Leeds Office of NHS West Yorkshire Integrated Care Board (WYICB)

Our Celebration of Equality, Diversity, and Inclusion

Contents

Local population profile, demographic data, and health inequalities

Leeds is an area of great contrasts, including a densely populated inner-city area with associated challenges in relation to poverty and deprivation, as well as a more affluent city centre, and suburban and rural areas with villages and market towns.

The most recent census (2021) indicated that Leeds has a population of 811,953 representing an 8.05% growth since the previous census of 2011. Leeds has a relatively young and dynamic population and is an increasingly diverse city with many ethnic communities including black, Asian, and other ethnically diverse populations representing 22.1% of the total population compared to almost 19% in 2011.

In relation to spoken languages the census 2021 showed that after English (87.83%), the most common spoken languages across Leeds are Polish (1.02%); Arabic (0.59%); Romanian (0.58%); Urdu (0.54%); and Panjabi (0.52%).

The census 2021 showed that 0.05% of the Leeds population use British Sign Language.

In July 2024 our records showed there were 936,625 people registered with General Practitioners (GPs) in Leeds. This data provides us with more up to date information that helps us understand the health and care needs of our population.

The Leeds Health and Wellbeing Strategy 2023 to 2028 sets out a clear commitment that:

“Leeds will be a health and caring city for people of all ages, where those who are poorest improve their health the fastest”.

More information about the Leeds Health and Wellbeing Strategy can be found here:

Leeds Health and Wellbeing Strategy

The role health and social care will play to support achievement of this aim is set out The Healthy Leeds Plan

The Healthy Leeds Plan contains two clear goals, through which we will support delivery of the overall Health and Wellbeing Strategy commitment.

The table below shows how our commitment is driven by action and measured by impact through two system wide goals.

Goal 1 and 2 focus on 26% of the population who live in the 10% most deprived areas nationally.

Goal 1 **Reduce preventable unplanned care utilisation across health settings**	**Goal 2** **Increase early identification and intervention (of both risk factors and actual physical and mental illness)**
Leeds to achieve a 25% reduction in **preventable** unplanned utilisation for those in IMD 1 (people who live in the 10% deprived areas nationally) by 2028, against a 2022 baseline	To be determined However, we know this will have a focus on people who live in the 10% most deprived areas nationally, and for the first year will be delivered with a focus on hypertension and mental health
We will know whether we have achieved this target when we have reduced: • The number of unplanned admissions to hospital (we count the number of days people stay in hospital) • The number of times people used A&E, walk in centres, and Urgent Treatment Centres • The number of times people accessed mental health crisis services • The number of days people stayed as a mental health inpatient We know that some emergencies are unavoidable, and when people need A&E and other same-day services these need to be easily available and accessible. However, we also know that sometimes people end up in hospital in an unplanned way when we could have done something sooner that would have kept them healthier and happier at home or in the community. We want to make sure that people only come into hospital as an emergency when there was no other, better option.	To be determined

We take a person centred and proactive approach by working with people and staff to design solutions together.

Several programmes sit underneath the Healthy Leeds Plan goals, targeting specific groups of people identified through data analysis, to talking to clinicians, our communities, and patients.

We're now going through this process again to work out what to measure and how to set a target for Goal 2, however, we know it will focus on improving the health of the most deprived communities and those facing health inequalities.

The Healthy Leeds Plan has a specific focus on health inequalities. This is because we know that 26% of our population and around a third of all children in Leeds live in neighbourhoods in the 10% most deprived nationally (IMD1).

We know that health and wellbeing is affected by social, economic, and environmental factors that go beyond good healthcare. These are often referred to as the wider determinants of health and include factors such as income, education, access to green spaces and healthy food, employment, and housing.

Inequalities in relation to the wider determinants of health can lead to health inequalities between different populations and therefore addressing these wider socio-economic inequalities is a crucial part of reducing health inequalities for the people in Leeds.

Leeds has also committed to become a Marmot City. Marmot Cities are cities that are committed to reducing health inequality and improving health through improving the wider determinants of health. You can read more about Marmot Cities on the Institute of Health equity website and our initial Fairer Healthier Leeds Reducing inequalities report. Through this programme, Leeds is working in partnership with the Institute of Health Equity to take a strategic, whole-system approach to improving health equity.

Details regarding the population profile, demographics and health inequalities within Leeds can be found in the Leeds Joint Strategic Assessment 2024.

An overview of some of the changing population needs and characteristics identified within the needs assessment include:

- Leeds has a rapidly growing population versus national and regional averages, with growth fastest in inner-city areas where we are also seeing increased density.
- However, the birth rate is continuing to fall, and we are yet to see this level off.
- Population continues to age in line with national patterns, but we are also at peak population size for children and young people with the 'bulge' cohort of the 2010s working through secondary school and into post-16 education.
- The city is much more diverse than a decade ago – minority populations are significantly more likely to experience poverty and inequality, concentrated in inner-city communities.

- The student population is growing year-on-year, but there are early signs it is shifting spatially with growth largely concentrated in the city centre rather than the traditional student communities.
- The proportion of people living with multiple long-term conditions is increasing, with this likely to start earlier in life for people living in the poorest neighbourhoods, creating a need for more adaptable and coordinated services focused on preventing and meeting complex needs.
- The gap in life expectancy in Leeds, could mean that a female living in Harewood can expect to live 11.5 years longer than a female in Hunslet and Riverside, with similar gaps for men.
- Suicide rates are highest among middle-aged men, whilst girls and young women have the highest rates of hospital admissions due to self-harm. Both have higher rates in the city's low-income communities

We have developed a robust population health infrastructure in Leeds designed to put the diverse needs of our population at the heart of everything we do and move decision making closer to the people using our services. Within Leeds we have described the different needs of the population using nine mutually exclusive population segments:

- Children and Young People
- Maternity
- Healthy Adults
- People with a Learning Disability and/or Neurodiversity
- Serious Mental Illness
- Cancer
- Long Term Conditions
- Frailty
- End of Life

By looking at our population in this way, we can better understand what people need to address, the challenges they face and how we as a health and care system can help.

Each population segment has a corresponding Population Board, which brings together experts and representatives from across health and care, the third sector, and Healthwatch to support, inform, and shape decisions that impact their population.

Further information can be found at our website: Population health infrastructure - Leeds Health and Care Partnership (healthandcareleeds.org)

Leeds Health and Care Partnership and equality, diversity, and inclusion

We work together with our partners and the people of Leeds and work as one team, where staff work for Leeds, rather than for individual organisations.

We are committed to sharing resources, ideas, and best practice to improve health outcomes, access, and experience of healthcare and to reduce health inequalities across the city for all our diverse communities.

The vision for Leeds Health and Care Partnership is that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

Our vision for Leeds is owned by all partners and delivered through action, using our diverse and unique skills, knowledge, and experiences. We will work together, using our collective resources to create a fairer and healthier Leeds for all.

The Leeds Health and Care Website (healthandcareleeds.org) provides more information about the partnership arrangements across Leeds.

As an integrated partnership we continue to work together in the transformation of our healthcare services. In relation to equality, diversity, and inclusion, we ensure that service specifications include the need to have robust policies and processes in place to make sure that the needs of all diverse communities and other health inclusion groups are considered in respect of the delivery of their service and that workforce policies are fair and equitable.

We continue to proactively integrate quality and equality impact assessments and equality impact assessments within all our business processes

Equality analysis and assessment of impact continues to be integrated within all the work our communication, insight and involvement team do.

Equality, diversity and inclusion networks and forums

Our aim is to continually improve equality, diversity, and inclusion (EDI) in relation to being an inclusive employer, reducing health inequalities and removing barriers to accessing healthcare, therefore we continue to work together with our partners and continue to be members of the following:

Leeds NHS Equality Leads Forum

As members of the Leeds NHS Equality Leads Forum, we continue to work in partnership with all NHS organisations in Leeds to ensure that there is a joined-up approach in relation to equality, diversity, and inclusion in relation to our workforce. In addition, we work together to explore inequalities experienced by some of our diverse communities in relation to health outcomes and access to, and experience of healthcare.

For example, we continue to work in partnership to address inequalities experienced by people with sensory impairments in relation to their communication and information needs, specifically in respect of implementation of the Accessible Information Standard; share good practice in relation to all staff networks; continue to work collaboratively in relation to NHS Equality Delivery System

2022; NHS Workforce Race Equality Standard; NHS Workforce Disability Equality Standard; NHSE six High Impact Actions; Patient Carer Race Equality Framework (PCREF).

Leeds Equality Network

During 2024, working in collaboration with Leeds City Council we re-established Leeds Equality Network.

Leeds Equality Network brings together public sector, private sector, education organisations and third sector representation across Leeds. The purpose of the network is:

- To work collectively and collaboratively to contribute to a fair and inclusive society. The network seeks to be more than the sum of its parts, driving meaningful change through partnership working and learning together to make a positive, lasting impact on the city.

- To collectively identify and address inequalities in Leeds, focusing on the protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, sexual orientation). We will also include Care Experience, Carers and Socio-Economic Inequality and other communities who experience inequalities.

- To deepen our understanding of poverty and deprivation, and the impact they have on inequality across the city, ensuring that these factors are taken into account in our work.

- To maximise the impact of partnership working across member organisations, sharing best practices, promoting events, and sharing intelligence related to equality, diversity, and inclusion. This collective effort will strengthen the city's resources and enhance outcomes for communities

The network is made up of practitioners supporting each other to work more effectively by working in partnership and therefore aim to move beyond a 'compliance' approach, with a commitment to be truly inclusive and work towards the creation of a fair and equitable society where everyone can fulfil their true potential.

To help organisations achieve this, members of the network will agree on annual themes or communities of interest, identifying activities to be developed and delivered collaboratively in relation to these areas.

The areas of focus so far for the network have included protected characteristics and care experience, socio-economic duty, West Yorkshire Integrated Care System "Equity and Justice for Health: A Shared West Yorkshire Vision" Strategy, international days and collaboration and an overview of hate crime.

Communities of Interest Network

We are members of the Communities of Interest Network (COIN) which aims to highlight and address the needs and challenges faced by groups and communities which experience the greatest inequalities, with a focus on health and wellbeing. COIN does this by promoting two-way

communication and collaborative working between the Public Sector and Third Sector organisations that represent these communities.

A key focus of the network is to understand and raise awareness of the importance of intersectionality, where people's overlapping social identities may mean they experience disadvantages or discrimination: Communities of Interest - Forum Central

LGBTQIA+ Health and Wellbeing Network

We know that some of us identify as LGBTQIA+. This means we may be lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual. Or we may define our gender and sexuality in other ways. Stonewall's glossary lists many more terms.

We are members of Leeds LGBTQIA+ Health and Wellbeing Network, which aims to:

- Improve the health and wellbeing of the LGBTQIA+ population in Leeds by linking services and professionals and sharing best practice.
- Identify potential workstreams and work across service and organisations to progress these workstreams
- Act as a reference group for other groups and organisations who wish to consult with the group
- Act as a forum for debate, discussion, and strategic planning as it relates to the health of LGBTQIA+ people in Leeds.

Leeds NHS Provider Trust's Equality Performance

We continue to work in partnership with our NHS provider trusts in relation to the EDI work we do across the city.

Details of the Leeds NHS provider trust's EDI work and associated reports can be found in the website links below:

Leeds Teaching Hospital NHS Trust: www.leedsth.nhs.uk/about/trust/equality-diversity/

Leeds Community Healthcare NHS Trust: www.leedscommunityhealthcare.nhs.uk/about-us-new/equality-and-diversity/

Leeds and York Partnership NHS Foundation Trust: www.leedsandyorkpft.nhs.uk/about-us/equality-and-diversity/

Insight, communication, and involvement

Our Insight, Communications, and Involvement Team at the ICB (Integrated Care Board) in Leeds is committed to involving people who are protected by the Equality Act 2010, health inclusion groups and other communities who experiences inequalities.

Examples of the ways we are working in Leeds to understand and involve people with differing needs and promote inclusion, include:

The Leeds People's Voices Partnership (PVP)

The PVP brings together senior involvement leads from across the public and voluntary sectors in Leeds. Together we coordinate involvement activities across the city to put the voice of inequalities at the heart of decision-making.

Our joint working includes the Big Leeds Chat, the Leeds Citywide Public Involvement Network, and the development of the Leeds Involvement library. All these projects are focussed on listening and responding to the voice of inequalities.

You can learn more about our work with the PVP on the Healthwatch Leeds website: (healthwatchleeds.co.uk/our-work/pvp/)

Listening to local people

Over the last year we have been working with the PVP and our partners across the city to ensure that our boards are hearing from local people, acting on what matters to them and feeding back how their views have shaped our decision. The main part of this work over the past year has involved updating insight reports for our population boards.

The insight reports are written in partnership with public and third sector partners and bring together what we already know about the needs, preferences, and experiences of people in Leeds.

The reports include a section dedicated to highlighting what matters to people with protected characteristics. In addition, we have identified additional communities where we want to focus our involvement. These are people who have experienced; homelessness, deprivation, difficulties accessing digital technology, serving in the forces and people with caring responsibilities.

Working in this way enables us to focus the boards' attention on equality issues so that we can 'improve the health of the poorest, the fastest'. You can view all our population board insight reviews on the Leeds Health and Care Partnership website.

A recent example of this work has been our insight review into the experiences of people using language and British Sign Language (BSL) translation services across West Yorkshire. We worked with our partners across West Yorkshire to identify common patient experience themes over the last few years, which included the following:

- People tell us that we need to support greater use of digital technology but ensure that patients are offered a choice.
- People tell us they would like an option to create an audio recording for feedback.
- People tell us that communication needs to be accessible, and the complaints process should be clear to patients and to carers.
- People tell us there are delays to treatment due to a lack of BSL interpreters.
- People tell us that the information technology system needs to record and flag patients' communication needs.
- People tell us that the quality of professional interpreters used is important and that this is consistent – BSL and language interpreters could be trained in medical terminology.

Involvement input to BSL / Interpreting Services Procurement

We have been working with colleagues to provide input to the recent West Yorkshire wide procurement for BSL and Interpreting services, considering and scoring bidder applications on questions relating to involvement and putting what we know matters to people at the heart of these decision-making processes.

Equality, diversity and inclusion and our Pathway System Integration Team

Examples of our proactive work in relation to EDI and health inclusion include, but not limited to:

Children and Young People

Kooth

Kooth is an anonymous online mental wellbeing community which helps children and young people to feel safe and confident in exploring their concerns and accessing mental health support whenever they need it.

Delivered in partnership with the NHS, Kooth is a free service, 24 hours a day, 365 days a year and is available to anyone between the ages of 11-18, and in some areas, it extends up to age 25.

Kooth does not require a GP or school referral. There are no waiting lists or thresholds to meet. Anyone wishing to access Kooth services just needs to register with an anonymous username and support can be accessed immediately.

Inequalities and Children and Young People's Mental Health

Kooth has been working in partnership with the Centre for Mental Health and recently launched an interactive map and report highlighting the stark disparities in children and young people's mental health in the UK.

Children's chances of having good or poor mental health are shaped by the places they live in and the support available there. This new map tool enables schools, health services and local councils to understand the mental health needs of the children and young people they serve.

You can access the Centre for Mental Health map using this link and read the full report Mapping the mental health of the UK's young people (Kooth and Centre for Mental Health)

The new map tool is intended to support the provision of targeted and preventative support, accounting for wider issues linked to poor mental health, such as racism and racialised inequalities and poverty.

In relation to Leeds the map shows:

- Rates of school absence in the UK by local authority - Leeds: Absence among pupils in 2022/23 (% of half days missed): 7.63%
- Rates of mental health and other needs - Leeds: Primary school pupils with social, emotional, and mental health needs as primary Special Educational Needs and Disability category (%): 2.1
- Rate of suicide among children and young people (per 100,000): 6.6 for Leeds. Metric used: Suicide rate per 100,000 10 to 24 year olds in 2018-2022.

Ethnicity Data for children and young people using Kooth in Leeds:

Between 1st November 2023 - end of October 2024, **19.2% of new registrations** (total registrations were 2,237) **were from ethnically diverse service users.**

- **6.2% Asian / Asian British**
- **6% Mixed Ethnicity**
- **4.6% Black & Black British**
- **2.4% Other ethnic groups**
- **5.7% non-stated**

Kooth adapts their engagement and involvement approach to support health inequalities work and seldom heard groups. Health inequalities and Core20+5 is something they always consider and focus on in their engagement work.

For example:

- In relation to schools, they always make sure they are reaching out to those in more deprived areas or with a high percentage of free school meals.
- In recognition that young Muslims are more likely than young people of other faiths to struggle with their mental health due to factors like Islamophobia and stigmas around mental health, Kooth released a brand-new series of articles on kooth.com to support young Muslims, all of which were co-created with a group of young Muslims.
- Kooth hold Talks (webinars / training for professionals and parents / carers) and Kooth Klass (sessions for children and young people) throughout the year on a range of themes such as: Breaking the Mental Health Stigma in the Muslim Community and Why supporting diverse and seldom-heard students is more important than ever.

'Time for Young People, Leeds'

'Time for Young People Leeds' is a new service designed to deliver community-based early emotional and mental health support for children and young people in Leeds, with a particular focus on children and young people aged 11-25 who need support outside of school or NHS services settings.

'Time for Young People, Leeds' is available for children and young adults up to 18 years old, including care leavers and young people with special educational needs and disabilities up to age 25, as well as their parents and carers.

Time for Young People, Leeds, offers evidence-based therapeutic services for a range of common mental health difficulties, including mild to moderate anxiety and depression. These include weekly wellbeing drop ins, one-to-one structured support, group work, wellbeing resources and information, awareness raising and education, and support for professionals working with young people.

Time For Young People Leeds commits to reducing health inequality, through community engagement, while empowering individuals and communities, ensuring that interventions are culturally appropriate, and addressing both the medical and social determinants of health through proactive systems change lens. The service focus is to progress toward closing the gap in health disparities and building healthier, more inclusive communities.

The current top five themes being shared by children and young people accessing the service are: **anxiety, anger, stress, trauma, and sleep.**

Night OWLS

Night OWLS is an overnight listening service which covers the whole of West Yorkshire, including Leeds. It forms part of NHS England's Long-Term Plan, which says that by 2023/24 every single area in England will have a 24 hour, 7 days a week age-appropriate crisis service for children and young people. Night OWLS has been running for over three years now.

Night OWLS aims to offer emotional health and wellbeing support and strategies, and is open to children of any age, young people, and parents/carers. Night OWLS works collaboratively with services in local areas, to offer support as close to home as possible and proactively sign posts into local areas.

Night OWLS embraces the Leeds Survivor-Led Crisis Services ethos, to support children, young people and parents/carers using the Carl Rogers, person centred approach combined with a trauma informed approach.

Over the last six months they have provided emotional support to a small number of children (2%) aged between 5 and 11 who have approached the service.

The Culturally Diverse Groups (CDG) that have been supported by Night OWLS over the last 12 months are:

- Mixed Black/White Caribbean
- Mixed Black/White African
- Mixed Asian/White
- Asian Indian
- Asian Pakistani
- Black Caribbean
- Black African
- Chinese

CDGs are under- represented in relation to using the service and the aim is to encourage more children, young people, parents / carers to reach out and use Night OWLS.

The top five themes being shared by CDG are: anxiety/fear, depression, family issues, lack of support and emotional pain.

#BlackBoyJoy

GIPSIL, a voluntary sector organisation in Leeds was formed in 1992 as “Gipton Supported Independent Living”. GIPSIL works with children, young people, and families in Leeds to realise their potential.

GIPSIL recognised that young people from culturally diverse communities in the most deprived areas of Leeds were disproportionately accessing Social Emotional and Mental Health Support (SEMH) across all GIPSIL services from school-based to outreach provision.

Subsequently GIPSIL began working with Marvina Newton and Black Lives Matter Leeds in 2022 to build on the Speak Up Leeds, Black Boy Joy insight work that had taken place at Carr Manor

School. Together, they developed a programme that could be taken to schools across Leeds that provided a platform for Black boys.

Since 2022 they have delivered six groups at Allerton High School, two groups at Co-op Academy Leeds and are starting to work with Leeds City College. During this time, they have also worked with a group of 17-year-old care-leavers and unaccompanied asylum seekers in their supported accommodation.

From February 2024, GIPSIL have been working closely with the school's senior leaders, identified black allies across the staff team, as well as community leaders, parents, and Black boys, to co-produce and deliver #BlackBoyJoy #SpeakUpLeeds in Co-op Academy Leeds.

The programme aims to empower young black and ethnically diverse students by addressing racial trauma and fostering resilience through creative expression and systemic change. The project utilises a holistic approach, engaging students, educators, and the wider community to co-create a more inclusive and supportive school environment.

Their vision is to create an environment where Black boys can thrive, express their identities, and experience unmitigated joy and success. Their mission is to advance racial equity and build resilience by providing culturally responsive education, mentorship, and community support.

The programme included various co-production sessions with Co-op Academy Leeds. including a workshop with senior leaders, an assembly with 80 black boys, a co-production session with teaching and pastoral staff, identified black allies and a community and parents evening with a presentation, conversations, and cultural food.

Cancer

Prostate Awareness

The North East and Yorkshire region has the highest percentage (20.1%) of men in England who are diagnosed with prostate cancer too late to be cured.

Statistically Black men are twice as likely as those from other ethnicities to be diagnosed with prostate cancer in their lifetime, with one in four black men affected.

Despite this increased risk, work carried out by Unique Improvements on behalf of the Leeds Cancer Population Board showed that awareness of symptoms remains patchy within the black community, and that black men are more likely to be diagnosed with the disease at a later stage and to die of it as a result.

To help tackle this inequality the Cancer Population Board provided additional funding to Unique to help to tackle the barriers to early diagnosis for black men.

As early diagnosis is reliant on primary care, the first stage of the work was to carry out focus groups and insight gathering with the target populations, which shaped the content of a series of webinars for clinical and non-clinical GP staff held in November 2024. These webinars sought to

describe the barriers to men accessing GP services when they had symptoms or they were worried about their risk of prostate cancer, and to identify ways in which these barriers could be overcome. For instance, by offering different routes to accessing primary care, by increasing cultural awareness of staff and by myth-busting in relation to diagnostic and treatment pathways.

Following on from this work there is a plan to present findings at GP TARGET events (training events for GPs) in the New Year and then to run a public awareness raising campaign (working title ‘love your prostate’)

Prior to commencing the public campaign there will be engagement to better understand the lived experience of men coming forward for diagnosis, to test existing materials and to provide case studies to support the campaign.

The campaign will take place in Wortley, Armley, Belle Isle and Middleton, and Chapeltown and Harehills. These areas have been selected due to their diverse populations and due to their differing levels of involvement in previous prostate awareness work, enabling the board to have a clearer idea as to which approaches work best in which circumstances

Complex Needs

Complex Needs - Leeds Small Supports

More than 2,000 people with learning disabilities and/or autism are in inpatient units in England, according to NHS figures.

The Transforming Care programme aims to improve the lives of children, young people, and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.

In Leeds we have been creative in identifying bespoke solutions to address this need. Over the last couple of years, we have worked with Leeds City Council to develop small support organisations, creating change in the local market with a new way of commissioning.

The purpose of this model is to provide support to people with a learning disability and autistic people who have experienced long stays in mental health hospital, through a service designed around the person, enabling them to live a healthy and fulfilling life outside of a hospital setting.

Human rights, equality, diversity, and inclusion are the foundation of small supports and as such the organisations stick with the person through good times and difficult times; they build trusting, respectful and reliable relationships with the person they support and with each other.

What are Small Supports?

Small Supports organisations provide support through a service designed around an individual. This bespoke support enables people to have their health needs met as well as their wants and wishes fulfilled.

From the first steps the person (and their chosen family and friends) has as much control as possible and there is a commitment to this control growing.

The starting point to developing great support is the person's aspirations about where they want to live and the life they want to have; conversation about support then follows from this.

Supporters (staff) are recruited by and around the individual. They don't work across services. Staff are not a substitute for friends, community peers, co-workers, and neighbours.

People choose where they live and who, if anyone, they live with. People are the tenant or owner of their own home or perhaps live with family. There is a clear separation of housing and support.

Funding is sustainable and is designed and used around the individual.

Small supports organisations stay with people. Change and challenges are expected so they don't withdraw support or 'sell' services on.

In their work, leadership, recruitment and actions, small supports organisations are rooted in their local community.

The organisations stay relatively small. Knowing each person well means not growing by more than three to five people a year and finding a natural size where people are known and valued, and the organisation is financially sustainable.

Small supports organisations are developed around these practices. Taking some of these practices and making them aspirations within large, segregated services will not deliver the desired outcomes.

This link to the NHS England Homes not Hospitals web page shares a film called Homes not Hospital. The video tells the story of Mark, who was supported by Leeds small support provider, Unique Support Solutions, to return to community to live a rich and fulfilling life after many years in hospital.

Long Term Conditions

Access to dementia diagnosis

NHS England monitors dementia diagnosis rates for all NHS Integrated Care Boards and areas. Using this information, our work in Leeds includes an annual check on whether the population diagnosed with dementia reflects the ethnic diversity of the Leeds older population.

We also have a contract with Touchstone Leeds, a voluntary sector organisation, which includes the co-ordination of the Leeds Black and Minority Ethnic (BME) Dementia Forum, and dedicated support to people and carers of diverse south Asian origins.

Since this community-focused work started in 2012, Leeds has seen more ethnically diverse people diagnosed with dementia. The diagnosis rate did reduce during the COVID pandemic, however our monitoring shows that the increase in the diagnosis rate since 2021 has included people from diverse ethnicities across Leeds.

A level of variation expected in relation to dementia diagnosis, because some ethnically diverse populations are younger, when compared the White population and because health inequalities affect dementia prevalence across different population groups.

Ethnicity data, following work that took place during 2023/24 shows that Leeds has improved the coding of ethnicity in primary care, with fewer ‘unknown / not stated’

The data we have does show that people of Chinese origins are one of the population groups perhaps underrepresented in the diagnosed population.

The Memory Support Workers (Alzheimers Society service, commissioned by the ICB in Leeds and Leeds and York Partnership NHS Foundation Trust) report significant progress with the “Lychee Red” Chinese Elders’ group, which meets at Beeston Village Community Centre.

There are now local service leaflets translated into Hong Kong Chinese, and one of the Memory Support Workers has attended several meetings and presented in both English and Chinese with one of the group volunteers translating.

Frailty - Injuries and falls

Our injuries and falls programme linked to frailty is a priority programme for us in Leeds.

Following a review of data on falls and frailty in the city analysis indicated that falls rates were higher in more deprived areas of Leeds with Armley, York Road, Burmontofts, Harehills and Richmond Hill identified as areas with a high rate of admissions for falls and injuries.

Working with Local Care Partnerships several workshops were held in Armley, York Road and Burmantofts, Harehills and Richmond Hill areas working with local communities with the aim of reducing falls in the older population.

The project has a specific focus on inclusive access to services and social activities in the community; aiming to support older people to feel stronger and more confident and improve health and wellbeing.

The initial focus of the work has been in the Armley, and York Road areas and the programme has brought people and local organisations together within these communities from across the local care partnership including from local third sector organisations, neighbourhood networks, primary care, community health care, adult social care, housing, and local community groups.

This work is ongoing and takes a life course approach and will report in Spring 2025 with several areas identified for more targeted work and support, including:

- Supporting increased access to transport to attend falls, strength and balance classes, activity programmes and local lunch and social clubs.
- Increase number of/and access to reviews of medication and bone health assessment.
- Increase menopause education and awareness - impact on bone health
- Support around have better access to funding for housing adaptations:
- Increase awareness and support around alcohol harm reduction and hoarding.
- Work together to provide more consistent pathways of support from hospital to community
- Increased awareness of falls pathways within primary and community care.
- Improved support to care homes - a trial of care home risk assessment guidelines is underway which will inform the development of a standard training offer to care homes to support falls risk assessment, prevention and management.

Further work with people with lived experience and the local community is planned to inform a more targeted approach within these communities to inform an implementation plan during 2024/25.

Pulmonary Rehabilitation and Cardiac Rehabilitation Reducing Health Inequalities

Our programme of work supports the West Yorkshire approach to long term health conditions and personalised care. The robust partnership working arrangements between Leeds Community Healthcare NHS Trust (LCH) and Active Leeds, hosted by Leeds City Council, has enabled both a home exercise programme and targeted community programme to actively promote that people can remain as independent as possible with access to a menu of personalised interventions, which includes knowledge, skills, and confidence to help manage their needs/ symptoms more effectively.

Work that has been in development over the last two years has focused on reducing health inequalities and aligns with the Leeds city's ambition where, "Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest."

Pulmonary Rehabilitation

LCH have an established Pulmonary Rehabilitation (PR) programme run by specialist healthcare professionals. Classes are currently held at four venues across the city and have a virtual offer of PR for those patients unable to access the venues and promote self-management by promoting the use of the MYCOPD app.

Active Leeds works with LCH and jointly delivers Pulmonary Rehabilitation with the Physiotherapy Team in four venues across Leeds. In addition, Active Leeds offers free structured lower-level intervention classes (Targeted Community Programme) via a health coaching programme across eight leisure centres in Leeds with a wide menu of activities across local communities.

The Targeted Community Programme is delivered in areas where there are gaps in provision across the city. In some circumstances, the gaps are in areas of high deprivation in areas such as Beeston, Bramley, Chapeltown and Seacroft.

By delivering activities in these areas and where possible ensuring they are culturally sensitive, this will improve access to people with those communities, especially those from underrepresented populations such as those from diverse cultural backgrounds and females.

Cardiac Rehabilitation

Our programme of work aims to increase uptake and accessibility to cardiac rehabilitation in Leeds, striving towards the 85% target set by NHS England.

Home Exercise Programme (HEP)

Active Leeds became involved in this piece of work, early 2024. An Active Leeds Exercise Specialist delivers a HEP two days per week as a part of their duties. LCH have trained two staff from Active Leeds to deliver home visits as a part of HEP. There currently have been 131 patients seen at home by the Active Leeds Team. This has increased the capacity of the Physiotherapists to work on more complex patients. From those patients visited by Active Leeds 32 have built their confidence to start the 12-week activity programme delivered in Active Leeds venues and another 5 have started the Active Leeds Strength and Balance Programme as a part of their rehabilitation.

Cardiac rehabilitation is also part of the Targeted Community Programme. There are parts of the city where there are gaps in provision especially in the more deprived communities and there has been much collaboration with system partners to further understand how interventions can be offered to address people's needs. Areas include Beeston, Bramley, Seacroft and Chapeltown as with PR. There is also a Wharfedale Cardiac Club (peer support group) run by people with lived experience with a system partnership approach to share knowledge and learning.

The Home Exercise Programme provides people who are unable to get out of their homes or with mobility issues to access cardiac rehabilitation in their own home. This is a city wider offer but provides a service to those with the greatest need that otherwise would be excluded from any face-to-face offer.

Data for both the heart and lung programme 12-week programme over the last five months shows:

- Just under 400 people have been part of the programmes
- Double the number of men have participated in the programmes compared to women
- The programmes are most popular with people in the 65-74 age group.

The Targeted Community Programme is aiming to improve and increase access from underrepresented populations and will continue to do this as the programme develops in the areas highlighted. Furthermore, interventions have shown that there is a growing number of people receiving interventions in IMD areas 1 and 2.

Overall, the benefits for both the PR and CR programmes, creates more capacity within the Leeds Community Healthcare Physiotherapy Team to focus their work on more complex and complicated patients who would otherwise have a much longer wait to be seen, improving the outcome for the patient. There is also an opportunity to share learning (have access to shared records and other joint resources) across the services and to be fed into the Leeds/ West Yorkshire Health and Care Partnership and learning shared nationally.

The programmes continue to develop the targeted community offers that are co-produced with local communities and voluntary sector to ensure the activities support local people and are culturally sensitive.

For further information regarding the impact of the Home exercise programmes please see the Current evaluation for the service

Healthy Adults

Basis Leeds

Basis Yorkshire, based in Leeds, is a specialised organisation that provides outreach support women and non-binary individuals working in the sex industry. The organisation's primary goal is to empower these individuals to make safer and healthier choices by offering information, support, and options, and advocacy.

Key Services and Approaches

Support Services: Basis Yorkshire offers safety information and support to female and trans+ sex workers in Leeds, as well as girls and young women experiencing sexual exploitation.

Health Services: They provide advocacy and access to sexual health services, as well as support for physical and mental health needs.

Housing Assistance: The organisation supports service users with housing-related issues by connecting them with the relevant housing services.

Training and Education: Basis Yorkshire produces educational materials and offers accredited training, workshops, and events for professionals working in related fields.

Impact on Service Users

The impact of Basis Yorkshire on its service users is multifaceted:

- **Empowerment:** By providing information and support, Basis Yorkshire empowers individuals to make safer and healthier choices
- **Stigma Reduction:** The organisation works to challenge stigma and inequality of access to services for all their service users.
- **Advocacy:** Basis Yorkshire advocates for women's right to work more safely, while also supporting those who are sexually exploited to be safer and free from harm.

- **Tailored Support:** Their services are designed and delivered in close collaboration with the women and young people they serve, ensuring that their voices and experiences are at the centre of their work.
- **Holistic Care:** By addressing all aspects of their service users' lives - from sexual health to housing and mental wellbeing - Basis Yorkshire provides comprehensive support.
- **Safety Enhancement**: Through their work, they aim to create a safer environment for sex workers and those at risk of sexual exploitation

By focusing on these areas, Basis Yorkshire strives to make a significant positive impact on the lives of vulnerable individuals in Leeds, helping them to navigate challenges, access necessary services, and work towards safer and healthier futures.

Solace Leeds

Solace is a Leeds-based charity that provides specialised and tailored support and services to refugees and asylum seekers in Leeds (and Yorkshire). Their work focuses on improving the mental health and wellbeing of individuals who have often experienced trauma, persecution, and exile.

Key Services:

Therapeutic Support: Solace offers a range of therapies, including:

- Individual psychotherapy
- Group stress management sessions
- Pain management programs
- Family therapy

Cross-Cultural Approach: Their therapeutic work is cross-cultural and often involves the use of interpreters to ensure effective communication,

Expertise Sharing: Solace has developed e-learning courses to share their knowledge with professionals working with refugees and asylum seekers across the UK.

Impact on Service Users

- **Mental Health Improvement:** Solace provides over 3,000 hours of therapy to more than 250 people annually, helping alleviate suffering and improve emotional wellbeing
- **Empowerment:** Their services empower clients to navigate the challenges of adapting to a new cultural context while dealing with the UK asylum process
- **Reduced Isolation:** During challenging times like the COVID-19 pandemic, Solace's support has been described as a "lifeline" for many clients, helping to combat feelings of isolation and abandonment.
- **Increased Understanding:** Solace's work helps clients better understand their situations and rights, reducing anxiety stemming from lack of information or language barriers.

- **Wider Impact**: Through their e-learning initiatives, Solace has reached over 1,700 professionals across various sectors, enhancing the capacity of other organisations to support refugees and asylum seekers effectively.
- **Advocacy**: Solace advocates for their clients' needs, including supporting with housing and welfare appeal processes when necessary.

By providing these comprehensive services, Solace plays a crucial role in supporting some of the most vulnerable individuals in society, helping them to heal from past traumas and build more stable lives in their new communities.

The West Yorkshire Community Chaplaincy Project (WYCCP):

WYCCP is an organisation that focuses on supporting individuals who have been in prison, aiming to support them as they transition back into the community and addressing the other factors that impact on health inequalities.

Services Provided

Mentoring and Resettlement Support: WYCCP offers mentoring and resettlement support for people leaving prison and their families.

Transition Assistance: The team acts as a "scaffolding" that supports service users through the transition from prison to stability in the community. This support can be adjusted based on the individual's progress or problems.

Practical Help: Community chaplains assist ex-offenders with various practical needs, including:

- Securing accommodation
- Managing money
- Obtaining benefits
- Accessing foodbank vouchers
- Acquiring furniture and clothing
- Accompanying them to appointments

Impact on Service Users

- **Addressing Immediate Needs:** WYCCP helps address pressing concerns of ex-offenders, such as housing, mental health issues, and substance abuse problems, access to primary care services.
- **Preventing Re-offending:** By providing comprehensive support, the project aims to prevent re-offending and help ex-offenders reintegrate into society
- **Emotional Support:** Community chaplains offer crucial emotional support during the challenging transition period from prison to community life.
- **Holistic Approach:** The project takes a holistic approach to supporting ex-offenders, addressing various aspects of their lives to promote successful reintegration.

In summary, the West Yorkshire Community Chaplaincy Project provides crucial support to ex-offenders, helping them navigate the challenges of reintegrating into society and working towards reducing recidivism through practical assistance, mentoring, and emotional support.

Leeds GATE

Leeds GATE (Gypsy and Traveller Exchange) is an organisation that provides targeted support for the mental health and wellbeing of Gypsy and Traveller communities in Leeds and West Yorkshire.

Key Services

Mental Health Support:

- One-to-one targeted mental health support
- Caseload management for individuals with mental health needs
- Expanded services to cover West Yorkshire with support from the West Yorkshire Integrated Care Board

Holistic Approach:

- Address various aspects of wellbeing, including practical needs like accommodation and benefits
- Offer emotional support and advocacy
- Provide spaces for community members to share skills and build confidence

Cultural Competence:

- Services designed by and for Gypsy and Traveller communities
- Staff with lived experience of the community, enhancing trust and engagement

Impact on Service Users

- **Improved Mental Health:** The targeted support has helps community members manage and recover from mild to moderate mental health issues.
- **Increased Awareness:** Work has been done to reduce stigma around mental health within the community and increase understanding of available support.
- **Enhanced Access**: By providing culturally competent services, Leeds GATE has improved access to mental health support for a community that often faces barriers to mainstream services.
- **Holistic Support:** Addressing various aspects of wellbeing has helped service users manage multiple challenges simultaneously.
- **Community Trust:** The use of staff from the community has built trust and encouraged more people to seek help.
- **Expanded Reach:** The extension of services across West Yorkshire has allowed more community members to access support.

- **Visibility of Issues:** The project has helped make the mental health challenges faced by Gypsy and Traveller communities more visible to the ICB and wider region.
- **Hope and Compassion:** Service users have reported feeling a sense of hope and experiencing compassion, which are crucial for engagement and recovery.
- **System Change**: Leeds GATE's work is not only supporting individuals but also working to change systems to better serve Gypsy and Traveller communities in the long term.

Leeds GATE's work in health and wellbeing is addressing critical needs within a community that faces significant health inequalities. Their culturally sensitive approach and focus on both individual support and systemic change are having a meaningful impact on the mental health and overall wellbeing of Gypsy and Traveller communities in the region.

Mental Health

Transformation of Community Mental Health Services

As we continue the Transformation of Community Mental Health services, equality diversity and inclusion continue to be at the heart of all considerations across the whole Mental Health programme. Some recent examples include:

- Transformation has seen the emergence of Community Mental Health hubs. These hubs aim to enable access close to people's communities, they are aligned to local care partnerships (LCPs) and are designed to meet bespoke local population needs. Targeted new investment into Voluntary, Community and Social Enterprise (VCSE) organisations, and particularly grassroots organisations/groups, has been an underpinning strategic investment approach to reaching previously underserved communities. This approach aims to improve provision of bespoke and culturally competent care and support offers within communities, to improve equalities in access, experience, and outcomes.

- Leeds Community Foundation and Forum Central have partnered with the ICB in Leeds to deliver the Transforming Mental Health Grants programme, engaging local Community Organisations in Leeds. Guidance to underpin the delivery and targeting of the transformation grants funding has been developed. This has been directly informed through lived experience involvement and activity, and engagement with 109 third sector organisations/ community groups in Leeds to understand how we can better serve people within the scope of Community Mental Health Transformation. People with lived experience have additionally been directly involved in the decision-making process and represented through the grants award process as panel members. At a celebration event stakeholders heard the immense impact on people with complex needs through strengths-based approaches - this will be captured through the end of grant reports, a toolkit for organisations and a film.

- People with complex and enduring mental health need are one of the plus groups within the national Core20PLUS5 programme to reduce health inequalities. Improving access to

Physical health checks is one of the identified clinical areas within the Core20PLUS5 programme that require accelerated improvement and is also a key requirement within the community mental health transformation programme. This is in response to the significant inequality of premature mortality for people with serious mental illness. Leeds continues to perform well on the NHS England requirement. We have increased and tested more targeted support for those not accessing physical health checks, including introducing pilots of primary care-based roles and outreach provision. We have undertaken an evaluation of the pilots tested which concluded key recommendations for targeting resources to areas with higher population cohorts with severe mental illness, utilising a range of personalised communication and contact methods, longer appointment times, and ensuring tailored approaches to health checks including availability of home visiting options. These will be taken forward in further mobilising the new model of care.

High Intensity Use Service (BARCA Outreach Support Team)

Barca Outreach Support Team (BOST) started in November 2015 to support people who are having frequent contact and presentations to urgent and emergency healthcare services. The team works with people who are 'high users' to identify the impetus behind their attendances and to support them with these aspects. BOST use a navigator model, providing flexible, intensive support.

The main aim of the service is to support and improve the wellbeing of these identified individuals, working with them to create a parity between the self-management of their physical and mental health needs. The majority of people supported by the service live within the most deprived parts of our city.

Navigators visit people in their home or in the community where they may feel most comfortable exploring the underlying reasons behind their frequent emergency visits. This assessment aims to explore the biopsychosocial aspects such as living environment, social isolation, financial situation, substance misuse or unmanaged mental or physical health, which may be contributing to their frequent use of service.

This approach helps to strengthen and build a therapeutic support relationship, providing a trauma-informed response to the person's needs. This is particularly important when working with people who may have been supported by several different services and organisations during their lives and can sometimes feel let down by the support that they have previously been offered.

Taking the time to focus on establishing and building trust in the support provided is a vital element of the BOST model.

The team ensure that the focus of support is not always on the challenges that people may be experiencing, but also on wellbeing and enjoyment. This is an important aspect in broadening the person's identity and developing the therapeutic support.

Developing a person's health literacy is a crucial part of the team's work. Using a strengths-based practice they support people to self-manage care of their physical and mental health, educating about the health and social care system helping them to navigate and engage with appropriate primary and secondary health care services, and discuss other specialist providers and organisations in Leeds.

With the consent of the individual, BOST then works with them and other relevant organisations across Leeds to support any identified unmet needs. This includes services such as: primary and secondary care, addiction services, community mental health support, housing support, welfare and benefits services, support for people who are sex working, peer support and other groups to reduce social isolation, and other specialist organisations.

Equality, diversity and inclusion and our Primary Care Team

Our primary care team continue to promote EDI, health inclusion and initiatives.

People with a hearing loss or impairment:

Our primary care team have continued to work with the DEAForum to understand what changes they would like to see put in place in GP practices to improve their experience of engaging with primary care services. We are also working with BID Services to better understand the needs of and provide support to Deaf patients.

BID is a voluntary sector organisation that provides a range of specialist services for Leeds residents who are d/Deaf, hard of hearing, sight impaired, severely sight impaired or deafblind and their family/ carers.

In order to effect positive change, we:

- have streamlined the scheduled booking services provided by Language Empire making booking an interpreter easier for practice staff. This has included raising awareness of the services available.
- are developing NHS App training with BSL interpretation

Translation and Interpretation

The commissioning of interpretation services within primary care (GP Practices) has been identified as an opportunity to collaborate at scale across places at West Yorkshire to reduce duplication, maximise funding and provide consistency.

The identified benefits of this include:

- Demonstrates joint commissioning across West Yorkshire – potentially paving the way for further collaboration of services/with other providers
- Opportunity to collectively improve service provision and address patient and provider feedback re service delivery

- Fewer providers to access on behalf of their patients
- Reduce duplication in service provision
- Provides opportunity for working at scale
- Provides opportunity to access wider range of providers

Over the last year primary care commissioning, contracting, communication and engagement colleagues have worked together to explore and progress a joint procurement of interpretation services.

Involvement and Engagement Leads across all places produced an insight report pulling together an understanding of the experiences, needs and preferences of patients and carers accessing interpretation services across West Yorkshire. A West Yorkshire wide Equality Impact Assessment was also completed. Both documents were used to heavily influence the development of the service specification and evaluation questions that have been used in the procurement.

In addition, input into the service specification and evaluation questions was received from clinicians, Health Improvement and the West Yorkshire Healthwatch colleagues who have all provided valued feedback which to further shape the service specification. This involvement will continue throughout the procurement process and mobilisation.

The tender closes on 11 November and the new provider of services will be awarded the contract in January ahead of go-live on 1 April 2025.

Adaptive Action Workshop (Healthy Communities Together) (HCT)) Accessing Interpreting and Translation services in Primary Care.

The workshop focused on the needs of asylum seekers and refugees who experience some of the most severe health inequalities and therefore the poorest health outcomes long term.

The session aimed to take a whole systems view, to see where the strongest partnerships can be formed and make lasting change. The purpose of the session was to explore the experiences of different stakeholders in accessing interpreting and translation services in a primary care setting and to gain a greater understanding about the issues being faced by our communities, with a view to how we can commission and deploy language support more effectively.

Extended Access

GP practices are required to deliver services during their core hours of 8.00am– 6.30pm Monday to Friday. From 1st October 2022, Primary Care Networks were required to deliver an Enhanced Access Service over and above core hours. At minimum a PCN must provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays. The Practices work together to provide a wide variety of services. This Enhanced Access offer contributes to the improvement of patient access to primary care.

In Leeds 16 of our 19 PCNs continue to sub-contract the Enhanced Access service to the Leeds GP Confederation. Three PCNs provide this service themselves. These services are tailored to population need and offer a combination of virtual and face to face services.

Each PCN also offer a proportion of planned and same day service responses as part of this access model. PCNs deliver services working in collaboration with providers including Physiotherapy, Mental Health, Medicine Optimisation, Social Prescribing to review and hone their models of service to meet health needs of their population.

Advancement in service provision ensures the PCNs work with the Leeds GP Confederation to provide proactive care preventative care. This includes offering NHS Health Checks, the successful integration of Cervical Screening in 17 PCNs and LARC (Long-Acting Reversible Contraception) to service models in 11 PCNs. In addition, childhood vaccination and immunisations have been piloted in one PCN.

This recognises that members of the population cannot always attend for preventative and screening care during traditional core hours and opens a wider menu of choice to enable attendance opportunities.

Working with refugees, asylum seekers and migrant communities

Our primary care team work closely with colleagues in Leeds City Council to support families residing in hotels following their arrival in the UK. During 2024/25 this work has continued, and the following information provides an update on the services being implemented throughout the year

In relation to the Interim Hotel Accommodation Service, Bevan Healthcare continue to provide bespoke health services to individuals and families residing hotels following their arrival in the UK.

In respect of mental health and wellbeing, Solace, who provide free counselling, psychotherapy and advocacy in the Yorkshire and Humber region to the survivors of persecution and exile, provides 1:1 intervention and family interventions and a range of services through 2 practitioners within the hotels, including group sessions, gender specific groups and individual support.

Solace also developed additional support materials, for example, audio and video tools to offer direct support to individuals and families in managing stress and other low level mental health issues and translated audio and video psycho education tools for refugees and asylum seekers who arrive in Leeds and West Yorkshire.

WYICB is in the process of completing mapping exercise of current mental health provision for asylum seekers and refugees across all places, to facilitate improvements in meeting the mental health and wellbeing needs of vulnerable migrants, and to understand what support or additionality could be provided by West Yorkshire Inclusion Health Unit.

The mapping exercise aim to improve the promotion of good mental health and wellbeing, prevention of mental health issues occurring as well as putting in place interventions for those requiring more specialist support for their mental health.

General Practice Outcomes Programme

Across Leeds we have a local enhanced service entitled “General Practice Outcomes Programme (GPOP) which aims to deliver specific outcomes for our populations. Our GPOP contributes to our work in relation to health inclusion.

Our Primary Care Health Inequalities Scheme (now included in General Practice Outcomes Programme (GPOP) has improvement targets for all practices:

- Smoking - Record Smoking Status
- Smoking – Offer Brief Advice
- Smoking – Refer to Stop Smoking Service
- Alcohol – Increased number of AUDIT-C Screening.
- Alcohol – Offer Brief Advice
- Increase Number of Carers Registered
- Record Ethnicity of 95% of Registered Patients
- Record First Language of 95% of Registered Patients

Safer Surgeries

Safe Surgeries aim to remove barriers faced by many in relation to accessing healthcare and ensure inclusive general practice for communities.

We have asked all practices to be signed up to Safer Surgeries by April 2025.

Our current position is:

- 66 Practices have signed up Safer Surgeries and we are aiming for all practices to be signed up by the end of the 24-25 year.
- 100% of PCNs across Leeds have at least one practice that is accredited by the Royal College of General Practitioners to be Veteran Friendly
- Overall, 60% practices who are veteran friendly
- 24 Practices noted as Pride in Practice accredited on the Pride in Practice Website

Cervical Screening

With the aim of improving cervical screening across all the diverse communities in Leeds, cervical screening letters have been translated (audio and written) into several languages. These include Romanian, Polish, Urdu, Portuguese, Arabic, Tigrinya, Kurdish, Punjabi, Bengali, Czech, French, Spanish, Lithuanian, Italian, Slovak and the BSL video with English subtitles.

Gypsy, Traveller, Roma communities

Following merger of Fountain Medical Centre and Morley Health Centre we are carrying out a mapping exercise to ensure patients still have choice in relation to registering with a GP practice and to ensure that there is equity of access for the traveller community in that area.

Accessible Information Standard (AIS) and Reasonable Adjustments (RA) Digital Flag

Our Data Quality Team are working on clinical system templates for AIS, RA and Digital Inclusion, to make them more user-friendly for Practice staff, to include flagging, pop-ups, reporting for review communication preferences, referral letters etc.

In early 2025, NHS England is launching a refreshed version of Accessible Information Standard (AIS). Along with this, they are introducing a self-assessment framework to help organisations evaluate their progress and plan improvement regarding AIS. Leeds has been selected as a pilot area, giving a unique opportunity to test this framework and provide feedback on its effectiveness.

Healthwatch Leeds is leading on the project to review, input and offer feedback on the framework. Colleagues across the ICB in Leeds, along with other stakeholders in Leeds, has been invited to take part in the pilot project for the AIS Self-Assessment Framework.

Primary Care Network (PCN) Projects

All PCNs continue to work on various schemes and projects to improve equality, diversity, and inclusion.

The following information provides a brief overview of the work in Burmantofts, Harehills and Richmond Hill (BHR) PCN as an example of multiple projects that are taking place:

- **Severe Mental Illness (SMI)-** working in collaboration with Touchstone and the recovery team from LYFPT we provide a gym session twice week dedicated to SMI patients only.
- **Physical Health Checks** - all practices continue to prioritise physical health checks for people with a learning disability and people with SMI with continued improvement in the overall number of checks undertaken.
- **SMI non-engagers** - the Population Health Management Hub (HPMH) Team provide an outreach service for SMI annual reviews. For patients not engaging we will do a home visit to check contact details and if patient consents, we do an annual review. If no answer, then a letter is left asking patients to contact practice to make an appointment and update contact details.
- **Public Health Mental Health Team -** run and/or attend community events/venues, for example women's health events, Bevan asylum seeker monthly events and provide hypertension case finding. The team also run hypertension educational sessions

Equality, diversity and inclusion and our NHS Continuing Care Service

Choice and Equity Commissioning Policy Improving our Approach to Best Value Care

The All Age Continuing Care Service (AACC) service has a statutory duty to break-even financially. Therefore, when making decisions about commissioning services, it must balance a range of factors including individual choice and preferences, quality, safety, and value for money.

Throughout this process, the service must recognise the need to achieve best value in its use of financial resources, in order that it can share limited NHS resources equitably across all patients for whom it has commissioning responsibility. It can do this through carefully considering the offer that is made available to each person.

The Choice and Equity Commissioning Policy when used with the Commissioning Principles aims to support the AACC Services in each of the five places of the West Yorkshire ICB to deliver fair and efficient use of public money and to support places to commission safe, affordable, and high-quality local provision working with partners across the ICB and the local authority.

In addition, it will assist in ensuring that the information we provide is clear, accessible, and up to date, that staff have clear direction, policies and standards underpinning the service and the service has robust governance arrangements.

Of key importance is that all people being assessed receive equitable and comparable, high quality, consistent experience regardless of their age, sex, ethnicity, gender identity, religion or belief, sexual orientation, or disability.

The underpinning commissioning principles which will be used by staff and published on our website with translation available in multiple languages. An Easy Read version is in development for the New Year.

Key indicators are being developed by the ICB to ensure that the impact of the policy is measurable and equitable across all areas and these measures will form part of the quarterly reporting. In addition to this we are working with system providers to ensure that the equality monitoring is captured at point of referral to enable accurate reporting of key indicators.

Equality, diversity and inclusion and our Medicines Optimisation Team

Stopping the overmedication of people with learning disabilities or autism or both

‘STOMP’ is an acronym for Stopping over Medication of People with a learning disability, autism, or both with psychotropic medicines. (These are prescribed drugs that affect the mind, emotions, and behaviour by changing how the brain works).

A national health campaign was introduced in 2016 to stop the over-use of psychotropic medication to manage people’s behaviour and has been identified as a priority in the NHS long

term plan. The STOMP programme aims to improve the quality of life of people with a learning disability (LD) and autism or a learning disability alone by reducing the potential harm of inappropriate psychotropic drugs by having a specific STOMP medication review.

Psychotropic medicines are used to treat mental health conditions. It is estimated that on an average day in England between 30,000 and 35,000 people with a learning disability, autism or both are taking prescribed psychotropic medication without appropriate clinical justification. This is medication which results in alterations to perception, mood or consciousness. Long-term use of these medicines puts people at unnecessary risk of a wide range of side effects including weight gain, organ failure and even premature death.

A six-month pilot which started in August 2024 across two primary care networks (PCN), West Leeds and Seacroft is being collaboratively led by the Leeds and York Partnership NHS Foundation Trust (LYPFT) Mental Health Pharmacy Team and LYPFT Community Learning Disability Team (CLDT).

The ICB in Leeds is providing medicines optimisation expertise for the project to facilitate integration into primary care. Phase 1 for the PCN pharmacy team will focus on those patients who are currently on a psychotropic drug without a documented indication on their medical record to ensure the appropriateness of the drug. A STOMP template was created on the GP systems for the STOMP review to take place was created and allows pharmacists to send advice guidance to LYPFT requests for further help and advice.

Chronic Kidney Disease (CKD) Project – PCN led approach

Kidney disease does not affect everyone equally in the UK. There is a complex and unequal distribution of risk factors across people's life course and across stages of kidney disease.

Social deprivation, ethnic background, gender, mental health, age, and geography are all factors that affect the risk of developing kidney disease, how the disease progresses, treatments and outcomes. These factors often interact with each other, and it can be difficult to untangle the association between them. The research summary is presented in the infographic (source). These research findings support targeted approaches in population health management of kidney health.

Two of the selected four PCNs include areas of IMD1 (Source). Seacroft and Burmantofts/Harehills/Richmond Hill (BHR) PCNs have Index Multiple Deprivation (IMD) decile score of 1, and where prevalence and or complications of CKD are higher and connect to the ICB's Leeds place-based multimorbidity work.

Reducing unwarranted kidney health inequalities must become everyone's responsibility. To achieve this, clinicians, renal services, the wider renal community in the UK and policymakers need to think disruptively and create their own opportunities to change the system.

This joint working initiative with Astra Zeneca, aims to reduce progression of chronic kidney disease (CKD) and adverse cardiovascular outcomes for people living with CKD (with or without

Type 2 diabetes). The pilot project focuses on people living in most deprived areas of Leeds who are culturally diverse, specifically those whose genetic and diet predispose them to higher risks of diabetes, CKD and cardiovascular events, where traditional access to health system is a barrier.

Kidney disease is more likely, progresses faster, and is associated with earlier death amongst people from more deprived backgrounds. It also progresses faster in people from Black, Asian and UK minority ethnic populations, who are also less likely to receive a transplant. Women are more likely to get kidney disease, but men are more likely to start dialysis. Older people are less likely to receive a transplant.

The project recognises the disparities and is trying to address some of these inequalities. It is piloting an integrated approach to care, focusing on delivering better care closer to home.

The aim is to upskill PCN pharmacists and nurses in CKD management, in order to improve diagnosis and self-management, to optimise standard care, including the addition of the SGLT2-inhibitor drug (dapagliflozin). The project team has sourced wide range of information in foreign languages to support the work.

The PCNs are being supported by the PCN diabetes specialist pharmacists, and consultant nephrologist as well as a kidney nurse to help with education, guidelines, and more complex patients.

Optimal Lipid Management

This is one of the five key clinical areas in relation to health inequalities. In 2024, we continued our Soar Beyond project and System Transformation Fund (STF) Lipid Optimisation Project, both of which started in 2023.

The main goal to upskill primary care colleagues to transform lipid optimisation in GP practices and PCNs. Our data suggested that there was a higher proportion of patients with cardiovascular disease (CVD) and non-optimised lipids levels from the most deprived areas compared to the least deprived areas (CVDPrevent, 2022).

CVDPrevent is a national primary care audit that automatically extracts routinely held GP data covering diagnosis and management of six high risk conditions that cause stroke, heart attack and dementia.

In line with the CORE20PLUS5 approach, both projects engaged GP practices and PCNs from Leeds in areas with IMD score of 1.

Soar Beyond project was funded through a successful bid with NHS England's National Lipid Programme Workforce Support. Six PCNs in Leeds were involved (Burmantofts, Harehills and Richmond Hill; Beeston; Middleton and Hunslet; Seacroft; Cross Gates; West Leeds).

The evaluation of this nine-month project was completed by Soar Beyond in August 2024 with following results:

- It increased lipids competencies of the PCN workforce (80% compared to 58% at baseline).
- It improved patient access to clinical pharmacy lipid appointments (343 targeted review appointments per week).
- It alleviated GP pressure in respect of the Addition Roles Reimbursement Scheme (ARRS), which is a program in the NHS that funds new roles in primary care to improve access to general practice. (100% of PCNs had local lipid protocol in place compared to 17% at baseline).
- 100% of PCN adopted national lipid pathway and improved access to new lipid lowering therapies.

The STF Lipid Optimisation Project was another successful bid with NHS England, led by Leeds Place for West Yorkshire ICB between March 2023 to August 2024. An integrated lipid multidisciplinary team service (primary and secondary care clinicians) was set up by Leeds Teaching Hospitals NHS Trust to support participating PCNs through clinical leadership and a new electronic advice and guidance pathway. In Leeds, the participating PCNs were Burmantofts, Harehills and Richmond Hill; Beeston; Middleton and Hunslet; Seacroft; Bramley, Wortley, and Middleton.

According to CVDPrevent CVDP007CHOL indicator, which measures the percentage of patients with CVD and a blood cholesterol level that meets target in the previous 12 months, for Leeds most deprived area, the percentage of patients with cardiovascular disease (CVD) treated to lipid target increased by 10.79%.

Chronic Obstructive Pulmonary Disease (COPD) Project

COPD is highlighted as a key clinical area in the CORE20PLUS5 approach. We are working with Interface Clinical Services through the donations and grants route via Glaxo Smith Klein Plc. to implement care optimisation in COPD by pharmacist-led COPD clinical reviews across all practices in Leeds (April 2024 to March 2025).

The project targets high-risk COPD patients to help reduce clinical complications or unplanned admissions; to assess and proactively manage patients with COPD through optimisations of pharmacological and non-pharmacological therapies, including referrals to smoking cessation, vaccination and pulmonary rehabilitation programmes.

Leeds Scabies Case Study – Leeds Health Protection

In April 2023, a scabies outbreak was detected in Leeds, particularly affecting families in deprived areas with high health inequality, such as Harehills, Burmantofts, and Richmond Hill.

Primary Care data and surveillance reports confirmed an increase in cases in these areas. A response was coordinated with local partners to overcome barriers related to healthcare access, limited awareness, and socioeconomic challenges. This included:

- Expanding the Leeds minor ailments scheme (Pharmacy First) to include scabies treatment for unregistered patients.
- Coordinating with NHS England and Department of Health and Social Care to address stock shortages.
- Providing training to 51 local professionals to improve community awareness and access to care.
- Sharing communications with local stakeholders, including third-sector organisations, to boost awareness.
- Supporting families with laundry facilities and essentials to help control infection spread.

The team continues to monitor scabies cases, support care homes with treatment guidance, hold regular review meetings, and update primary care prescribing data every six months to ensure proactive response to potential outbreaks. Additionally, there is a focus on broader pest issues such as bed bugs and head lice, identified as ongoing community concerns.

Equality, diversity and inclusion and our Safeguarding Business Unit

An example of our proactive work in relation to EDI and health inclusion include:

Our Safeguarding Team works together with many organisations across Leeds to contribute to improving outcomes for children, young people, and adults at risk.

This year our Safeguarding Team has supported both the citywide self-neglect and serious youth violence consultations. Including professionals, service users, and their families was a primary focus of the consultations to provide the opportunity to hear the views of all our diverse communities.

Our Safeguarding Team actively promoted the serious youth violence **“share your voice”** consultation, led by the West Yorkshire Violence Reduction Partnership (VRP) across the Leeds health economy.

The consultation included a variety of inclusive approaches to encourage engagement and during the three-month consultation views were sought from people who lived in communities experiencing serious violence, people with lived experience of serious violence including victim and or survivors, and parents and carers, as well as the views front-line staff.

National data shows that black and mixed heritage boys are more likely to acquire a criminal record, have interrupted education training and employment, and potential disruption to the wider family.

The Designated Nurse for Safeguarding Children represents the health economy at the Leeds City Council Serious Violence and Organised Crime Board (SVOC) ensuring health economy engagement. SVOC Board activity this year has included the identification of and strategy planning to address racial disproportionality and serious youth violence in the city.

Additionally, each of the Population Health Boards is linked to a member of the safeguarding team to support the Leeds Health and Wellbeing Strategy ambition for Leeds to be a 'healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

NHS Equality Delivery System 2022 (EDS22)

The NHS England Equality Delivery System 2022 webpage provides more detailed information about EDS22:

Leeds NHS organisations continue to work in partnership in relation to the EDS22 Domain 1: Commissioned or provided services and we continue to provide peer support for Domain 2: Workforce Health and Wellbeing; and Domain 3: Inclusive Leadership.

We use EDS22 across Leeds and the wider West Yorkshire Integrated Care System to:

- Assess our performance in addressing our equality, diversity, and inclusion (EDI) priorities.
- Provide opportunities for stakeholders to analyse our performance data and input into that assessment.
- Assist with identifying our EDI priorities for the future.
- Provide opportunities to work in partnership to deliver and assess those priorities consistently

In relation to Domain 1, which assesses equality performance for commissioned or provided services, WYICB and NHS providers are required to engage, assess, develop, and deliver an improvement plan for three services each.

In 2024 across West Yorkshire, it was agreed each place would take a partnership approach to focus improvements on specific clinical pathways:

- Palliative and End of Life Care
- Cancer (Early Diagnosis)
- Suicide Prevention

In collaboration with Leeds NHS providers, we chose to review services around Palliative and End of Life Care (PEoLC) to:

- Respond to recent findings from local and national patient and carer feedback including the Peoples experiences of end of life care report by West Yorkshire Healthwatch and the Parliamentary and Health Service Ombudsman report End-of-life care: improving 'do not attempt CPR' conversations for everyone
- Support EDI improvement work with Leeds Palliative Care Network

It should be noted that the EDS22 is a review of a sample of services delivering care within the pathway, not a review of the whole pathway.

Within the Palliative and End of Life Care (PEoLC) pathway, the following services have been sampled across Leeds in our EDS22 assessment for 2024:

- Respiratory End of Life Care (EoLC) (ICB in Leeds)
- Children's Community Nursing (LCH)
- Homeless Health Inclusion Team (LCH)
- Neighbourhood Nights (LCH)
- Cancer Service (LTHT)
- In-hospital Palliative Care Team (LTHT)
- Dementia Wards (LYPFT)
- Care Homes Team (LYPFT)
- LTHT Easy Read material in the Learning Disability Team
- LYPFT Functional Ward

An initial peer review was held in November where we were joined by representatives from Leeds NHS provide trusts, third sector and Leeds Palliative Care Network to review the service-specific self-assessments and to consider previous patient, carer, and community insight alongside provider and population data to identify what is already known about the EDS22 outcomes in PEoLC and what gaps/improvements these identified.

The EDS22 process and scoring so far has evidenced that there are many strengths in the way PEoLC is delivered to marginalised groups at risk of inequity. The peer review identified opportunities for learning across services and partners to embed these strengths more consistently.

The EDS22 process has also helped the NHS in Leeds to identify the several areas for improvement and subsequent actions across the PEoLC pathway. Whilst recognising all the suggested actions are key to addressing the areas for improvement that have been identified, a collective proposal, across the NHS in Leeds, has been reached to prioritise the following actions for 2025:

- Improving data collation and analysis

- Cultural competence, building on the 2023 focus in relation to Children and Young People Mental Health Services and Maternity Services.

- Increasing and using feedback from groups and communities who experience inequalities, barriers to accessing services and are seldom heard.

Leeds NHS organisations are currently undergoing a period of further engagement with partners and communities to identify:

- any other strengths or gaps that groups were aware of
- whether the initial peer review fits with their knowledge of the palliative and PEoLC pathway for groups at risk of inequalities
- what the priority actions should be and how the proposed priorities fit with their work/priorities for the next year
- how we would continue to engage with those groups and coordinate any shared work

Leeds NHS engagement with partners and communities will be completed by the end of January 2025, which will enable us to finalise our priority areas for improvement in relation to PEoLC and subsequently meet the mandatory requirements associated with EDS22. This means we must publish our evidence and priorities/objectives on WYICB website and submit them to NHS England by 28 February 2025.