Report author: Angela Brogden

Tel: 0113 3788661

# The impact of Covid-19 and the ongoing recovery measures across the local health and care system.

Date: 16th November 2021

Report of: Head of Democratic Services

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

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

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

## What is this report about?

**Including how it contributes to the city's and council's ambitions**

- At the request of the Adults, Health and Active Lifestyles Scrutiny Board, this report presents an update on the current understanding of the system impact of the Covid-19 pandemic in Leeds through the lens of health and care service provision. This report also provides an insight to the response plans and measures, based on collaboration and partnership, that are currently in place.

### Recommendations

Members are requested to consider and provide any comment on the information presented within this report.

**Why is the proposal being put forward?**

1. Since the outbreak of the Covid-19 pandemic, the Adults, Health and Active Lifestyles Scrutiny Board has maintained a key focus on how the Council and its partners are working collaboratively to support the broad range of patients, service users and stakeholders across the health and care system during such an unprecedented and difficult period.

2. At the request of the Scrutiny Board, this report presents a further update on the current understanding of the system impact of the Covid-19 pandemic in Leeds through the lens of health and care service provision. It also provides an insight to the response plans and measures, based on collaboration and partnership, that are currently in place.

**What impact will this proposal have?**

| **Wards affected: All** | | |
|---|---|---|
| Have ward members been consulted? | ☐ Yes | ☐No |

3. The updated position is set out within the attached briefing paper, which has been produced in liaison with partners across the local health and care system. The paper provides an insight into the significant and sustained pressure on health and care services provision as a consequence of the Covid-19 pandemic, as well as an insight into the immediate and continuing partnership response to mitigate the impact of:

   - Widespread increases in demand for health and care services
   - Challenges in optimising system flow
   - Workforce retention, resilience and recruitment

**What consultation and engagement has taken place?**

4. Partners across the local health and care system have been consulted in terms of informing the attached briefing paper and local health and care representatives will also be attending today's meeting to help address Members' questions.

**What are the resource implications?**

5. Any associated resource implications will be set out within the attached briefing paper.

**What are the legal implications?**

6. This report has no specific legal implications.

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

7. Any associated risk implications will be set out within the attached briefing paper.

**Does this proposal support the council's three Key Pillars?**

☐ Inclusive Growth ☒ Health and Wellbeing ☐ Climate Emergency

8. The Leeds Health and Well-being strategy sets out the ambition that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The aims of integrated care support many of the strategy's priorities including "the best care, in the right place, at the right time".

## Appendices

**9.** Appendix 1 – Briefing paper on the impact of Covid-19 and the ongoing recovery measures across the local health and care system.

## Background papers

10. None.

# Briefing Paper to the Adults, Health and Active Lifestyles Scrutiny Board

## 16th November 2021

### Purpose of the briefing paper

This paper aims to guide the Adults, Health and Active Lifestyles Scrutiny Board through our current understanding of the system and health protection impact of the COVID-19 pandemic in Leeds. This impact will be presented through the lens of health and care service provision, whilst documenting the continued outbreak control, infection prevention, management and response measures in place as we approach winter. The paper will cover the impact of COVID-19 and the impact on system flow, wider system demand, workforce and health inequalities. It will include the vaccine and shielding programmes as examples of key new programmes, best practice and partnership working.

### Summary Headlines

1. Despite extensive and far-reaching health protection measures, the Leeds Health and Social Care System has and continues to experience significant and sustained pressure on service provision due to COVID-19. This pressure exceeds that experienced during the annual Winter pressures. This picture is not unique to Leeds, or indeed West Yorkshire. This demand has placed substantial pressure on the physical and mental health of staff in hospitals, social care, public health and community services across the public, independent and third sector.

2. The headline causal factors for these pressures are:
   - Widespread increases in **demand** for health and care services following pause in provision during first wave
   - Challenges in optimising **system flow**
   - **Workforce** retention, resilience and recruitment
   - Pre-existing and new **health inequalities**

3. The immediate and continued response to the pandemic has showcased some of the very best of the Team Leeds approach. Collaboration and partnership working has been a golden thread that has run through the strategic, tactical and operational levels of the Leeds health and care system. Robust measures are in place as we approach winter and we are further developing the vaccine programme and maintaining support for people who are clinically extremely vulnerable.

4. Despite this approach, health and wider inequalities have been exacerbated during the pandemic. Vaccine uptake is lower in deprived areas and morbidity and mortality are higher in black and minority groups. As COVID-19 has impacted physical health, poverty, loneliness and have impacted mental health at all ages.

**Conclusion**

5. To support recovery from the pandemic and 'build back fairer' the city will require clear partnership strategies and delivery plans that outline how all parts of the health and care system will clear backlogs, manage waiting lists, restart electives, focus on proactive care, address new demands (long COVID) and support the health and wellbeing of staff.

6. The city will also require a consistent, long term and proportionate approach to existing and COVID-19 related inequality and to link this to Leeds health and care partnership strategies focused on improving health, addressing inequalities and workforce. Strategic and operational plans are increasingly placing tackling inequality front and centre of their approach.

**COVID-19 Overview**

7. Figure 1 below illustrates the impact of COVID-19 over time in four waves:
   - Immediate mortality and morbidity of COVID-19
   - Impact of resource restriction on urgent non-COVID conditions
   - Impact of interrupted care in chronic conditions and
   - Psychic trauma, mental illness, burnout and economic injury

   This model is a helpful way to consider the impacts of COVID-19 over time, although we recognise these waves are interrelated, cross over and are experienced unequally.

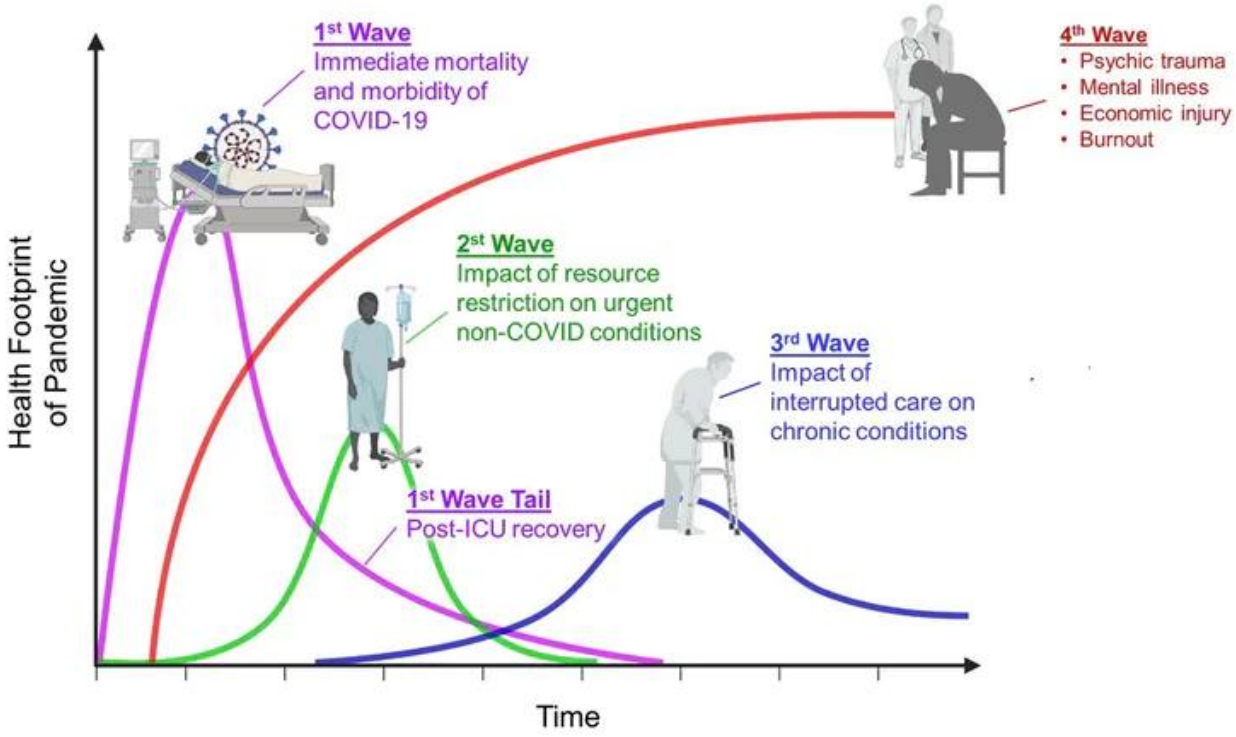



*Figure 1. Four waves of the COVID-19 Pandemic*

8. As of 25th October, Leeds had a 7-day rate of 488.1 per 100,000 for the period October 14th to October 20th. This indicates that the rate is stable with a slight reduction as compared to the previous week's rate (490.2 per 100,000). The 7-day rate for the same period for Yorkshire and Humber was 474.4 per 100,000 (a 3% decrease over the past 7 days) and for England was 488.5 per 100,000 population (a 15% increase over the past 7 days). The rate for West Yorkshire, as of 26th October, is 477.9 per 100,000. Leeds remains the second highest out of the 5 local authorities in West Yorkshire, however all areas in the region have either seen a reduction or stabilisation in infection rate.

9. The current rate for Leeds in the over 60s population is 315.1 per 100,000, which is a 9% increase from the previous week. The current rate for over 60s in Yorkshire and Humber is 255.4 per 100,000, which is a 3% increase from the previous week. The over 60s rate for West Yorkshire is 284.8 per 100,000, a 4% increase from the previous week. Leeds is the second highest across West Yorkshire for the over 60s rate. There has been an increase in the case rates for the 60-79 age group and the over 80s population, which is a trend replicated across other local authority areas in the region. There is ongoing work focusing on those most at risk of harm from COVID particularly during Winter. Key messages about staying safe aimed at over 60s are being developed and will be shared by partners. The booster vaccination programme is likely to mitigate the risk of hospitalisations and severe illness in the older adult population.

10. In the latest week, cases are again highest in the 11-16 and 5-10 age groups respectively, however there are signs that rates are levelling off and there will be a decreasing trend. The lowest rates continue to be in the 19–24 age group and this has decreased since last week. Similar trends for case rates among these age groups are generally being observed across Yorkshire and Humber and some parts of the country, particularly in the major cities.

11. Testing positivity across Leeds continues to be stable at 11.4%. Positivity for Yorkshire and Humber was 11.6% in the latest 7 days.

12. As of 26th October, there are 12 ongoing outbreaks in older people's care homes. In total, across these sites, there are 55 residents and 33 staff who are PCR positive. The number of sites reporting outbreaks remains stable, however there has been an increase in the number of residents testing positive from 29 last week. All care homes continue to be monitored and receive support to manage outbreaks. Care home rates will continue to be monitored closely and the booster vaccination programme is being rolled out at pace.

**Health Protection (outbreak control, infection prevention, management and response)**

13. Throughout the Covid-19 Pandemic, from the first confirmed case in Leeds to the current time, the public health protection system has provided solid and consistent leadership to the local system in the response to outbreak control, infection prevention, management and response. The system has provided evidence based and coordinated action as the pandemic unfolded, providing intelligence led decision making, mobilising services to minimise transmission and protect the most vulnerable.

What has been delivered?

14. The Leeds Outbreak Management Plan was developed in the context of the detailed plan published in summer 2020, combined with all the learning from the multi-agency working and in the context of the broader coronavirus response and recovery plan. It takes learning from good practice nationally, from Association of Directors of Public Health (ADPH), and in the context of the latest national Contain Framework on GOV.UK.

15. The Leeds approach to prevent transmission of coronavirus (COVID-19) is through intensifying a combination of interventions and measures to minimise harm, keep people safe, protect vulnerable people and minimise poverty and inequalities. Our approach continues to be comprehensive across the whole system and informed by the full range of public health measures from vaccination, infection prevention control, communications, managing outbreaks and preventative activity, including encouraging safe practices and choices.

16. In particular, the approach adapts to changing circumstances as the pandemic evolves. The transition from summer to autumn and winter presents the risk of increased cases as people spend more time indoors and immunity from previous infection wanes, while the prospect of new variants means there could be a resurgence of COVID-19 in the autumn and winter, coupled with seasonal viruses such as flu and norovirus. The outbreak prevention and management approach we have in place has been built on existing strong systems, following national policy. We take a dynamic, risk assessed approach where a full range of preventative measures are recommended on a setting by setting basis. We implement this in a way that protects people, minimising spread, protecting the most vulnerable and identifying clusters early. This includes incident management support ensuring that settings are supported with outbreak prevention control measures as required.

17. The Health Protection system developed and enhanced key features that were an important part of our Leeds response to Covid outbreaks and minimising the spread infection:

- Took an Adaptive and flexible approach, led by Leeds City Council Public Health and owned by all partners across health and care systems.
- Ability of the health and care system to work at a fast pace and with agility supported by Health Protection.
- The emergency response was heavily supported by NHS CCG and LCC communications teams with a greater command and control direction coming from the centre than ever before. The efforts of local communication teams to balance rapidly evolving central control messaging with the requirement to meet the needs of local communities was highly effective, building on existing comms structures.
- Innovative thinking and new technologies – development of a local surveillance system that informs a timely response to outbreaks and incidents. HP STAR (Surveillance, Tracking and Reporting)
- Working across organisational boundaries and removing barriers e.g. rapidly agreeing joint working agreements between partners.
- Delivered our wider health protection services through a one-system response by blending the skills and capabilities of the key teams.
- Interpreting rapidly emerging public health evidence relating to PPE, informing local decision making to protect staff working in high risk and vulnerable settings.

Key achievements

- Led system response to reduce the impact of significant outbreaks in care homes, education and workplace settings through a robust incident management system. At the peak we were leading up to 15 outbreaks per week.
- Rapidly recruited to and scaled up infection prevention service, environmental health and health protection team to ensure a resilient local health protection service.
- Environmental Health, supported 1,200 local businesses to implement control measures, to respond to over 90 workplace outbreaks including contact tracing in complex cases.
- Leeds Community Healthcare infection prevention services provided swift responses to over 40 outbreaks per day in care settings at the peak of the pandemic.
- Led the development of a LCC public health single point of contact for the system to alert us of incidents and outbreaks.
- Developed joint working agreements including surveillance reporting with all six universities Public Health England, LCC public Health and local support services
- Developed a testing strategy, intelligence led deployment of mobile testing including, pop up testing facility and surge testing to respond to local community need. Established local testing sites accessible for local communities
- Established the Leeds Contact tracing service to contact up to 100 people a day who had not been contacted through the national NHS T and T system and offer support to isolate.
- Increased allocation of funding to third sector prioritising health inequalities through provision of community engagement support in areas of high rates and

deprivation including door knocking taking place providing support to test and isolate
- Provided proactive infection control training and support to schools, nurseries and care homes.
- Delivered an enhanced response to areas with high infection rates through community engagement plans

**Impact of COVID-19 in Leeds**

**Health Inequalities**:

18. The impact of the COVID-19 pandemic has fallen disproportionately and widened health inequalities amongst groups of people internationally, in the UK and in Leeds (UCL, 2020, The LGA, April 2021, The Health Foundation, July 2021).

19. During 2020, clear trends and evidence emerged nationally showing that COVID-19 mortality and morbidity impacted more severely on certain groups in our population with disproportionate impacts dependent upon age, gender, pre-existing conditions, ethnicity and deprivation. Working age people living in the 10% most deprived areas were 4 times more likely to die from COVID-19 than those in the wealthiest 10%. The local areas with the highest COVID-19 mortality rates for people under 65 tended to have a lower life expectancy, lower employment rates and more overcrowded housing, deprivation, and child poverty. People with a disability, and those from a Black, Asian, and ethnic minority background were shown to be disproportionately affected to a devastating degree. For example, MENCAP found that 8 out of 10 deaths for people with learning disability were due to COVID-19 (UCL, 2020, The LGA, April 2021, The Health Foundation, July 2021).

20. An early local analysis or morbidity and mortality found similar patterns in Leeds relating to age and deprivation and to a lesser extent, due to small numbers and poor ethnicity recording, ethnicity (Wood, May 2020). Over the course of the pandemic, there was an increase in the number of deaths per week compared to previous years in Leeds. As at 2021 week 34, there were over 700 excess deaths in Leeds.

21. Nationally mortality rates have also been shown to be higher in some occupational groups (figure 2). Many of the occupations found to be at higher risk are those which are public facing, low paid roles, often with an over-representation of people from Black, Asian and ethnic minority backgrounds.

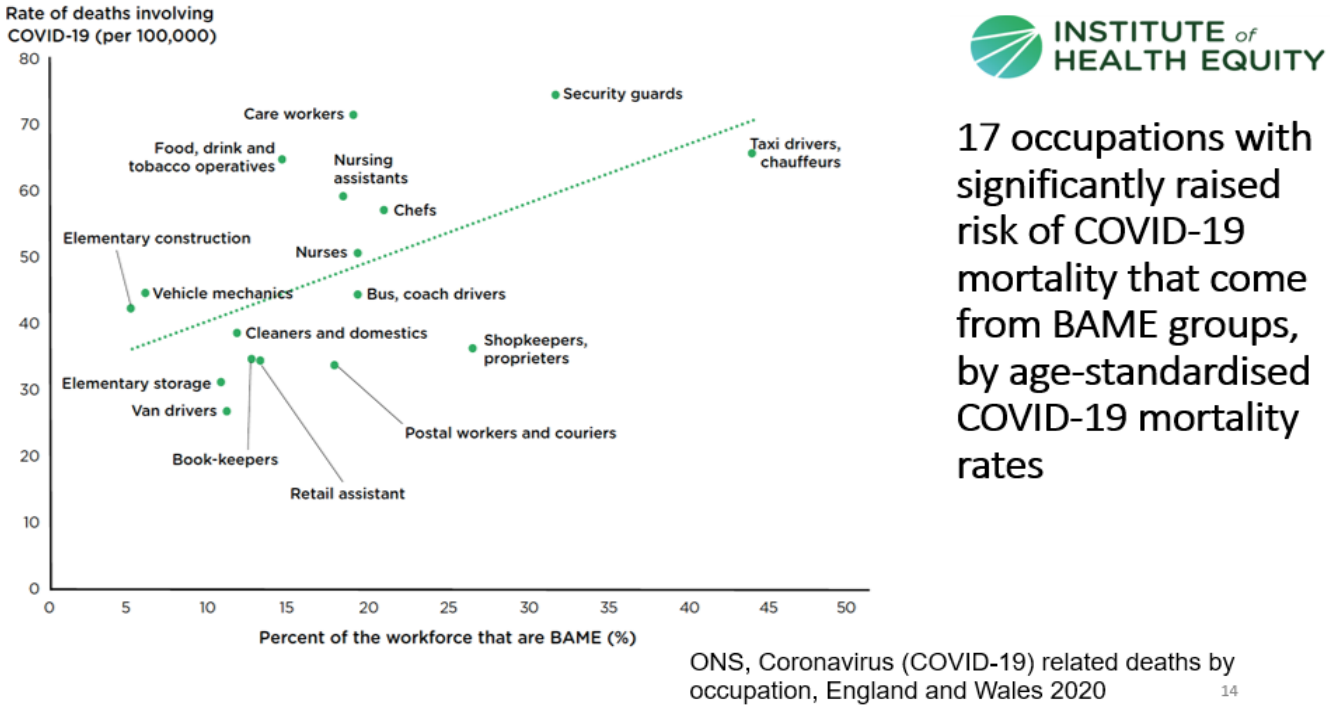



*Figure 2. Occupations at increased risk of mortality from COVID-19.*

22. In addition to the immediate unequal impact of COVID-19 on morbidity and mortality, health inequality has been experienced directly and indirectly and will continue to do so. Key examples of the long-term disproportionate impact on groups facing multiple risk factors include children. The Children's Commissioner Anne Longfield, said "It's impossible to overstate how damaging the last year has been for many children – particularly those who were already disadvantaged...How many children are in families that are struggling to support them; how many are starting school so far behind they'll never catch up; how many children with mental health needs or special education needs aren't getting the help they should be?"

23. Another key concern is the unequal impact of COVID-19 directly and indirectly on mental health. The mental health impacts of COVID-19 are far-reaching across all ages both in the short, medium and longer term, impacting on people's resilience and ability to cope and exacerbating the burden of mental ill health in the community long after recovery. The mental health impacts, from a service provision and demand perspective, of COVID-19 are drawn upon later in this paper.

<u>Leeds Response to tackling health inequalities.</u>

24. Leeds has a long history of taking action to address health inequalities. In recent years this has been co-ordinated through the Leeds Health and Wellbeing Strategy and the Health and Wellbeing Board under a broad city-wide aspiration to improve become the best core city for health and wellbeing and to improve the health of the poorest the fastest. Improving the health of the poorest the fastest is intended to focus the system on inequality and to ensure all partners, whether commissioning

or delivering services, ask themselves about access, diversity and their wider impact on the city.

25. This work is underpinned by our joint strategic assessment, which functions as a robust analysis of health and wellbeing in Leeds, with a strong focus on tracking health inequalities over time. The 2021 JSA was presented to the Health and Wellbeing Board in September, and the evidence gleaned from the JSA process will be used to review and revise the Health and Wellbeing Strategy over coming months.

26. The recent arrangements made by Health and Wellbeing Board members to partner with key stakeholders working with inclusion health groups or communities of interest signals Leeds broader commitment to addressing not only inequalities related to place but those experienced by different groups and communities in the city.

27. NHS partners in the city have embedded addressing health inequalities into their strategic and operational plans; including Leeds CCG Health Inequalities Strategy and the Leeds Community Healthcare's Healthy Equity Plan, whilst The Leeds Health Inequalities group has developed the toolkit (https://bit.ly/healthinequalitiestoolkit), to enable healthcare organisations and settings to translate these aspirations into measurable outcomes.

28. Finally, The Leeds Best Council Plan 2020 to 2025 aims to directly tackle poverty and reduce inequalities. It has as its three pillars: the Leeds Inclusive Growth Strategy, Leeds Health & Wellbeing Strategy and the city's Climate Emergency Declaration. Taken together, the eight Best City priorities are designed to improve outcomes for everyone in Leeds:
    - Inclusive Growth
    - Health and Wellbeing
    - Sustainable Infrastructure
    - Child-Friendly City
    - Age-Friendly Leeds
    - Housing
    - Safe, Strong Communities
    - Culture

**System Impact:**

**Demand**

Adult Social Care

29. Where possible the data used is based on monthly data from April 2019 to September 2021 in order to provide a long enough timescale to show patterns of activity both before, during and following the height of the COVID 19 pandemic.

Contact Centre

30. Over the entire period the number of calls offered to the call centre in a month has remained broadly steady although a fall can be seen between April and June 2020

and more recently a peak in May-July 2021 where call levels are higher than pre pandemic levels.

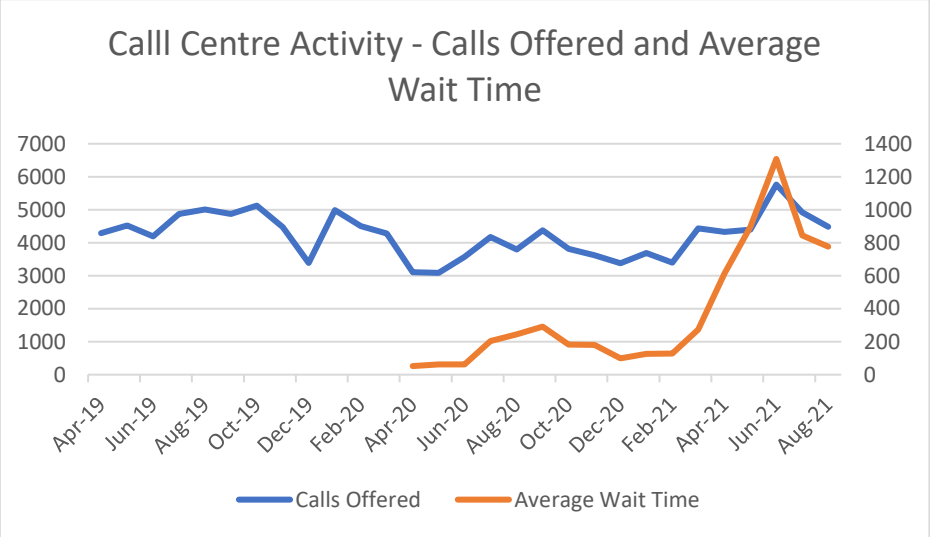



*Figure 3. Call centre activity.*

31. It remains to be seen if this new higher level of contacts will continue. The average wait time has increased substantially from April 2021 to a peak in June 2021 before falling slightly more recently but still remaining high.

Referrals

32. Overall referral activity has continued to increase over the period but shows a clear fall in activity around March to July 2020 relating to COVID 19. Current monthly levels of activity are now higher than pre-pandemic. In terms of referrals from potential new service users these follow a similar pattern.

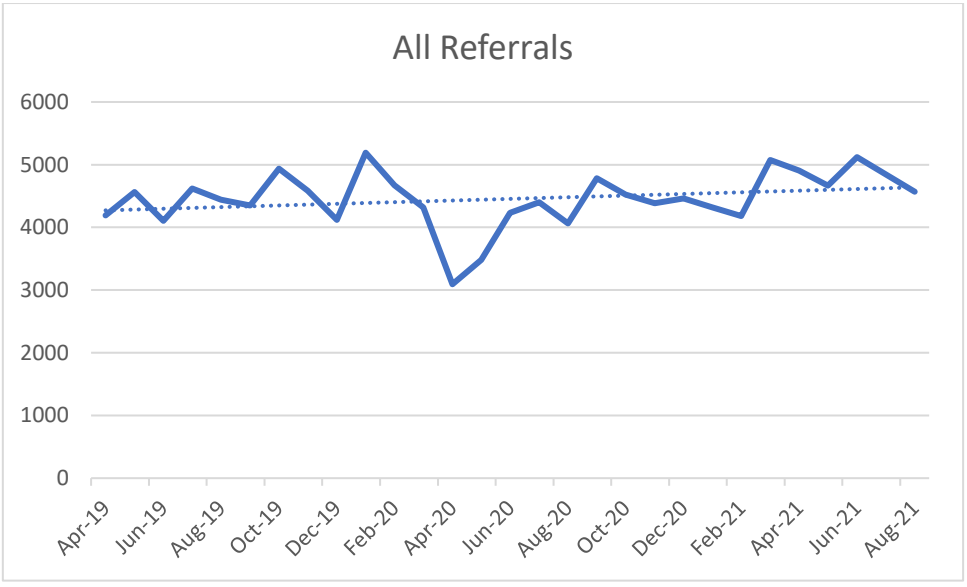



*Figure 4. Number of referrals into adult social care services*

Assessments

33. Over the whole period there appears to be a general downwards trend in the number of assessments started each month. However, this is influenced by the March to July 2020 period when a noticeably lower number were completed each month. Since then and particularly in more recent months numbers appear to have moved back in line with pre-pandemic levels.

34. The percentage of assessments completed within 28 days has been on a downward trend throughout the period despite the lower volumes of activity. This may be linked to staffing pressures.

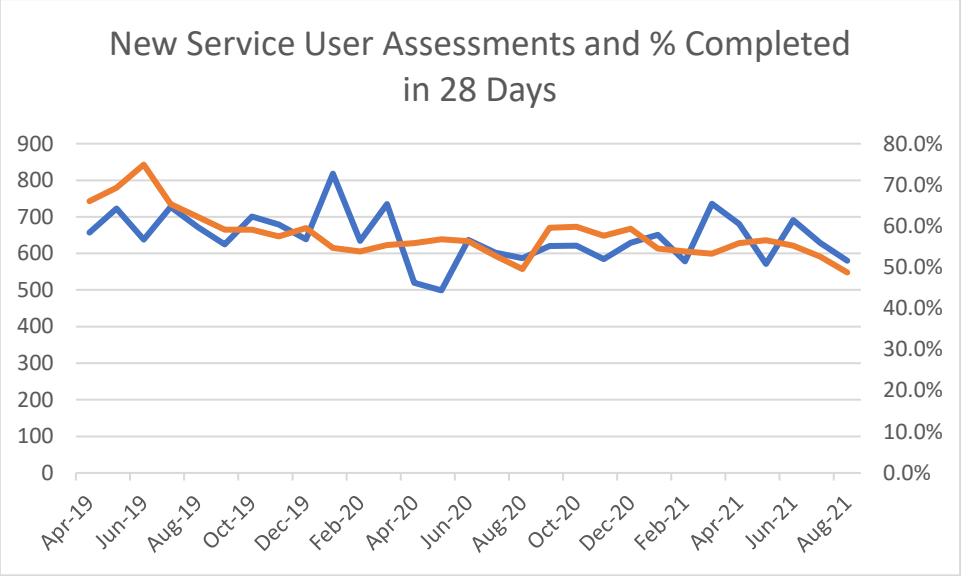



*Figure 5. New service user assessments and % completed in 28 days*

Reviews

35. Over the period the number of reviews completed each month has decreased. However, unlike referrals and assessments there was an increase in activity around the start of the pandemic as service users were reviewed to ensure they were receiving the care they needed. Again staffing capacity issues will have a role to play in the number of planned reviews taking place.

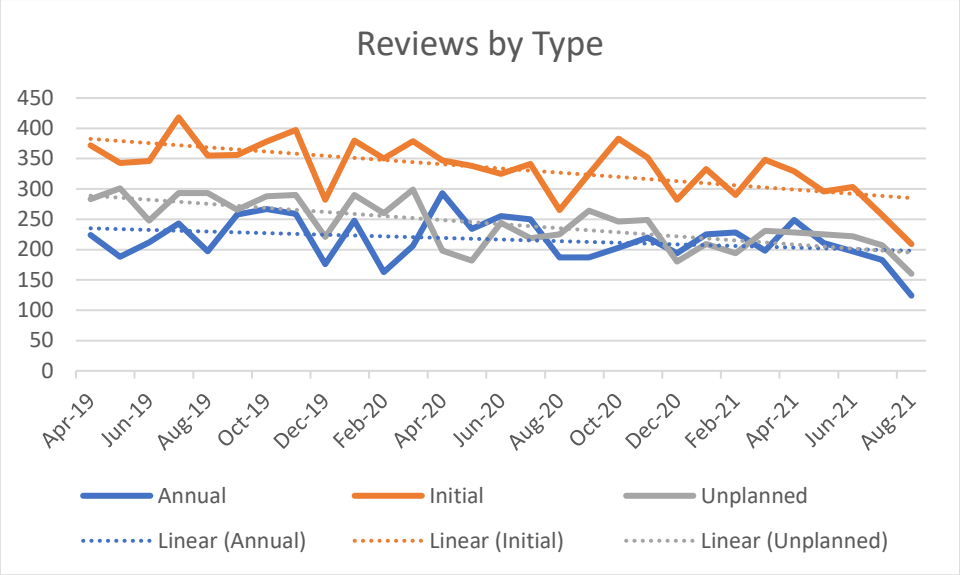



*Figure 6. Number of reviews by type.*

Unallocated Cases

36. There has been a clear increase in the number of unallocated cases each month both for social work and decision support tool cases (DST) over the period. The Decision Support Tool (DST) - used in continuing care decisions – is a document which helps to record evidence of an individual's care needs to determine if they qualify for continuing care funding.

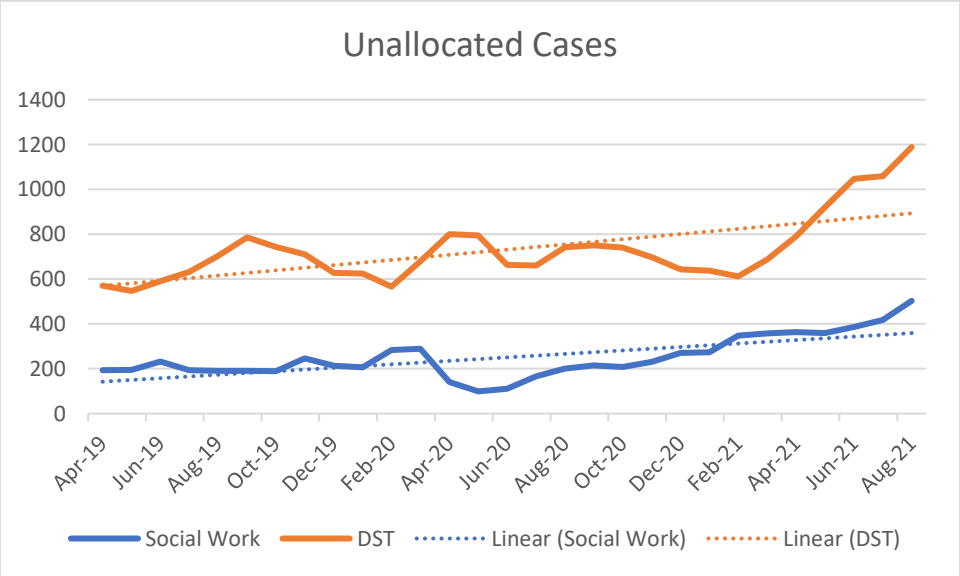



*Figure 7. Number of unallocated cases by type,*

Mental Health Activity

37. There has been an increase in demand for MH activity, both in terms of referrals to the mental health unit and the number of Mental Health Act assessments carried out each month. It is also noticeable that this increase is most noticeable from the start of the pandemic.

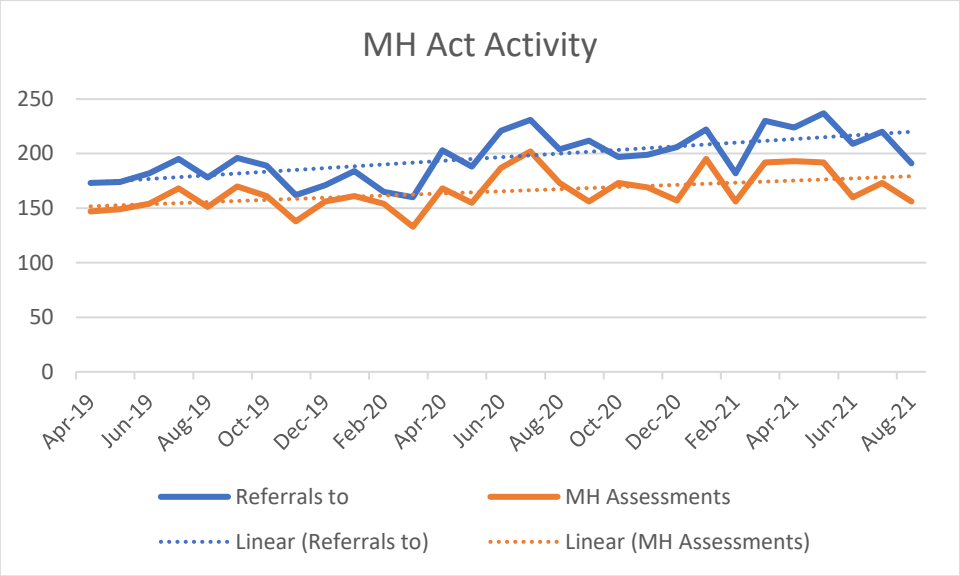



*Figure 8. Number of referrals to, and subsequent mental health assessments.*

Safeguarding Activity

38. There has been an increase in the number of safeguarding concerns each month whilst the number of safeguarding enquiries started has decreased. It is thought this is linked to a more risk averse culture in terms of making referrals.

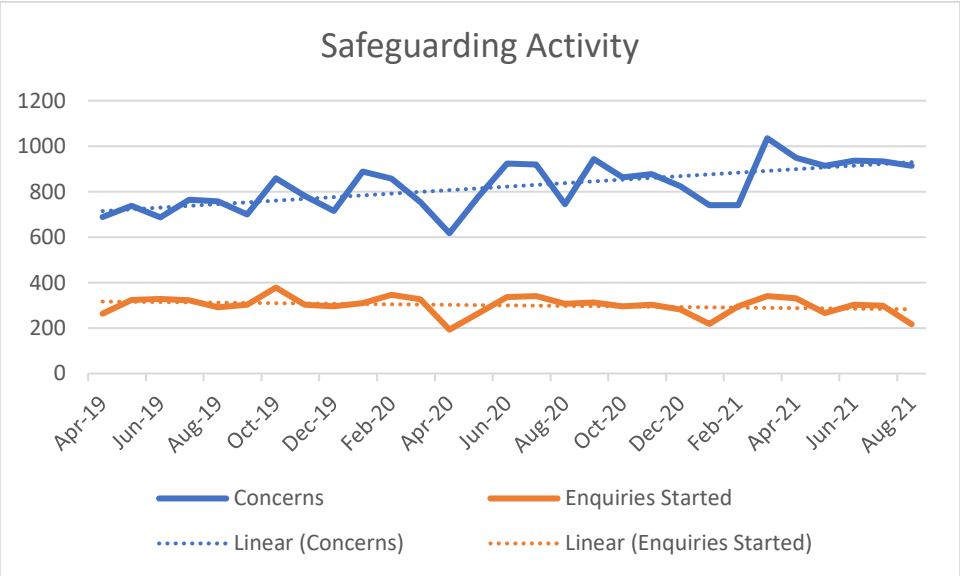



*Figure 9. Number of safeguarding concerns raised and subsequent enquiries started.*

Homecare

39. Overall new homecare packages appear to be relatively stable across the period with noticeable peaks in April 2020 and April 2021 linked to the changing of packages for existing services users. However this hides a noticeable upward trend for new service users over the period. Similarly the number of people receiving homecare appears broadly steady since Q1 2020/21. For the same period the number of hours delivered fell before increasing again to the current level which is the highest in the period covered.

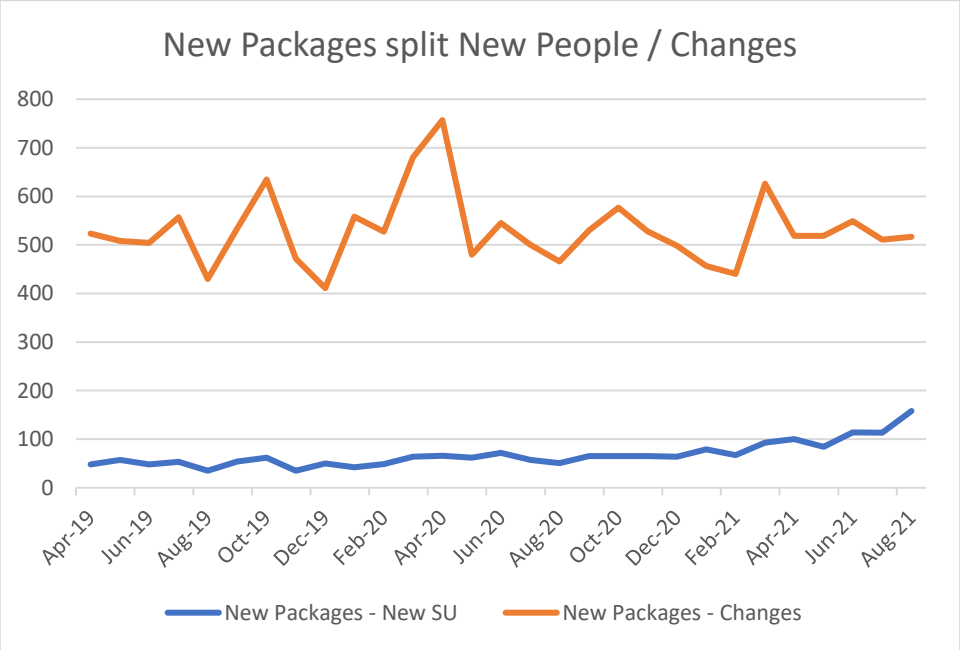



*Figure 10. Number of new packages, and changes of existing packages of care.*

40. Outstanding individual service agreements fell at the start of the pandemic in April 2020 substantially but have gradually increased although not quite to pre pandemic levels.

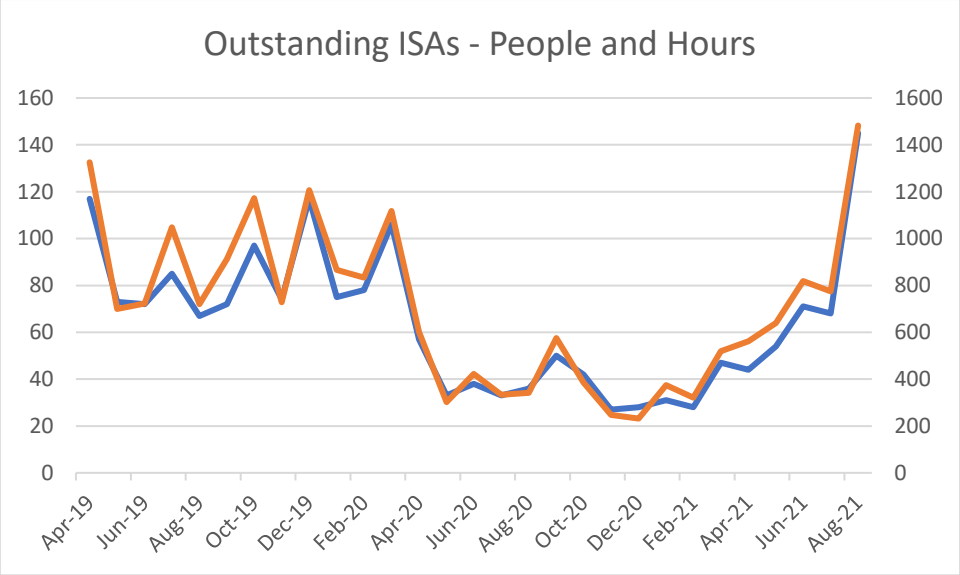



*Figure 11. Number of outstanding individual service agreement.*

Decision Support Tool Assessments (DST)

41. Quarterly data shows a decrease in the number of DST assessments both starting and ending in a quarter over the period. Despite this there is also a downward trend in the number of assessments completed within 28 days. These measures can be linked to the above measure showing the increase in the number of unallocated DST cases.

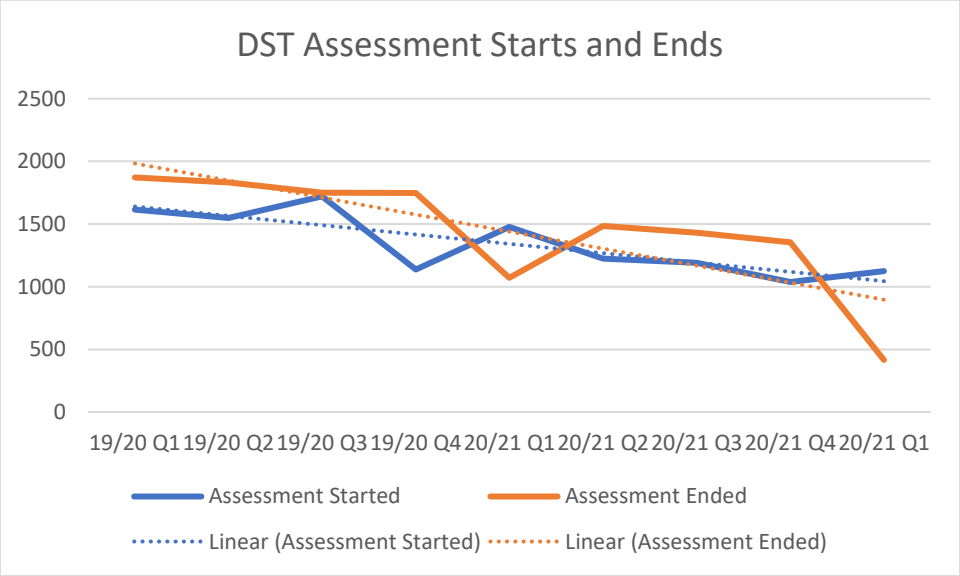



*Figure 12. Number of DST assessments.*

Reablement

42. The pandemic saw a substantial fall in the number of referrals for reablement between April and July 2020. Since then numbers have recovered and for the most recent months are at levels above those seen pre pandemic. A similar pattern though on a smaller scale can be seen in terms of both starts and ends of reablement packages.

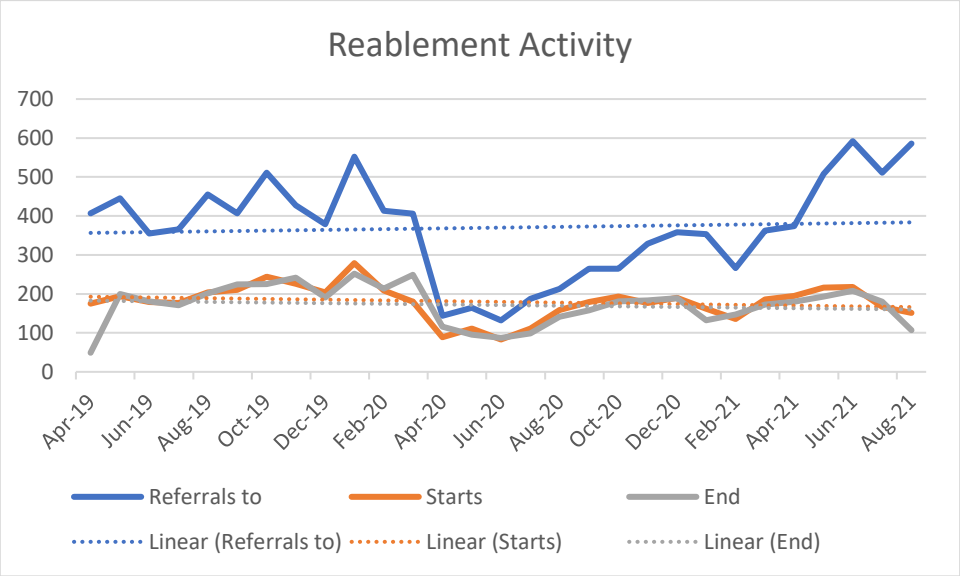
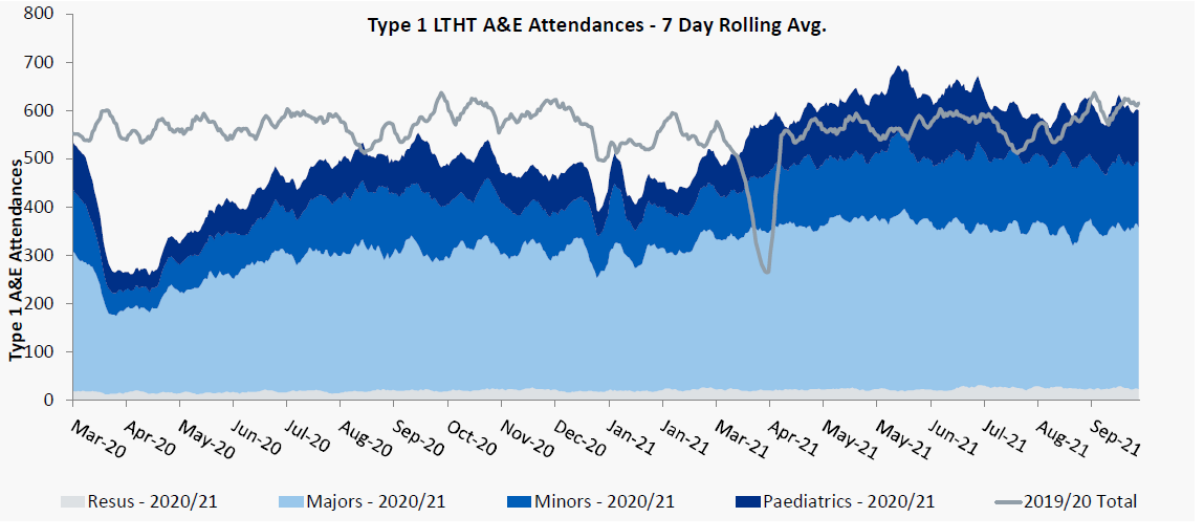



*Figure 13. Number of referrals in to, starts and ends to reablement services.*

Health Services

43. Attendance across urgent care settings continue to be very high. Specifically, A&E numbers are still significantly above pre-COVID levels. Figure 14 details A&E attendances across a rolling 7 day average.

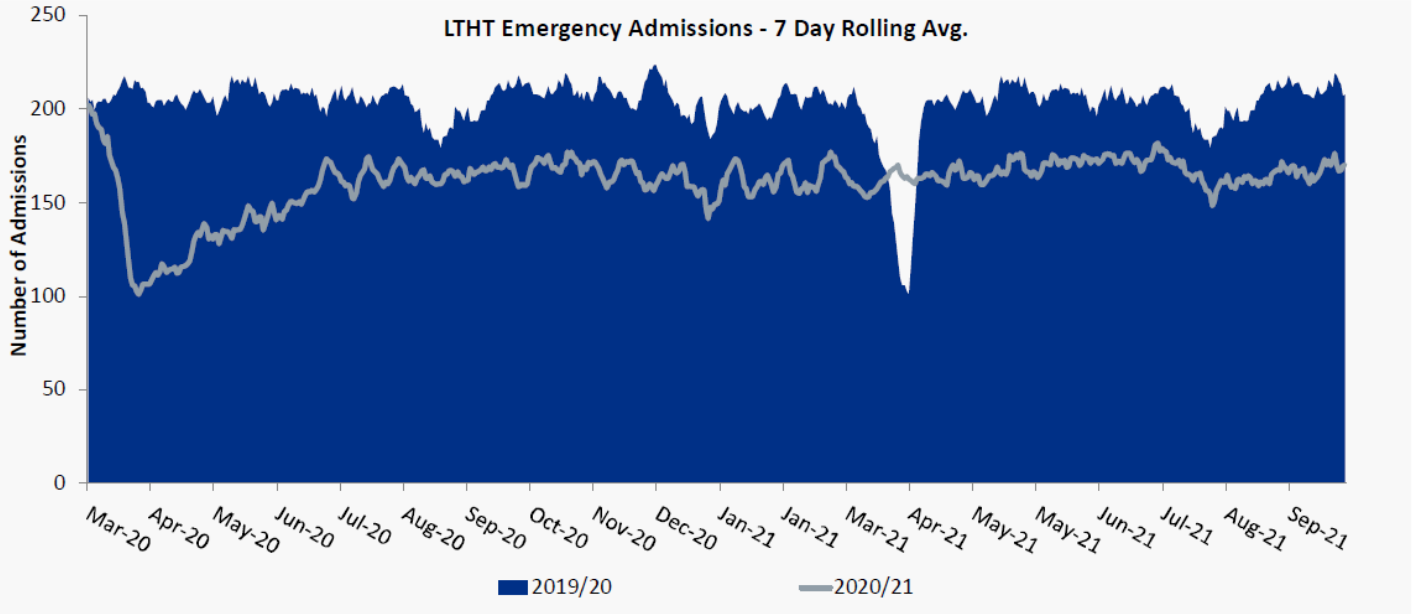



| Type 1 A&E Attendances (2020) | 11-Oct | 12-Oct | 13-Oct | 14-Oct | 15-Oct | 16-Oct | 17-Oct | 18-Oct | 19-Oct | 20-Oct | 21-Oct | 22-Oct | 23-Oct | 24-Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Resus | 17 | 41 | 33 | 22 | 19 | 19 | 27 | 22 | 24 | 24 | 26 | 25 | 19 | 20 |
| Majors | 338 | 377 | 309 | 344 | 285 | 302 | 346 | 369 | 338 | 358 | 338 | 341 | 308 | 304 |
| Minors | 143 | 133 | 171 | 118 | 151 | 122 | 115 | 146 | 138 | 111 | 121 | 133 | 141 | 144 |
| Paediatrics | 144 | 122 | 134 | 116 | 96 | 105 | 123 | 106 | 106 | 122 | 101 | 94 | 98 | 124 |

*Figure 14. A&E Attendances LTHT*

44. Beds in LTHT that are designated for COVID positive patients have seen a recent increase, and the proportion of people with COVID in critical care remains at higher levels than in previous waves. Overall bed occupancy (including non-COVID conditions) is very high and considerably above other places within the regional ICS.

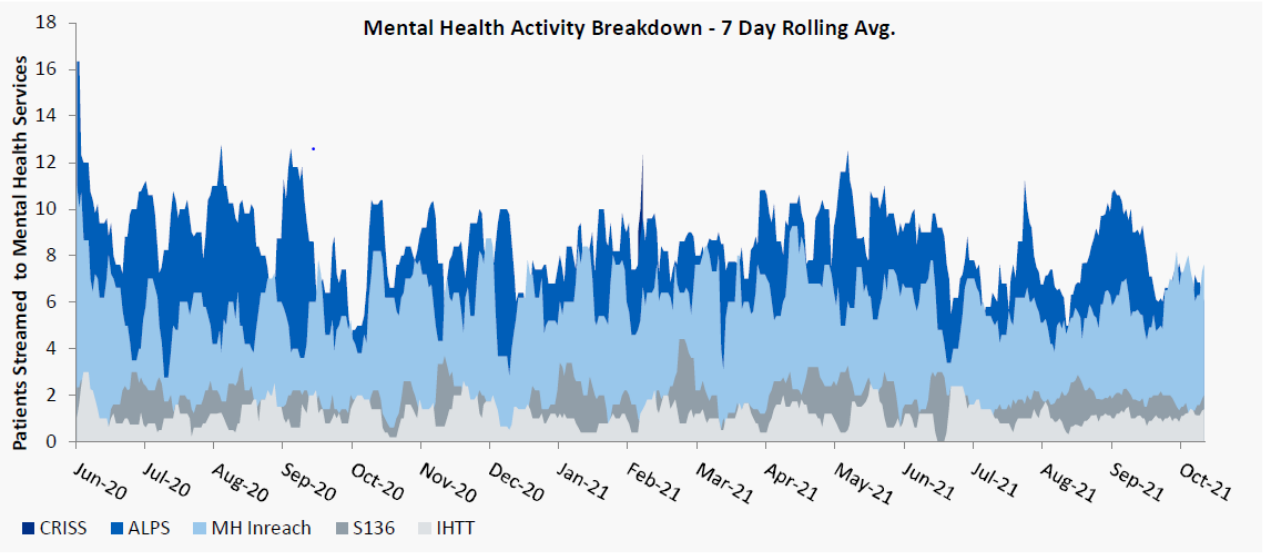
Figure 15 details LTHT emergency admissions across a 7 day rolling average.




| LTHT Emergency Admissions | 11-Oct | 12-Oct | 13-Oct | 14-Oct | 15-Oct | 16-Oct | 17-Oct | 18-Oct | 19-Oct | 20-Oct | 21-Oct | 22-Oct | 23-Oct | 24-Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021 | 165 | 181 | 200 | 192 | 169 | 145 | 135 | 184 | 209 | 156 | 169 | 171 | 162 | 140 |
| 2020 | 241 | 138 | 158 | 238 | 230 | 268 | 223 | 223 | 192 | 151 | 216 | 218 | 225 | 228 |

*Figure 15 Number of emergency admissions.*

45. LYPFT has had beds and wards closed due to COVID on a number of occasions, which is impacting on occupancy and the use of out of area placements. Below, figure 16 depicts a time series (by month) account of patients streamed to emergency and acute mental health services.




| Mental Health Services | 20-Oct | 21-Oct | 22-Oct | 23-Oct | 24-Oct | 25-Oct | 26-Oct | 27-Oct | 28-Oct | 29-Oct | 30-Oct | 31-Oct | 01-Nov | 02-Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALPS | 7 | 7 | 8 | 7 | 7 | 7 | 7 | 7 | 6 | 7 | 7 | 7 | 6 | 6 |
| CRISS | 14 | 13 | 12 | 12 | 12 | 12 | 13 | 11 | 11 | 10 | 11 | 11 | 11 | 9 |
| IHTT | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| MH Inreach | 7 | 8 | 7 | 7 | 7 | 8 | 8 | 7 | 7 | 6 | 6 | 6 | 7 | 8 |
| S136 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 |

*Figure 16 number of patients streamed to mental health services.*

46. The volume of referrals being issued to community services can be seen below. These levels are operating at significantly higher than the yearly mean. This data (Figure 17) specifically relates to Single Point of Urgent referrals in to community services from LTHT.

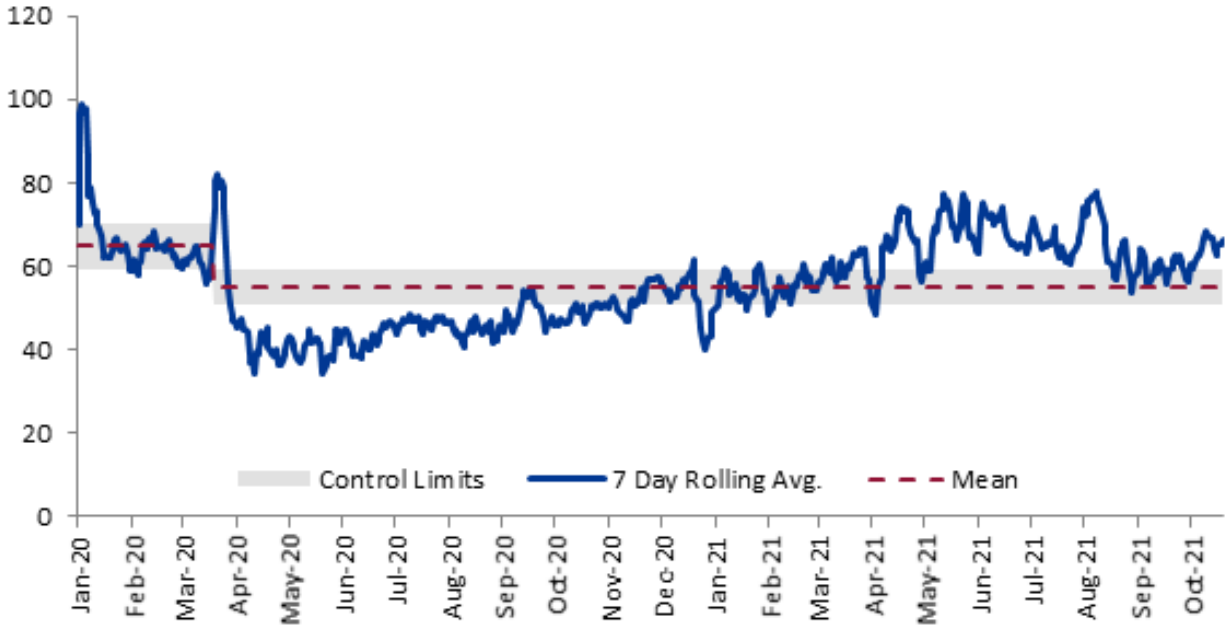



*Figure 17 number of Single Point of Urgent into community services.*

47. Concurrent to this, figure 18 depicts number of referrals into local Neighbourhood Teams is significantly higher that the yearly mean.

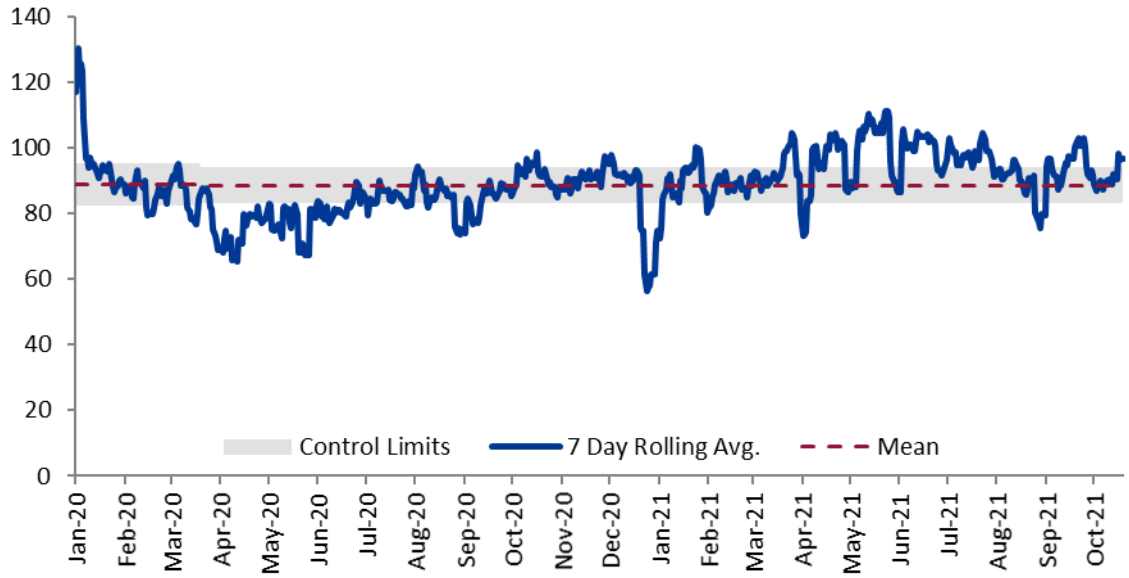



*Figure 18 number of referrals to Neighbourhood Teams*

48. In general practice, the volume of calls into and out of practices has significantly increased (77%) from levels pre-pandemic (Figure 19). The number of current appointments in general practice are significantly higher than those seen pre-pandemic (figure 20). More recent data for these measures were not available at the time of writing this paper.

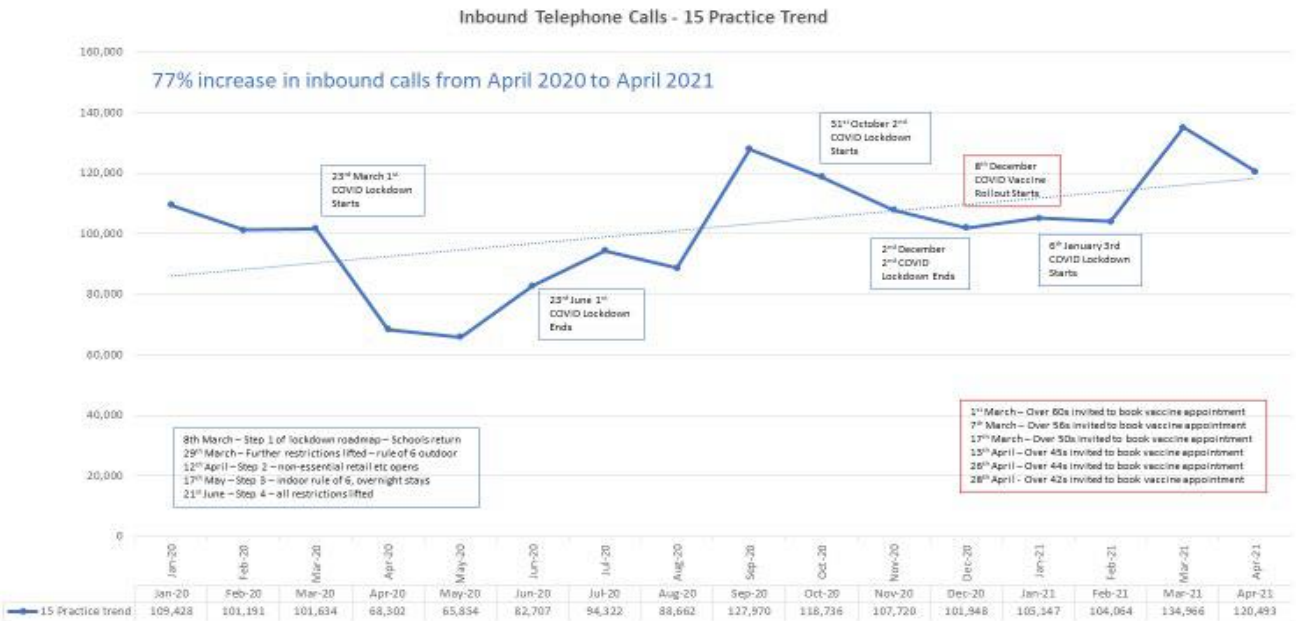
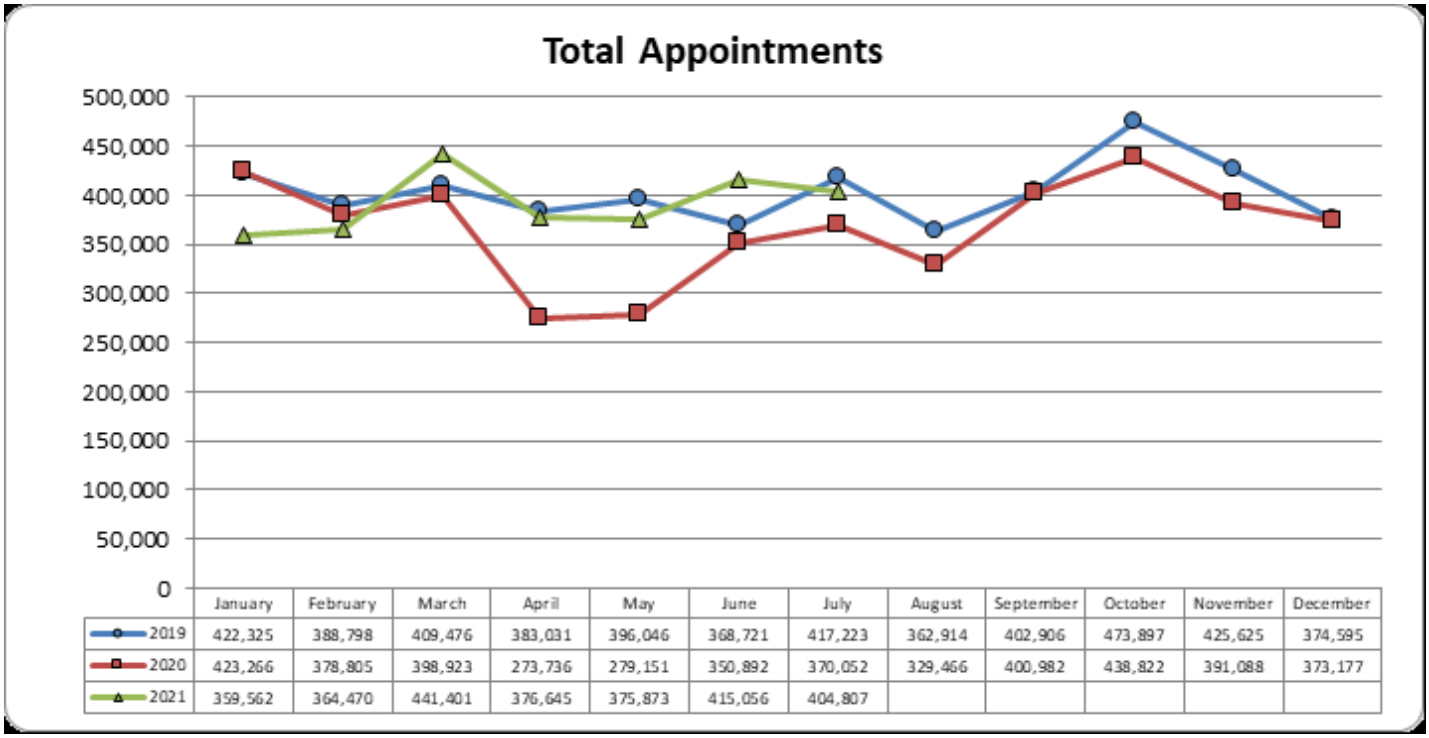



*Figure 19 volume of calls in and out of general practice.*




| | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019 | 422,325 | 388,798 | 409,476 | 383,031 | 396,046 | 368,721 | 417,223 | 362,914 | 402,906 | 473,897 | 425,625 | 374,595 |
| 2020 | 423,266 | 378,805 | 398,923 | 273,736 | 279,151 | 350,892 | 370,052 | 329,466 | 400,982 | 438,822 | 391,088 | 373,177 |
| 2021 | 359,562 | 364,470 | 441,401 | 376,645 | 375,873 | 415,056 | 404,807 | | | | | |

*Figure 20 number of GP appointments.*

**System Flow:**

49. The system recognise that it has significantly high numbers of patients waiting for over 12 hours in Emergency Departments, and this was raised as an issue of concern by NHSE recently. The data below demonstrates that the long lengths of stay are mainly for those people needing to be admitted to a bed. Figures 21, 22 and 23 below show the high proportions of people with longer lengths of stay (21 and 22), the numbers of people with 'no reason to reside' (23). More recent data for emergency department 12 hours stay were not available at the time of writing this paper.

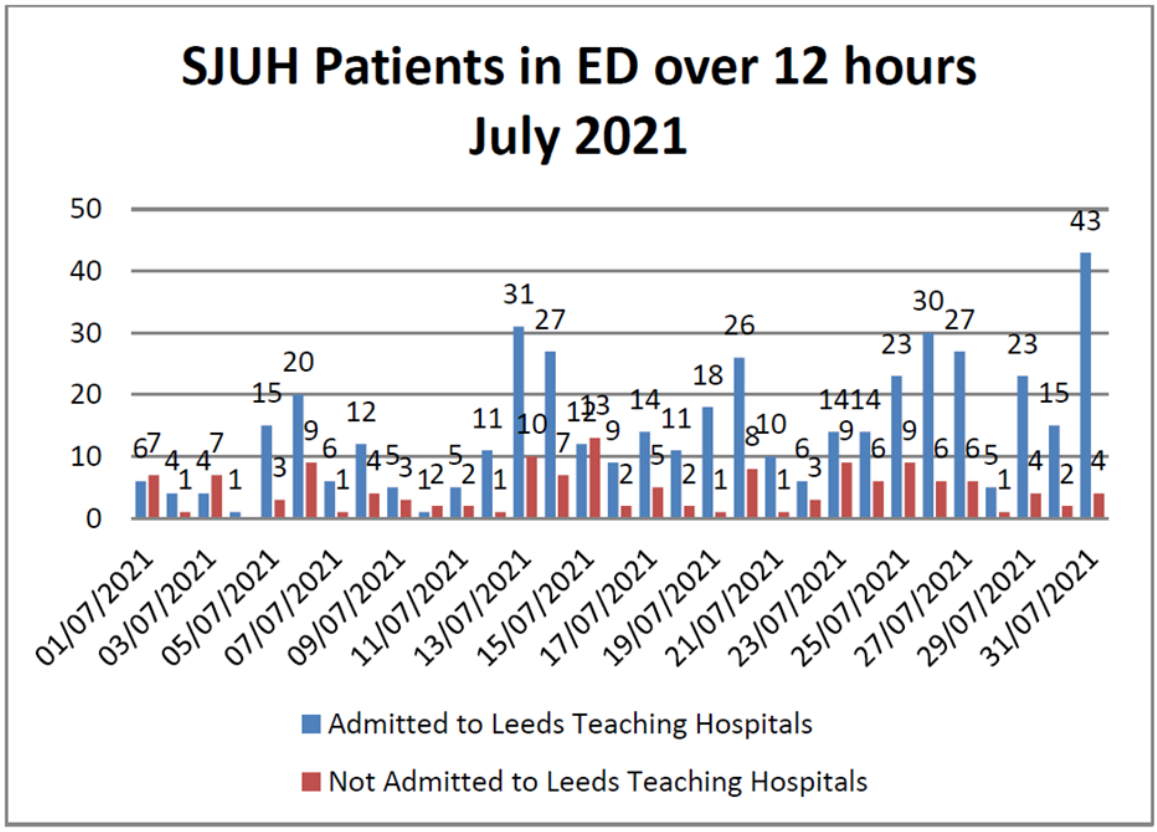
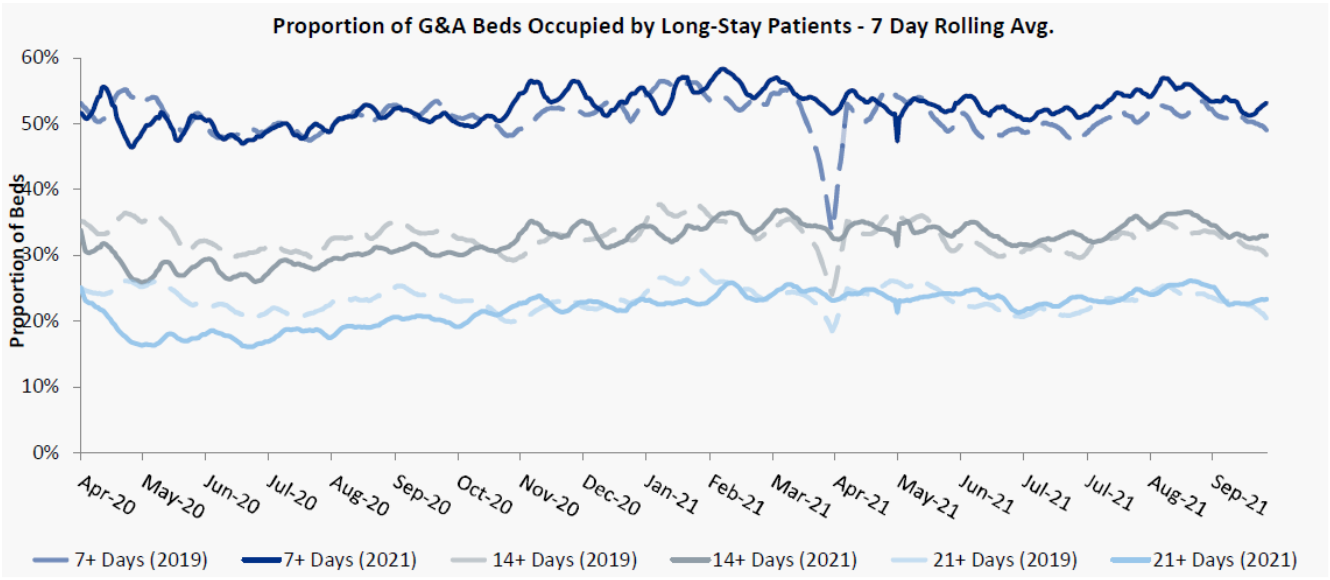
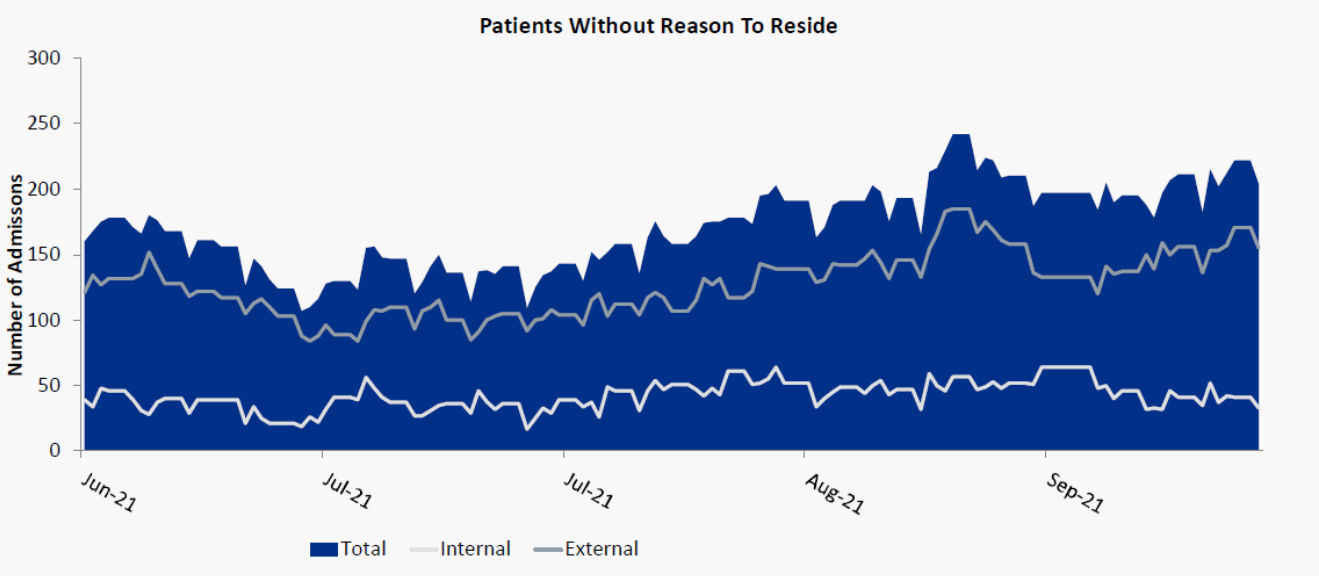



*Figure 21 number of people in emergency department over 12 hours.*




| Beds Occupied by Long-Stay % | 11-Oct | 12-Oct | 13-Oct | 14-Oct | 15-Oct | 16-Oct | 17-Oct | 18-Oct | 19-Oct | 20-Oct | 21-Oct | 22-Oct | 23-Oct | 24-Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Length of Stay 7 days + | 818 | 806 | 816 | 827 | 789 | 794 | 814 | 826 | 828 | 856 | 838 | 799 | 799 | 855 |
| Length of Stay 14 days + | 514 | 510 | 528 | 514 | 505 | 510 | 516 | 521 | 509 | 518 | 526 | 498 | 498 | 530 |
| Length of Stay 21 days + | 350 | 351 | 366 | 366 | 357 | 359 | 365 | 367 | 364 | 369 | 368 | 352 | 352 | 375 |

*Figure 22. Proportion of general and acute beds occupied by long-stay patients.*




| Reasons To Remain | 12-Oct | 13-Oct | 14-Oct | 15-Oct | 16-Oct | 17-Oct | 18-Oct | 19-Oct | 20-Oct | 21-Oct | 22-Oct | 23-Oct | 24-Oct | 25-Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal | 33 | 32 | 46 | 41 | *n/a* | *n/a* | 35 | 52 | 37 | 42 | 41 | *n/a* | *n/a* | 33 |
| External | 139 | 159 | 150 | 156 | *n/a* | *n/a* | 136 | 153 | 153 | 157 | 171 | *n/a* | *n/a* | 155 |
| Total | 178 | 197 | 207 | 211 | *n/a* | *n/a* | 182 | 215 | 202 | 212 | 222 | *n/a* | *n/a* | 204 |

*Figure 23. Number of patients without reason to reside.*

## Workforce Pressures

50. Specific to Social Care, during the height of the pandemic there were increasing numbers of people who gained employment as care workers within adult social care services. This was especially evident in domiciliary care, with providers reporting significantly improved recruitment and retention of home care staff.

51. As the lockdown measures eased, and with the retail and hospitality sectors re-opening, care providers started to see a reduction in new people entering the sector and from early summer providers started to experience difficulties in staff retention, with some home care providers seeing over 50% staff turnover rates.

52. The workforce pressures in home care during the summer were exacerbated by high staff absences either through care staff having to self-isolate or due to annual leave during school holidays.

53. Within care homes, many providers have reported staff burnout as a major cause of high staff turnover. This has been especially the case with registered managers and nursing staff, with a number of care homes currently recruiting to these critical vacant posts. The requirement for mandatory vaccinations for care home staff have also been identified as contributing to an increase in staff turnover.

54. Pay rates and terms and conditions of employment in sectors such as retail are more attractive where pay rates are £10.50 per hour and above and much of the social care workforce has been lost to other service sectors.

55. FTE numbers for area and hospital teams, Learning Disabilities and Mental Health Teams and DST have all remained broadly consistent across the period with small increases in numbers being shown from late 2020. Sickness levels in area and hospital teams in 2020/21 were higher than corresponding months in 2019/20 peaking in October 2020 and March 2021 and continue to be high in the first 5 months of 2021/22. In LD and MH teams sickness levels increased over 2020/21 reaching a peak in February 2021 but appear to have since started to fall into 2021/22. The picture is more volatile in DST, however, there still appears to be a peak in February 2021, figures then fell at the start of 2021/22 but have since begun to rise again

56. The impact of the workforce pressures is that care and support providers are currently not able to provide capacity to meet demand for care services. Priority continues to be placed on securing services for people who are in hospital where they need a care home placement or need home care to be arranged before they can return home.

57. Specific to health services, partners report a significant and cross cutting risk to recruitment, retention and resilience of the work force. This is corroborated by consultation with primary care partners and evidenced in the 'word shower' (figure 24) following the question 'how does it feel'.

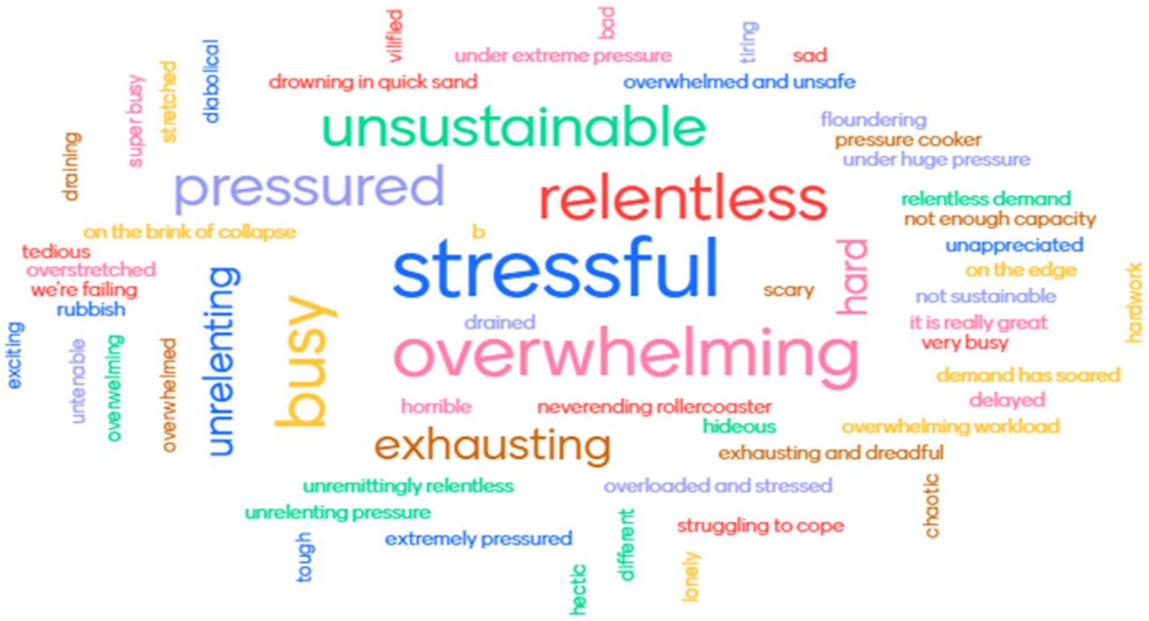



*Figure 24. Word shower taken from consultation exercise with general practice.*

## System Response

58. Winter 2021/22 is predicted to be very challenging. Seasonal pressure is multi-faceted and an integrated partnership approach to winter planning is critical to maintain resilience and ensure safety. The system will need to work together across the whole care pathway, with input from all system partners.

59. Winter planning this year will be an iterative process and systems will need to adapt plans due to the aforementioned competing demands as a result of the COVID-19 pandemic.

60. In the context of the pressures of the national pandemic recovery as well as the uniquely challenging circumstances this winter will bring, Leeds will need to demonstrate a robust approach with several specific aims. The aims of response planning are:

- To ensure that planning for the winter is completed at all levels in good time to ensure patient safety and quality of care is not compromised
- To ensure plans are integrated at a system level and that pressure and risk is evenly spread across systems and is not focussed on one section of the care pathway
- To ensure that plans are robust and consider the business-as-usual seasonal pressures alongside emerging challenges and effectively balance these together
- Supersedes previous West Yorkshire & Harrogate ICS Winter Delivery Agreement

## Governance Arrangements:

61. Clear citywide system Governance in place to be able to raise any urgent escalation.
- Chief Officers meet weekly
- System Resilience Operational Group meet on a Tuesday (ToR, see appendix)
- System Resilience and Reset Assurance Board meet monthly on a Monday (ToR, see appendix)
- Silver (StAR) meet on a Wednesday (ToR, see appendix)
- Urgent City Silvers called by any partner at any point
- Primary Care Silver meets weekly (ToR, see appendix)
- Care Homes Silver meets weekly
- End of Life Bronze Group meets weekly

62. Figure 25 below, details this current governance arrangement in operation adopting a 3 tier approach (Strategic, Tactical, and Operational).

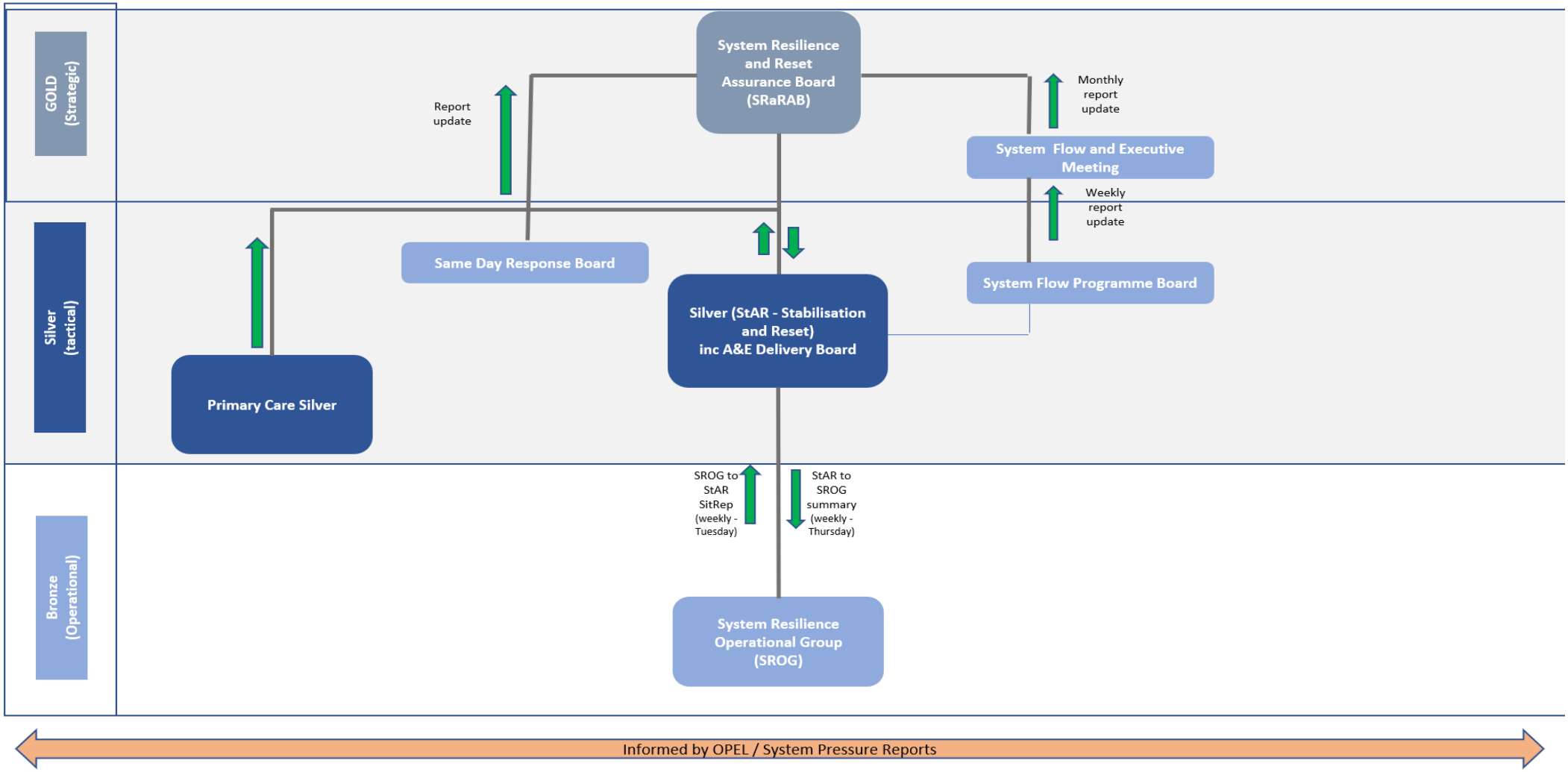



*Figure 25 current governance structure.*

63. The purpose of this 3 tier approach to governance is to collectively gain assurance that the health and care system remains resilient to meet the needs of the population and where necessary address weaknesses /remove barriers. This approach aims to collectively ensure assurance for the whole population that the health and care system has robust recovery strategies and plans in place as required. In addition, it is in place to ensure the system approach delivers proactive action, considers scenarios, and prepares plans to prevent risks or performance failure. Lastly, the governance approach aims to mandate priorities to sustain system resilience and / or recovery to ensure needs are met for all individuals and communities.

64. Decisions and priorities are continually informed and led by the follow data sources:
    - Weekly dashboard of indicators for SRaRAB
    - Weekly dashboard of indicators for SROG
    - Weekly dashboard of indicators for System Flow Programme Board
    - Daily OPEL / System Pressures report
    - Comparators via NEY reporting
    - Weekly ICS discharge data

**Demand and System Flow**

65. A system flow plan has been developed by the Leeds Health and Care system and is currently being externally reviewed for appropriateness. A programme board has been established, reporting to System Resilience and Reset Assurance Board (SRARAB) and chaired by Director of Adults and Health and Deputy Medical Director of CCG. The appointed board will ensure these actions are implemented, and ensure, as necessary, escalation through SRaRAB. Exception reports, and the Key Performance Indicators will be shared regularly at this programme Board. This Board will also consider trajectories for improvement. The System is also adding additional dedicated resources in quality improvement, informatics and project management, recognising the day to day pressures on all local system staff that impact on ability to deliver complex change. Each workstream is led by a Board level officer from one of the Partner organisations.

66. Headlines include for the plan includes 7 workstreams:
    - Hospital systems and processes to support discharge
    - Implement a transfer of care hub and improve end-to-end discharge
    - Reablement
    - Intermediate tier beds
    - Social care workforce
    - Addressing the needs of people with specific needs
    - Informatics infrastructure and reporting.

Same Day Response

67. The System remains committed to reducing arrivals of people at the Emergency departments who can be provided with more appropriate care in other settings, improving the capacity to treat those people who present in the Emergency Departments and to reduce their waits and minimise overall numbers in the departments at any one time. In collaboration with West Yorkshire ICS partners, we continue to work on elements such as the use of clinical assessment services for people using the 111 digital offer, and ongoing improvements to our directories of service for people using 111. YAS 111 service have an ongoing recruitment initiative to increase call handling and clinical support staff within the 111 service. This will include supporting new ways of working including support home working. Local Clinical Assessment Services (CAS) continue to provide clinical assessment for all 1-2 hour primary dispositions, managing between 60-70% cases virtually. We are beginning a pilot in Leeds to scope the benefits in clinically validating online emergency department referrals to either manage virtually, signpost/book into alternatives or convert into a ED heralded patient.

68. The YAS 999 service through national funding have submitted robust trajectories to:
    - Increase clinical and non-clinical capacity within the Emergency Operations Centre to achieve national call answer standard by the end of November
    - Expand crew capacity to deliver direct performance improvements including hear, see and treat rates and the ensure the sustainability and resilience of the service to manage further surges in demand in Q3/4.

69. We as a system continue to try to maximise Primary care capacity, including call handling capacity, to ensure that wherever possible people with a primary care need can be managed within primary care. We have recently agreed plans to increase capacity in primary care using the Covid recovery funding. The initial estimates are that there will be a minimum of 8,000 additional appointments between July and December, and we are working up plans for Q4. Workforce availability remains a key risk in this as in other areas of the plans.

70. The system continues to also increase its capacity for same day community response through increasing its virtual ward offer and ongoing work with YAS and primary care to ensure suitable patients only attend ED if they cannot access the virtual ward. We have strengthened and greatly improved our Primary Care Access Line offer to support these ambitions. However, we recognise that patients currently still choose in many cases to attend ED with conditions that could be managed elsewhere, and the numbers choosing to do this have increased markedly in the past few months, particularly on the LGI site. Therefore, we have plans in place to further enhance staffing levels across these settings, so that people can be seen

promptly in the settings at which they present. The key actions impacting on the flow within the Emergency Departments are:

- enhancing the staffing in the LGI Paediatrics area,
- creating additional capacity outside the main ED for minor illness LGI,
- Strengthening Same Day Emergency Care in Medicine/Elderly Medicine at St James's.

## Workforce

71. The Leeds One Workforce Team and Health and Care Academy have a clearly defined remit to support city partners with short, medium and long term workforce priorities. In addition to the standing portfolio of training and collaborative workforce projects, the team is a shared city resource which can mobilise expertise and networks at pace to support urgent initiatives (for example the recruitment and training of the COVID Vaccination workforce in 2020 / 2021). Regular discussions at the Leeds Health and Care HR Directors' Group provide the opportunity to share and monitor significant workforce issues and pressures in real time, and where necessary, respond quickly. As a result of increasing risk, the Director of Leeds Strategic Workforce (Kate O'Connell) was asked to join the city's Stabilisation and Reset group in August 2021 to help connect the city's workforce response to 2021 winter pressures. This enabled the One Workforce Programme and Academy portfolio to adapt delivery to ensure that we optimise workforce support for System Flow and Same Day Response over the winter months.

72. In the September Leeds One Workforce Strategic Board (LOWSB) meeting, there was a scheduled discussion around the Leeds collective response to winter pressures which enabled a joint review of the impact of current activity and the opportunity to seek additional stretch. As a result, an extraordinary LOWSB meeting was held to explore any further collaboration which might mitigate the evident workforce risk. This work is also linked closely with the WY ICS People Board and Programme networks to ensure that we optimise wider support and resource from around our region. The culmination of this work has led to an agreed set of priority actions and monitoring process across Leeds partners supported by the Leeds One Workforce and Academy team.

Review of current workforce initiatives

73. **Leeds Talent Pipeline Service**

**Aim:** To encourage and support new entrants and to retain existing talent in the Leeds heath and care system.

**Objectives:** Managing and enhancing candidate experience as part of Team Leeds; developing and supporting new pipelines of suitable candidates; brokering potential roles across all our partner employers; and increasing workforce supply to priority Leeds services.

**Progress to date:**

- 400+ candidates in the pipeline at the start of July 2021, contacted and offered support to secure roles outside the Covid Vaccination programme
- 198 candidates actively seeking alternative roles in September 2021.
- September position:
  - 29 candidates have been placed into employment in Leeds health and care roles
  - 29 candidates are currently involved in a selection process
  - 140 candidates are still actively interested in securing work

**Intended Impact on Winter Pressures:** To increase the number of staff working in priority services over winter. To support retention of talent within our Leeds system and to attract new entrants into the workforce.

74. **Narrowing Inequalities Through Careers Programme**

**Aim:** To engage with, recruit and develop a diverse health and care workforce from local communities.

**Objectives:** Working with people in disadvantaged or under-represented communities in Leeds we will:

- Encourage interest in diverse health and care careers
- Improve access to real opportunities helping individuals to secure local jobs, training & volunteering
- Provide practical support to help people succeed in their chosen career
- Connect interested people with the Leeds Talent Pipeline Service

Longer term, this programme will be embedded in partner recruitment and career strategies with on-going support from One Workforce.

**Progress to date:**

- Building on partner expertise from the Lincoln Green project, We Care Academy and Step into Care, a flexible engagement and recruitment model for campaigns has been developed and was launched in July 2021
- 400+ people connected with the first campaign (Armley and Wortley) to explore working in health and care
- 100+ people engaged in the webinar.
- 70 people applied for available roles.
- To date, 17 candidates have secured employment across a range of different roles, or have taken up places on a Leeds Health and Care Employability programme.

- Remaining candidates are being connected with the Leeds Talent Pipeline Service.

**Intended Impact on Winter Pressures**: To recruit, train and support local residents into local health and care services, increasing the numbers, diversity and community connectivity during a period of increased service pressures and beyond.

75. **Workforce Mobility Framework**

**Aim:** To set up a Leeds staff mobility framework to facilitate urgent temporary deployment of staff to priority services from across health and care partners.

**Objectives:**

- September 2021 - Sign and launch framework across statutory partners; LCC, CCG, LYPFT, LCH and LTHT
- Mobilise framework as needed over winter period, monitoring use and service impact
- October 2021 to June 22 - Extend framework to wider health and care partners and invite Leeds Private, Independent and Voluntary Organisations to participate in the framework in anticipation of winter service and staffing pressures.

**Progress to date:** All five statutory partners have agreed the framework in principle. Four out of the five have signed the agreement ready for mobilisation, and some minor adjustments are being finalised to enable a signature from Leeds City Council. The agreement has not yet been deployed.

**Intended Impact on Winter Pressures:** Building on the Team Leeds approach to services and vaccination centres through Covid, this framework will now enable swift deployment of staff across organisational boundaries, to deliver critical services during the winter months. The framework ensures liabilities and practicalities are in place and removes the need for lengthy negotiations which might otherwise delay an emergency response.

76. **Academy Health Care Support Worker Programme**

**Aim:** To improve attraction, development and retention of staff across a diverse range of entry-level health and care support worker roles.

**Objectives:**

1. Attraction – to attract diverse candidates to priority roles by:
    i. Embedding values and behaviours in attraction materials and campaigns
    ii. Spotlighting priority roles and focusing on areas with high turnover or hard-to-fill roles
    iii. Developing communications materials which demonstrate the breadth of roles and opportunities at this level

2. Recruitment – to pilot a collaborative pre-employment programme with Generation UK for health-focused roles, complementing existing employer-led programmes.

3. Onboarding – to welcome new starters to their role by providing them with a welcome pack and guidance for navigating the first few months in role

4. Retention – to support new starters to thrive in their role through providing early peer mentoring support, networking and development opportunities

**Progress to date:** The first cohort launched with Generation UK on 27 September supporting 22 unemployed applicants. The average age of the participants is 31, and over half are from Black or other ethnic minority backgrounds. In November, every candidate will have a guaranteed interview with at least one of the four health and care employer partners taking part in the pilot. If successfully appointed, they will be supported with a 12 month support package through the Academy to help them thrive during a very pressurised time for our health and care system.

**Intended Impact on Winter Pressures:** To grow numbers of health and care support workers in hard-to-fill roles, providing training and support to help individuals to secure a role which aligns with their personal aspirations and skills. To provide ongoing support to help reduce turn-over in the first 12 months.

77. **Leeds Mental Health Project**

**Aim**: To improve mental health infrastructure, capabilities and accessibility across the whole health and care workforce

**Objectives**: Enhancing employee assistance offer to support wider contributors to health and wellbeing; developing organisational capabilities which promote and sustain person-centred compassionate support; and improving accessibility to mental health information, resources and specialist services.

**Progress to date**:

- Access to and promotion of the WYH Mental Health hub
- Nov to Mar - Plan for externally funded roll-out of Mental Health First Aid Training including the opportunity to subsidise smaller service providers to enable them to release staff to undertake the training
- Nov to Mar - Plan for creation of externally funded Health and Wellbeing Champions network, training and resources, with a similar approach to subsides backfill of roles to enable participation
- Nov to Mar - Plan for introduction of Compassionate Circles supporting partner organisations to enhance support for compassionate leadership and colleague care

**Intended Impact on Winter Pressures**: To improve staff wellbeing across our Health and Care system while dealing with very challenging service demands; to increase individual and team capacity to deliver high quality services; and to

improve retention and progression of talent within our city for the benefit of patients and citizens.

**Shielding/ support for people who are clinically extremely vulnerable.**

78. We are focusing current key messages to people who are at a higher clinical risk in Leeds to be one of re-assurance. Firstly that the assessed risk from coronavirus is now significantly lower than it was in March 2020 when shielding was first introduced. Secondly, that local practical and emotional support will remain in place in Leeds for people who are higher risk, and that we will continue to work closely as health and care partners to make sure that people are informed about the support that is available.

79. We continue to direct people at higher clinical risk to central helpline number for advice or assistance – 0113 3760330 - and this service can also refer people to a wide range of practical or emotional support. This works in conjunction with our social prescribing service Linking Leeds – 0113 3367612 – so that no matter where someone presents – they can get access to the right support that suits them.

80. As a city, we continue to offer to access food to anyone who is unable to shop for themselves for whatever reason. This is through a free, direct to doorstep food delivery or by volunteer assisted shopping depending on a person's preference. As well as local community hubs providing food deliveries, we also have a citywide cultural food offer – covering south Asian, middle eastern, African diets, and a specialist offer for people on restricted diets for medical or health reasons.

81. We have made a flexible support payment available for people who have been impacted financially because of their clinical vulnerability – this can help with the increased costs of shopping online, paying for private transport to attend appointments, or the increased fuel or heating costs of spending more time at home. We have also increased our specialist financial support and advice for those who are facing money worries on a longer term basis.

82. We have got a comprehensive offer of community and mental health support- including specialist counselling for people who spent time shielding. This includes physical and social confidence re-building for people who were impacted by the long periods of inactivity or isolation. As well as a full range of community activities and opportunities for people who want to socialise in settings that still respect social distance, or are sensitive to those at higher clinical risk. This includes guided walks, allotment projects, t'ai chi and balance sessions, swimming, 1-2-1 fitness advice and much more.

83. We also run a free iPad lending scheme for people at higher clinical risk that provides free data with optional help to learn or improve digital skills.

84. We wrote out to all clinically extremely vulnerable in August 2021 and this included a 30 page booklet outlining the support that continues to be available to them – both with the ongoing challenges of being at higher risk as well as to deal with the legacy that shielding during the peak periods of the pandemic had on their mental or physical health. This can be downloaded from here: https://bit.ly/CEVSupportLeeds

85. On 16th September the Government announced its decision to end the national shielding programme for clinically extremely vulnerable people and sent a letter to the 54,000 people in Leeds who were classed as clinically extremely vulnerable to make them aware of this change in policy. A copy of the letter can be viewed here: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19.

86. Within this group of 54,000, there are approximately 8000 people who are immuno-compromised by their clinical conditions, or immuno-suppressed from medication they take to manage their conditions. For most people in this sub-group, they will have a weaker response to vaccination – for a small number, this could be a significantly lower level of protection (levels of protection range from 4% to 70%) – and this group of people are being given guidance by their NHS hospital consultant/ team on how to manage their exposure to Covid-19 as well as other viruses in common circulation.

87. In Leeds we continue to support people who are at increased risk from the virus and will use local information channels to make people aware of the support that will continue to be available to them. Our Routes to Support document has been revised in light of this change in national policy.

88. Winter priorities for working with people at higher clinical risk include:

- Practical support channels will remain in place, and we will be prepared to step up support for the significantly immunocompromised/ immunosuppressed if national measures are put in place

- We will continue to provide support for people to access vaccination and understand when and how to access a third primary dose where clinically indicated, or booster doses for those who are now due them. We will do this both through targeted messaging to people who are higher clinical risk, via our call back service where people can talk through their questions or practical hurdles to accessing vaccination and through community messaging and alternative formats.

- We have sent reminders to Primary Care that they can continue to refer anyone who is clinically vulnerable - with practical or emotional support needs to their local council support teams

- Further advice and guidance is being sought from DWP which will be relayed to primary and secondary care about the provision of fit notes for people who are immunocompromised/ immunosuppressed who are in high exposure occupations, as well as to frontline advice services across the city.

89. In addition, our colleagues in Public Health have developed the 'Over 60's harms minimisation plan' with the following objectives:

**Key objectives**

- Intelligently map over 60s to target resources to reduce transmission, with a proportionate focus on those at high clinical and social need
- Proactively engage with those most at risk and their carers and families
- Increase capacity within communities and partners to provide effective preventative and supportive approaches
- Develop messages for health and care staff to support them to make every contact count
- Wider health protection action to keep people safe over winter
- Disseminate information to communities and organisations
- Ensure all sections of the Outbreak Plan (e.g Test and trace; future Vaccination programme) are Age Friendly and targeting over 60s.

**Vaccination**

90. At the time of writing, the Leeds Vaccination Programme have delivered the following highlights:

- Almost 574k people have had a 1st vaccination (73.3% of eligible GP registered)
- 89.1% of CEV and 84.9% of 'at-risk' have been vaccinated (0.1% increases respectively)
- 43% of 16-17, 23.7% of 12-15 CV and 15.6% of 12-15 not CV have been vaccinated
- Almost 530k people have had a 2nd vaccination (67.7% of eligible GP registered)
- Over 62k people have had a 3rd / Booster vaccination (17.7% of eligible GP registered in groups 1-9)

91. The vaccination programme continues to highlight some of the best examples of partnership working across Leeds. However, data informs us that there is significant variation in the level of vaccination uptake within and between diverse communities. 56.8% of Diverse Communities (DC) in all priority groups 2-12 have had a first vaccination, compared to 83.0% in white. Again, using white community groups as the comparator, the vaccination groups 2-9 figures are:

- 76.2% for DC and 92.0%.
- 82.1% of DC CEV have been vaccinated compared to 91.8%.
- In the 'at-risk' group, 72.9% of DC compared to 87.2% have been vaccinated.

In terms of indices of multiple deprivation:

- 64.6% of those living in the most deprived areas have been vaccinated, compared to 91.9% in the least deprived areas.

- In groups 2-9 figures are 80.6% in most deprived and 95.7% in least deprived.
- 88.1% of people with Learning Disability have now been vaccinated (0.5% increase), and 79.9% of all those with serious mental illness have been vaccinated (0.2% increase).
- 83.7% of those recorded with English as their main language have been vaccinated (0.4% increase), compared to 47.8% of those with any other language recorded as their main language (0.3% increase) in all groups.

92. The Leeds Leaving No-one Behind COVID-19 Vaccine Group is a multi-agency partnership that report to the wider Vaccination Programme. The group brings together members from public health, NHS providers, commissioners, third sector, elected members, and local authority to address the variation in vaccination uptake across Leeds.

93. The Vaccination Programme recently has secured funding for a Clinical Cultural Diversity Lead to provide key clinical leadership and strategic direction for improving COVID-19 vaccination uptake amongst culturally diverse groups and communities across Leeds. This role is being tendered for expressions of interest to partners across Leeds who currently hold a nursing or allied health professional registration.

**Dentistry**

94. Covid-19 has impacted, and continues to impact, on NHS dental services. There have been a number of changes, since March 2020, to manage services safely through the COVID-19 outbreak for patients and clinicians alike.

95. At the end of March 2020, following advice from the Chief Dental Officer, dentists were asked to stop routine treatment and provide remote consultations and triage. An urgent dental care system was established to ensure that patients, who were in pain, could access remote triage and then (face to face) treatment where it was clinically necessary and appropriate.

96. All practices reopened for provision of face to face care between July and September 2020 and have steadily increased activity since then. The NHS contractual expectation is that all NHS funded capacity is used to safely deliver the maximum possible volume of care for patients, however contractual targets have been in place since July 2020, which outline the requirements on dental practices to deliver a proportion of their normal activity volumes.

97. Activity levels have increased since then and from 1 October 2021 the minimum expectation is for practices to be delivering 65% of their contract. However, it will be some months before dental services return to providing care in a similar manner and to the activity levels that patients previously experienced. It is also dependent on the further easing of COVID-19 infection prevention and control measures which is being led nationally. Given this reduction in the number of available

appointments, there is a significant backlog of unmet need, delayed and suspended treatments.

98. Practices have been asked to prioritise patients with the greatest need into their available NHS treatment capacity, those requiring urgent dental care and vulnerable patients are prioritised, which likely means a delay for patients seeking an appointment for non-urgent (such as -ups) treatment.

99. There are some localities where patients have had historical and continuing problems accessing NHS dentistry and plans were being developed to increase capacity and look at alternative ways of providing care in these areas. Unfortunately, the COVID-19 pandemic has temporarily delayed progressing with this. Once the NHS emerges safely from the on-going Covid-19 pandemic our intention is to continue with this work to improve general access and reduce inequalities, where possible.

Current advice on accessing urgent dental advice/treatment

100. If a patient's teeth and gums are healthy – a check-up, or scale and polish may not be needed for up to 24 months

101. The infection control process for dentistry has not changed with the lifting of COVID19 restrictions – masks and hand hygiene measures are still required.

102. All NHS dental practices are following the guidance, and private dental practices are recommended to follow them by the health regulator, the Care Quality Commission.

103. Advice is that the infection prevention control measures in dentistry should continue to be followed until further notice. Dental practices will continue to have restrictions on leaving time between patients to ventilate rooms – this has an impact on how many patients they are able to see each day.

104. All dental practices are prioritising patients for treatment based on urgency and priority groups, such as those more at risk of dental disease or children.

105. Many NHS dental practices also offer private appointments which, as independent contractors, they are at liberty to do. Mixed practices, offering both NHS and private treatment, tend to have both separate appointment books and staff teams for their NHS and private treatments. NHS provision is delivered across their contracted opening hours and demand for NHS treatment is such that they could have used up their available NHS appointments and so the practice may offer private appointments to patients.

106. GP practices are unable to make direct referrals to a dentist, as these are primary care services, patients can access them directly.

Resumption – General Overview

107. The focus of NHS England's dental commissioning team is to support providers to resume services, in line with Standard Operating Procedures and IPC guidance.

108. Primary Care – all primary care providers are open and providing services outlined in national Standard Operating Procedures and should be prioritising urgent dental care for all patients making contact with the practice.

109. Patients are not 'registered' with a primary care dental practice, but prior to the pandemic, practices tend to see a patient regularly for their routine dental care.

110. Urgent Care – urgent care can be accessed directly from local practices or via NHS111. There is one urgent dental care clinic in Leeds, accessed only via NHS111, which is open 365 days a year.

111. Access scheme – There are ten practices in Leeds that are part of the Yorkshire and the Humber Access Scheme. The overall aim of the scheme is to improve access to dental services by enabling participating practices to increase the number of appointment available to patients.

112. Community Dental Services – Leeds Community Health Trust provide services to adults and children with complex needs and one-off courses of treatment for some children, where this cannot be provided safely within primary care practices.

113. Orthodontics – A procurement exercise was paused due to the pandemic but restarted in summer 2021. New contracts have been awarded in Leeds North, Leeds Central and Leeds South, services will commence on 1 June 2022. Mobilisation is underway and a communications plan developed to ensure patients are aware of how any changes will affect their assessment waiting times and treatment plans.

114. Immediate Minor Oral Service (IMOS) – There is one IMOS service based in Leeds, though West Yorkshire patients can opt to be seen at any IMOS provider across the county (Bradford, Huddersfield, Dewsbury and Wakefield). Patient referrals are managed via a Referral Management System (RMS). The Leeds based IMOS provider is seeing patients at a temporary clinic due to a fire at their practice in the centre of Leeds; this is not having an impact on patient waits at this time.

115. Secondary Care – Leeds Teaching Hospitals NHS Trust dental specialties (oral surgery, max fax, orthodontics, oral medicine and paediatrics) provide care primarily to the residents of Leeds. The Trust have reported that services have recommenced and that they are accepting new referrals which are clinically triaged, and a prioritisation model is in place.

Next steps

- For the first half of 2021/22, General Dental providers were expected to achieve 60% of their annual contract target. With effect from 1 October 2021, this has been increased to 65%
- Orthodontic providers are expected to achieve 85% of their activity in quarter three of 2021/22.
- This figure reflects the ongoing challenges of delivering services in the current climate.
- NHS England continues to work with providers to ensure that services are delivered in line with the Standing Operating Procedure and the prioritisation of patients in need.

## Conclusions

116. The Leeds Health and Social Care System has and continues to experience significant and sustained pressure on service provision due to COVID-19. This pressure exceeds that experienced during the annual Winter pressures. This picture is not unique to Leeds, or indeed West Yorkshire. This demand has placed huge pressure on the physical and mental health of staff in hospitals, social care, public health and community services across the public, independent and third sector.

117. The headline causal factors for these pressures are:

- Widespread increases in **demand** for health and care services
- Challenges in optimising **system flow**
- **Workforce** retention, resilience and recruitment
- Pre-existing and new **health inequalities**

118. The immediate and continued response to the pandemic has showcased some of the very best of the 'Team Leeds' approach. Collaboration and partnership working has been a golden thread that has run through the strategic, tactical and operational levels of the Leeds health and care system. Robust measures are in place as we approach winter and we are further developing the vaccine programme and maintaining support for people who are clinically extremely vulnerable.

119. Despite this approach, health and wider inequalities have been exacerbated during the pandemic. Vaccine uptake is lower in deprived areas and morbidity and mortality are higher in black and minority groups. As COVID-19 has impacted physical health, poverty and loneliness have impacted mental health at all ages.

120. To support recovery from the pandemic and 'build back fairer' the city will require clear partnership strategies and delivery plans that outline how all parts of the health and care system will clear backlogs, manage waiting lists, address new demands and support staff.

121. The city will also require a consistent, long term and proportionate approach to existing and COVID-19 related inequality and to link this to wider city strategies focused on health and the wider determinants of health.