INSTITUTE of HEALTH EQUITY

FAIRER, HEALTHIER LEEDS: REDUCING HEALTH INEQUALITIES

INTRODUCTION

A growing number of people are living in poverty and with worse health in Leeds, West Yorkshire. This is the result of continuing impacts of reduced funding for local authorities in England, pressures related to the increasing cost of living, and the lingering effects of the COVID-19 pandemic. Meanwhile, the demographic characteristics of Leeds are changing, affecting how the city must plan its future services: the city's population is growing in every age band and becoming more ethnically diverse, particularly in areas of high deprivation.

To better tackle health inequalities in the city and enable Leeds to maximise its opportunities, the *Fairer, Healthier Leeds* programme[1] was launched in June 2023. This report draws on learning from the programme's first year and provides a short analysis of health inequalities in Leeds, recommends action to reduce them and ways to improve the social determinants, or building blocks of health.

Since the programme's inception, the Institute of Health Equity has identified several excellent approaches and examples of good partnership working in Leeds, and this is to be built upon. However, Leeds can go further. A whole-system 'Marmot Leeds' approach that develops and delivers interventions and policies to improve health equity based on the Marmot principles requires:

- **A** — **Strengthening and further developing the current system to one in which all partners work collaboratively to improve the building blocks of health and tackle health inequalities.**
- **B** — **System leadership for health inequalities within and across system partners with clear lines of accountability, along with strengthened workforce capacity.**
- **C** — **Strengthening partnerships to have an ambitious, collegial and trusting approach to improving the building blocks of health and to be bold in adopting a proportionate universalist approach to the design and delivery of actions and in their resourcing.**
- **D** — **Shifting funding to longer-term and primary prevention approaches, in line with a health equity in all policies approach.**
- **E** — **Ensuring those acting to reduce inequalities work with communities to identify how best to improve the lives and health of those living in the most deprived neighbourhoods in Leeds.**

By placing an even stronger strategic focus on health inequalities and inequality more broadly, Leeds will be better positioned to tackle these problems and reverse the impacts of COVID-19, inflation and the rising cost of living. This requires that all partners work collaboratively, prioritising health equity and strengthening the whole 'health equity system'. Without steadfast commitment to action, Leeds like many other locations in the UK, may witness inequalities worsening faster and further.

[1]The Fairer, Healthier Leeds programme is led by the Public Health team, with political support from the executive member for equality, health and wellbeing and the executive member for adult social care, active lifestyles and culture.

THE IHE METHOD

The building blocks or the social determinants of health, describe the social and environmental conditions in which people are born, grow, live, work and age, which shape and drive health outcomes (1) (2). There are eight Marmot principles to reduce health inequalities based on shaping these determinants:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention
7. Tackle racism, discrimination and their outcomes
8. Pursue environmental sustainability and health equity together.

A **Marmot approach** develops and delivers interventions and policies to improve health equity based on these eight principles; it embeds health equity approaches in local systems and takes a long-term, whole-system approach to improving health equity. A Marmot approach is **proportionate universalist** – that is, it applies policies to all but with services and support increasing at a scale and intensity proportionate to the degree of need. The aim is to raise overall levels of health at the same time as flattening the gradient in health. (2) ***Only focusing on one group of individuals or a few geographical areas will not deliver change.***

In our first year in Leeds, to help deliver this whole-system approach, IHE, in partnership with the city's public health team and other stakeholders:

- Analysed health outcomes and data related to the building blocks or social determinants of health (e.g. housing, education).
- Reviewed existing city approaches to tackling health inequalities by making a 'health equity' assessment of its strategies, policies and programmes.
- Mapped community insights aligned to the eight Marmot principles.
- Focused on two key priorities: Best Start (for children aged 0–5 years) and housing, meeting key stakeholders delivering these services and holding two workshops.
- Developed health equity indicators to measure progress.
- Created **Fairer, Healthier Leeds Marmot recommendations** to challenge Leeds to focus on the system changes needed to comprehensively address health equity and embed health equity and fairness in decision-making. The recommendations focus on actions across organisations: Leeds City Council, businesses, public services, communities and community organisations and health and social care.

This report addresses three key areas in turn: leadership and accountability, partnerships and research/data. Evidence of inequalities in Leeds is provided in data packs on the IHE website, alongside the Fairer, Healthier Leeds Marmot recommendations, full indicator set and other related publications. (3)

Leeds is now part of the **Marmot places network**. (4) Marmot places commit to making a more concerted and focused effort to address health inequalities. This involves identifying leaders to improve understanding of health inequalities across stakeholders and committing to consistently hold the city system accountable for tackling inequalities.

THE LEEDS CONTEXT

Leeds is a city of over 820,000 residents. Its population is growing and is poorer than the England average: 24% of its population live in the most deprived decile, IMD 1,[2] compared to 10% of England's population living in this decile.

Leeds targets many of its services and approaches to reduce inequalities based on deprivation deciles, frequently concentrating its action on those living in IMD 1 neighbourhoods. The numbers living in high deprivation in Leeds are increasing: the Office for National Statistics estimates 24% of Leeds' population live in IMD 1 neighbourhoods, increasing from 179,000 in 2013 to 200,000 in 2022. (5) In 2024 37% of children in Reception were living in the most deprived neighbourhoods in Leeds, compared with 34% in 2021. (6)

Life expectancy for all populations in Leeds was stagnating before COVID for both men and women but the most recent figures show that while life expectancy has increased slightly after the worst of the pandemic, wide inequalities remain within the city. Women living in Leeds's most deprived neighbourhoods live, on average, nine years less than women living in the least deprived neighbourhoods; for men, the difference is 10 years (see Table 1). This difference in life expectancy is even greater for certain groups. For example, Gypsy and Traveller communities in Leeds have an average life expectancy close to 50 years, compared with the city average of 78 years.

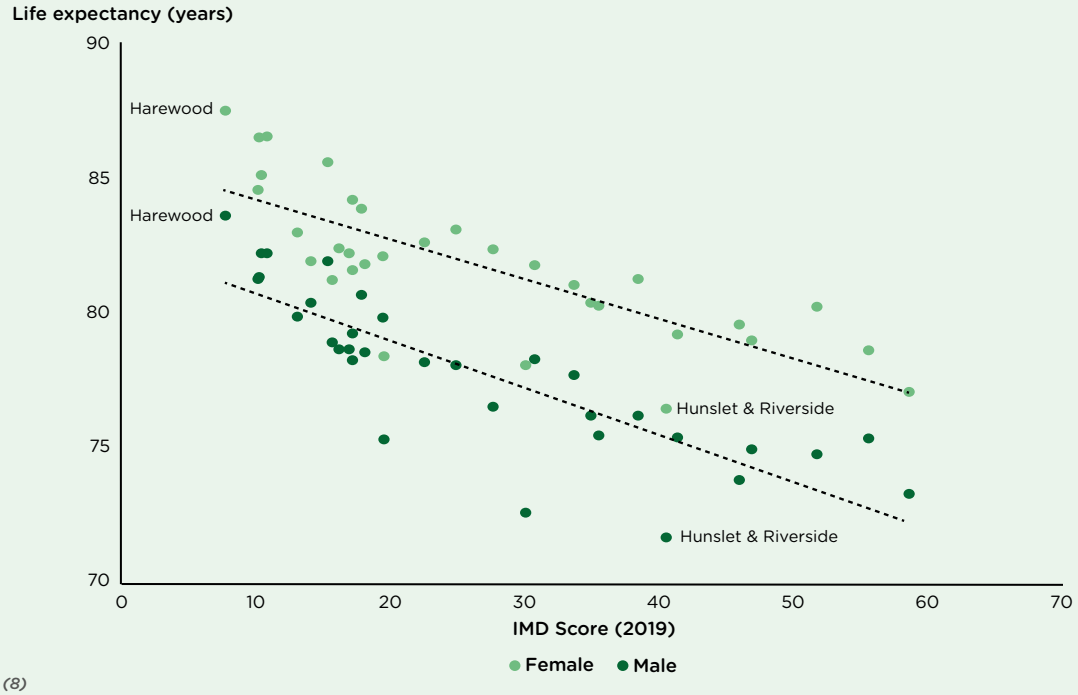
Table 1. Estimated female and male life expectancy at birth, averages for most deprived (IMD 1) and least deprived (IMD 10) neighbourhoods in Leeds, 2019–21 and 2020–22

Source: Office for National Statistics (7)

	2019-21	2020-22
Female IMD1 (most deprived)	77.4 years	77.6 years
Female IMD 10 (least deprived)	87.2 years	86.9 years
Male IMD 1 (most)	72.9 years	73 years
Male IMD 10 (least)	82.9 years	83 years

Figure 1 shows these inequalities in life expectancy clearly: as levels of deprivation increase in Leeds's wards, life expectancy decreases. It can be seen that Harewood is among the least deprived neighbourhoods and has high average life expectancy, and Hunslet and Riverside, the fourth most deprived ward in Leeds, has the lowest life expectancy.

Figure 1. Estimated female and male life expectancy at birth and deprivation (IMD 2019), Leeds wards, 2016–2020



Source: Office for National Statistics (8)

[2]IMD is the Index of Multiple Deprivation (IMD), the most common measure of the socioeconomic circumstances in which people live. The IMD summarises how 'deprived' an area is. Neighbourhoods are ranked from 'most deprived' to 'least deprived'. IMD 1 is the most deprived 10%, IMD 2 is the second most deprived decile and IMD 10 the least deprived.

The Leeds Joint Strategic Assessment and Leeds Observatory provide an extensive analysis of health inequalities in Leeds. (9) (10) These reports outline the significant and persistent inequalities in Leeds across a range of outcomes. Inequalities are evident in health outcomes such as life expectancy and the incidence of low birthweight babies, and in the building blocks/social determinants of health such as earning a 'living wage' and good educational attainment. Leeds compares unfavourably across several measures with other core cities in England. A detailed analysis of health outcomes and data covering the building blocks of health are included in the IHE slide set that accompanies this report.[3]

Leeds has an ethnically diverse population; in particular, the Black/Black British and African ethnic minority population is slightly larger proportion-wise than the England average. (11) The population living in the most deprived neighbourhoods is more ethnically diverse than the rest of Leeds: 63% of the city's Black/Black British ethnic group, 40% of its mixed ethnic group and 36% of its Asian ethnic group live in the most deprived neighbourhoods (in IMD 1). (12)

AUSTERITY PRESSURES

> "These aren't choices Leeds City Council would want to have made."
>
> (Leeds City Council)[4]

> "Systems are under unbelievable pressure."
>
> (Leeds City Council)

The cuts to local government budgets in the last 14 years have hit Leeds City Council hard, and in the last year budget cuts and increasing pressures on the NHS in Leeds have led to shortfalls being forecast for at least the next three years. (13) These cuts, in addition to persistent short-term central government funding settlements (of six months or a year), prevent places from implementing longer-term, preventive approaches that would better enable them to address issues such as health inequalities and increasing poverty.

The **cuts to local authority budgets in England have severely impacted services that are supportive of many of the building blocks or determinants of health** and have been linked to decreases in life expectancy. Between 2013 and 2017, it is estimated that each £100 reduction in annual central funding to local government (per person) was associated with an average decrease in life expectancy of 1.3 months for men and 1.2 months for women. (14) This is worsened by the fact that cuts to local government spending have been regressive: areas of highest deprivation have seen the deepest cuts. Between 2009/10 and 2019/20 the most deprived tenth of councils saw their fiscal revenue per person decline by just under 30%, or £453 per person. In comparison, the least deprived tenth of councils saw their fiscal revenue decline by 16%, £166 per person. (15) In the region **where Leeds is located, Yorkshire and the Humber, spending per person fell by 23%,** significantly greater than the cuts of 15% in the South West. (15) The Institute for Fiscal Studies estimates that councils in England will receive 4% less in real terms in 2024/25 than they might have expected a year ago. (16)

[3]See: https://www.instituteofhealthequity.org/resources-reports/new-marmot-places-work-announced-in-leeds

[4]All quotes are taken from interviews carried out during the first year of IHE's work in Leeds.

SYSTEMS CHANGE TO IMPROVE HEALTH EQUITY

A. LEADERSHIP AND ACCOUNTABILITY FOR HEALTH EQUITY

Strong, accountable and identifiable leadership on health equity within organisations is needed to lead action. Leadership involves giving workforces in different organisations greater capacity to act on the building blocks of health and putting in place measures to hold people accountable for this action. The challenge is to take existing bold statements, strategies and policies and implement the further action necessary, focus staff and approaches to improve healthy life expectancy, and – in Leeds's own words – improve the health of 'the poorest the fastest'. Where bold strategies do not exist, the challenge is to create new ones, in partnership. The Fairer, Healthier Leeds Marmot recommendations we present in this report challenge Leeds to be more specific in setting aspirations to tackle health inequalities and to have clear accountability measures across the city's systems to support delivery of the recommendations.

LEEDS CITY COUNCIL FOR HEALTH EQUITY

> "How do we do health inequalities as a system? We need senior leadership for the city – leaders talking to each other – to create joint accountability, joint budgets, joint posts. When money gets difficult, people retreat."
>
> (Leeds City Council)

Effective leadership for health equity focuses on addressing health equity across organisations and working in partnership. Bringing together housing, economic development, environment, transport, education and culture challenges departments and people to shift their current ways of working. Across Leeds City Council there has been ambitious leadership action to reduce health inequalities.

Scaling up good practice

- Leeds City Council has made a clear commitment to create and sustain healthy and thriving places. Its **Best City Ambition** states that by 2030, Leeds "will be a healthy and caring city for everyone: *where those who are most likely to experience poverty improve their mental and physical health the fastest*, people are living healthy lives for longer, and are supported to thrive from early years to later life". (17) The contribution of the Leeds Health and Care Partnership (HCP) to the health and wellbeing strategy is delivered through the **Healthy Leeds plan**. This also places inequalities centrally within its plans; its vision is for a "healthy and caring City for all ages where people who are the *poorest improve their health the fastest*". (18)
- In April 2023 Leeds City Council **increased its minimum pay rate to the UK Real Living wage** of £12.00/hour, above the central government-set UK living wage. The City Council also committed to pay the national minimum rate of pay for apprentices, above the national recommended rate. (19)
- Leeds is one of about 20% of council areas in England to have a **Selective Licensing (SL) scheme**, which aims to improve the management and condition of properties in the private rented sector. SL requires all private landlords in a selected area to obtain a licence for each property they rent out. The licence has conditions by which a landlord has to abide during the period of the scheme, which can be up to five years. The Scheme also requires that an applicant for a licence has to be considered a "fit and proper person" to hold a licence.
  - > Parts of Beeston and Harehills, densely populated areas of Leeds, are covered by the SL scheme. Landlords pay £825 per licence. Homes are inspected and up-to-date gas safety certificates are required, along with electrical appliances and furniture. The scheme also includes a discussion with tenants where information about health and the building blocks of health are collected.
  - > The current SL scheme in Leeds is due to finish in 2025. In 2023 Leeds's Public Health team offered to work in partnership with Leeds City Council Housing team to support an evaluation of the current scheme to understand its impact on health and inequalities. The evaluation provided evidence of the impacts of SL processes on health and inequalities. A 2023 evaluation of SL in London found improvements in area-based mental health outcomes and reductions in antisocial behaviour. (20) In March 2024 the Council's Executive Board approved the consideration of further SL schemes in Leeds. Any further SL schemes, if approved, will build on the lessons learned and involve better partnership working with health as well as evaluation built-in from conception.

- Leeds's local approach to **temporary accommodation** has meant it has kept these numbers low compared with other areas, improving the support it offers and saving the council money. Across the UK, the lack of private rented sector housing is increasing pressure on temporary accommodation. Leeds's approach involves speaking to people who need temporary accommodation at the earliest opportunity: ***"We're proactive to opening cases at the earliest time to help to prevent homelessness. When there are a few cracks, that's when we want to talk to people."*** To keep temporary accommodation lists small, they fund specialist advice to people in need, provide funding for bonds in the private rented sector and a rent guarantee scheme for landlords where they guarantee tenants for 12 months. A fundamental difference to other cities is that Leeds gives customers who are rehoused in the private sector the option to remain on the Leeds Housing Register.

  > The rate of people living in temporary accommodation has increased in Leeds in the last two years although the numbers remain far below England averages. In 2022 there were only eight families in temporary accommodation; in June 2023 there were 66 families, with some in B&B accommodation. Recent data shows the highest number of households in temporary accommodation on record. (21)

Unified leadership across Leeds can go further to identify goals for the short and long term, and identify when, for example, 'task and finish' groups are needed (such as existing Breakthrough groups – see below) or when longer-term partnerships are better.

- The **Health and Housing Breakthrough Group** is made up of Leeds City Council, NHS and Third Sector partners. This group was initially established as a short-term task and finish group. However, due to its successes, it has now become a formally established strategic partnership. In its first few months the group mainly discussed actions related to housing and respiratory conditions in children. Despite the positive aspects, interviewees also spoke of the desire for this group to be ***"more strategic"*** and to identify ***"longer-term goals"*** and opportunities for ***"joint commissioning, or combined commissioning and joint budgets"***.

HEALTHCARE SYSTEMS FOR HEALTH EQUITY

Recent policy changes, such as the requirement for Integrated Care Boards (ICBs) to address health inequalities, has led to health equity and the building blocks of health being of central concern for the NHS. Leeds NHS Boards can strengthen and focus their strategies on the building blocks, working in partnership to extend activity beyond usual anchor approaches. In addition, primary care in Leeds can better support action to reduce inequalities by working to improve local living and working conditions, being a strong advocate and working with individual patients to improve the building blocks of health.

Scaling up good practice

Several groups and strategies in the NHS in Leeds are addressing inequalities. There is value in consolidating this work and clarifying the role of each.

- The **Leeds Health and Social Care Hub**, a new partnership between national and local government, seeks to address and improve action on health inequalities and improve health and life outcomes for Leeds's residents.
- The **Tackling Health Inequalities Group** was set up in June 2020. The group provides expert advice on health inequalities related to healthcare services and recommends how NHS funding on inequalities should be spent and challenges where health inequalities funding goes.
- The **Communities of Interest Network** highlights the needs and challenges faced by groups and communities that experience the greatest inequalities.
- The **Leeds Out of Hospital (OOH) project** was awarded recurrent funding in 2023/24 and offers short-term intensive support to rehabilitate people who are homeless with a long-term health need/reablement need, through nine beds in temporary housing units. It is managed by a multi-disciplinary team (a clinical lead – nurse, GP, housing worker, dedicated social work time, and wellbeing workers). The project supports people to move to permanent accommodation. It has reduced A&E attendance for those who have completed their journey and been discharged from the temporary housing units, and has reduced unplanned admissions. Between April 2022 and April 2023 all patients who were homeless were discharged into either local authority tenancies, private rentals or to a nursing home.

The NHS in Leeds can go further to address health inequalities. Across England, NHS organisations are looking at what they can do within their own buildings and among their staff, using NHS data to look at how they can reduce inequalities. For example, this can involve looking at 'did not attend' rates for services according to level of deprivation (as measured by the IMD) and ethnicity, and taking small, clear actions, such as redesigning letters to improve clarity, and shifting times of clinics. This involves leaders and senior managers listening and considering the urgency of change, and including people from the places and communities suffering from avoidable ill health to allow them to "influence how services are organised…for radical change, not small tweaks or business as usual". (22)

Primary prevention delivered in partnership with the NHS and partners outside of health is needed to reduce inequalities. As part of its action to reduce inequalities, the Leeds Health and Care Partnership has concentrated on reducing the number of Emergency Department attendances and inpatient stays among children with asthma. This is a welcome city-wide partnership approach to addressing health inequalities; however, its action still focuses on secondary prevention of health problems after they have occurred. A primary prevention approach in Leeds would focus more on working across the city's IMD 1 neighbourhoods, bringing together key partners to reduce the likelihood of health problems starting. With regard to children and asthma, a primary prevention approach would involve working with partners such as housing providers, communities, schools, nurseries and the Third Sector to better support the families of children likely to develop this condition. **Addressing the causes of the causes, improving these building blocks of health – the social determinants – is needed to reduce inequalities at scale**.

Better focusing on primary prevention to reduce health inequalities involves **adopting a proportionate universalist approach**. Long-term funding should be allocated to organisations that are working in Leeds's most deprived neighbourhoods to achieve improved and more equitable outcomes in the building blocks of health, including investments for communities and the Third Sector and shifting to recurrent, dependable funding.

Primary care in Leeds can go further by working better with the NHS and other partners to take more action on the building blocks of health. Primary Care Networks (PCNs), with their budgets and workforce capacity (especially link workers), have the potential to better tackle health inequalities. Leeds PCNs commission Linking Leeds to provide social prescribing in the city. Social prescribing can tackle health inequalities but it needs to be targeted at areas of higher deprivation and be given time to work with clients and do more than refer. Interviewees stated that **social prescribing has further potential to address health inequalities** but requires more innovative commissioning and service redesign. In addition, the primary care system should monitor and reduce the risk of inequalities widening in **Leeds's inner-city areas of high deprivation due to the difficulties of recruiting staff in these areas**.

BUSINESSES FOR HEALTH EQUITY

The IHE report *The Business of Health Equity: The Marmot Review for Industry* examined the ways in which businesses shape the conditions in which people live and work and, through these, their health. (23) Businesses affect the health of their employees and suppliers through the pay and benefits they offer – hours worked, job security and conditions of work. They affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held. Three-quarters of the estimated 413,000 people who work in Leeds work in the private sector.

Businesses can also affect the health of individuals in the communities in which they operate and in wider society, through local partnerships, procurement and supply networks, and in the way they use their influence through advocacy and lobbying. Reducing the harmful impact of business and enhancing their positive contribution is vital for health and wellbeing and reducing inequalities.

Scaling up good practice

- **The Leeds Health and Care Talent Hub** works to get people living in areas of high deprivation or who have been out of work for a long time back into work in health and care organisations in the city. This work is based on **Connecting Communities with Health and Care Careers (CCHCC)**, a city-wide partnership that aimed to reduce health inequalities. CCHCC targeted specific communities to work within the health and care system. This collaboration between Leeds City Council and Leeds Teaching Hospital Trust (LTHT) and local charity *Learning Partnerships* initially supported residents in Lincoln Green through a recruitment and employment programme to improve IT skills, build confidence and support with job application and interview skills. (24) (25) The Talent Hub has transformed into a wider partnership between universities, the Third Sector, City Council and NHS in Leeds. It has developed pre-employment programmes to meet Leeds's health and care workforce needs, providing a pool of potential employees. In 2023/24 it supported more than 1,600 candidates living in Leeds's most deprived neighbourhoods. The largest proportion came from Black, African, Black British and Caribbean ethnic groups and were aged between 18 and 35 years. The vast majority were unemployed and female.

Three Leeds anchor networks and an inclusive growth strategy are examples of how the system in Leeds is seeking to improve equality.

- The **Leeds Business Anchors Network** encourages businesses to work together, alongside other partners in the city such as the City Council, to maximise their contribution to benefit the people of Leeds. This Network also encourages businesses to adhere to the city's Inclusive Growth Strategy.

- The **Leeds Inclusive Anchors Network** is a group of 13 of the city's largest, mainly public sector employers. They focus on areas where they can make a difference for people as an employer, through procurement, service delivery or as a civic partner. As part of this network, the NHS has assessed its role as an anchor institution and committed to leveraging its position as employers, purchasers of goods and services, owners of local buildings, land and other assets and leaders in the community to effect change.

- The **Leeds Community Anchor Network** is a movement of independent local organisations promoting citizen-led activity and partnerships. In addition to their own activities, Community Anchors help and support other groups and communities, and act as advocates at a city level.

Leeds City Council has taken a number of steps to understand how to improve equity in the city. **The Leeds Inclusive Growth Strategy** signals that the city wants a different style of growth, one that focuses on good health and opportunities for its employees on lower incomes as much as on all other employees. (26) It is a signal that businesses can work better with local communities, taking more than a corporate social role to truly work in partnership and be key players in improving the building blocks of health.

The **Leeds Social Value Guidelines and Charter** guide organisations to make changes in the way they work to make Leeds a fairer, more equal place. Leeds commissioned the Centre for Local Economic Strategies (CLES) to drive their inclusive strategy to better reduce gender inequalities. CLES recommends working with women in the city to place **gender equality** at the core of Leeds's economic approach and to create a baseline to measure the impact of interventions. Our Fairer, Healthier Leeds Marmot recommendations for the inclusive growth plan are similar in that we recommend making reducing inequities central to the inclusive growth strategy.

Leeds can take the Inclusive Anchors Network further by encouraging its members to agree to place skills development and local recruitment at the top of their agenda and focusing in the coming year on increasing the opportunities for young people living in IMD 1 and 2 neighbourhoods. This could be achieved by committing to new approaches and partnerships with education, primary and secondary schools, further education, the Third Sector and Leeds Learning Alliance. Improving employment opportunities is key to increasing social mobility, giving local opportunities to local young people. This also necessitates better training, mentoring and interning opportunities and working with employers to provide careers advice relevant to the Leeds job market.

THIRD SECTOR AND COMMUNITIES FOR HEALTH EQUITY

Leeds has an active and respected Third Sector, which is included in many of the city's and NHS's strategies. Building relationships and coalitions with the Third Sector, and with local residents and communities, is key to the success of interventions and policies to reduce health inequalities and improve the building blocks of health. Encouragingly, the majority of the registered charities and Third Sector organisations already have aims to improve the building blocks of health.

Scaling up good practice

Voluntary Action Leeds, the voluntary sector infrastructure organisation, is actively engaged with reducing health inequalities and improving the social determinants of health. In Leeds an additional organisation, **Forum Central**, provides key organisational functions for Third Sector organisations working in health and social care and acts as the collective voice for the sector delivering these services in Leeds. Forum Central is jointly funded by Leeds City Council and the NHS.

- Many Third Sector organisations are working with their local communities to improve aspirations. For example, **CATCH Leeds** is helping young people "reach their full potential". It believes its work is effective because of the collaborative approach it takes with the public sector, Third Sector organisations and the private sector. It states it is able to "join up capacity, resources and service provision around relevant groups that others cannot engage well with, and focus on the needs of those groups". CATCH's funders see their role in the building blocks of health but are often reluctant to fund action because, according to CATCH, "they all see their part of the picture, but not the whole picture and their part in it". CATCH, like many other Third Sector groups, has multiple partners and sources of funding, including: police, fire and ambulance services; schools, colleges, universities and local Cluster teams [see below]; the youth justice service; early intervention practitioners; the armed forces; local authority departments, including Communities, Safer Leeds, Public Health, Parks & Countryside; charities (local and national) and informal community groups and businesses (national and local). (27)

While the **Third Sector** offers a wide range of services in Leeds, there are **further opportunities to provide its organisations with strategic power to tackle health inequalities**. This requires understanding the entirety of the services they offer across the city and communicating the impacts of their work on health inequalities. In 2024 the Third Sector called for Leeds's city leaders to ***"remove process obstacles that hamper operational cross working"*** and asked that:

- resources into areas or communities be pooled to better address health inequalities
- more focus for the city's budgets be placed on areas of higher need
- bureaucracy be reduced in reporting how Third Sector organisations spend their money
- budgets be spent on public sector and Third Sector staff together, carrying out more collaborative working, and delivering "what works".

Leeds can make efforts to work more in partnership with the Third Sector to improve action on health inequalities. In interviews, people gave numerous examples of the Third Sector and communities working together. Many interviewees remembered the trusting relationship that existed between statutory services and the Third Sector during the pandemic and lamented the missed opportunities to build on the cohesive service delivery that happened during that time. In particular, they referred to the list of 'vulnerable residents' created during the COVID-19 pandemic, where many people were identified who were not previously known to any service providers. They suggested this powerful tool and approach to creating the list be resurrected to better coordinate services for this group.

Third Sector organisations are dealing with budget cuts from key funders such as the NHS and Leeds City Council, increasing energy and staff costs, and a drop in charitable donations and volunteers. Across Marmot places, a recurrent theme is the challenge of short-term funding streams; successful services have to close down or spend months dedicating staff time to finding funding instead of delivering services. A smaller Third Sector would have a negative impact on all partners working to reduce health inequalities in Leeds, and increase pressures on the statutory sector. The Third Sector in Leeds acknowledges central government's funding is pushing local Leeds commissioners to think in the short term but it has argued that: "Short-term funding results in a focus on outputs rather than outcomes, encourages people to engage with Third Sector organisations in a less meaningful way, and creates fluctuations in staffing and workflows. Although there is an understanding that central government funding is devolved to our public sector partners with a specific time-frame to spend it, we should continue to work together to explore ways to flex funding streams, so that they are sustained and responsive to local need." (28)

HEALTH EQUITY IN ALL POLICIES

Another way for Leeds to improve its success in addressing health inequalities is by adopting a 'health equity in all policies' (HEIP) approach. Far from being a tick-box exercise, an HEIP approach relies on effective, consistent and committed leadership. It places equity at the beginning of planning processes in services delivered by the council, NHS and key partners. The approach is not a panacea but it is a tool to ensure every policy, strategy and intervention is considered for its equity impact on residents, from where cycle lanes are situated to where trees are planted and take-away planning applications are accepted or rejected, from where nurseries are closed down to where family hubs are created – these are decisions that cumulatively contribute to health inequalities.

For Leeds to take this approach requires additional focused commitment from public health so that the wider Leeds system and its leaders (i.e. Boards and Councillors) are provided with knowledge and inspiration to improve the building blocks of health to help the city's system create, deliver and sustain programmes to support greater equity.

LEADERSHIP AND ACCOUNTABILITY RECOMMENDATIONS

AIM: Increase accountability, ensure action takes place and measure impact

1. Identify named senior leaders who are accountable for health equity in Leeds.
2. Commit to closing the gap in health outcomes as measured by the Fairer, Healthier Leeds Marmot indicators over a five to ten-year period and set out implementation plans to do this.
3. Leaders, organisations and partnerships to adopt a health equity in all policies approach to identify, test and embed processes that deliver health equity across the system.
4. Continue to allocate senior capacity and resource in public health to lead the Leeds health equity approach and maximise the expertise of the wider public health team in planning and delivery.
5. Continue to deliver the inclusive growth agenda with a focus on IMD 1 and 2 neighbourhoods. Leeds City Council to convene partners and anchor organisations to maximise the impact of their work in these areas. Scale up employment and skills training that meets the needs of communities and residents in IMD 1 and 2 neighbourhoods.
6. Leeds health and care partnership to continue to build on Core 20PLUS5 to reduce inequalities in health ensuring action is scaled up to meet the needs of communities in IMD 1 and 2 neighbourhoods.
7. Continue to enable the Third Sector to play a lead strategic role in addressing heath equity and, through fairer funding agreements, to deliver sustainable action on the social determinants of health.
8. Ensure the needs of ethnic minority populations in Leeds are addressed in all citywide strategies to reduce inequalities.

B. EFFECTIVE PARTNERSHIPS FOR HEALTH EQUITY

> "We need ourselves and partners to work in a different way."
>
> (Leeds City Council)

Stakeholders we interviewed in Leeds stated that current partnerships often involve the same people asking similar questions. People from across the system spoke of ***"duplication"*** and the need to ***"have less meetings and more outcomes"***; others spoke of working in ***"silos"*** or ***"little bubbles"*** despite these partnerships. Many spoke of depending on personal relationships rather than a trusting partnership approach that values helping colleagues within their own organisation and beyond.

Lack of governance structures can inhibit partnerships between, for example, the NHS and local authorities and this seems to be relevant in Leeds. One interviewee observed: ***"We have groups of partners coming together and running programmes of work but no link to a formal governance structure. We don't have a clear way to make decisions across the city."*** Partnerships in themselves do not guarantee change: they require clear governance and goals focused on reducing health inequalities.

Scaling up good practice

Leeds is on its way to working better across organisations and services. Partnerships are at the centre of its Best City Ambition and the Health and Housing Breakthrough Group are a blueprint for a more joined-up and strategic approach to tackling inequalities. The Health and Housing Breakthrough Group is a city-wide strategic partnership that focuses on improving housing, one of the key building blocks of health. Based on the achievements of this group, future new partnerships and existing partnerships tackling health inequalities in Leeds should identify specific short- and long-term goals, actively hold partners to account and include a wide membership (e.g. other public services, including schools, transport, housing and regeneration).

Schools and partnerships

- There are **22 'Clusters'** in Leeds providing place-based partnerships to support families, children and young people most in need of help, and all are based in IMD 1 and IMD 2 neighbourhoods. (29) The Clusters include staff from schools, health services, Area Inclusion Partnerships, Early Start teams in children's centres, police, social work, the Third Sector, and other relevant services such as housing. The role of health and public health in the Clusters varies and **no formal evaluation of the work of Clusters has been done**, including if any of them are improving educational attainment or reducing health inequalities.
- The **Leeds Learning Alliance** (LLA) is a network that provides a space for schools to share experiences, support each other and improve outcomes for pupils in the city. Members include many of the same partners present in the Clusters: the police, primary to university education institutions, the private sector, Leeds City Council and the Third Sector. LLA focuses on inclusion and inclusive leadership.
- A whole-school partnership approach, can address health inequalities. Such as approach involves the senior leaders listed above, along with teachers, parents, mental health specialists, inclusion workers and the wider community working together to develop children's essential emotional and social skills. (30) In addition, a whole-school approach can better link Leeds's education strategy with its inclusive growth strategy to help improve social mobility.

Improving partnerships for children aged 0–5

Attendees at our 0–5s workshop in January 2024 stated that the needs of parents and families of children in this age group should be the starting point and that services need to break out of their silo mentalities and work better together. A key theme was the need to better connect services. Many attendees stated it was difficult to find the 'right' people to work with – in education and schools, health, the council and the Third Sector. Many said they did not know exactly what services were offered to 0–5s and that parents also struggled. They called for leadership to facilitate better sharing of information between partners and consequently between families and key stakeholders.

Communities and partnerships

- Leeds has a number of neighbourhood and community approaches. A review in 2021 recommended Leeds adopt a "more holistic, less siloed approach to early intervention and prevention and ways of working to tackle poverty and address inequality especially in the least advantaged 1–10% areas... **Services [need to be] more accountable to and co-produced with communities.**" (31) Interviewees reiterated this point, and also spoke of the need to reduce duplication and better coordinate community approaches, making them ***"more citizen led"*** and to ***"create a clearer narrative for communities"*** with the comment ***"there's lots going on but how does it connect?"***
- **Current approaches**, such as the Leeds Locality Working approach and prioritising certain wards, **lack evaluations specifically analysing their impact on reducing health** inequalities. Interviewees wanted help to create measures ***"to ensure they are on the right trajectory"***. There is an **opportunity here for universities to help Leeds better evaluate** existing and future interventions, including working with the Third Sector in IMD 1 and 2 neighbourhoods to better develop future approaches and understand the impact of these 'bottom-up' approaches.
- Some partnership approaches will require more fundamental reconsiderations because of the duplication in areas and lack of connectivity in others. As one Leeds City Council interviewee stated: ***"We operate on different footprints – ward boundaries, community committee boundaries, local care partnerships, school clusters – all services working to funding footprints. It's not impossible but we haven't cracked how to focus on the person and not the service footprint. We need a person-centred solution."***

EFFECTIVE PARTNERSHIPS RECOMMEDATIONS

AIM: Existing and future partnerships prioritise greater health equity in Leeds

9. Adopt more ambitious health equity goals in existing strategic partnerships.

10. For each Marmot principle, ensure that membership of relevant networks and/or partnerships is broad enough to facilitate actions on the social determinants of health.

11. Working with the Third Sector, involve communities in identifying drivers of poor health and in the design, implementation and evaluation of actions to reduce them.

12. Clarify community approaches to addressing the social determinants of health in IMD 1 and 2 neighbourhoods, including joining up programmes, reducing duplication and scaling up what works.

C. RESEARCH AND MONITORING FOR HEALTH EQUITY

> "We need a stronger research basis with universities – more important[ly] than ever. [Otherwise] how do we genuinely influence what is going on on the ground?"
>
> (Leeds City Council)

> "We don't stop and understand, we don't know what is working and if Leeds are doing it."
>
> (Leeds City Council)

Building the evidence base of what works in Leeds and utilising the range of academic expertise in the city and region are ways for Leeds to improve its approach to reducing health inequalities in the short and long term. **Two existing partnerships have the capacity to accelerate evidence-based action** in the city to improve the building blocks of health:

- The **Leeds Academic Health Partnership** (LAHP) brings together the NHS, Leeds City Council, Leeds Beckett University, University of Leeds and Leeds Trinity University with the aim of reducing health inequalities in the city.
- The **Leeds Inclusive Anchors Network** brings together Leeds's largest public sector employers and the three universities also participate in this network.

It is essential for **both these partnerships to align their broad research agendas** and to provide the capacity for individual researchers and research centres to **study the causes and consequences of health inequalities and approaches to improving the building blocks of health in Leeds**.

Developing research and monitoring for health equity in Leeds and focusing on what works to reduce inequalities involves **collaborating with the individuals and communities** affected by health inequalities in the design and implementation of research. In addition, the Third Sector is a key partner and the LAHP should work more actively with its organisations to explore their role in research to reduce health inequalities and to understand the Third Sector's role in creating an inclusive economy. (32)

The LAHP can help Leeds to better integrate evaluation into interventions and help identify the effective actions that should be scaled-up and those that should not. These efforts should also include data intelligence, to communicate findings to commissioners, boards and residents who want to understand what stakeholders are doing.

Robust, timely, reliable and appropriately disaggregated data covering the Marmot 8 principles and related health outcomes is essential to help evaluate and track the impact of policies and interventions, to identify new and emerging issues and ensure there is accountability for health inequalities.

The **Fairer, Healthier Leeds Marmot indicators** were created in partnership with Leeds. The indicator set is the best available data to assess and monitor action on improving and reducing inequalities in the building blocks of health, factors that affect the early years, children and young people in school, and factors related to work and housing. The indicators are inspired by Marmot indicator sets in other Marmot places: Cheshire and Merseyside, Gwent and Coventry. (33) (34) The Fairer, Healthier Leeds Marmot indicators align with the Social Progress Index (SPI), which aims to understand the impact of the Best City Ambition and inclusive growth strategy.

Health equity in research: rapid mapping of inequalities through resident engagement in Leeds

The public health team mapped recent consultations and engagement work to understand residents' views in relation to the Marmot 8 principles. The aim was to identify gaps in understanding and good practice in hearing community voices to improve the building blocks of health.

The mapping exercise found primary and secondary pupils were frequently engaged by researchers for their views but also identified gaps, which included the views of families with children aged 0–5. Leeds City Council had researched the impact of the cost-of-living crisis and living in poverty but there was less analysis of the impact of housing on health – although the Centre for Ageing Better has reported on the impacts of housing on elderly residents in Leeds.

This quick mapping exercise showed how Leeds City Council can improve its approaches in engaging with communities to better understand the impact of and ways to address health inequalities.

RESEARCH AND MONITORING RECOMMENDATIONS

AIM: Drive more effective interventions and evaluations and collect data on the Fairer, Healthier Leeds Marmot indicators

13. Leeds Academic Health Partnership to continue to have 'reducing health inequalities' as its central focus and to increase activities to facilitate closer working and better understanding of the social determinants of health within the Leeds academic community.

14. Develop the Fairer, Healthier Leeds Marmot indicators and collect data and communicate progress against them.

15. Ensure that the Fairer, Healthier Leeds Marmot indicators findings influence strategic approaches (e.g. Joint Strategic Assessment and Best City Ambition) and delivery of programmes (e.g. Early Years, planning).

The second year of IHE's work in Leeds will focus on supporting the city's response to the recommendations and how it further develops its ambitions to tackle health inequalities and improve the social determinants of health.

FAIRER, HEALTHIER LEEDS (MARMOT CITY) INDICATOR SET

	Leeds Marmot Indicator	Disaggregation	Source
1	Life expectancy at birth in years	Ward MSOA IMD Decile Sex	NHS Digital and ONS
2	Babies with low birth weight, rate per 1,000 live births	Ward MSOA IMD Decile Sex	NHS Digital
3	Percent of children with a healthy weight at reception age (4-5 years olds)	Ward MSOA IMD Decile Sex Ethnicity FSM status	NHS Digital
4	Percent of pupils achieving a good level of development at end of reception	Ward MSOA IMD Decile Sex Ethnicity FSM status	National Consortium of Education Results
5	Percent of pupils meeting expected standards in reading, writing and maths (combined) end of Key Stage 2	Ward MSOA IMD Decile Sex Ethnicity FSM status	Local
6	Average Attainment 8 score	Ward MSOA IMD Decile Ethnicity FSM status	Local
7	Percent of school children who reported feeling happy every or most days	tbc	Leeds My Health My School survey
8	Percent of 16-17 year-olds not in employment, education, or training	Ward MSOA IMD Decile Sex Ethnicity	Local with DfE definitions
9	Prevalence of common mental health issues, recorded by GPs, all ages, directly age standardised rate per 100,000 people	Ward MSOA IMD Decile Sex Ethnicity Age	Local
10	Prevalence of severe mental illness, recorded by GPs, all ages, directly age standardised rates per 100,000 people	Ward MSOA IMD Decile Sex Ethnicity Age	Local
11	Percent of people earning less than UK Real Living wage	Ward MSOA IMD Decile Sex Ethnicity Age	Local
12	Number of households in temporary accommodation	LA	ONS, ASHE Survey
13	Percent of physical inactivity, recorded by GPs, adults 50+ years	IMD decile / MSOA Ethnicity	Local
14	*Households in fuel poverty - annual*	*In development**	*In development*
15	*Workforce by ethnicity (TBC)*	*In development***	*In development*

* Developmental indicator - as a place holder pending the development of WYCA fuel poverty measure.

** Developmental indicator - support the development of this aspirational indicator by reporting current information made available at city level.

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