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Proposal for Leeds to become a Marmot City

Date: 11 January 2022

Report of: Director of Public Health

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

- Leeds has had a strong focus on tackling health and economic inequality for a number of years and this has guided our major strategies, service design and operational practice.
- Increases in life expectancy have stalled in Leeds and health inequalities have widened. We expect this position to worsen reflecting the impact of the pandemic. Some of this reflects worsening national trends and some is more specific to Leeds.
- This report outlines a proposal for Leeds to become a Marmot City, in order to build on existing system-wide partnerships and strategic aims to tackle health inequalities in the city at this critical time.
- The Marmot framework provides an opportunity to use evidence of what works to reduce health inequality, for a renewed call to action to change this worsening trend. This approach will be part of our wider city ambition and link with existing priorities on health, climate and inclusive economy.

Recommendations

The Scrutiny Board is asked to:

a) Note and comment on the content of the report.

b) Support the proposal to work to become a Marmot City.

Why is the proposal being put forward?

1 Some people in Leeds experience poorer health and wellbeing than people in many parts of the country. These inequalities in health are long-lasting, persistent, and driven by social, economic and environmental inequalities.

2 Life expectancy has stagnated in Leeds in recent years, with the gap between deprived Leeds and the city average widening in the decade up to 2019. A recent Lancet report highlighted that one area of Leeds (Leeds Dock, Hunslet and Stourton) has the lowest female life expectancy in England.

3 The latest Leeds Joint Strategic Assessment (JSA) highlights several structural challenges in the city. An increasing proportion of people in Leeds live in the most deprived parts of the city. 26% of the GP registered population (and 34% of pupils in primary schools) in Leeds live in areas which are categorised as the 10% most deprived nationally.

4 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. Clear trends and evidence have emerged showing that the impact of COVID-19 varies dependent upon age, gender, pre-existing conditions, ethnicity, deprivation, density of housing and working in insecure and frontline employment, resulting in higher morbidity and mortality in communities with more of these risk factors.

5 Taken together, these challenges mean we need to drive forwards a step change in our commitment and action on reducing health inequalities to see improvements in this challenging picture, using the evidence of the Marmot approach to inform this.

6 More detailed information is provided within the appended briefing paper for Members' consideration.

What impact will this proposal have?

Wards Affected: All		
Have ward members been consulted?	☐Yes	☒No

7 Becoming a Marmot City means taking action to reduce health inequalities by focusing on the social determinants of health as set out in the most recent Marmot report, Build Back Fairer.

8 Marmot calls for evidence-based action across six key policy areas:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

9 It is proposed that Leeds will initially focus on taking a Marmot approach to giving children the best start in life which would have lifelong and intergenerational benefits. Once established the Marmot approach would be expanded into other key areas of collective action, guided by a gap analysis.

10 A core principle of the Marmot approach is that by working across the social gradient and distributing resources according to need (otherwise known as proportionate universalism) health gains can be achieved across the population and health inequalities can be reduced. This would help the city progress towards the ambition of improving the health of the poorest the fastest.

11 Taking a Marmot approach now would have several advantages including:

- National expertise from the Marmot team in University College London will help us evolve our Health and Wellbeing Strategy and City Plan and reshape services to respond to inequality
- We can scope the input to local needs and evidence
- We will galvanise partners/citizens and demonstrate our commitment to tackling inequality
- Becoming a Marmot city will provide opportunities for research, showcase the city and help shape local evidence about 'what works'
- The Marmot approach will strengthen future funding bids (National Institute for Health Research, Kings Fund, Health Foundation etc)
- Will help us prioritise limited resources and guide commissioning
- Potential to invigorate conversations about wider determinants and key areas of concern impacting on children, young people and healthy ageing

What consultation and engagement has taken place?

12 No formal or informal consultation and engagement has taken place with Leeds residents or external stakeholders. Key internal stakeholders have been involved in the development of this proposal.

What are the resource implications?

13 As a Marmot City Leeds would work with the Institute of Health Equity (IHE) to create packages of support relevant to local areas. Charges for support from the IHE are calculated on a daily rate meaning the overall cost of becoming a Marmot City would be determined by local priorities and the level of support desired.

14 Learning from existing Marmot areas, the main resource implication is for a small core dedicated staffing resource to drive forward local work and co-ordinate actions with the national Marmot team. For the whole programme, indicative amounts are in the region of £140,000 a year for both staffing and programme costs. Resources for this in Leeds would need to be met within existing budgets, primarily within LCC public health and health partnerships resources.

15 We will also prioritise leverage of existing NHS and partnership resources for health and wellbeing using the integrated partnership infrastructure already in place.

What are the legal implications?

16 The Scrutiny Board may wish to consider any specific resource, procurement or value for money matters associated with this matter.

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

17 There is a risk that by not taking further action at this critical time health inequalities will continue to increase, and people will live shorter lives and spend less time in good health.

18 Recent reports have specifically highlighted Leeds in relation to health inequalities and reduced life expectancy which comes with reputational risks for the city.

Does this proposal support the council's 3 Key Pillars?

☒Inclusive Growth ☒Health and Wellbeing ☒Climate Emergency

19 The Marmot approach supports all three of the council's key pillars through its focus on improving health and wellbeing by taking action on the social determinants of health.

Options, timescales and measuring success

a) What other options were considered?

20 Becoming a Marmot City is not the only option available to reduce health inequalities. Other options, including continuing with the current approach, were discussed however it was felt that the added benefit of the strong, evidence-based recommendations provided by the Marmot approach made this the most appropriate option.

b) How will success be measured?

21 Success will be measured by monitoring inequalities in a number of core outcome measures which will be identified as the proposal is further developed. Data on many of these potential outcomes are already collected and reported as part of the JSA and routine public health outcome monitoring.

c) What is the timetable for implementation?

22 Becoming a Marmot city should be seen as a long-term approach to reducing inequalities within Leeds. In the short term more detailed planning and development work would enable detailed aims, objectives and timescales to be identified.

Appendices

23 Appendix 1 – Briefing paper 'Build Back Fairer: Proposal for Leeds to become a Marmot City'

Background papers

23. None.

Appendix 1

Build Back Fairer: Proposal for Leeds to become a Marmot City

Summary

- Some people in Leeds experience poorer health and wellbeing than people in many parts of the country. These inequalities in health are long-lasting, persistent, and driven by social, economic and environmental inequalities.
- Life expectancy has stagnated in Leeds in recent years, with the gap between deprived Leeds and the city average widening in the decade up to 2019. A recent Lancet report highlighted that one area of Leeds (Leeds Dock, Hunslet and Stourton) has the lowest female life expectancy in England.
- The latest Leeds Joint Strategic Assessment (JSA) highlights a number of structural challenges in the city. An increasing proportion of people in Leeds live in the most deprived parts of the city. 26% of people (and 34% of pupils in primary schools) in Leeds live in areas in the 10% most deprived nationally.
- 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. Clear trends and evidence have emerged showing that the impact of COVID-19 varies dependent upon age, gender, pre-existing conditions, ethnicity, deprivation, density of housing and working in insecure and frontline employment, resulting in higher morbidity and mortality in communities with more of these risk factors.
- Taken together, these challenges mean we need to drive forwards a step change in our commitment and action on reducing health inequalities to see improvements in this challenging picture, using the evidence of the Marmot approach to inform this.

1. Introduction

Despite a strong focus on tackling health inequalities in Leeds, increases in life expectancy have stalled and health inequalities have widened. It is expected that this position will worsen, reflecting the disproportionate impact of the pandemic. Health inequities are not fixed and are amenable to change. Given this increase, it is necessary to increase our efforts to reduce health inequalities in Leeds.

This paper outlines a proposal for Leeds to become a Marmot City in order to build on existing system-wide partnerships and strategic aims to tackle health inequalities in the city. It has been written to be read alongside the Joint Strategic Assessment and City Plan. The Marmot framework provides an opportunity to use evidence on what works to reduce health inequality for a renewed call to action to change this worsening trend. This approach will be part of our wider city ambition and link with existing priorities on health, climate and inclusive economy. A summary of the recommendations made in the Marmot Build Back Fairer report are included in appendix i to inform our discussions about how a Marmot approach would help us as a city to address our health inequality problem.

Inequalities in health are long-lasting, persistent, and driven by social, economic and environmental inequalities. Over the last forty years review after review from the Black Report (1980), to Marmot (2010, 2020) and Due North (2014), have all described these inequalities and set out clear recommendations for action to tackle them. Health inequalities are not inevitable, they are preventable.

Addressing the unjust differences in health between our communities has always been important. However, as the disproportionate impact of the COVID-19 pandemic, and its roots in the social and economic structure of our society becomes increasingly clear, the challenge to address health inequality is greater and there is an even more compelling case to act now to prevent further worsening of inequalities. This challenge has been clearly evidenced in key reports including Build Back Fairer (December, 2020), Unequal pandemic fairer recovery (The Health Foundation, July 2021), A perfect storm - health inequalities and the impact of COVID-19 series of reports (Local Government Association, April 2021), A year of COVID-19 in the North: Regional inequalities in health and economic Outcomes (September 2021), What geographic inequalities in COVID-19 mortality rates and health can tell us about levelling up (The Health Foundation, July 2021) and The Child of the North: Building a fairer future after COVID-19 (NIHR Applied Research Consortium, 2021).

There is a moral case to addressing health inequalities and to organising our city so that everyone has the same opportunity to be healthy. There is also an economic case for addressing inequalities, poorer health is associated with health and social care costs and higher welfare payments. Finally, living in more equal societies has been shown to be better for everyone (Wilkinson and Picket, 2010). More equal societies not only mean that resources like good housing and access to education are more easily accessed by everyone, but they are characterised by higher levels of trust and community cohesion which will support wellbeing for all communities in Leeds.

This report covers:

- The Marmot approach
- Health inequalities in Leeds
- Impacts of the COVID-19 pandemic on inequalities in Leeds
- The response to health inequalities in Leeds so far
- What more we could do – Leeds as a Marmot city
- An initial area of focus and future possibilities

2. The Marmot approach

Understanding and addressing health inequalities has been a key focus for local authorities over many years. It has been shown that only 10-15% of the gap in premature mortality can be directly affected by healthcare interventions. To reduce health inequalities further and faster intervention on the wider determinants of health is required and local authorities are well placed to make an impact.

In 2010 the Institute of Health Equity (IHE), based in University College London, published the Marmot report, Fair Society, Healthy Lives, following a review of health inequalities in England. Marmot considered evidence-based strategies to reduce health inequalities and called for action on 6 key policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

A core principle of Marmot's work is that there is a gradient in health outcomes across a population, from those living in the most deprived areas who generally have the poorest outcomes, to those living in the least deprived areas who generally have the best health outcomes. We can think of this as a slope of inequality. By working across the social gradient and distributing resources according to need (otherwise known as proportionate universalism) Marmot's work attempts to improve the health and wellbeing of entire populations.

In February 2020 the IHE published the follow up Marmot report, Health Equity in England: The Marmot Review Ten Years On. This report set out the impact of a decade of austerity. Health had

stopped improving. Life expectancy was stalling and sometimes falling, and people were spending more years in poor health, a picture that resonates in Leeds. The number of children living in poverty was rising. The prevalence of long-term conditions, which we know now to increase the severity of COVID-19, remained high. Importantly, these changes were not experienced equally across the population. People in deprived communities were impacted disproportionally meaning inequalities were getting worse not better.

This meant that the impacts of the COVID-19 pandemic disproportionally impacted on poorer communities; poor health and inequalities left areas of the UK more vulnerable to COVID-19 and its direct and indirect impacts. COVID-19 has exposed the way in which structural inequalities are related to health inequalities. During the pandemic, structural inequalities played a significant part in the risk of contracting COVID-19 and of subsequently suffering the worst effects. These were then amplified by inequities in healthcare provision and wider factors such as racism and discrimination which affected trust in the vaccine programme.

In December 2020 the IHE published the third Marmot report, Build Back Fairer, which showed how the COVID-19 pandemic has affected health inequalities in England. Key messages from the report include:

- Inequalities in social and economic conditions before the pandemic contributed to the high and unequal death toll from COVID-19
- The nation's health should be the highest priority for government as we rebuild from the pandemic
- The economy and health are strongly linked – managing the pandemic well allows the economy to flourish in the longer term, which is supportive of health
- Reducing health inequalities, including those exacerbated by the pandemic requires long-term policies with equity at the heart
- To build back fairer from the pandemic, multi-sector action from all levels of government is needed
- Investment in public health needs to be increased to mitigate the impact of the pandemic on health and health inequalities, and on the social determinants of health.

Marmot states "As the UK emerges from the COVID-19 pandemic it would be a tragic mistake to attempt to re-establish the status quo that existed before – a status quo marked in England, over the past decade, by a stagnation of health improvement that was the second worst in Europe, and by widening health inequalities."

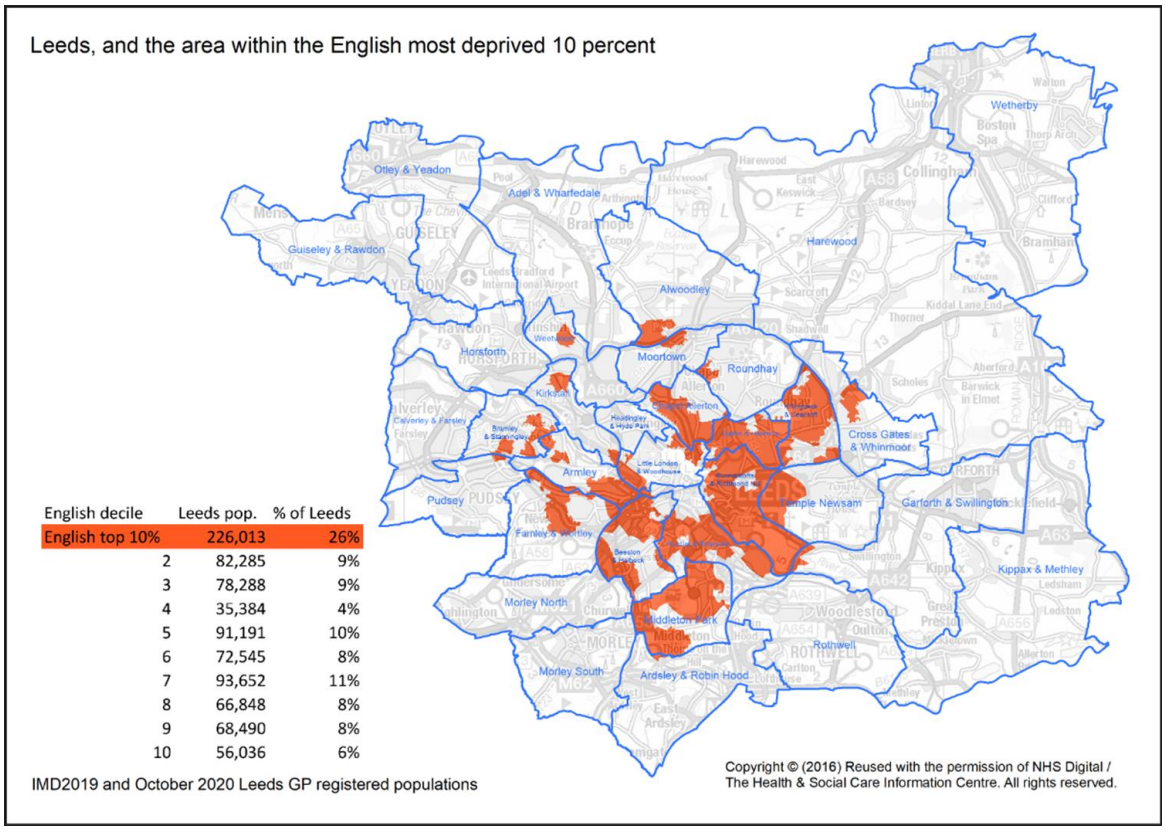
Marmot calls to build a fairer society based on the principles of social justice, with health and wellbeing at the heart of government strategy and a more equal society that can respond to the climate crisis as well as achieving greater health equity.

Becoming a Marmot City means working with colleagues from the Institute of Health Equity (IHE) to be part of a Marmot programme of work with the aim of reducing health inequalities. Several other cities and regions in the UK including Coventry, Stoke, Newcastle, Gateshead, Bristol, Somerset, Greater Manchester and Cumbria and Lancashire are already Marmot cities. The potential benefits of becoming a Marmot city are discussed later in this paper.

3. Health inequalities in Leeds

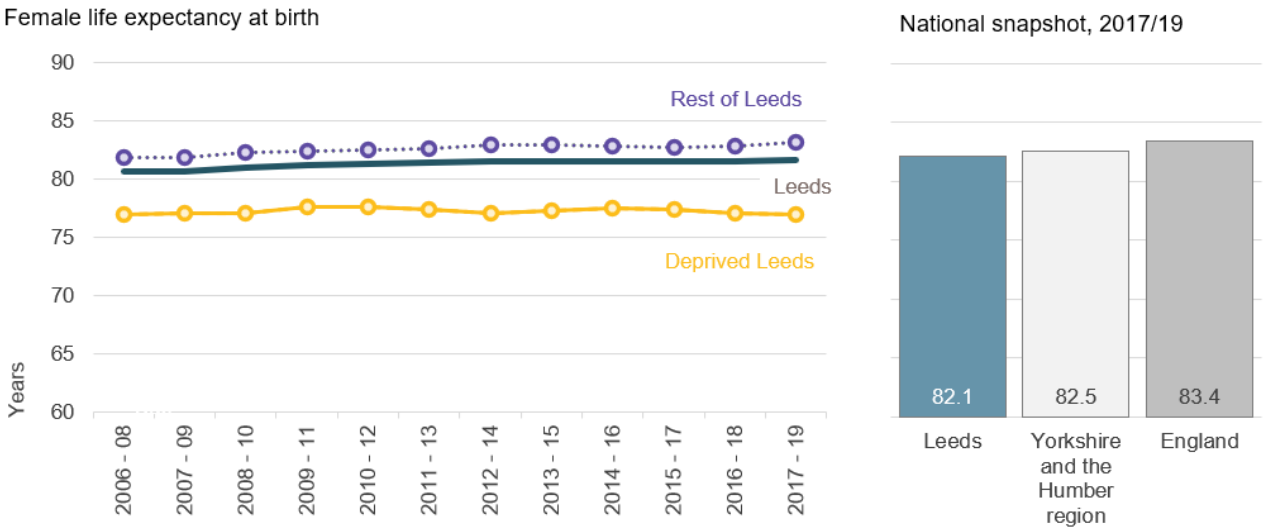
Analysis of health inequalities in Leeds over the past decade, pre COVID-19, showed that though Leeds fared well on average compared to core city peers, this masked deep health inequalities experienced by some communities in the city. Ten years ago, 20% of the Leeds population lived in areas ranking in the 10% most deprived nationally, this figure now stands at 26% for the Leeds GP registered population (figure 1).

Figure 1 - Areas in Leeds which fall into the most deprived 10% in England



Life expectancy has stagnated in recent years, with the gap between deprived Leeds and the city average widening in the decade up to 2019 (figures 2 and 3). In deprived Leeds, the female life expectancy at birth figure appears to have fallen back slightly in recent years (figure 2), however, none of these changes are classed as statistically significant. In terms of wider comparisons, Leeds lags regional and national averages for female life expectancy with a recent Lancet report highlighting that one area of Leeds (Leeds Dock, Hunslet and Stourton) has the lowest female life expectancy in England (Imperial College London, 2021).

Figure 2 - Female life expectancy at birth



Male life expectancy in Leeds shows a similar pattern (figure 3) though life expectancy in deprived Leeds has seen a slight uplift since 2016-18. Once again none of these changes in deprived Leeds is statistically significant. Looking more widely, male life expectancy in Leeds also lags regional and national averages.

Figure 3 - Male life expectancy at birth

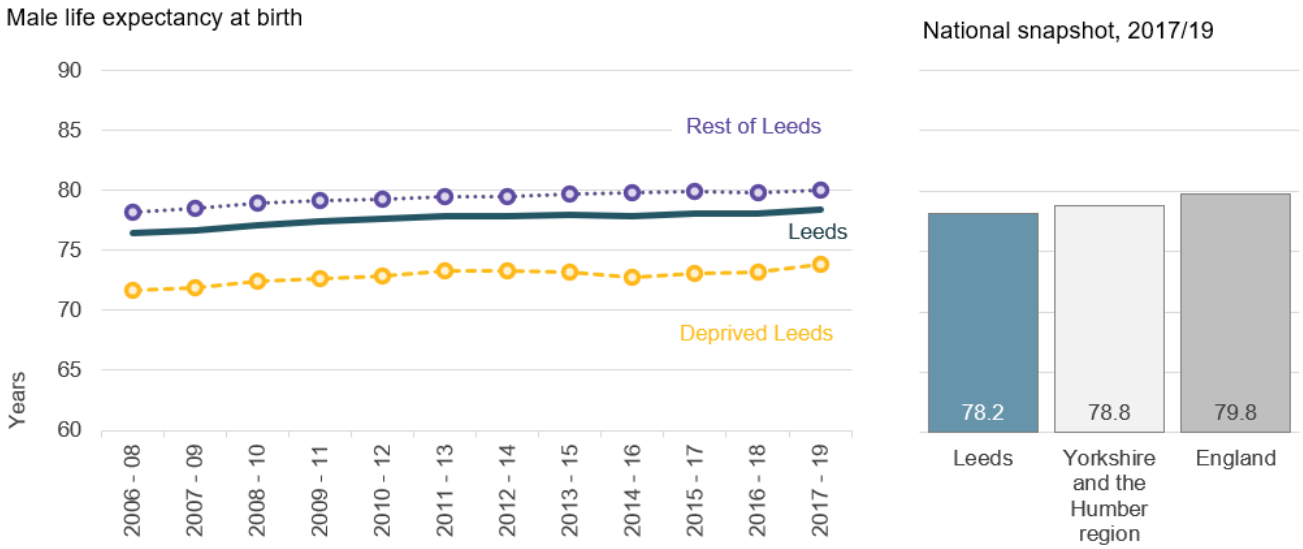
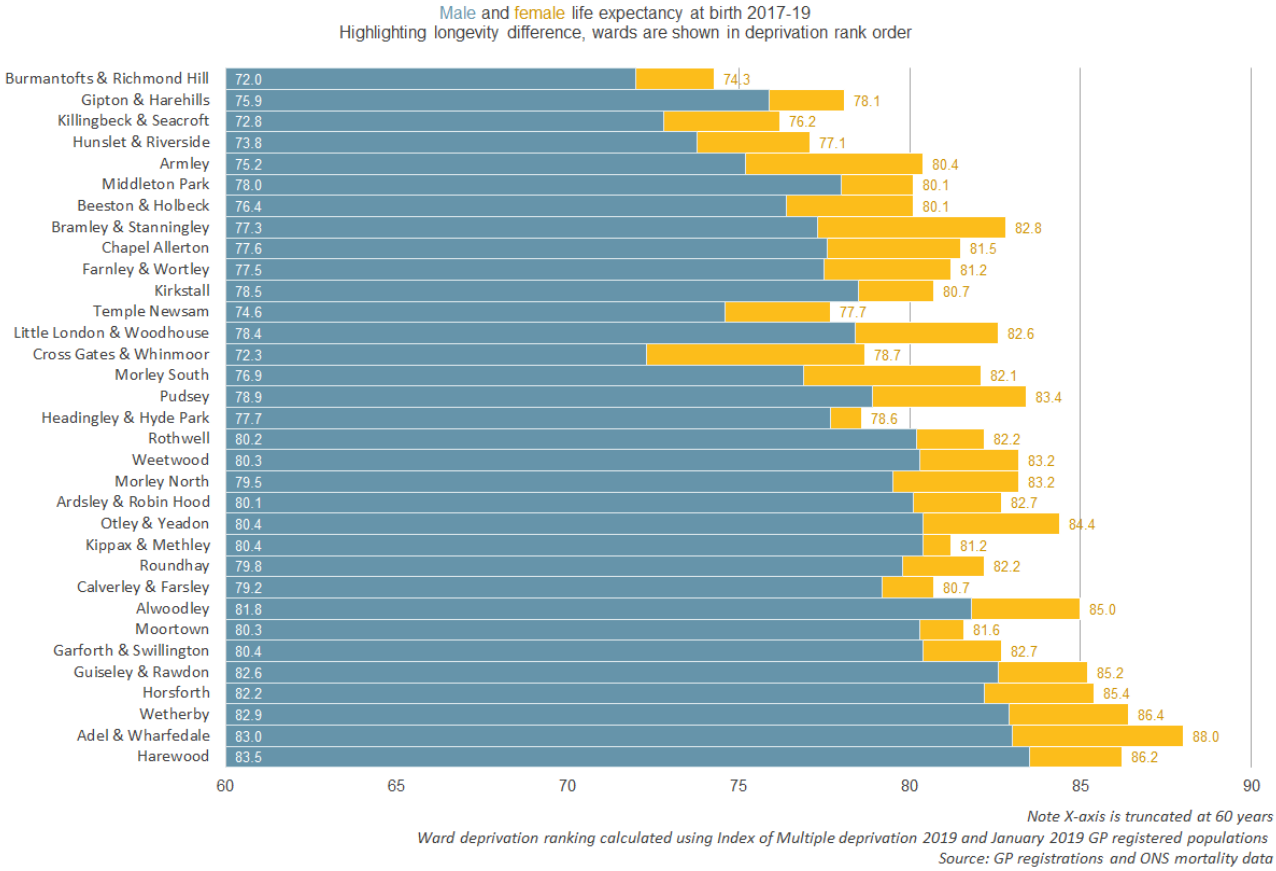


Figure 4 below highlights the variations in life expectancy by ward across the city. It highlights the gap in life expectancy between of some of our most and least affluent areas as illustrated by a difference in life expectancy of 12 years for women and 11 years for men, between the ward of Burmantofts and Richmond Hill in the inner city, and that of Adel and Wharfedale in the outer area. It is also important to note there will be differences in life expectancy within ward areas.

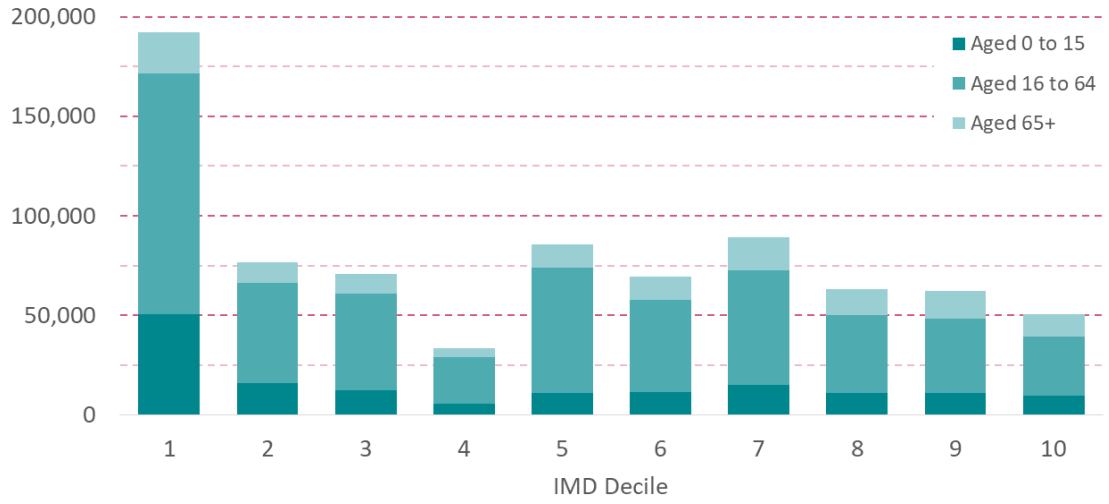
Figure 4 - Male and female life expectancy by ward



Prior to the pandemic, Leeds experienced a growth in the proportion of children living in more deprived deciles between 2012 and 2019, and the diversity of ethnic background has increased. Figure 5 shows the number of people in each deprivation decile by age (based on Index of Multiple Deprivation 2019 Mid-Year Population Estimates 2019).

The effect of the pandemic and wider political and economic climate on the future strength of this growth is not certain. Much of this population growth is centred around more deprived inner-city areas of Leeds. The Leeds School Census shows that 34% of pupils in primary schools in Leeds live in areas in the 10% most deprived nationally, rising to 37% of those in Reception classes. Excluding reception starters, 48% of primary pupils who moved into Leeds and enrolled in school in 2021 lived in areas in the 10% most deprived nationally. With evidence showing that growing up in a deprived area increases the chance of adverse childhood experiences (ACEs) and reduces the likelihood of entering higher education it will be imperative to ensure this cohort receives additional support to promote individual resilience and social mobility and are enabled to access the jobs of the future.

Figure 5 - Number of people by age and deprivation decile in Leeds



In summary, the widely reported recent slowing in life expectancy gains at a national level are reflected in the latest data for the city. The data also confirm the stubborn gap in life expectancy between our most deprived and least deprived communities emphasising the need to improve the socio-economic conditions in our most deprived communities. The disproportionate number of children in our most deprived communities highlights the need to take action to minimise the future impacts on health inequalities in the city.

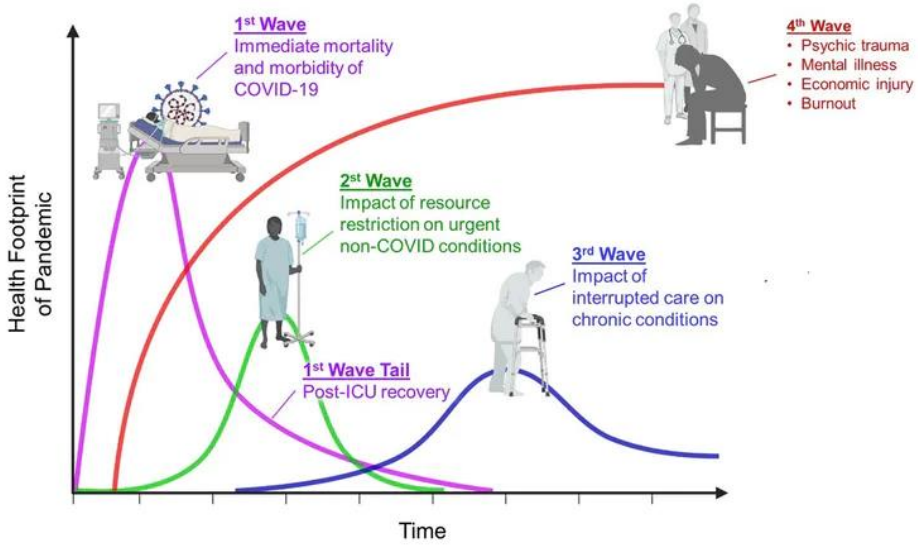
4. Impacts of COVID-19 on health inequalities in Leeds

Figure 6 below illustrates the impact of COVID-19 on health 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 6 - Four waves of the COVID-19 Pandemic (Victor Tseng)



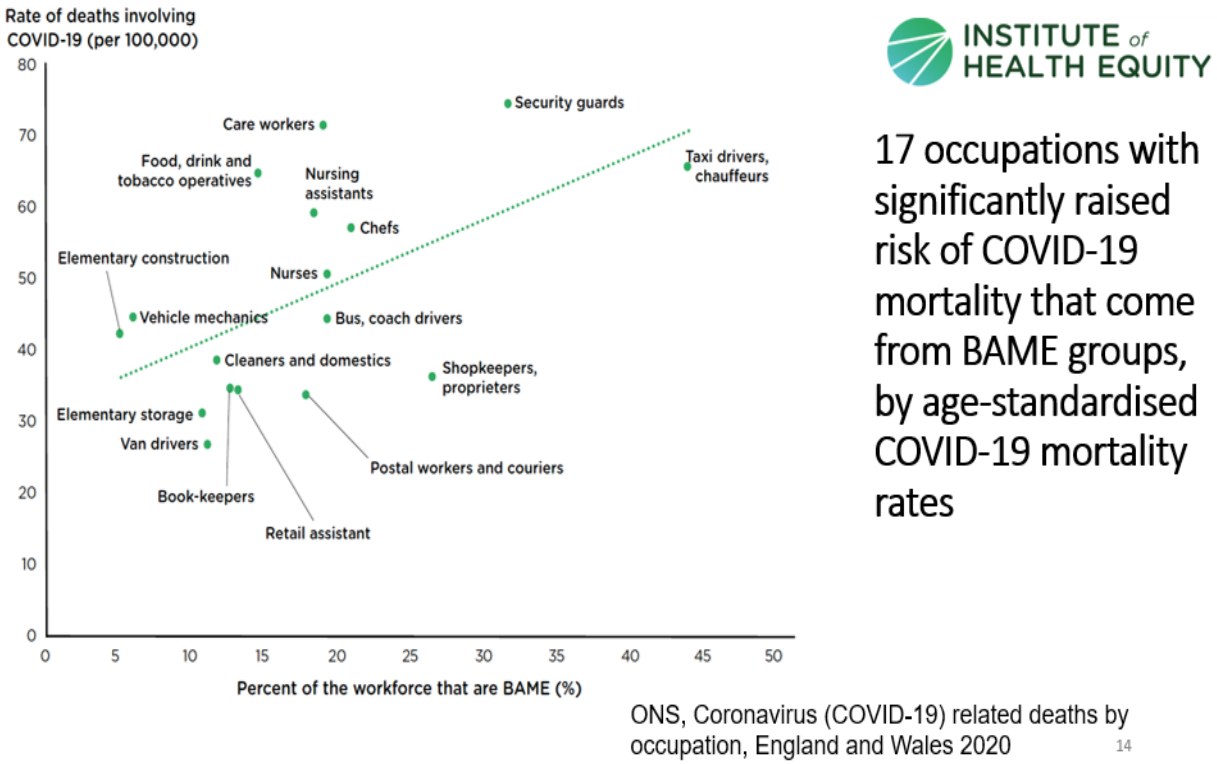
The impact of the COVID-19 pandemic has fallen disproportionately and widened health inequalities amongst groups of people internationally, in the UK and in Leeds (UCL, 2020, The LGA, April 2021, The Health Foundation, July 2021).

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 four 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. For example, MENCAP found that in the week up to 22nd January 2021, 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).

An early local analysis of 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.

Nationally, mortality rates have also been shown to be higher in some occupational groups (figure 7). 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 7 - Occupations at increased risk of mortality from COVID-19.



In addition to the immediate unequal impact of COVID-19 on morbidity and mortality, longer term direct and indirect health inequalities are likely. A key example of the long-term disproportionate impact on groups facing multiple risk factors is 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?"

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. Mental health difficulties, primarily anxiety and depression have increased, sometimes referred to as the silent pandemic. The Local Government Association and the Association of Directors of Public Health (ADPH) jointly produced a briefing about the public mental health and wellbeing issues arising from the COVID-19 outbreak. The briefing highlighted the far-reaching impacts of COVID-19 across the life course and identified key issues to consider, including the need for a whole system approach, to build on existing arrangements and to tackle inequalities.

Further information on the impacts of COVID-19 on inequalities can be found in the Leeds Joint Strategic Assessment.

5. The response to health inequalities in Leeds so far

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 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.

This work is underpinned by our JSA, which functions as a robust analysis of health and wellbeing in Leeds, with a strong focus on tracking health inequalities over time (Leeds City Council and Leeds CCG, 2021). 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.

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.

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.

Finally, The Leeds Best Council Plan 2020 - 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

6. What more could we do – Leeds as a Marmot city

The long-term effect of COVID-19 on mortality and morbidity are not yet fully known. However, in the medium term, it is likely we will need to adapt to endemic COVID-19 cases. Ongoing inequalities in vaccine uptake and, inequalities in types of employment and inequalities in underlying medical conditions means endemic COVID-19 is likely to cause persistent health inequalities. We are also likely to have a cohort of people living with long term effects of COVID-19.

Added to the pre-existing inequalities and changing demographics of the city, the need to maintain a broad view of health inequalities and act on the social determinants of health is a priority. This highlights the need for Leeds as a city to build on the previous good work and look to the future to consider what more we can do to tackle health inequalities as we begin to move out of the pandemic.

Taken together, these challenges mean we need to drive forwards a step change in our commitment and action on reducing health inequalities to see improvements in this challenging picture. The Marmot framework provides an opportunity to use evidence on what works to reduce health inequality for a renewed call to action to change this worsening trend.

It is proposed that by becoming a Marmot City, Leeds will be able to build on the strong system-wide partnerships and strategic aims of the city to tackle health inequalities at this critical time. It will enable Leeds to focus on addressing the slope of inequality, benefits of which would be felt across the whole population, allowing Leeds to emerge from the pandemic in a stronger position. Taking a Marmot approach will allow us to respond to the recommendations made in Build Back Fairer (appendix i) and work with the IHE to create packages of support relevant to local areas.

The Marmot approach mirrors many of the aims of The Leeds Best Council Plan and the developing City Ambition, particularly the themes around improving the health of the poorest the fastest, creating

an inclusive economy and creating safe, strong communities. As a Marmot City, Leeds will be able to strengthen action around these existing priorities and make the Marmot approach part of our wider city ambition.

The Marmot team consider Leeds to be in a strong position due to our strategies and approaches to system leadership, health inequality and partnership working. The Marmot team have suggested initial work in Leeds could focus on:

- Understanding what Leeds city has been doing and what we could do more of
- Developing a single programme of work which could then be used to link in with Integrated Care System to expand to a regional plan.
- Consideration of what more businesses could contribute more to reducing to health inequalities in Leeds. This is an emerging direction of work in other areas.
- The use of an asset-based community development approach, and the role of business, faith groups, and community groups including opportunities to take this further beyond local authority commissioning.

Benefits of becoming a Marmot city could include:

- Support Leeds to be more systematic in our approaches by use of evidence from Marmot and to further endorse and strengthen our approach to improving the health of the poorest fastest, given worsening health inequality through new commitment to agreed priorities in the social determinants of health. Using an evidence-based Marmot approach will support further building our Leeds approach, ensuring Marmot principles underpin all major programmes of work and shape all investment decisions.
- Further endorses and builds on Leeds commitment to reduce health inequality, which is already at the centre of the Health and Wellbeing Strategy. A Marmot approach could provide further challenge and support on how we achieve this as we come through pandemic.
- Add opportunity to focus on further strengthening key local priorities.
- The opportunity to have Professor Marmot and his team attend events and galvanise senior leaders from across the system around ongoing work focused on reducing health inequality.
- The Marmot brand is well established and respected. Being able to refer to Leeds as a Marmot city demonstrates a commitment to tackling inequality. This can assist in securing external funding.
- Institute for Health Equity (IHE) colleagues can provide expert consultancy support to help Leeds.
- IHE colleagues provide additional expertise around inequalities and data analysis, using this information to develop stronger arguments/clearer narratives; bringing together partners from across the system to act on inequalities and social determinants of health

Challenges could include:

- Trying to cover too much within the Marmot programme may not lead to any noticeable impact so there is a need to prioritise specific areas of focus.
- Making a real impact with the work will require some dedicated resource.

Working with the Institute of Health Equity to develop the Marmot approach has associated costs. Charges for support from the IHE are calculated on a daily rate meaning the overall cost of becoming a Marmot City would be determined by local priorities and the level of support desired.

Learning from existing Marmot areas, the main resource implication is for a small core dedicated staffing resource to drive forward local work and co-ordinate actions with the national Marmot team. For the whole programme, indicative amounts are in the region of £140,000 a year for both staffing and programme costs. Resources for this in Leeds would need to be met within existing budgets, primarily within LCC public health and health partnerships resources. We will also prioritise leverage of existing NHS and partnership resources for health and wellbeing using the integrated partnership infrastructure already in place.

7. Initial area of focus

It is proposed that Leeds will initially focus on taking a Marmot approach to giving children the best start in life. This was one of the key recommendations of the original 2010 Marmot report and the local data showing the high numbers of children in Leeds living in the most deprived areas, coupled with the changing demographics of the city, clearly identify that action is needed to reduce health inequalities for this age group. Improving life chances for children has both lifelong and intergenerational benefits through the use of a family approach to reducing health inequalities.

There are several existing programmes of work in the city which link closely with this proposed area of focus. These include programmes linked to Child Friendly Leeds, the Leeds Children and Young People's Plan, the Best Start Strategy, Early Help Strategy, Maternity Strategy, Nesta partnership, Attainment Achievement and Attendance strategy and the Thriving strategy.

8. Future possibilities

Once established, it is anticipated that the Marmot approach could be expanded into other key areas of collective action to strengthen our commitment and existing work to reduce health inequalities. A gap analysis of current activity, facilitated by the IHE, would help to identify future priority areas for action and allow for further engagement with key stakeholders.

9. Conclusions

COVID-19 has exacerbated existing health inequalities in Leeds with a resultant need for urgent action to redress this trend. Partners in Leeds are committed to reducing health inequalities and this work is embedded in core Leeds strategies. Becoming a Marmot City provides an opportunity to further focus and accelerate work to reduce health inequalities in Leeds, using the evidence-based recommendations made in Build Back Fairer as a framework for action.

Summary of advantages

- National expertise from the Marmot team in University College London will help us evolve our Health and Wellbeing Strategy and City Plan and reshape services to respond to inequality
- We can scope the input to local needs and evidence
- We will galvanise partners/citizens and demonstrate our commitment to tackling inequality
- Becoming a Marmot city will provide opportunities for research, showcase the city and help shape local evidence about 'what works'
- The Marmot approach will strengthen future funding bids (NIHR, Kings Fund, Health Foundation etc)
- Will help us prioritise limited resources and guide commissioning
- Potential to turbocharge conversations about wider determinants and key areas of concern impacting on children, young people and healthy ageing

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Appendix i) Build Back Fairer recommendations

Reducing inequalities in early years

Long term

- Reduce inequalities in early years development as a priority for government

Medium term

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Improve availability and quality of early years services, including Children's Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce

Short term

- Early years settings in more deprived areas are allocated additional Government support to prevent their closure and staff redundancies.
- Improve access to availability of parenting support programmes
- Increase funding rates for free child childcare places to support providers

Reducing inequalities in education

Long term

- Put equity at the heart of national decisions about education policy and funding.
- Increase attainment to match the best in Europe by reducing inequalities.

Medium term

- Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

Short term

- Inequalities in access to laptops, are addressed and the programme designed to enable provision of laptops to more deprived pupils is expanded and adequately resourced.
- Significantly greater focus on achieving equity in assessments for exam grading.
- Catch up tuition is fully rolled out for children in more deprived areas urgently
- Additional support is provided for families and pupils with SEND
- Excluded pupils are urgently given additional support and enrolled in Pupil Referral Units

Recommendations to Build back fairer for children and young people

Long Term

- Reverse declines in the mental health of children and young people and improve levels of well-being, from the present low rankings internationally, as a national aspiration.
- Ensure that all young people are engaged in education, employment or training up to the age of 21.

Medium Term

- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course
- Improve prevention and treatment of mental health problems among young people.

Short Term

- Reduce child poverty: - Remove the 'two-child' and benefit cap - Increase child benefit for lower income families to reduce child and food poverty - Extend free school meal provision for all children in households in receipt of Universal Credit.
- Urgently address children and young peoples mental health with a much strengthened focus in schools and teachers trained in mental first aid.
- Increase resources for preventing identifying and supporting children experiencing abuse.
- Develop and fund additional training schemes for school leavers and unemployed young people.
- Further support young people training and education and employment schemes to reduce NEET and urgently address gaps in access to apprenticeships.
- Raise minimum wage for apprentices and further incentivise employers to offer such schemes
- Prioritise funding for youth services.

Recommendations for creating fair employment and good work for all

Long Term

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life.
- The social safety net must be sufficient such that people not in full time work receive a minimum income for healthy living
- Engage in a national discussion on the balance of the work-life balance including consideration of a four-day week.

Medium Term

- Reduce the high levels of poor-quality work and precarious employment.
- Invest in good quality active labour market policies
- Increase the national living wage to meet the standard of minimum income for healthy living

Short Term

- Provide subsidies or tax relief for firms that recall previously dismissed workers
- Coronavirus Job Retention Scheme to be extended to cover 100% of wages for low-income workers.
- Enforcement of minimum wages so that the large number of workers who are currently exploited earn their entitlement

Ensuring a healthy standard of living for all

Long Term

- Establish a national goal so that everyone in full-time work receives a wage that prevents poverty and enables them to live a healthy life without relying on benefits.
- Make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living.
- Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
- Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
- Review the taxation and benefits system to ensure they achieve greater equity and are not regressive.

Medium Term

- Make permanent the £1,000-a-year increase in the standard allowance for Universal Credit.
- Ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty.
- Eradicate food poverty permanently and remove reliance on food charity
- Remove sanctions and reduce conditionalities in benefit payments.

Short Term

- Increase the scope of the furlough scheme to cover 100 percent of low-income workers.
- Eradicate benefit caps and lift the two-child limits
- Provide tapering levels of benefits to avoid cliff edges.
- End the five-week wait for Universal Credit and provide cash grants for low-income households.
- Give sufficient Government support to food aid providers and charities.

Creating and developing healthy and sustainable places and communities

Long Term

- Invest in the development of economic, social and cultural resources in the most deprived communities.
- Ensure 100 percent of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Aim for net-zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

Medium Term

- Increase deprivation weighting in the local government funding formula.
- Strengthen the resilience of areas that were damaged and weakened before and during the pandemic
- Reduce sources of air pollution from road traffic in more deprived areas.
- Build more good-quality homes that are affordable and environmentally sustainable.

Short Term

- Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls.
- Increase government allocations of funding to the voluntary and community sector.
- Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates.
- Remove the cap on council tax.
- Urgently reduce homelessness and extend and make watertight the protections against eviction.

Strengthening the role and impact of ill health and prevention

Long Term

- A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health.
- Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities

Medium Term

- Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities.
- Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.

Short Term

- Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient
- Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

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