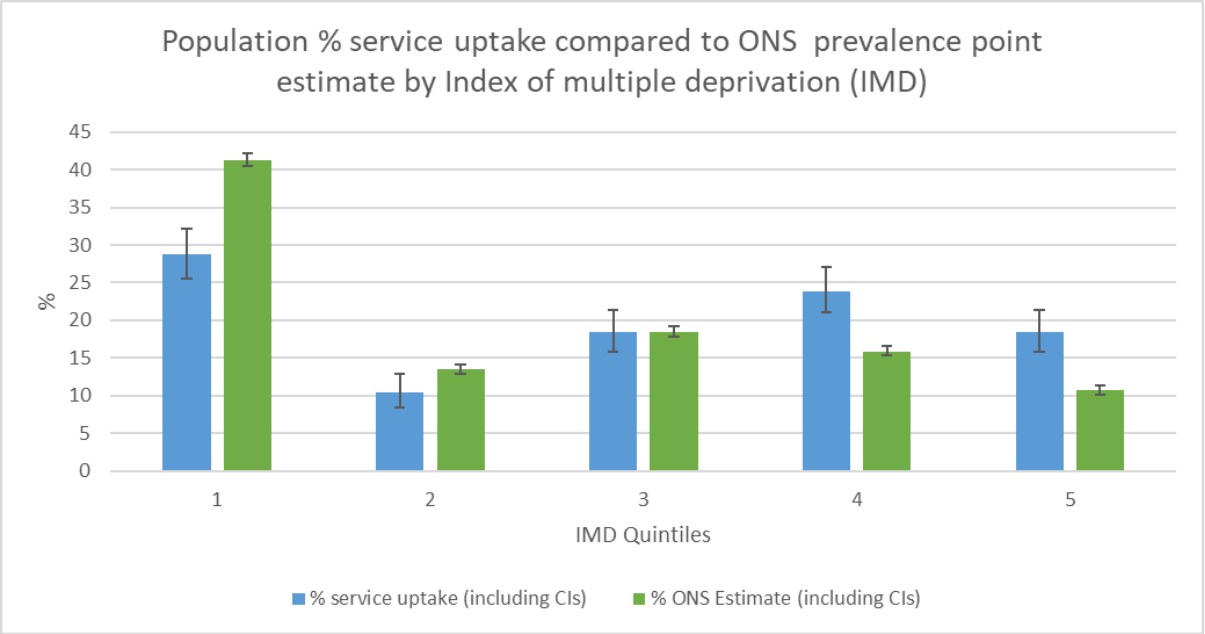


Chart 3 shows that although proportionately a greater number of people who were referred to the Long Covid service (blue bar) were from the most deprived areas IMD quintile 1, relative to the ONS prevalence estimate (green bar), uptake from this group may be underrepresented when considering potential unmet need. In contrast, percentage service uptake from people in the least deprived IMD quintiles 4 and 5, respectively, maybe overrepresented relative to the ONS prevalence estimate. These differences in each of these respective quintiles were statistically significant.

Chart 4.

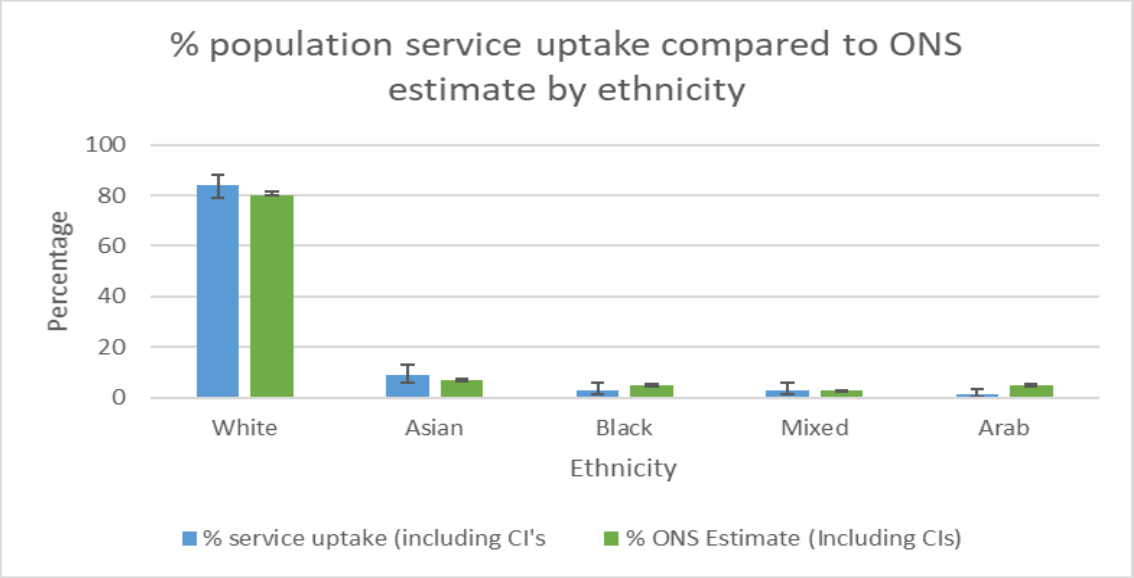


Chart 4 shows proportionately that a greater number of people referred to the Long Covid service were from a White ethnic background. Whilst those referred from Asian, Black, and Mixed backgrounds, respectively, was significantly lower in comparison, relative to the ONS prevalence estimates, any difference was not statistically significant suggesting uptake to the service may not be underrepresented in these groups. Referrals to the service from those categorised as Arab (to note, Arab also includes those from *Chinese and other* backgrounds) were lower relative to the ONS prevalence estimate, which was statistically significant. It's important to note that over 5% of the Leeds GP Registered ethnicity population data used in this analysis was categorised as either *'ethnicity not known/not stated' or 'blank'.*

Caution needs to be applied in drawing any definitive conclusions from these data due to several caveats and limitations. For example, the ONS Long Covid Prevalence Study estimates are based on self-reported Long COVID and not clinically diagnosed. There is also some evidence nationally through early analysis of GP clinical coding data that prevalence of Long COVID was higher in both Asian and Black ethnic groups in comparison to the ONS estimates. However, use of this relatively new GP code in primary care for clinical diagnosis of Long COVID is low and varies across the country suggesting under-coding. Early analysis of local Long COVID clinical code data in Leeds reinforces this.

In addition, local analysis of cumulative COVID-19 cases and positivity rates (from August 2020-May 2021) shows statistically significant higher rates in those from an Asian background (Appendix 2) which may have yielded higher numbers experiencing Long COVID in people from this ethnic group who might not be accessing support.

Chart 5.

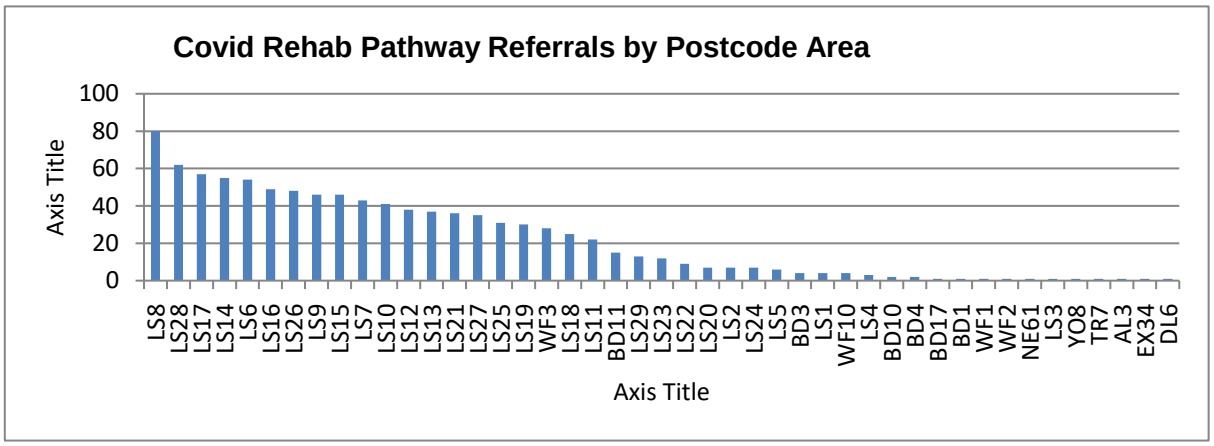


Chart 5 shows the variation in referrals to the service across the City. Following increased promotion of the service to previous low or nil referring practices we are now receiving referrals for all postcodes. However, LS3 has referred one person. Postcode areas with highest referrals are LS8, LS28 and LS17, LS14, LS16 (more than 50 per postcode area) evidencing 5 postcode areas are referring >25% of the total caseload. Some of this variation may be based on actual prevalence and some based on inequity of access. It is also important to highlight that not everyone experiencing Long Covid symptoms will require referral to the specialist service and may be directed to other sources of self-care support.

Long Covid is likely to amplify existing inequalities as disadvantaged groups are more likely to experience the wider health, financial and social impacts of long Covid. It is important that the needs and issues in relation to Long Covid within these groups is understood and that clinical and other sources of support are accessed.

Mitigation actions to help reduce and/or prevent any inequity of access to the specialist service and sources of support have focussed on communication to partners and engaging communities where it is suspected uptake might be low and there is unmet need. This includes raising awareness of signs and symptoms and the help available. This has included:

- A briefing note on Long COVID distributed to partners (including 3rd sector) to help raise awareness in communities (Appendix 1.)
- Communication messages on Long COVID through LCC communication routes.
- A live 'Want to Know More' webinar was delivered in April by the specialist service which was attended by a range of partners (including 3rd sector).
- Forum Central have promoted key messages on the website and through social media.
- Awareness raising and promotion by Better Together providers, targeting IMD 10% most deprived areas.
- Translation of key messages from above briefing note in different languages.
- Promotion of the service to previous low or nil referring GP practices.

6.0 Developments in the assessment of children and young people with Long Covid

The prevalence of Long Covid in children is lower than in the Adult population (ref: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00198-X/fulltext). However, some children will still experience symptoms of Long Covid. Long Covid in children is not well defined, and it may be difficult to distinguish between Long Covid and other conditions. However, families have reported that Long Covid symptoms are having a significant impact on their children's day-to-day lives both physically and psychologically, and that some of the children had missed school because of the symptoms (Ref: https://commins.org.uk/documents/Long-COVID-in-children-

report-21_07_21.pdf). It is therefore important to ensure that a comprehensive service is available to support those children who need it as soon as possible.

Leeds have established a Long Covid assessment clinic for 0-16-year olds, providing a multi-disciplinary assessment including input from a paediatrician, psychologist, occupational therapist, and a physiotherapist. This service accepts referrals from across West Yorkshire and Harrogate Integrated Care System, via local community paediatricians. Following the successful bid to deliver a treatment centre, Leeds Teaching Hospitals NHS Trust is also mobilising a regional treatment service for these children to access following assessment.

It has been agreed the adult Leeds Long Covid Community Service will accept referrals for those over aged 16 years. Professional links have been established to ensure seamless transition between services and to provide ongoing clinical advice and guidance.

7.0 Summary

The Leeds Community Services Long Covid Pathway began developing during the spring of 2020 shaped by the early evidence of need from people who six to twelve weeks following discharge from hospital, were asked to take part in a clinical audit screening tool by telephone. The implementation of this screening tool, developed by local clinicians and research fellows (C19-YRS), enabled the service to anticipate the clinical needs of the population with Long Covid whilst informing the workforce required. The service continues to be responsive, collaborative and agile as research and evidence informs the future service offer.

There are impacts in scientific advancement yet be experienced regarding service demand. How will the vaccination programmes fully impact on the service model required and the continued demand? Where will the economic impact be felt and those upon wellbeing and healthy living where 57% of people on the pathway in Leeds are yet to be well enough to return to work?

Local and national data continues to be evaluated to ensure a clear understanding of prevalence and any inequity of access to the service and sources of support. Health Inequalities work will continue to ensure the service is accessible for all, engaging communities and ensuring positive impact and change.

Whilst there is uncertainty in predicting the population needs for a condition which continues to evolve we can be assured the Leeds system will respond at pace ensuring the future is representative of the past in using the latest evidence and research to model and respond.

Appendix 1.

Long Covid: a briefing note for partners

Updated 20th May, 2021

The purpose of this briefing is to help:

1. **Raise awareness of Long Covid**
2. **Ask for community intelligence**
3. **Determine if partners are seeing an increase in service usage**

Increasing medical evidence and patient testimony is showing that a small but significant minority of people who contract Covid cannot shake off the effects of the virus months after initially falling ill – also known as 'Long Covid'.

What are the symptoms?

The most common symptoms people report are fatigue, ongoing shortness of breath, muscle pains, chest pains, palpitations, "brain fog" and anxiety. A wide range of other symptoms have also been reported. Typically symptoms can fluctuate over weeks, so individuals can seem to be getting better, then get worse again. Most people get better slowly, but may need lots of time and rest to get better.

Since many people were not tested for Covid-19 in the first wave (March-April 2020), it has been suggested that a positive test is not a prerequisite for diagnosis where there is a clear history of viral infection consistent with Covid-19.

The National Institute of Clinical Excellence (NICE) have recently published the following case definitions to define the effects of COVID-19 at different time points:

Acute COVID-19 infection
Signs and symptoms of COVID-19 for up to 4 weeks.

Ongoing symptomatic COVID-19
Signs and symptoms of COVID-19 from 4 weeks up to 12 weeks.

Post-COVID-19 syndrome
Signs and symptoms that develop during or following an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis. It usually presents with clusters of symptoms, often overlapping, which can fluctuate and change over time and can affect any system in the body.

Post-COVID-19 syndrome may be considered before 12 weeks while the possibility of an alternative underlying disease is also being assessed.

There is still uncertainty regarding what is known about the long-term effects of COVID-19. As we learn more and the evidence base is developed, this will inform guidelines on how best to support people with ongoing symptoms.

How common is it?

A recent study by the Office for National Statistics, estimates that the overall prevalence rate of self-reported long COVID at 6th March 2021 was 1.7% of the UK population living in private households. Of those who have had a positive test for Covid, it has been estimated that 13.7% continued to experience symptoms for at least 12 weeks. Based on the same study, it is estimated that Long Covid symptoms could be adversely affecting day-to-day-activities of 8,000 people in Leeds. However, it is still not exactly clear how common Long Covid is.

Who is at greater risk for getting Long Covid?

Long Covid is more commonly reported among people aged 35 to 69 years, females, people from more deprived areas, those with pre-existing health conditions and among health and social care workers. Some of this difference might be because some groups have had a higher chance of getting initial Covid infection, and many people reporting Long Covid had no pre-existing health problems. We do know that COVID-19 has a disproportionate effect on certain parts of the population, including older people, care home residents, those living in deprived areas, and people from black and ethnic minority communities. Black and Asian communities have seen high death rates and there are concerns about other minority groups and the socially disadvantaged. Long Covid is likely to amplify existing inequalities as disadvantaged groups are more likely to experience the wider health, financial and social impacts of Long Covid.

It is important that the particular needs and issues in relation to Long Covid within these groups is understood and that clinical and other sources of support are accessed.

What help and support is there?

People in Leeds who are struggling with ongoing symptoms should consult their GP. There is a Covid Rehabilitation pathway in Leeds that people can be referred into, if needed.

Local information on recovering from Covid is available here: https://www.leedsccg.nhs.uk/health/coronavirus/recovering-from-coronavirus/

In addition, www.yourcovidrecovery.nhs.uk is a self-care resources that people can access to help support COVID-19 recovery and the management of ongoing symptoms.

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Dr Stephen Halpin, Consultant in Rehabilitation Medicine (Leeds Teaching Hospital NHS Trust)

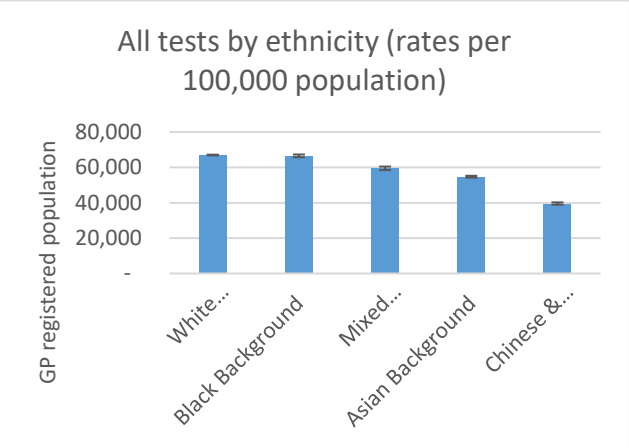
Appendix 2

Cumulative COVID-19 cases and positivity rates in Leeds (from August 2020-May 2021)

4. All tests by ethnicity (rates per 100,000 population)

Ethnicity	Testing rate per 100,000	LCI	UCI	LCI	UCI
Ethnicity Not Known/Not Recorded	510,721	508,677	512,770	2,043.48	2,049.66
White Back-ground	66,967	66,769	67,167	198.61	199.06
Black Back-ground	66,504	65,730	67,285	774.14	780.98
Mixed Back-ground	59,460	58,472	60,461	988.32	1,000.84
Asian Back-ground	54,710	54,176	55,248	533.88	537.83
Chinese & Other Back-ground	39,546	38,874	40,226	671.50	680.19

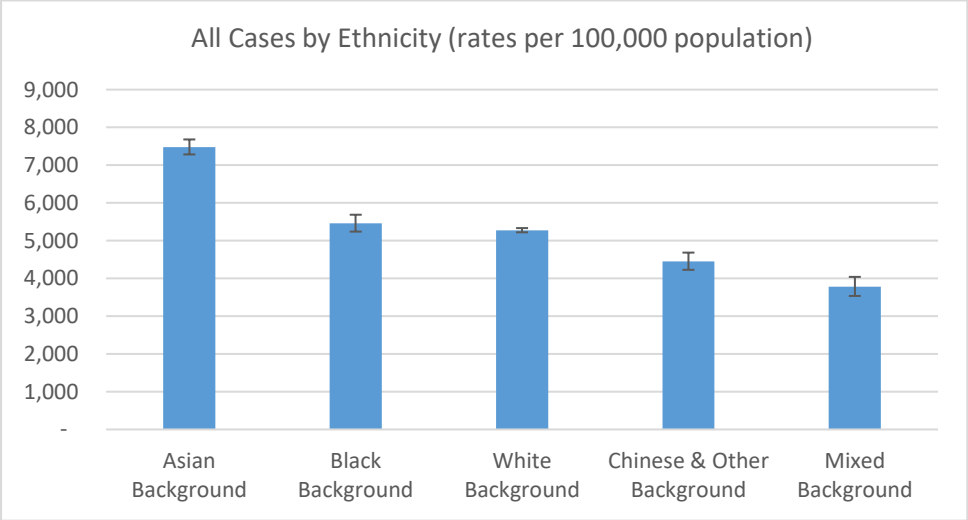
Ethnicity	Testing rate per 100,000	LCI	UCI	LCI	UCI
Indian	58,060	57,067	59,065	992	1,005
PAKISTANI	54,295	53,460	55,139	834	844
Bangladeshi	44,666	42,769	46,625	1,897	1,959



- Missing ethnicity category for volume of tests conducted has resulted in the unrealistic testing rate by exciding the number of populations allocated to the "Ethnicity not known" from GP registered population (excluded in the chart)
- The highest test rate number overall is among white back-ground population, second is Black Background popula-tion
- The highest test rate among Asian background population is Indian ethnicity

table 5. All Cases by Ethnicity (rates per 100,000 population)

Ethnicity	Covid-19 cases rate per 100k	LCI	UCI	LCI	UCI
Ethnicity Not Known/Not Recorded	30,503	30,005	31,007	497.875	504.065
Asian Background	7,480	7,284	7,681	196.593	200.556
Black Background	5,460	5,239	5,687	220.205	227.082
White Background	5,277	5,221	5,333	55.648	56.094
Chinese & Other Back-ground	4,451	4,228	4,683	223.391	232.131
Mixed Background	3,781	3,535	4,040	246.164	258.786
PAKISTANI	9,013	8,675	9,361	338.108	347.909
Indian	6,548	6,217	6,891	330.475	343.480
Bangladeshi	6,577	5,862	7,355	715.180	778.371

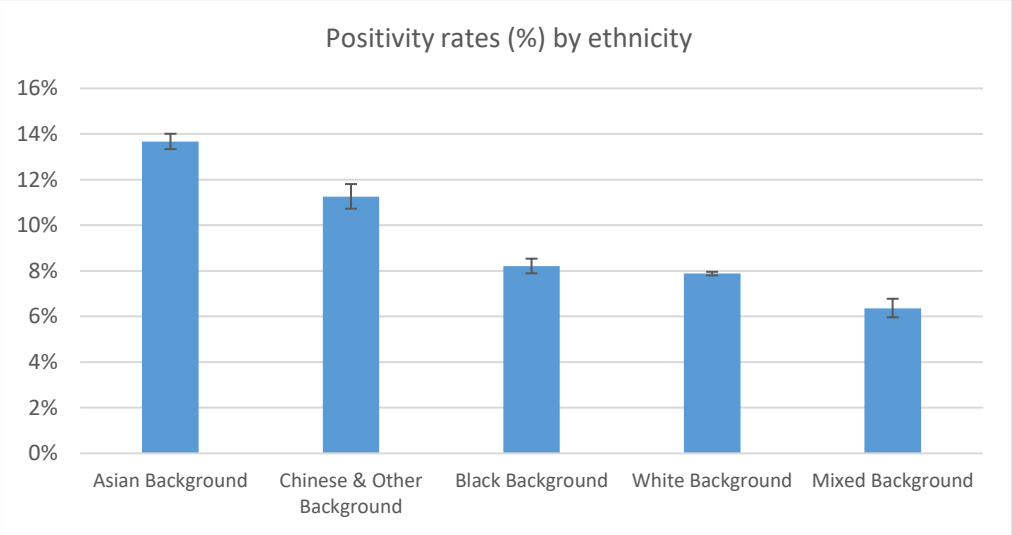


Covid -19 cases rate per 100,000 for Asian Background population is statistically significantly higher than the rest of ethnicities

table 6. Positivity rates (%) by ethnicity

Ethnicity	Positivity %	LCI	UCI	LCI	UCI
Asian Background	13.7%	0.13	0.14	0.0033	0.0034
Chinese & Other Background	11.3%	0.11	0.12	0.0053	0.0055
Black Background	8.2%	0.08	0.09	0.0031	0.0033
White Background	7.9%	0.08	0.08	0.0008	0.0008
Mixed Background	6.4%	0.06	0.07	0.0040	0.0042
Ethnicity Not Known/Not Recorded	6.0%	0.06	0.06	0.0009	0.0010

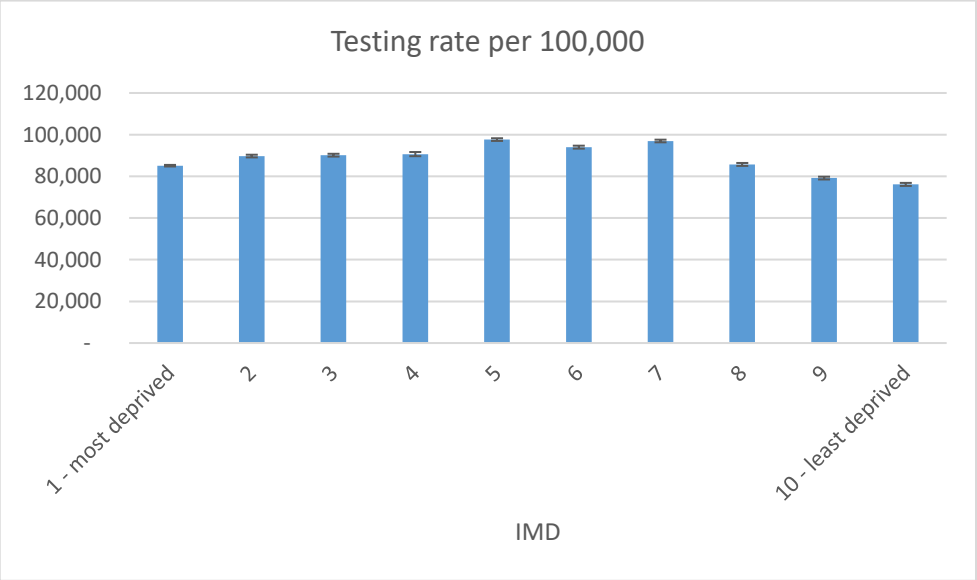
PAKISTANI	16.6%	0.2	0.2	0.0057	0.0058
Indian	11.3%	0.1	0.1	0.0053	0.0055
Bangladeshi	14.7%	0.1	0.2	0.0146	0.0159



- Covid -19 Positivity rate for Asian Background population is statistically significantly higher than the rest of ethnicities

table 7. All tests by depravation decile (rates per 100,000 population)

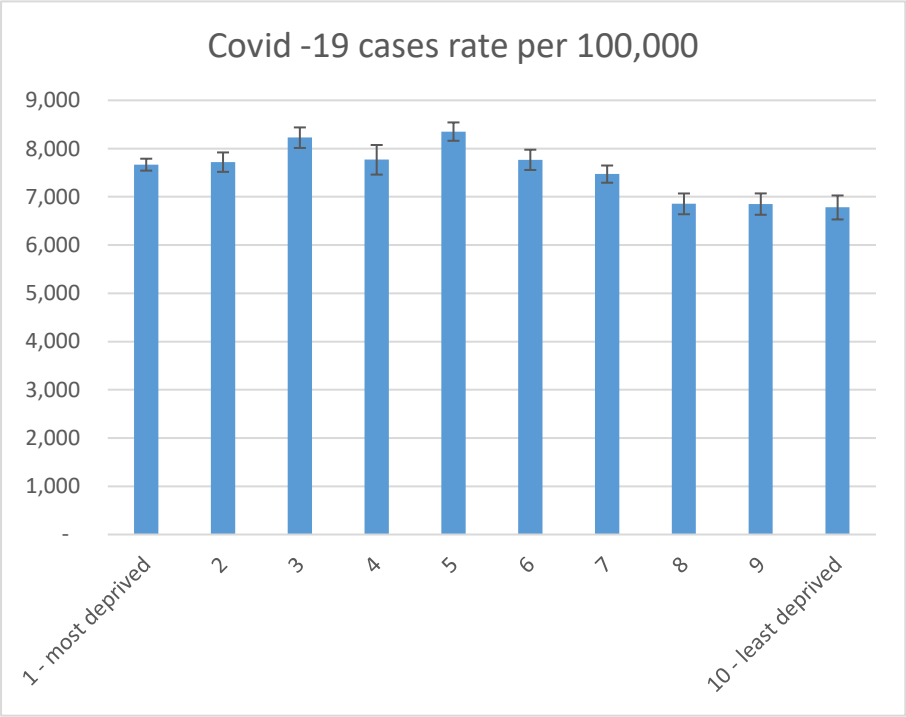
IMD Decile	Testing rate per 100,000	LCI	UCI	LCI	UCI
1 - most deprived	85,108	84,729	85,489	379.34	380.62
2	89,734	89,088	90,383	646.19	649.71
3	90,160	89,494	90,829	665.73	669.45
4	90,675	89,685	91,673	990.19	998.40
5	97,644	97,004	98,287	639.50	642.67
6	94,018	93,313	94,727	705.47	709.48
7	96,969	96,339	97,602	629.75	632.85
8	85,721	85,020	86,427	701.07	705.41
9	79,166	78,500	79,836	666.05	670.30
10 - least deprived	76,139	75,418	76,866	721.39	726.57



- The highest statistically significant testing rate per 100,000 is visible in IMD decile 5 and 7
- IMD decile 10 had the lowest statistically significant testing

Table 8. All cases by IMD (per 100,000)

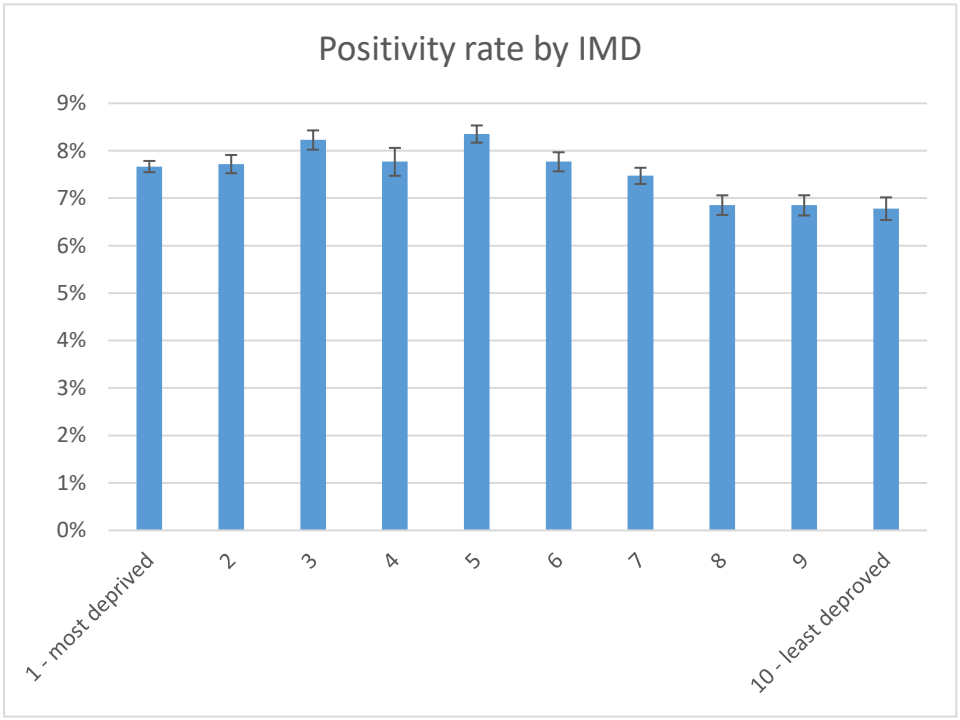
IMD Decile	Covid -19 cases rate per 100,000	LCI	UCI	LCI	UCI
1 - most deprived	7,667	7,544	7,792	123	125
2	7,721	7,521	7,924	199	203
3	8,228	8,017	8,443	211	215
4	7,772	7,469	8,083	302	311
5	8,353	8,165	8,545	189	192
6	7,769	7,561	7,981	208	212
7	7,472	7,296	7,652	177	180
8	6,857	6,644	7,075	213	218
9	6,852	6,633	7,076	219	224
10 - least deprived	6,783	6,538	7,035	245	252



- IMD decile 5 had the highest statically significant case rate compared to all other deciles apart from decile 3.
- IMD decile 10, 9, and 8 had the lowest statistically significant case rate compared to the rest of the deciles.

Table 9. Positivity rate by IMD (%)

IMD Decile	Positivity rate by IMD	LCI	UCI	LCI	UCI
1 - most deprived	7.7%	0.08	0.08	0.001	0.001
2	7.7%	0.08	0.08	0.002	0.002
3	8.2%	0.08	0.08	0.002	0.002
4	7.8%	0.07	0.08	0.003	0.003
5	8.4%	0.08	0.09	0.002	0.002
6	7.8%	0.08	0.08	0.002	0.002
7	7.5%	0.07	0.08	0.002	0.002
8	6.9%	0.07	0.07	0.002	0.002
9	6.9%	0.07	0.07	0.002	0.002
10 - least deprived	6.8%	0.07	0.07	0.002	0.002



- IMD decile 10, 9 and 8 had the lowest statistically significant case rate compare to the rest of the deciles